DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

James Ravindran
Quality Reimbursement Services, Inc.
150 N. Santa Anita Ave., Ste. 570A
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RE: ***Board Decision and Scheduling Order***
Mat-Su Regional Medical Center (Provider Number 02-0006)
FYE: 12/31/2014
Case Number: 17-2027

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the documentation in Case No. 17-2027 pursuant to a jurisdictional challenge filed by the Medicare Administrative Contractor ("MAC"). The Board's decision is set forth below.

Background

On August 4, 2017, the Provider appealed an original Notice of Program Reimbursement ("NPR") dated February 2, 2017 for its fiscal year end ("FYE") December 31, 2014 cost reporting period. The initial individual appeal request contained the following four (4) issues:

1) Disproportionate Share Hospital ("DSH") Payment/Supplemental Security Income ("SSI") Percentage (Provider Specific)
2) DSH – Medicaid Eligible Days
3) Uncompensated Care ("USS") Distribution Pool
4) Two Midnight Census IPPS Payment Reduction

The Board received the MAC's jurisdictional challenge on April 10, 2018, which challenged jurisdiction over Issues 1, 2 and 3, to which the Provider responded on May 4, 2018. On April 26, 2018, Issue 3 was transferred to PRRB Group Case No. 18-0113GC and Issue 4 was transferred to PRRB Group Case No. 18-0112GC. On November 22, 2022, the Provider withdrew Issue 2. This decision addresses the jurisdictional challenge to Issue 1, the only issue remaining in this appeal.

Issue 1 – DSH SSI Percentage (Provider Specific)

In its initial appeal request, the Provider contends that the MAC did not determine Medicare DSH reimbursement in accordance with 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 pursuant to 42 C.F.R. § 412.106(b)(2)(i).

The Provider contends that its' SSI percentage published by the Centers for Medicare and Medicaid Services ("CMS") was incorrectly computed because the Centers for Medicare and Medicaid Services ("CMS") failed to include all patients that were entitled to SSI benefits in their calculation. The Provider explains that it 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.

Also, the Provider indicated that it is preserving its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period, citing 42 U.S.C. § 1395(d)(5)(F)(i).

Finally, the Provider contends that CMS inconsistently interprets the term "entitled" as it is used in the statute. CMS requires SSI payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the denominator. The Provider asserts that 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 Parties' Contentions:

In its jurisdictional challenge, the MAC contended that the Provider was appealing the issue of DSH SSI realignment, and there was no final determination on this issue. Further, the MAC asserted that the Provider's appeal of this issue was premature.

In the Provider's response, received on May 4, 2018, the Provider explained that this issue was not addressing a realignment of the SSI percentage, but was addressing the various errors of omission and commission that did not fit into the "systemic errors" category. Accordingly, the Provider asserted that this was an appealable item because the MAC specifically adjusted the Provider's SSI percentage and the Provider was dissatisfied with the amount of DSH payments that it received for fiscal year 2014 resulting from its understated SSI percentage.

The Provider contended:

> The . . . [CMS] in *Northeast Hospital Corporation v. Sebelius* (D.C. Cir. September 13, 2011) specifically abandoned the CMS Administrators December 1, 2008 decision that the SSI ratio cannot be revised based upon updated data after it has been calculated by CMS. Accordingly, the Provider believes that it can specifically identify patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS. *See Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008). Once these patients are

> identified, the Provider contends that it will be entitled to a correction of these errors of omission to its SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) [("Baystate")] that errors occurred that did not account for all patient days in the Medicare fraction.

The Provider, in its Final Position Paper filed on September 22, 2022, asserted that Issue 1 has two (2) subparts: (1) whether the correct SSI percentage was used in the DSH calculation, and (2) whether the numerator of the "Medicaid fraction" properly includes all "eligible" Medicaid days, regardless of whether such days were paid days.

The Provider asserted that, at the time of filing its Final Position Paper, it has been unable to analyze the Medicare Part A data because it has not yet received the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") from CMS. Upon release of the complete MEDPAR data, the Provider will seek to reconcile its records with that of CMS, and identify patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS based on the Federal Fiscal Year End (September 30) when it determined the Provider's SSI, citing *Baystate.*[1]

In its Final Position Paper, the MAC contended that the Provider is simply arguing that there may be additional SSI days, it has not identified errors with the Secretary's SSI ratio, even though MEDPAR data has been available to the Provider to reconcile its listing of SSI days it believes were omitted from its SSI percentage. The MAC explained that the Provider claimed that it is seeking MEDPAR data in order to reconcile its records with CMS data but has yet to receive the data, but that this statement by the Provider was misleading. MEDPAR data was available to the Provider prior to the date of its appeal request. Specifically, according to CMS, the Provider's request for its MEDPAR data was processed by CMS on March 17, 2017, and therefore, the Provider was in possession of this data prior to filing this appeal.

The MAC further argued that a Provider claiming that additional SSI days should be included in its SSI percentage, at a minimum, should provide a listing of SSI days it believes should be used to calculate its SSI percentage. The Provider has received this information from CMS and has failed to analyze this data. If additional SSI days exist, the Provider has failed to explain why such days were not included in its SSI percentage. It has been almost 3 years after the end of the cost reporting period in question (at the time the MAC filed its position paper), and the Provider has failed to identify any listing of SSI days, and has failed to analyze their MEDPAR data from CMS that was processed on March 17, 2017. The MAC believes the Provider's failure to support its contention related to additional SSI days demonstrates that this issue should be dismissed.

Board Analysis and 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

[1] *Baystate Medical Center v. [Leavitt]*, 545 F. Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37, 44 (D.D.C. 2008).

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.

SSI Provider Specific

Based on the Provider's initial appeal request, the jurisdictional analysis for Issue 1 has two relevant aspects to consider: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, and 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

1. First Aspect of Issue 1

The Board's review of the first aspect of Issue 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—found that it is duplicative of the DSH SSI Percentage (Systemic Errors) issue filed by commonly owned entities in PRRB Case No. 16-1192GC, *Community Health Systems 2014 DSH Post 1498R SSI Data Match CIRP Group*. The DSH SSI Percentage (Provider Specific) issue in the present appeal is described as follows:

> [T]he 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.[2]

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.[3]

In Case No. 16-1192GC, the group issue statement states as follows:

> Issue Description for DSH SSI Data Match Issue
>
> The failure of the Fiscal Intermediary and the Centers for Medicare and Medicaid Services (CMS) to properly determine the ratio of patient days for patients entitled to Medicare Part A and Supplemental Security Income (SSI) benefits (excluding any State supplementation) to patient days for patients entitled to Medicare Part A (Medicare Proxy or Fraction) for the Provider in its Disproportionate Share Hospital (DSH) eligibility determination and payment calculation, including any related impact on capital DSH. The Provider asserts that the Medicare Proxy is improperly understated due to a number of factors, including CMS's inaccurate

[2] Provider's Request for Hearing, Tab 3, at Issue Statement, Issue 1 (Aug. 4, 2017).
[3] *Id.*

and improper matching or use of data along with policy changes to determine both the number of Medicare Part A SSI patient days in the numerator of the fraction and the total Medicare Part A patient days in the denominator, as utilized in the calculation of the Medicare percentage of low income patients for DSH purposes and/or low income patient (LIP) adjustment for Inpatient Rehabilitation Facilities (IRFs) and/or IRF units.

CMS's improper treatment and policy changes resulted in an underpayment to the Providers as DSH program eligible providers of services to indigent patients, and includes any other related adverse impact to DSH payments, such as reduced capital DSH payments or LIP adjustments. Also, this treatment is not consistent with Congressional intent to reimburse hospitals for treatment of indigent patients when determining DSH program eligibility and payment pursuant to 42 U.S.C. § 1395ww(d)(5)(F), 42 C.F.R. § 412.106, Medicare Intermediary Manual § 3610.15, or any other applicable statutes, regulations, program guidelines, or case law.

On March 22, 2006, the Provider Reimbursement Review Board (PRRB) issued a decision in the Baystate case that was favorable to the provider. The PRRB identified significant flaws in the compilation of Medicare SSI days and held, among other things, that: 1) the law requires accuracy in the reporting of SSI days; 2) the PRRB has the authority-to require CMS to recalculate the SSI Percentage if necessary; and 3) there would not be a significant administrative burden required to redesign CMS's computer programs and processes to more accurately identify Medicare SSI eligibility.

The PRRB's decision was supported by the March 31, 2008, D.C. District Court decision which found CMS did not use the most reliable data available to determine which patient days should be counted in the SSI percentage and that such was "arbitrary and capricious." The Court additionally held that if an agency has sole possession of the information needed by an opposing party to prove its claim, then it cannot simply reject the party's allegations based upon the party's lack of proof.

CMS issued Ruling 1498-R on April 28, 2010 in response to the Baystate court decision. This significant Ruling sets forth, among other things, a revised and corrected data match process CMS would use to determine Providers' appropriate Medicare proxies and overall DSH adjustments. Providers assert that errors and problems still exist in the data match process, as well as improper policy changes by CMS, which are resulting in understated DSH

> adjustments for Providers, including the failure to include all Dual Eligible (Medicare/Medicaid) patient days in the Medicare fraction numerator as intended by Congress or alternatively in the Medicaid fraction numerator. CMS asserts in Ruling 1498-R that such Dually Eligible/Crossover days, including such days that are Medicare Non-Covered days, are being included in the Medicare proxy for discharges occurring on or after October 1, 2004. Providers assert that all such days are not properly being captured in the Medicare proxy of the DSH and/or LIP calculation.[4]

The first aspect of Issue 1 in the present appeal concerns "whether the [MAC] used the correct [SSI] percentage in the [DSH] calculation."[5] 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)."[6] 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."[7] The DSH SSI Data Match CIRP Group in Case No. 16-1192GC, similarly alleges that the Medicare Contractor and CMS improperly calculated the DSH/SSI Percentage, 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 that the first aspect of Issue 1 in this appeal is duplicative of the group issue in Case No. 16-1192GC, for other commonly owned entities and the same fiscal year. Pursuant to 42 C.F.R. § 405.1837(b)(1):

> Two or more providers under common ownership or control that wish to appeal to the Board a specific matter at issue that involves a question of fact or interpretation of law, regulations, or CMS Rulings that is common to the providers, and that arises in cost reporting periods that end in the same calendar year, and for which the amount in controversy is $50,000 or more in the aggregate, must bring the appeal as a group appeal.

Because the issue is duplicative, the Board requests that this aspect of the DSH/SSI (Provider Specific) issue be transferred to PRRB Case No. 16-1192GC. 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 must pursue that issue as part of the group under Case No. 16-1192GC, with other providers which are under the same parent corporation. 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.[8] In this respect, the Provider has failed to sufficiently explain (or give any

[4] Provider's Request for Hearing, Tab 2, Statement of Issue (Mar. 1, 2016).
[5] Provider's Request for Hearing, Tab 3, at Issue Statement, Issue 1.
[6] *Id.*
[7] *Id.*
[8] The types of systemic errors documented in the Baystate did not uniformly impact the SSI calculation for all providers but that does not make the errors any less systemic. *See Baystate Medical Ctr. v. Mutual of Omaha Ins.*

examples or provide evidence) as to how the alleged "provider specific" errors can be distinguished from the issue appealed in Case No. 16-1192GC, even if the Provider considers that issue to be "systemic" issues rather than provider-specific.

Accordingly, the Board finds that Issue 1 and the group issue in Case No. 16-1192GC are the same issue. Because the issue is duplicative of the specific matter appealed in the group appeal for which there are other providers under the same common ownership as the Provider in this case, and the group in Case No. 16-1192GC is not yet fully formed,[9] ***the Board is giving the Provider 10 days from the date of this letter to transfer this issue to Case No. 16-1192GC***, in order to become compliant with the CIRP regulation, as quoted above. *Be advised that the above filing deadline is firm.* Accordingly, failure of the Provider to respond by the above filing deadline will result in the dismissal of this case. With the transfer of the issue, no issues will remain in the appeal.

2. Second Aspect of Issue 1

In its initial appeal request, the Provider stated that it preserved its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. However, the Provider indicated in its jurisdictional response dated May 4, 2018, that it was not addressing a realignment of the SSI percentage.

Accordingly, 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—will be dismissed by the Board for lack of jurisdiction. Under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request…" Without this written request, the Medicare Contractor cannot issue a final determination with which the Provider can be dissatisfied for appeal purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding the Provider's DSH SSI Percentage realignment. As such, the realignment portion of Issue 1 is dismissed.

Decision

The Board finds that the first aspect of Issue 1 (the DSH/SSI (Provider Specific) issue) is duplicative of the group issue being pursued in Case No. 16-1192GC, and therefore, the Provider has **10 days from the date of this letter** to transfer that aspect of Issue 1 to Case No. 16-1192GC in order to comply with 42 C.F.R. § 405.1837(b)(1).

Further, there is no final determination from which the Provider can appeal the SSI realignment issue within Issue 1, and therefore that aspect of Issue 1 is dismissed.

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).

[9] *See* 42 C.F.R. § 405.1837(e), which provides that when the Board has determined that a group appeal brought under paragraph (b)(1) of this section (quoted above) is fully formed, no other provider under common ownership or control may appeal to the Board the issue that is the subject of the group appeal with respect to a cost reporting period that falls within the calendar year(s) covered by the group appeal.

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

Board Members Participating:

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

For the Board:

9/6/2023

X Kevin D. Smith, CPA

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

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

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RE: ***Board Decision***
Dignity Health CY 2013 Medicare Part C Days in Realigned SSI Ratio CIRP Group
Case Number: 20-0770GC

Dear Mr. Bunting:

The Provider Reimbursement Review Board ("Board" or "PRRB") has reviewed the subject group appeal and notes an impediment to jurisdiction over the participants that appealed from revised Notices of Program Reimbursement ("RNPRs"). A brief procedural history, the pertinent facts regarding the appeals of these Providers and the Board's Determination are set forth below.

Procedural History

On January 28, 2020, Moss Adams LLP ("Moss Adams") filed the "Dignity Health CY 2013 Medicare Part C Days included in CMS Realigned SSI Ratio CIRP Group" under Case No. 20-0770GC. The group is not designated to be fully formed and includes seven participants ("Providers"):

- Mercy Medical Center (05-0444) (RNPR)
- Marian Regional Medical Center (05-0107) (RNPR)
- Sierra Nevada Memorial Hospital (05-0150) (RNPR)
- St. Rose Dominican Hospitals - Rose De Lima Campus (29-0012) (RNPR)
- Mercy Medical Center Redding (05-0280) (RNPR)
- Mercy San Juan Medical Center (05-0516) (RNPR)
- St. Rose Dominican Hospitals - San Martin Campus (29-0053) (RNPR)

The group appeal issue filed from the receipt of RNPRs by the Providers is "Medicare DSH Payments – CMS Inclusion of Medicare Managed Care Part C Days in the Realigned SSI Ratio Determined By CMS."

Pertinent RNPR Facts for Mercy Medical Center

- RNPR Date: 8/1/2019
- Audit Adjustment Nos.:

#1 Completed cost reporting forms & pages in accordance w/current regulations
#4 To adjust the SSI% and the Disproportionate Share Amount based on the latest CMS Letter of SSI% Realignment

- Provider included in appeal on January 28, 2020.

Pertinent RNPR Facts for Marian Regional Medical Center

- RNPR Date: 8/1/2019
- Audit Adjustment Nos.:
  #1 Completed cost reporting forms & pages in accordance w/current regulations
  #4 To adjust the SSI% and the Disproportionate Share Amount based on the latest CMS Letter of SSI% Realignment
- Provider included in appeal on January 28, 2020.

Pertinent RNPR Facts for Sierra Nevada Memorial Hospital

- RNPR Date: 8/1/2019
- Audit Adjustment Nos.:
  #2 To revise the SSI and DSH percentage for proper calculation of DSH adjustment amount
- Provider included in appeal on January 28, 2020.

Pertinent RNPR Facts for St. Rose Dominican Hospitals - Rose De Lima Campus

- RNPR Date: 1/28/2020
- Audit Adjustment Nos.:
  #1 Completed cost reporting forms & pages in accordance w/current regulations
  #4 To adjust the SSI% and the Disproportionate Share Amount based on the latest CMS Letter of SSI% Realignment.'
- Provider added to appeal on July 26, 2020.

Pertinent RNPR Facts for Mercy Medical Center Redding

- RNPR Date: 3/5/2020
- Audit Adjustment Nos.:
  #1 Completed cost reporting forms & pages in accordance w/current regulations
  #4 To adjust the SSI% and the Disproportionate Share Amount based on the latest CMS Letter of SSI% Realignment
- Provider added to appeal on August 31, 2020.

Pertinent RNPR Facts for Mercy San Juan Medical Center

- RNPR Date: 4/29/2020
- Audit Adjustment Nos.:
  #1 Completed cost reporting forms & pages in accordance w/current regulations

#4 To revise the SSI and DSH percentage for proper calculation of the DSH adjustment amount

- Provider added to appeal on October 12, 2020.

Pertinent RNPR Facts for St. Rose Dominican Hospitals - San Martin Campus

- RNPR Date: 7/2/2020
- Audit Adjustment Nos.:
  #1 Completed cost reporting forms & pages in accordance w/current regulations
  #4 To include the SSI percentage as calculated by CMS at the request of provider and to revise the DSH percentage.
- Provider added to appeal on December 18, 2020.

Board Determination:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2015), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final contractor determination, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

A. RNPR Appeals

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

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

Additionally, 42 C.F.R. § 405.1889 explains the effect of a cost report revision:

> (a) If a revision is made in a Secretary or contractor determination or a decision by a reviewing entity after the determination or decision is reopened as provided in §405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the provisions of §§ 405.1811, 405.1834, 405.1835, 405.1837, 405.1875, 405.1877 and 405.1885 of this subpart are applicable.

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

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

> (a) *Right to hearing on final contractor determination*.
> A provider . . . has a right to a Board hearing, as a single provider appeal, with respect to a final contractor or Secretary determination for the provider's cost reporting period, if -
>
> (1) The provider is dissatisfied with the contractor's final determination of the total amount of reimbursement due the provider, as set forth in the contractor's written notice specified under § 405.1803. **Exception**: If a final contractor determination is reopened under § 405.1885, **any review by the Board must be limited solely to those matters that are specifically revised in the contractor's revised final determination** (§§ 405.1887(d), 405.1889(b), and the "Exception" in § 405.1873(c)(2)(i)).
>
> (2) The amount in controversy (as determined in accordance with § 405.1839) must be $10,000 or more.
>
> (3) Unless the provider qualifies for a good cause extension under § 405.1836, the date of receipt by the Board of the provider's hearing request must be no later than 180 days after the date of receipt by the provider of the final contractor or Secretary determination.[2]

The Board has determined that it does not have jurisdiction over the Part C Days issues that were appealed from the Providers' RNPRs. The Board finds that the RNPRs for the seven Providers were issued as a result of SSI Realignment requests, and the RNPRs did not adjust the Part C Days issue.[3] Thus, the Providers do not have the right to appeal under 42 C.F.R. § 405.1889(b) as referenced in § 405.1835(a)(1).

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[1] 42 C.F.R. § 405.1889(b).
[2] (Emphasis added).
[3] From the Providers' Request to Reopen and the Medicare Contractor's Notices of Reopening, it is clear from the audit adjustment reports that the RNPRs were issued as a result of the Providers' requests for Realignment.

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] The reopenings for these Providers were a result of the Providers' requests to realign their SSI percentages from the federal fiscal year end to their individual cost reporting fiscal year ends. Based on the audit adjustments associated with the RNPR under appeal for each Provider, it is clear that the revision to the SSI percentage was adjusted only in order to realign it from a federal fiscal year to the providers' respective fiscal years. More specifically, the determinations were only reopened to include the realigned SSI percentage where the SSI percentage was realigned from the federal fiscal year to the providers' fiscal year, *and* the realignment process (as described in the Federal Register) does not change any of the underlying data that is gathered on a month-by-month basis since CMS does not rerun the data matching process in order to effectuate a realignment.[5] In other words, the determinations were only being reopened to include the realigned SSI percentages and CMS' realignment process (as described in the Federal Register) does ***not*** entail re-running of the data matching process (much less revise any of the Part C days included in the underlying month-by-month data).[6] Since the only matters specifically revised in the RNPRs were the adjustments related to realigning the SSI percentages from federal fiscal year to the providers' fiscal years, the respective Providers do not have a right to appeal under 42 C.F.R. §§ 405.1889(b) and 405.1835(a)(1) for the Part C Days issues. 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]

B. Duplicate Appeals

Furthermore, in reviewing the documentation, it was noted that the Providers have already appealed the Part C days issue for this specific fiscal year, in another group case. Specifically,

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[4] 42 C.F.R. § 405.1889(b)(1).

[5] CMS describes the matching process that it uses as part of the FY 2011 IPPS final rule published on August 16, 2010. *See* 75 Fed. Reg. 50042, 50275-85 (Aug. 16, 2010). However, CMS does not utilize or re-run the data match process when it issues a realigned SSI percentage. Rather, when CMS conducts the realignment process, all of the underlying data which has already been gathered on a month-by-month basis through that data matching process remains the same. The realigned SSI percentage simply reflects a different 12-month time period being used. *See* 42 C.F.R. § 412.106(b)(2) (noting that CMS gathers data on a month-by-month basis). 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 based on the provider's cost reporting period instead of the September 30 FFY. *See also* 75 Fed. Reg. 50042, 50279 (Aug. 16, 2010) (stating: "The SSI fractions are generally based on the Federal fiscal year; however, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived from the data match process for the two Federal fiscal years that spanned the hospital's cost reporting period.); 70 Fed. Reg. 47278, 47439 (Aug. 12, 2005) (stating: "Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period, and *the hospital* ***must accept*** *the resulting DSH percentage for that year, whether or not it is a more favorable number than the DSH percentage based on the Federal fiscal year*." (emphasis added)).

[6] *See id*.

[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).

the Providers were also participants in PRRB Case No. 16-1121GC, Dignity Health 2013 DSH SSI/Medicaid Part C Days CIRP Group.

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

> Two or more providers under common ownership or control that wish to appeal to the Board a specific matter at issue that involves a question of fact or interpretation of law, regulations, or CMS Rulings that is common to the providers, and that arises in cost reporting periods that end in the same calendar year, and for which the amount in controversy is $50,000 or more in the aggregate, must bring the appeal as a group appeal.[8]

Board Rule 4.6.1 also addresses duplicate filings:

> A provider may not appeal an issue from a single final determination in more than one appeal (individual or group).

As both group appeals are pursuing the same issue, i.e., Part C Days, the Board finds that Case No. 20-0770GC is a duplicate of Case No. 16-1121GC in violation of the CIRP regulations at 42 C.F.R. § 405.1837(b)(1) and (e) and the PRRB Rules involving duplicate appeals, 4.6.1.

Conclusion

The Board finds that it lacks jurisdiction over the Providers Mercy Medical Center (05-0444), Marian Regional Medical Center (05-0107), Sierra Nevada Memorial Hospital (05-0150), St. Rose Dominican Hospitals - Rose De Lima Campus (29-0012), Mercy Medical Center Redding (05-0280), Mercy San Juan Medical Center (05-0516), and St. Rose Dominican Hospitals - San Martin Campus (29-0053) that appealed from RNPRs because the issue under appeal in the group was not specifically revised in the RNPRs which were the basis for the respective Providers' appeals. The Board hereby dismisses Case No. 20-0770GC and removes it from the Board's docket.

As a result of our review of the record, the Board ***admonishes Dignity Health and reminds it of its responsibility to oversee*** *its designated agents that pursue the claims of Dignity Health and its providers for additional Medicare reimbursement before the Board. The Board notes that Dignity Health has an open CIRP group (16-1121GC) for DSH SSI/Medicaid Part C Days with a majority of the same Providers. The Board reminds Dignity Health that it has a responsibility to ensure that it (through its agents) complies with the CIRP group requirements and does not pursue* ***duplicative*** *claims/appeals.*

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.

[8] 42 C.F.R. § 405.1837(b)(1).

Board Members:

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

For the Board:

9/6/2023

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
Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Glenn Bunting
Moss Adams LLP
2882 Prospect Drive, Suite 300
Rancho Cordova, CA 95670

RE: ***Board Decision***
Dignity Health CY 2014 Medicare Part C Days in Realigned SSI Ratio CIRP Group
Case Number: 20-1622GC

Dear Mr. Bunting:

The Provider Reimbursement Review Board ("Board" or "PRRB") has reviewed the subject group appeal and notes an impediment to jurisdiction over the participants that appealed from revised Notices of Program Reimbursement ("RNPRs"). A brief procedural history, the pertinent facts regarding the appeals of these Providers and the Board's Determination are set forth below.

Procedural History:

On May 4, 2020, Moss Adams LLP ("Moss Adams") filed the "Dignity Health CY 2014 Medicare Part C Days included in CMS Realigned SSI Ratio CIRP Group" under Case No. 20-1622GC. The optional group is not designated to be fully formed and includes ten participants ("Providers"):

- California Hospital Medical Center (05-0149) (RNPR)
- St. Rose Dominican Hospitals - San Martin Campus (29-0053) (RNPR)
- Mercy Hospital of Folsom (05-0414) (RNPR)
- St. Rose Dominican Hospitals - Rose De Lima Campus (29-0012) (RNPR)
- Mercy General Hospital (05-0017) (RNPR)
- Mercy Medical Center (05-0444) (RNPR)
- Mercy Medical Center Redding (05-0280) (RNPR)
- St. Bernardine Medical Center (05-0129) (RNPR)
- St Joseph's Medical Center (05-0084) (RNPR)
- St. Rose Dominican Hospitals - Siena Campus (29-0045) (RNPR)

The group appeal issue filed from the receipt of the RNPRs by the Providers is "Medicare DSH Payments – CMS Inclusion of Medicare Managed Care Part C Days in the Realigned SSI Ratio Determined By CMS."

Pertinent RNPR Facts for California Hospital Medical Center

- RNPR Date: 11/6/2019
- Audit Adjustment Nos.:
  #1 Completed cost reporting forms & pages in accordance w/current regulations
  #4 To include the SSI percentage as calculated by CMS at the request of provider and to revise the DSH percentage.
- Provider included in appeal on May 4, 2020.

Pertinent RNPR Facts for St. Rose Dominican Hospitals - San Martin Campus

- RNPR Date: 11/14/2019
- Audit Adjustment Nos.:
  #1 Completed cost reporting forms & pages in accordance w/current regulations
  #4 To adjust the SSI% and the DSH amount based on the recalculation.
- Provider added to appeal on May 6, 2020.

Pertinent RNPR Facts for Mercy Hospital of Folsom

- RNPR Date: 12/2/2019
- Audit Adjustment Nos.:
  #1 Completed cost reporting forms & pages in accordance w/current regulations
  #4 To adjust the SSI% and the Disproportionate Share Amount based on the latest CMS Letter of SSI% Realignment.
- Provider added to appeal on May 27, 2020.

Pertinent RNPR Facts for St. Rose Dominican Hospitals - Rose De Lima Campus

- RNPR Date: 1/3/2020
- Audit Adjustment Nos.:
  #1 To revise the SSI and DSH percentage for proper calculation of DSH adjustment
  Provider added to appeal on May 27, 2020.

Pertinent RNPR Facts for Mercy General Hospital

- RNPR Date: 2/18/2020
- Audit Adjustment Nos.:
  #1 Completed cost reporting forms & pages in accordance w/current regulations
  #4 To adjust the SSI% and the Disproportionate Share Amount based on the latest CMS Letter of SSI% Realignment
- Provider added to appeal on August 11, 2020.

Pertinent RNPR Facts for Mercy Medical Center

- RNPR Date: 2/26/2020
- Audit Adjustment Nos.:
  #1 Completed cost reporting forms & pages in accordance w/current regulations
  #4 To revise the SSI and DSH percentage for proper calculation of the DSH adjustment
- Provider added to appeal on August 14, 2020.

Pertinent RNPR Facts for Mercy Medical Center Redding

- RNPR Date: 2/26/2020
- Audit Adjustment Nos.:
  #1 Completed cost reporting forms & pages in accordance w/current regulations
  #4 To revise the SSI and DSH percentage for proper calculation of the DSH adjustment amount
- Provider added to appeal on August 14, 2020.

Pertinent RNPR Facts for St. Bernardine Medical Center

- RNPR Date: 2/21/2020
- Audit Adjustment Nos.:
  #1 Completed cost reporting forms & pages in accordance w/current regulations
  #4 To adjust the SSI% and the Disproportionate Share Amount based on the latest CMS Letter of SSI% Realignment.
- Provider added to appeal on August 14, 2020.

Pertinent RNPR Facts for St Joseph's Medical Center

- RNPR Date: 3/3/2020
- Audit Adjustment Nos.:
  #1 Completed cost reporting forms & pages in accordance w/current regulations
  #4 To incorporate the revised SSI ratio and DSH
- Provider added to appeal on August 14, 2020.

Pertinent RNPR Facts for St. Rose Dominican Hospitals - Siena Campus

- RNPR Date: 3/11/2020
- Audit Adjustment Nos.:
  #1 Completed cost reporting forms & pages in accordance w/current regulations
  #4 To revise the SSI and DSH percentage for proper calculation of the DSH adjustment
- Provider added to appeal on August 31, 2020.

Board Determination:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2015), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final contractor determination, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

A. RNPR Appeals

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

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

Additionally, 42 C.F.R. § 405.1889 explains the effect of a cost report revision:

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

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

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

[1] 42 C.F.R. § 405.1889(b).

> (2) The amount in controversy (as determined in accordance with § 405.1839) must be $10,000 or more.
>
> (3) Unless the provider qualifies for a good cause extension under § 405.1836, the date of receipt by the Board of the provider's hearing request must be no later than 180 days after the date of receipt by the provider of the final contractor or Secretary determination.[2]

The Board has determined that it does not have jurisdiction over the Part C Days issues that were appealed from the Providers' RNPRs. The Board finds that the RNPRs for the ten Providers were issued as a result of SSI Realignment requests, and the RNPRs did not adjust the Part C Days issue.[3] Thus, the Providers do 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[.]"[4] The reopenings for these Providers were a result of the Providers' requests to realign their SSI percentages from the federal fiscal year end to their individual cost reporting fiscal year ends. Based on the audit adjustments associated with the RNPR under appeal for each Provider, it is clear that the SSI percentage was adjusted only in order to realign it from a federal fiscal year to each providers' respective fiscal year. More specifically, the determinations were only reopened to include the realigned SSI percentage where the SSI percentage was realigned from the federal fiscal year to the providers' fiscal year, *and* the realignment process (as described in the Federal Register) does not change any of the underlying data that is gathered on a month-by-month basis since CMS does not rerun the data matching process in order to effectuate a realignment.[5] In other words,

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[2] (Emphasis added).

[3] From the Providers' Request to Reopen and the Medicare Contractor's Notices of Reopening, it is clear from the audit adjustment reports that the RNPRs were issued as a result of the Providers' requests for Realignment.

[4] 42 C.F.R. § 405.1889(b)(1).

[5] CMS describes the matching process that it uses as part of the FY 2011 IPPS final rule published on August 16, 2010. *See* 75 Fed. Reg. 50042, 50275-85 (Aug. 16, 2010). However, CMS does not utilize or re-run the data match process when it issues a realigned SSI percentage. Rather, when CMS conducts the realignment process, all of the underlying data which has already been gathered on a month-by-month basis through that data matching process remains the same. The realigned SSI percentage simply reflects a different 12-month time period being used. *See* 42 C.F.R. § 412.106(b)(2) (noting that CMS gathers data on a month-by-month basis). 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 based on the provider's cost reporting period instead of the September 30 FFY. *See also* 75 Fed. Reg. 50042, 50279 (Aug. 16, 2010) (stating: "The SSI fractions are generally based on the Federal fiscal year; however, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived from the data match process for the two Federal fiscal years that spanned the hospital's cost reporting period.); 70 Fed. Reg. 47278, 47439 (Aug. 12, 2005) (stating: "Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period, and *the hospital **must accept** the resulting DSH percentage for that year, whether or not it is a more favorable number than the DSH percentage based on the Federal fiscal year*." (emphasis added)).

the determinations were only being reopened to include the realigned SSI percentages and CMS' realignment process (as described in the Federal Register) does ***not*** entail re-running of the data matching process (much less revise any of the Part C days included in the underlying month-by-month data).[6] Since the only matters specifically revised in the RNPRs for were the adjustments related to realigning the SSI percentages from federal fiscal year to the providers' fiscal year, the respective Providers do not have a right to appeal under 42 C.F.R. §§ 405.1889(b) and 405.1835(a)(1) for the Part C Days issues. 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]

B. Duplicate Issue

Furthermore, in reviewing the documentation, it was noted that the Providers have already appealed the Part C days issue for this specific fiscal year, in another group case. Specifically, the Providers were also participants in PRRB Case No. 16-2569GC, Dignity Health 2014 Inclusion of Medicare Part C Days in the SSI Ratio CIRP Group.

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

> Two or more providers under common ownership or control that wish to appeal to the Board a specific matter at issue that involves a question of fact or interpretation of law, regulations, or CMS Rulings that is common to the providers, and that arises in cost reporting periods that end in the same calendar year, and for which the amount in controversy is $50,000 or more in the aggregate, must bring the appeal as a group appeal.[8]

Board Rule 4.6.1 also addresses duplicate filings:

> A provider may not appeal an issue from a single final determination in more than one appeal (individual or group).

As both group appeals are pursuing the same issue, i.e., Part C Days, the Board finds that Case No. 20-1622GC is a duplicate of Case No. 16-2569GC in violation of the CIRP regulations at 42 C.F.R. § 405.1837(b)(1) and (e) and the PRRB Rules involving duplicate appeals, 4.6.1.

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[6] *See supra* n. 5.
[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).
[8] 42 C.F.R. § 405.1837(b)(1).

Conclusion:

The Board finds that it lacks jurisdiction over all of the Providers in this group because the issue under appeal in the group was not specifically revised in the RNPRs which were the basis for the respective Providers' appeals. Additionally, the Board finds that Case No. 20-1622GC is a prohibited duplicate appeal of Case No. 16-2569GC. The Board hereby dismisses Case No. 20-1622GC and removes it from the Board's docket.

As a result of our review of the record, the Board ***admonishes Dignity Health and reminds it of its responsibility to oversee*** *its designated agents that pursue the claims of Dignity Health and its providers for additional Medicare reimbursement before the Board. The Board notes that Dignity Health filed a group case for Part C days in the SSI Ratio (16-2569GC). Thus, any appeal of the Part C days in the SSI Ratio should have been pursued in that CIRP group appeal. The Board reminds Dignity Health that it has a responsibility to ensure that it (through its agents) complies with the CIRP group requirements and does not pursue* ***duplicative*** *claims/appeals.*

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

Board Members:

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

For the Board:

9/6/2023

X Kevin D. Smith, CPA

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

cc: Kenton Fong, Dignity Health
Wilson C. Leong, Esq. Federal Specialized Services
Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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

Noridian Healthcare Solutions (J-F)
John Bloom
P.O. Box 6722
Fargo, ND 58108-6722

RE: ***Duplication of Common Issue Related Party ("CIRP") Groups***

Univ of Washington Med CY 2018 DSH SSI/Medicaid Medicare Managed Care Part C Days CIRP Group
Case Number: 22-1397GC

Univ of Washington Med CY 2018 DSH SSI & MCD Fractions – Medicare Managed Care Part C Days CIRP Group
Case Number: 23-0254GC

Dear Mr. Ravindran and Mr. Bloom:

The Provider Reimbursement Review Board (the "Board") has reviewed correspondence from Quality Reimbursement Services, Inc. ("QRS") dated August 31, 2023, in which it advises that the above-captioned group appeals are duplicative, as both cases involve the Inclusion of Medicare Part C Days in the SSI Ratio and the Exclusion of the Dual Eligible Medicare Part C Days from the Medicaid Ratio ("Part C Days") issue for the University of Washington Medicine organization for calendar year ("CY") 2018. Upon review, the Board notes that the first group, the "Univ of Washington Med CY 2018 DSH SSI/Medicaid Medicare Managed Care Part C Days CIRP Group" (Case No. 22-1397GC) was filed by QRS on September 1, 2022, and includes one provider.[1] The second group, the "Univ of Washington Med CY 2018 DSH SSI & MCD Fractions – Medicare Managed Care Part C Days CIRP Group" (Case No. 23-0254GC) was filed by QRS on November 17, 2022 and includes three different providers.[2]

Board Determination:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is

[1] The group was initially established for the SSI Fraction Part C Days issue and included only Northwest Hospital (Prov. No. 50-0001). On September 26, 2022, the Board consolidated the Medicaid Fraction Part C group, Case No. 22-1398GC into Case No. 22-1397GC. As a result, Northwest Hospital is listed as two participants: one for the SSI Fraction Part C issue and one for the Medicaid Fraction Part C issue.

[2] University of Washington Medical Center (Prov. No. 50-0008); Harborview Medical Center (Prov. No. 50-0064) & Valley Medical Center (Prov. No. 50-0088).

$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.

As the Parties are aware, it is the Board's policy to establish ***only*** one (1) CIRP group appeal per issue per fiscal year end.[3] In fact, the certification page of a group appeal request includes a statement that the Representative certifies ". . . the group issue filed . . . is not pending in any other appeal for the same period for the same provider, nor has it been adjudicated, withdrawn or dismissed from any other PRRB appeal."[4] Because there can be only one CIRP group for each CY, for each issue, the Board agrees that the two Univ of Washington Med CY 2018 Medicare Managed Care Part C Days CIRP Groups filed by QRS under Case Nos. 22-1397GC and 23-0254GC are duplicative. Therefore, in accordance with QRS' request, the Board is consolidating the earlier group under Case No. 22-1397GC into Case No. 23-0254GC.[5] Since there are no remaining participants in Case No. 22-1397GC, it is hereby closed and removed from the Board's docket.

The Board has previously directed QRS' attention to Board Rule 4.6 regarding duplicate appeals and 42 C.F.R. § 405.1837*, which indicates that related providers appealing a common issue for the same calendar year are required to pursue that issue in* ***only*** *one CIRP group appeal*.[6] Although QRS contends the establishment of the second CIRP group was inadvertent, the Board again reprimands QRS for filing the duplicate group. The Board, however, appreciates QRS' acknowledgement that this is not the first instance and its efforts to review its docket for other instances where this error may have occurred.

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

FOR THE BOARD:

9/7/2023

X Kevin D. Smith, CPA

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

cc: Wilson C. Leong, Esq., CPA, Fed. Specialized Svcs.

[3] *See* Board Rules 4.6, 5.4, 7.1.1. *See also* 42 C.F.R. § 405.1837(b).

[4] Appendix B: Model Form B – Group Appeal Request at time of filing (March 1, 2013, revised July 1, 2015, August 29, 2018 and November 1, 2021).

[5] As noted, Case No. 23-0254GC includes three participants so the Board agrees to consolidate the single provider (listed as two participants) from the earlier filed group, Case No. 22-1397GC.

[6] *See* 42 C.F.R. § 405.1837(b)(i) (stating "*Two or more providers under common ownership or control that wish to appeal* to the Board *a specific matter at issue* that involves a question of fact or interpretation of law, regulations, or CMS Rulings that is common to the providers, and *that arises in cost reporting periods that end in the same calendar year*, and for which the amount in controversy is $50,000 or more in the aggregate, ***must*** *bring the appeal as a group appeal*." (emphasis added)); 42 C.F.R. § 405.1837(b)(3) (stating "With respect to group appeals brought under paragraph (b)(1) of this section, one or more commonly owned or operated providers must make a written request for a Board hearing as a group appeal in accordance with paragraph (c) of this section. *Any group appeal filed by a single provider* ***must be joined*** *by related providers on common issues in accordance with paragraphs (b)(1) and (e) of this section*. (emphasis added)).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Glenn Bunting
Moss Adams LLP
2882 Prospect Dr., Ste. 300
Rancho Cordova, CA 95670

RE: ***Board Decision***
Dignity Health CY 2017 Medicare Part C Days in Realigned SSI Ratio CIRP Group
Case No. 21-0072GC

Dear Mr. Bunting:

The Provider Reimbursement Review Board ("Board" or "PRRB") has reviewed the subject group appeal and notes an impediment to jurisdiction over the participants that appealed from revised Notices of Program Reimbursement ("RNPRs"). The Board has also noted that the Common Owner of this group, Dignity Health, has already appealed this issue, on December 6, 2019 in Case No. 20-0454GC, for participants appealing from their original NPRs for this specific Fiscal Year . As such, the above CIRP group appeal is duplicative and must be dismissed. A brief procedural history, the pertinent facts regarding the appeals of these Providers and the Board's Determination are set forth below.

Background:

On October 12, 2020, Moss Adams LLP ("Moss Adams") filed the "Dignity Health CY 2017 Medicare Part C Days included in CMS Realigned SSI Ratio CIRP Group" under Case No. 21-0072GC. In filing this group appeal request, Moss Adams ***falsely*** certified that "the group issue filed in this appeal is not pending in any other appeal for the same period for the same providers, nor has it been adjudicated, withdrawn, or dismissed for any other PRRB appeal" because Dignity Health already had appealed this issue on December 6, 2019 under Case No. 20-0454GC. Moss Adams has not yet designated Case No. 21-0072GC fully formed and it includes nine participants ("Providers"), that are appealing from original NPRs and RNPRs:

- Glendale Memorial Hospital & Health Center (05-0058) **(RNPR)**
- Mercy Medical Center Redding (05-0280) **(RNPR)**
- Methodist Hospital of Sacramento (05-0590) (**RNPR)**
- Sierra Nevada Memorial Hospital (05-0150) **(RNPR)**
- St. Rose Dominican Hospitals - Rose De Lima Campus (29-0012) (ONPR)
- Mercy San Juan Medical Center (05-0516) (ONPR)
- Saint Francis Memorial Hospital (05-0152) (ONPR)
- Dominican Hospital (05-0242) (ONPR)
- St. Rose Dominican Hospitals - Siena Campus (29-0045) (ONPR)

Pertinent RNPR Facts for Glendale Memorial Hospital & Health Center

- RNPR Date: 4/15/2020
- Audit Adjustment Nos.:
  #1 Completed cost reporting forms & pages in accordance w/current regulations
  #4 To adjust the SSI% and the Disproportionate Share Amount based on the latest CMS Letter of SSI% *Realignment*
- Provider included in appeal on October 12, 2020.

Pertinent RNPR Facts for Mercy Medical Center Redding

- RNPR Date: 4/14/2020
- Audit Adjustment Nos.:
  #1 Completed cost reporting forms & pages in accordance w/current regulations
  #4 To adjust the SSI% to the *realigned* SSI% as calculated by CMS and to adjust the DSH payment percentage.
- Provider added to appeal on October 12, 2020

Pertinent RNPR Facts for Methodist Hospital of Sacramento

- RNPR Date: 6/30/2020
- Audit Adjustment Nos.:
  #1 Completed cost reporting forms & pages in accordance w/current regulations
  #4 To adjust the SSI% and the Disproportionate Share Amount based on the latest CMS Letter of SSI% *Realignment*
- Provider added to appeal on December 18, 2020.

Pertinent RNPR Facts for Sierra Nevada Memorial Hospital

- RNPR Date: 10/15/2020
- Provider *Realignment* Request Dated Dec. 4, 2019
- October 7, 2020 Reopening Notice and Audit Adjustment Report dated October 15, 2020 with Audit Adjustment Nos.:
  #1 Completed cost reporting forms & pages in accordance w/current regulations
  #4 To revise the SSI and DSH percentage for proper calculation of the DSH adjustment
- Provider added to appeal on April 16, 2021.

Pertinent NPR Facts for St. Rose Dominican Hospitals - Rose De Lima Campus

- Realignment Request Date: 12/4/2019
- NPR Date: 10/15/2020
- Audit Adjustment Nos.:
  #26 To properly report the current year DSH and IRF SSI%.
- Provider added to appeal on February 5, 2021.

Pertinent NPR Facts for Mercy San Juan Medical Center

- Realignment Request Date: 12/4/2019

- NPR Date: 8/18/2020
- Audit Adjustment Nos.:
  #29 To properly report the current year operating DSH SSI%.
  #30 To properly report the current year allowable DSH percentage.
- Provider added to appeal on February 5, 2021.ud

Pertinent Facts for Saint Francis Memorial Hospital

- Realignment Request Date: 12/4/2019
- NPR Date: 8/28/2020
- Audit Adjustment Nos.:
  #24 To properly report the current year operating DSH SSI% and report the current year IRF LIP SSI.
- Provider added to appeal on February 5, 2021.

Pertinent Facts for Dominican Hospital

- Realignment Request Date: 11/3/2019
- NPR Date: 8/31/2020
- Audit Adjustment Nos.:
  #27 To properly report the current year operating DSH SSI % and the IRF LIP SSI %.
  #28 To adjust the DSH % to agree to the MAC calculation.
- Provider added to appeal on February 5, 2021.

Pertinent Facts for St. Rose Dominican Hospitals - Siena Campus

- Realignment Request Date: 12/4/2019
- NPR Date: 10/31/2020
- Audit Adjustment Nos.:
  #34 To update the SSI% based on the CMS SSI Recalculation dtd January 6, 2020
- Provider added to appeal on April 23, 2021.

Board Determination:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2015), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final contractor determination, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

A. Providers Appealing from RNPRs

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

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

Additionally, 42 C.F.R. § 405.1889 explains the effect of a cost report revision:

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

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

> (a) *Right to hearing on final contractor determination*. A provider . . . has a right to a Board hearing, as a single provider appeal, with respect to a final contractor or Secretary determination for the provider's cost reporting period, if -
>
> (1) The provider is dissatisfied with the contractor's final determination of the total amount of reimbursement due the provider, as set forth in the contractor's written notice specified under § 405.1803. **Exception**: If a final contractor determination 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)).

[1] 42 C.F.R. § 405.1889(b).

> (2) The amount in controversy (as determined in accordance with § 405.1839) must be $10,000 or more.
>
> (3) Unless the provider qualifies for a good cause extension under § 405.1836, the date of receipt by the Board of the provider's hearing request must be no later than 180 days after the date of receipt by the provider of the final contractor or Secretary determination.[2]

The Board has determined that it does not have jurisdiction over the Part C Days issues that were appealed from the RNPRs by the following participants:

- Glendale Memorial Hospital & Health Center (05-0058);
- Mercy Medical Center Redding (05-0280);
- Methodist Hospital of Sacramento (05-0590); and
- Sierra Nevada Memorial Hospital (05-0150).

The RNPRs for these four Providers were issued as a result of SSI Realignment requests filed by the Provider, and the RNPRs did not adjust the Part C Days issue.[3] Thus, the Providers do 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[.]"[4] The reopenings for these Providers were a result of the Providers' requests to realign their SSI percentages from the federal fiscal year end to their individual cost reporting fiscal year ends. Based on the audit adjustments associated with the RNPR under appeal for each Provider, it is clear that the revision to the SSI percentage was adjusted only in order to realign it from a federal fiscal year to the providers' respective fiscal year. More specifically, the determinations were only reopened to include the realigned SSI percentage where the SSI percentage was realigned from the federal fiscal year to the providers' fiscal year, *and* the realignment process (as described in the Federal Register) does not change any of the underlying data that is gathered on a month-by-month basis since CMS does not rerun the data matching process in order to effectuate a realignment.[5] In

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[2] (Emphasis added).
[3] From the Providers' Request to Reopen and the Medicare Contractor's Notices of Reopening, it is clear from the audit adjustment reports that the RNPRs were issued as a result of the Providers' requests for Realignment.
[4] 42 C.F.R. § 405.1889(b)(1).
[5] CMS describes the matching process that it uses as part of the FY 2011 IPPS final rule published on August 16, 2010. *See* 75 Fed. Reg. 50042, 50275-85 (Aug. 16, 2010). However, CMS does not utilize or re-run the data match process when it issues a realigned SSI percentage. Rather, when CMS conducts the realignment process, all of the underlying data which has already been gathered on a month-by-month basis through that data matching process remains the same. The realigned SSI percentage simply reflects a different 12-month time period being used. *See* 42 C.F.R. § 412.106(b)(2) (noting that CMS gathers data on a month-by-month basis). 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 based on the provider's cost reporting period instead of the September 30 FFY. *See also* 75 Fed. Reg. 50042, 50279 (Aug. 16, 2010) (stating: "The SSI fractions are generally based on the Federal fiscal year; however, under the regulations at § 412.106(b)(3), a

other words, the determinations were only being reopened to include the realigned SSI percentages and CMS' realignment process (as described in the Federal Register) does ***not*** entail re-running of the data matching process (much less revise any of the Part C days included in the underlying month-by-month data).[6] Since the only matters specifically revised in the RNPRs for were the adjustments related to realigning the SSI percentages from federal fiscal year to the provider fiscal year, the respective Providers do not have a right to appeal under 42 C.F.R. §§ 405.1889(b) and 405.1835(a)(1) for the Part C Days issues. 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]

B. Duplicate Issue

Furthermore, in reviewing the documentation, it was noted that the five *remaining* Providers appealing from their original NPRs have already appealed the Part C days issue for this specific fiscal year, in another group case based on the ***same*** original NPRs. Specifically, the Providers were also participants in Case No. 20-0454GC Dignity Health CY 2017 DSH Medicare Part C - SSI Ratio/DE Part C - Medicaid Ratio CIRP Group, which was established on December 6, 2019 by a different representative, Toyon Associates, Inc. ("Toyon").

The issue in Case No. 21-0072GC (as established by Moss Adams on behalf of Dignity Health) is a challenge to inclusion of Part C days in the Medicare fraction, and reads:

> For each of the hospitals (i.e. group participant or Provider) in this group, CMS processed a SSI ratio realignment request submitted by the hospital in accordance with 42 CFR 412.106(b). Within each request for SSI ratio realignment, each group participant specifically requested CMS exclude Medicare managed care Part C days from the realignment process consistent with the federal appellate court decision *Allina Health Servs. V. Price*, No. 16-5255 (D.C. Cir. July 25, 2017) ("Allina II"). As a matter of background, on July 25, 2017, the United States Court of Appeals for the District of Columbia Circuit held that HHS violated the terms of the Medicare statute by failing to undertake notice-and-comment rulemaking in implementing its policy to treat Medicare Part C days as "days entitled to benefits under part A" in calculating hospitals'

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hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived from the data match process for the two Federal fiscal years that spanned the hospital's cost reporting period.); 70 Fed. Reg. 47278, 47439 (Aug. 12, 2005) (stating: "Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period, and *the hospital **must accept** the resulting DSH percentage for that year, whether or not it is a more favorable number than the DSH percentage based on the Federal fiscal year*." (emphasis added)).

[6] *See supra* note 5.

[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).

> disproportionate share hospital ("DSH") calculations. CMS has processed each Provider's SSI ratio realignment determination incorrectly by including Medicare managed care Part C days in each realignment calculation. This is inconsistent with the aforementioned decision. Further, the federal appellate court decision A*llina Health Servs. v. Price* was later upheld by the Supreme Court in *Azar v. Allina Health Services* decided on June 3, 2019.
>
> Each Provider disputes the SSI percentage developed by CMS and utilized by the MAC in their respective updated calculations of Medicare DSH payment. Specifically, each group participant has reviewed the underlying MedPar data CMS used in its SSI ratio realignment determination and has verified CMS incorporated Medicare managed care Part C patients in their determination. The Provider contends this is incorrect based upon the outcome of the Supreme Court decision referenced above.
>
> We contend each Provider's SSI ratio realignment should have been determined in a manner that is consistent with the Medicare statute and specifically it should exclude Medicare managed care Part C days. Calculations setting forth the expected Medicare reimbursement in dispute for each group participant have been submitted to the PRRB. The applicable Medicare regulation is 42 C.F.R. 412.106.

Similarly, Case No. 20-0454GC (as established by Toyon on behalf of Dignity Health) is challenging the inclusion of Part C days in the Medicare Fraction. The issue statement reads:[8]

> The Providers dispute the SSI percentage and the Medicaid percentage utilized by the MAC in its calculation of the Medicare DSH payment. Contrary to the MAC's calculations, all Medicare Part C days should be removed from the SSI Ratio calculation and all dual eligible Medicare Part C days should be included in the numerator of the Medicaid Ratio calculation.
>
> CMS' interpretation of including Medicare Part C Days in the SSI ratio and excluding dual eligible Medicare Part C Days from the Medicaid Ratio is tantamount to retroactive rule making, which the D.C. Circuit held impermissible in the Northeast Hospital decision. The Secretary has not validly changed her interpretation of the DSH calculation and because there is no statute that authorizes the Secretary to promulgate retroactive rules for DSH calculations, the Secretary cannot impose her new interpretation on the DSH

[8] PRRB Case No. 20-0454GC Group Issue Statement (December 6, 2019).

> payment calculation challenged in this appeal. The Providers' position is supported by the federal district court decision in Allina Health Services, et al, v. Kathleen Sebelius, Secretary, U.S. Department of Health and Human Services (Civil Action No. 10-1463 (RMC)).
>
> Under the law, only Medicare paid Part A days should be included in the SSI Ratio and Medicare Part C days should be excluded. Further, certain dual eligible Medicare/Medicaid patient days should have been included in the Medicaid ratio portion of the disproportionate share entitlement calculation. Specifically, the patient days pertaining to Medicaid eligible patients who were enrolled in the Medicare Part C Program (HMO, Managed Care, Medicare Plus Choice, etc.) should have been included in the Medicaid eligible days used to calculate the disproportionate share amount.
>
> The MAC made adjustments to the Providers' reported protest amounts which included this issue. The applicable regulation governing this issue is 42 C.F.R. §412.106.

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

> Two or more providers under common ownership or control that wish to appeal to the Board a specific matter at issue that involves a question of fact or interpretation of law, regulations, or CMS Rulings that is common to the providers, and that arises in cost reporting periods that end in the same calendar year, and for which the amount in controversy is $50,000 or more in the aggregate, must bring the appeal as a group appeal.[9]

Board Rule 4.6.2 also addresses duplicate filings:

> A provider may not appeal an issue from a single final determination in more than one appeal.

As both group appeals are pursuing the same issue, i.e., Part C Days, the Board finds that Case No. 21-0072GC is a duplicate of Case No. 20-0454GC in violation of the CIRP regulations at 42 C.F.R. § 405.1837(b)(1) and (e) and the Board Rules prohibiting duplicate appeals, 4.6.1. In making this ruling, the Board notes that Case No. 20-0454GC was fully formed on January 18, 2023 (*i.e.*, no other provider can join this group without leave of the Board) and that Case No. 21-0072GC has not been designated fully formed.

[9] 42 C.F.R. § 405.1837(b)(1).

Conclusion:

The Board finds that it lacks jurisdiction over the Providers Glendale Memorial Hospital & Health Center (05-0058), Mercy Medical Center Redding (05-0280), Methodist Hospital of Sacramento (05-0590), and Sierra Nevada Memorial Hospital (05-0150) as the issue under appeal in the group was not specifically revised in the RNPRs which were the basis for the respective Providers' appeals.

For the remaining providers appealing from original NPRs, St. Rose Dominican Hospitals Rose De Lima Campus (29-0012), Mercy San Juan Medical Center (05-0516), Saint Francis Memorial Hospital (05-0152), Dominican Hospital (05-0242, and St. Rose Dominican Hospitals Siena Campus (29-0045), the Board dismisses the Medicare Part C Days appeal PRRB Case No. 21-0072GC because Case No. 21-0072GC violates the CIRP regulations at 42 C.F.R. § 405.1837(b)(1) and (e) and the Board Rules prohibiting duplicate appeals, 4.6.1. Accordingly, the Board hereby closes Case No. 21-0072GC and removes it from the Board's docket.

As a result of our review of the record, the Board ***admonishes* Dignity Health and reminds it of its responsibility to oversee** *its designated agents that pursue the claims of Dignity Health and its providers for additional Medicare reimbursement before the Board. Here, Dignity Health* ***improperly*** *authorized two separate representatives (i.e., Toyon and Moss Adams) to submit duplicate appeals for 2017 on behalf of Dignity Health as follows:*

1. *For Case No. 20-0454GC—On January 31, 2020, Kenton Fong (the Dignity Health Director of Reimbursement) executed a representation letter authorizing Toyon to file CIRP group on behalf of Dignity Health for the attached list of 32 hospitals for "the DSH Medicare Part C – SSI Ratio / Dual Eligible Part C – Medicaid Ratio group appeal for FYE 06/30/2017.*

2. *For Case No. 21-0072GC—Kenton Fong (the Dignity Health Director of Reimbursement) executed separate letters of representation for each of the participants in the group where:*

   (a) 4 representation letters were executed between May 2020 and October 2020 and gave blanket authorization to Moss Adams to file appeals with the Board for 2017 with respect to the determination being appealed;

   (b) 4 representation letters were executed on December 20, 2020 and gave specific authorization ***only*** *to appeal "Medicare DSH – CMS Inclusion of Part C Days in the Realigned SSI Ratio" from the determination being appealed; and*

   (c) 1 representation letter was executed on April 22, 2021 and gave specific authorization to file appeals ***only*** *related to Audit No. 34 to update the SSI percentage based on the CMS recalculation dated January 6, 2020.*

Here, Dignity Health had a responsibility to oversee Moss Adams and ensure that Moss Adams did not file, on its behalf, a duplicate CIRP group on the Part C issue that it had already authorized Toyon to file and pursue. The Board reminds Dignity Health that it has a

responsibility to ensure that it (through its agents) properly manages its caseload, complies with the CIRP group requirements, and does not pursue ***prohibited duplicative*** *claims/appeals.*

Similarly, the Board ***reminds*** ***Moss Adams*** *that it should exercise diligence and take care when establishing CIRP groups on behalf of a health care chain* because a health care chain can ***only*** pursue a common issue for a particular year ***in one CIRP group.*** Here, when Moss Adams filed the group appeal request on October 12, 2020, Moss Adams *falsely* certified that "the group issue filed in this appeal is not pending in any other appeal for the same period for the same providers, nor has it been adjudicated, withdrawn, or dismissed for any other PRRB appeal" (NOTE—it was false in two respects: (a) there was already another CIRP group for the same issue and year; and (b) the participants in the group were already in the other CIRP group). Accordingly, the Board ***admonishes*** ***Moss Adams*** *for filing a false certification. To prevent false certifications*, the Board recommends that, in exercising diligence prior to establishing CIRP groups and making the requisite certifications, Moss Adams consult with the corporate offices of the hospital chain regarding any other relevant appeals for that same period/year by providers in that hospital chain (both closed, pending or yet-to-be filed appeals) ***and*** review its own files and those in OH CDMS (both for closed and pending cases that Moss Adams has filed).

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

Board Members:

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

For the Board:

9/8/2023

X Clayton J. Nix

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

cc: Kenton Fong, Dignity Health
Dylan Chinea, Toyon Associates
Wilson C. Leong, Esq. Federal Specialized Services
Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Jennifer Butler
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Byron Lamprecht
WPS Government Health Administrators (J-8)
1000 N 90th Street, Suite 302
Omaha, NE 68114-2708

RE: ***Notice of Dismissal of Appeal due to Untimely Filing of Initial Appeal Request***
PRRB Case No.: 19-1922
Provider No.: 15-0061 (Daviess Community Hospital)
FFY: 2019

Dear Ms. Butler and Mr. Lamprecht:

This case involves Daviess Community Hospital's ("Provider's") appeal of the reconsideration decision to uphold CMS' quality reporting program noncompliance decision, which concluded that the Provider did not meet the requirements of the Inpatient Rehabilitation Facility Quality Reporting Program and therefore was subject to a penalty. Following review of the administrative record in this case, the Provider Reimbursement Review Board ("Board") finds that the Provider failed to timely file its initial appeal request. Accordingly, the Board dismisses this appeal.

Pertinent Facts

On October 1, 2018, CMS issued its reconsideration decision upholding CMS' initial quality reporting program noncompliance decision. In that reconsideration decision letter, CMS indicated that the Provider "may appeal this decision through the Provider Reimbursement Review Board (PRRB) within 180 days of the date of this letter." That letter also indicated that "[f]or additional questions or concerns regarding this reconsideration decision, please contact the Appeals & Reconsiderations Program Lead" and provided that person's name and contact information.

On April 23, 2019, the Board received the Provider's Individual Appeal Request via FedEx, Priority Overnight service. The Initial Appeal Request includes Model Form A, on which the Provider indicated that the Date of Final Determination under Appeal was 02/07/2019[1], and that the final determination was not received more than 5 days after issuance.

[1] In late 2018 and early 2019, the Provider contacted the Appeals & Reconsiderations Program Lead at CMS several times regarding reconsideration. On February 7, 2019, the Appeals & Reconsiderations Program Lead emailed the Provider indicating that she believed she had sent a response in December which further clarified the bases for the reconsideration decision. This email reiterated that the Provider may appeal the reconsideration decision to the PRRB within 180 days of the date of CMS' reconsideration determination letter.

Board's Analysis and Decision

Pursuant to 42 C.F.R. § 405.1868(b) and Board Rule 4.1 (v. 2.0 Aug. 29, 2018), if a provider fails to meet a filing deadline or other requirement established by the Board in a rule or order, the Board may dismiss the appeal with prejudice. Pursuant to 42 C.F.R. § 405.1801(a) and Board Rules 3.2 and 3.3, the date of filing is the date of receipt by the Board, which, as applicable to this case, is the date of delivery by a nationally-recognized next-day courier.

42 C.F.R. § 405.1835(a)(3) states that a provider has a right to a hearing before the Board on a contractor or Secretary determination when, among other things, the date of receipt by the Board of the provider's hearing request must be no later than 180 days after the date of receipt by the provider of the final determination, unless the provider qualifies for a good cause extension under 42 C.F.R. § 405.1836.

In this case, CMS' reconsideration determination letter is dated October 1, 2018. The date of receipt by the provider is presumed to be 5 days after the date of the issuance of the determination letter,[2] and on the Provider's Model Form A, the Provider indicated the final determination was not received more than 5 days after issuance. Therefore, the 180-day deadline plus 5 days for receipt, fell on Thursday, April 4, 2019.

However, the Provider's Initial Appeal Request was not received by the Board until April 23, 2019, which is 204 days after the date of CMS' reconsideration determination letter. Therefore, the Provider's appeal request is untimely.

Board Rule 4.1 provides that "[a]ppeals that fail to meet the timely filing requirements or jurisdictional requirements will be dismissed."[3] Further, 42 C.F.R. § 405.1836 provides that a request for a Board hearing that the Board receives after the applicable 180-day time limit prescribed in 42 C.F.R. § 405.1835(a)(3), must be dismissed by the Board, except that the Board may extend the time limit upon a good cause showing by the provider.[4]

The Board finds that the Provider did not timely file its appeal from the October 1, 2018 final determination. For these reasons, the Board dismisses this appeal in accordance with 42 C.F.R. § 405.1836(a), (e) and Board Rule 4.1. 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.

[2] Board Rule 4.3.1 (Aug. 2018).
[3] *See also* 42 C.F.R. § 405.1868(b).
[4] 42 C.F.R. § 405.1836(b).

Board Members Participating:

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

For the Board:

9/11/2023

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: Ratina S. Kelly -S

cc: Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Allen Carlson
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605 Seventh Fairway Drive
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RE: ***Board Determination on Request to Reinstate***
Case No. 12-0453GC - Sutter Health 2003 Inpatient Crossover Bad Debt CIRP Group
Case No. 12-0452GC - Sutter Health 2003 Outpatient Crossover Bad Debt CIRP Group

Dear Mr. Carlson:

The Provider Reimbursement Review Board (the "Board" or "PRRB") has reviewed the above-captioned common issue related party ("CIRP") group appeals in response to correspondence received from A. Carlson Associates, LLC ("Mr. Carlson" or "Representative") on June 19, 2023. In it, the Representative requests that the Board reconsider its June 16, 2023 "Dismissal for Untimely Filing" and grant a reinstatement of the subject appeals claiming that it timely responded, *by email*, to the Board's May 12, 2023 CIRP Group Status Request. Essentially, the Provider's Representative failed to comply with the Board's mandatory electronic filing requirement that has been in effect for more than 1½ years and requires parties appearing before the Board to file electronically using the Office of Hearings Case and Document Management System ("OH CDMS"). The pertinent facts and the Board's determination are set forth below.

Mandatory Electronic Filing:

Board Rule 2.1 addresses filings with the Board and specifies in 2.1.1 that, effective November 1, 2021, all filings with the Board must be made electronically via OH CDMS.[1] This Rule also provides information on how representatives of parties appearing before the Board can register as users of OH CDMS. Specifically, Board Rule 2.1 states in pertinent part:

> **2.1.1 Mandatory Electronic Filing**
>
> Effective November 1, 2021, all filings must be submitted electronically using OH CDMS unless an **exemption** granted under Rule 2.1.2 applies. OH CDMS is a web-based portal for parties to electronically file and maintain their cases and to correspond with the Board. Access to the system is granted to registered users, as

[1] *See also* Board Rule 3.1 (stating: "Effective November 1, 2021, parties must submit documents and information electronically to the Board through OH CDMS unless an exemption granted under Rule 2.1.2 applies."); Board Rule 2.2.1 (stating: "Pursuant to Rule 2.1.1, all submissions (e.g., appeal requests, correspondence, position papers) must be filed electronically using OH CDMS unless an exemption granted under Rule 2.1.2 applies.").

needed, based on their roles. Access to specific cases is limited to the parties of each case, including party representatives.

Individuals registering for access to OH CDMS should allow for up to ***ten (10) days*** to complete registration as it is a multi-step process to obtain secure access to the web-based portal itself and to OH CDMS.

Refer to the webpage at https://www.cms.gov/Regulations-and-Guidance/ReviewBoards/PRRBReview/Electronic-Filing.html to access links for the following:

1. *The CMS Salesforce Enterprise Integration (SEI) Portal*.— . . . .

2. *The OH CDMS External Registration Manual*.— . . . .

3. *The OH CDMS PRRB User Manual*.— . . . .

. . . . For any technical system issues, please contact the OH CDMS Help Desk at 1-833-783-8255 or email helpdesk_ohcdms@cms.hhs.gov.

2.1.2 Exemptions to Mandatory Electronic Filing

The Board recognizes that, in limited circumstances, it may be necessary for a party to request to file an appeal or other documents in an existing case(s), in ***hard copy***, outside of OH CDMS. A party who desires an exemption to the mandatory electronic filing requirement of Rule 2.1 must file a request as described below. An exemption may be granted for a specified period of time or on a permanent basis. If the Board grants a request, then the Board will explain the scope and duration of the exemption.

A. Disability under Rule 1.6.—If filing through the electronic appeals system cannot be completed or is materially hindered due to a disability (see Rule 1.6), the party should contact the Board at least ***ten (10) days*** prior to the filing deadline. [2]

B. Extraordinary Circumstances.—A party may file in ***hard copy*** a request for an exemption due to extraordinary circumstances. Except in cases of impossibility, the request must be filed in hard copy and received by the Board at least ***ten (10) days*** prior to any filing deadline(s) impacted by the extraordinary circumstances. Please contact the Board at 410-786-2671 and PRRB@cms.hhs.gov for additional information if the request is time sensitive.

[2] (Emphasis in original.)

> **2.1.3 Extension for a Board-Set Deadline Due to Technical Difficulties with Electronic Filing**
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> ****
>
> If a case representative experiences technical issues during filing within OH CDMS (including technical issues related to becoming a registered user), the case representative should seek assistance from the OH CDMS Help Desk to both document their issue and to resolve it prior to the Board-Set Deadline. To the extent the issue cannot be resolved by the Board-Set Deadline and the case representative makes a late filing, then the ***registered*** user should document their issues and submit their filing electronically ***within twenty-four (24) hours*** of the issue being resolved by the Help Desk. As part of this filing, the case representative must request an extension due to technical difficulties and provide satisfactory proof to establish good cause for the late filing. In this regard, the request should:
>
> - Describe the technical issue;
> - Describe when it was identified;
> - Describe their efforts to resolve the issue;
> - Identify the OH CDMS Help Desk ticket number opened to address the issue;
> - Include a copy of the notice from the OH CDMS Help Desk confirming that the technical issue was resolved; and
> - Confirm whether there are any other registered users in the case representative's organization and, if so, explain why the other user(s) could not make the filing.
>
> If the Board finds good cause for the requested extension, then the Board will accept the filing as timely. Note that, for purposes of this Rule, an extension may not be based on administrative oversight, an ongoing discussion for administrative resolution, a change in case representative, or scheduled maintenance for OH CDMS.

The Board provided more than 120 days *advance notice* of the November 1, 2021 mandatory electronic filing requirement (consistent with the September 18, 2020 final rule which specifically authorized the Board to implement mandatory electronic filing).[3] Specifically, by Board Alert 21 and Board Order 1 issued on June 16, 2021, the Board gave 138 days *advance notice* of the mandatory electronic filing requirement going into effect on November 1, 2021.

Further, as OH CDMS went live several years earlier on August 16, 2018, OH CDMS was available and in use by parties appearing before the Board to use on a *voluntary* basis *for more*

[3] 85 Fed. Reg. 58432, 58986 (Sept. 18, 2020).

*than 3 years **prior to** making its use mandatory*.[4] During that 3 year period, the Board encouraged parties appearing before the Board to use the system.[5]

Board Rules 2.2.2 and 3.4 make clear that the Providers' representatives will receive email notice of filings by the opposing party or Board issuances made in OH CDMS for their case(s):

> **2.2.2 Board Correspondence and Decision Issuances**
>
> The Board utilizes OH CDMS to issue its correspondence via email to the parties of an appeal. That includes all types of correspondence, such as the Acknowledgement Letter, Notice of Hearing, requests for additional information or briefings, jurisdictional and substantive decisions, etc. When issued, an email will be sent to all parties with the referenced correspondence included as an attachment. OH CDMS maintains a copy of the correspondence in the electronic record for the relevant appeal(s) for reference in accordance with CMS record retention policies.
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> ****
>
> **3.4 Service on Opposing Parties**
>
> Copies of any document filed with the Board must simultaneously be sent to the opposing party **and** to the Appeals Support Contractor.
>
> **3.4.1 When Both Parties Are Registered for OH CDMS**
>
> OH CDMS will notify both parties and the Appeals Support Contractor of all submissions into the system. If both parties are registered for OH CDMS, then the system-generated notice confirming the correspondence will satisfy the requirement for service on the opposing party.

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[4] Board Alert 14 (Aug. 16, 2018) (announcing electronic filing is available through OH CDMS on a *voluntary* basis and encouraging parties appearing before the Board to register for the system and begin to use it.

[5] *See* Board Alert 13 (Aug. 2, 2018) (announcing that electronic filing was coming soon and encouraging pre-registration; Board Alert 14 (Aug. 16, 2018) (announcing that OH CDMS was now available for voluntary use and encouraging registration and use); Board Alert 18 (Sept. 25, 2018) (announcing temporary relocation of the Board due to a building emergency and encouraging Providers to file and correspond with the Board using OH CDMS); Board Alert 19 (Mar. 25, 2020) (announcing temporary changes in Board processes due to the Covid-19 pandemic and encouraging Providers to register with OH CDMS, if they have not done so, and to file and correspond with the Board using OH CDMS); Board Alert 20 (Aug. 20, 2020) (announcing a change in mailing address for the Board and encouraging providers to file and correspond with the Board using OH CDMS). *See also* Board Alert 15 (Aug. 29, 2018) (announcing the issuance of new Board Rules that introduce and incorporate OH CDMS into the Board processes); Board Alert 17 (Mar. 18, 2019) (requesting comments, feedback and experience on the implementation of OH CDMS and confirming that the Board was reviewing implementation of mandatory electronic filing consistent with the November 13, 2015 final rule at 80 Fed. Reg. 70298, 70551-70580, 70597-70604 (Nov. 13, 2015)).

Significantly, all Board issuances are shown as being sent from "noreply@salesforce.com on behalf of PRRB <prrb_ohcdms@cms.hhs.gov>." Exhibit A attached to this decision includes examples of this.

Finally, both *prior to* ***and*** after mandatory electronic filing in OH CDMS became mandatory, Board Rule 3.2 makes clear that emails are not an acceptable form of filing: "CAUTION: The Board does ***not*** accept appeals or other correspondence submitted by email or fax." This warning has been in Board Rule 3.2 since August 29, 2018.

Pertinent Facts:

On March 25, 2020, the Board issued Board Alert 19 to provide information on the temporary adjustments made to its processes and operations as a result of the public health emergency issued in connection with the COVID-19 virus. Among other things, Alert 19 provided the following guidance on filing electronically using the then-voluntary OH CDMS:

> **1. How to make filings with the Board.**
>
> - *Electronic Filings.* ***The Board encourages Providers to file and correspond electronically*** using OH CDMS. If you have not signed up to use OH CDMs, please visit the PRRB Electronic Filing webpage at https://www.cms.gov/Regulationsand-Guidance/Review-Boards/PRRBReview/Electronic-Filing or contact the Board via email at PRRB@cms.hhs.gov for more information.
>
> - *Hard Copy filings*. The Board and CMS support staff are currently maximizing telework in response to the March 17, 2020 OMB Directive (M-20-16), and are not on site. Therefore, if you make ***hard copy*** filings with the Board during the pendency of the Board's temporary change in operations, Board action on that filing will be delayed until after normal operations resume. Below are the instructions for making hard copy filings . . . .
>
> **2. Suspension of "Board-Set Deadlines" from Friday, March 13, 2020 Forward.**
>
> The Board has set deadlines to make certain filings in existing appeals including, but not limited to, deadlines for filing preliminary or final position papers, Schedules of Providers, witness lists, and case status reports (hereinafter "Board-Set Deadlines"). The Board encourages Providers and their representatives to continue to make these filings ***electronically*** through OH CDMS, as appropriate and in keeping with public health precautions. However, as the use of OH CDMS is not yet mandatory, the Board is suspending "Board-Set Deadlines" from Friday, March 13, 2020 forward until the Board is back to normal

> operations (see 42 C.F.R. § 405.1801(d)). Once the Board is in position to resume its normal operations, the Board will reassess the public health situation and post an alert for further guidance on the deadlines for these suspended filings.[6]

On May 21, 2020, the Board issued a "CIRP Group Status Request" in Case Nos. 12-0453GC and 12-0452GC. The notices confirmed that no providers had been added to either group since August 23, 2012 (*i.e.*, in over 10 years) and required the Representative to advise the Board, no later than August 22, 2020, whether the groups were fully formed based on existing participants. The Board's notice also requested that, if the groups were not yet complete, the Representative must identify the providers that had not yet received final determinations. The notices stated that "[f]ailure to submit a timely response to this request will result in dismissal of the case." Mr. Carlson did not file a response by the deadline but the Alert 19 suspension was in effect. No other activity subsequently occurred in these two cases.

On June 16, 2021, the Board issued an Alert via email to all representatives and providers to give them 120 days advance notice that it was adopting the OH CDMS mandatory electronic filing effective November 1, 2021 and provided an advance copy of the revised Rules.[7] Similarly, **on September 30, 2021**, the Board issued further revisions to Rules (which did not relate to the OH CDMS mandatory electronic filing requirement) and reaffirmed that the OH CDMS mandatory electronic filing requirement was effective November 1, 2021.[8]

On **November 7, 2022**, the Board issued Alert 23 and Board Order No. 3 to revoke Alert 19 effective December 7, 2022. More specifically, this Alert notified providers that "***Effective Wednesday, December 7, 2022***, Board Order No. 3 ceases suspension of deadlines and will hold parties to the deadline specified in: (1) any Board rule or instruction; and/or (2) any Board notice or correspondence issued ***on or after that date***."[9] Further the Alert specified with respect to suspended but unmet deadlines:

> For those previously suspended deadlines (original or revised) which have not been met and which have not been reissued with deadlines specifically *exempted* from Alert 19, Board Order No. 3 specifies that the Board will issue revised Notices of Hearing or Notices of Critical Due Dates on a rolling basis over the next 6 months, establishing new deadlines consistent with current Board Rules. If you have questions regarding your Notice of Hearing, please submit them in correspondence through OH CDMS on your specific case or contact the Board Advisor assigned to your case. If you have questions regarding any other deadline or

[6] (Emphasis in original.)
[7] Board Alert 21 (June 6, 2021) (available at: https://www.cms.gov/files/document/prrb-alerts.pdf (last visited Aug. 21, 2023)).
[88] Board Alert 22 (Sept. 30, 2021) (available at: https://www.cms.gov/regulations-and-guidance/review-boards/prrbreview/prrb-alerts (last visited Aug. 21, 2023))
[9] (Emphasis in original.)

> Notice, please submit them in correspondence through OH CDMS on your specific case.[10]

Finally, this Alert further reminded the provider community that the mandatory electronic filing went into effect on November 1, 2021.

On **May 12, 2023,** *consistent with Alert 23 and Board Order No. 3*, the Board issued another "CIRP Group Status Request" in Case Nos. 12-0453GC and 12-0452GC. The Status Requests again stated that no providers had been added to either group since August 23, 2012 (*i.e.*, in over 10 years) and required the Representative to advise the Board, no later than June 11, 2023, whether the groups were fully formed based on existing participants. The Board's Status Requests also instructed that, if the groups were not yet complete, the Representative must identify the providers that had not yet received final determinations. The Status Requests stated that "[f]ailure to submit a timely response to this request will result in dismissal of the case." Mr. Carlson again failed to properly file a response by the deadline.

On **June 16, 2023**, the Board dismissed both group cases for their failure to respond to the CIRP Group Status Requests by the deadline.

On **June 19, 2023**, Mr. Carlson filed a Response to the Dismissal Notices through the Office of Hearings Case & Document Management System ("OH CDMS") using the "Other Case Correspondence" feature. The Response consisted of a printout of an alleged reply-to-all email sent to prrb_ohcdms@cms.hhs.gov on June 19, 2023. This filing included several attachments:

(1) A copy of the Board's May 12, 2023 CIRP Group Status Request;

(2) A copy of the reply-to-all email dated May 15, 2023 from Mr. Carlson to prrb_ohcdms@cms.hhs.gov stating that it received a CIRP group status request letter in this these two cases but that "these group appeals are not fully formed because a Notice of Program Reimbursement has not yet been issued for the related hospital Provider #05-0047, California Pacific Medical Center for cost reporting period that ended on 12/31/2003"; and

(3) a copy of the Board's June 16, 2023 notice of dismissal for untimely filing.

The June 19, 2023 Response requested reinstatement of the subject group cases because it contends that the May 15, 2023 email shows that Mr. Carlson timely submitted a reply to the Board's May 12, 2023 CIRP Group Status Requests (by using a reply-to-all email) and that in that response he advised that the groups were not fully formed because he was still awaiting issuance of a final determination for California Pacific Medical Center. The June 19, 2023 Response further referenced language in the attached May 15, 2023 email wherein he requested that the Board inform him ". . . that this response is sufficient or give me further instructions on how to respond."[11]

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[10] (Underline emphasis added; italics in original.) *See also* Board Order 3 (available at: https://www.cms.gov/regulations-and-guidance/review-boards/prrbreview/prrb-instructions (last visited on Aug. 22, 2023).

[11] The email recipients on the "reply all emails" are "prrb_ohcdms@cms.hhs.gov"; jeprrbappeals@noridian.com; and board@fssappeals.com.

Board Determination:

The Board has reviewed the facts in the 2 subject CIRP group cases, as well as the Representative's June 19, 2023 Request for Reinstatement. Reinstatements are governed by Board Rule 47 which states in pertinent part:

> **Rule 47 Reinstatement**
>
> **47.1 Motion for Reinstatement**
>
> A provider may request reinstatement of an issue(s) or case within three years from the date of the Board's decision to dismiss the issue(s)/case or, if no dismissal was issued, within three years of the Board's receipt of the provider's withdrawal of the issue(s) (*see* 42 C.F.R. § 405.1885 addressing reopening of Board decisions). The request for reinstatement is a motion and must be in writing setting out the reasons for reinstatement (*see* Rule 44 governing motions). The Board will not reinstate an issue(s)/case if the provider was at fault. If an issue(s)/case was remanded pursuant to a CMS ruling (e.g., CMS Ruling 1498-R), the provider must address whether the CMS ruling permits reinstatement of such issue(s)/case. If the Board reinstates an issue(s) or case, the provider will have the same rights (no greater and no less) that it had in its initial appeal. . . .
>
> ****
>
> **47.3 Dismissals for Failure to Comply with Board Procedures**
>
> Upon written motion demonstrating good cause, the Board may reinstate a case dismissed for failure to comply with Board procedures. Generally, administrative oversight, settlement negotiations or a change in representative will not be considered good cause to reinstate. If the dismissal was for failure to file with the Board a required position paper, Schedule of Providers, or other filing, then the motion for reinstatement must, as a prerequisite, include the required filing before the Board will consider the motion.[12]

As set forth below, the Board finds that Mr. Carlson has failed to establish good cause for reinstating these 2 appeals because he was at fault due to administrative oversight in failing to properly and timely file a response in OH CDMS for each case.

The Board finds that, for each case, Mr. Carlson's June 16, 2023 "reply-all-email" response sent to prrb_ohcdms@cms.hhs.gov violates the Board's Rules, which were last revised November 1, 2021.

[12] (Bold and italics emphasis in original and underline emphasis added.)

Per to Board Rules 2.1.1, 2.2.1, and 3.1, effective November 1, 2021, **ALL** filings with the Board must be submitted to the Board electronically *using OH CDMS* unless an exemption granted under Board Rule 2.1.2 applies. The Board notes that no exception was requested, nor granted, to file any correspondence outside of OH CDMS. Finally, Board Rule 3.2 explicitly states emails are not accepted: "The Board does ***not*** accept appeals or other correspondence submitted by email or fax."[13]

The May 15, 2015 reply-to-all email that Mr. Carlson attached to its response submitted in both Case Nos. 12-0453GC and 12-0452GC does ***not*** *comply* with the mandatory electronic filing requirement and, therefore, neither can be recognized under Board Rules as a timely response to the CIRP Group Status Requests. Because the original May 15, 2023 reply-to-all email for both CIRP groups was not properly filed, neither can be included in the Case History records for these 2 cases.[14]

Board Rule 4.4.2 states the following:

> *All filings* other than an appeal request or request to add issues (*e.g.*, position papers and other responsive documents) ***must*** *be received by the Board no later than the date specified on the Board's notice* or, if silent, the date specified in these Rules. If a party fails to file by the established due date, the Board may take action as described in 42 C.F.R. § 405.1868. For example, Rule 23.4 addresses the timely filing of preliminary position papers and specifies that the Board will dismiss the appeal if the representative for the provider(s) fails to file their preliminary position paper or PJSO by the established due date.

Further, Board Rule 4.5 addresses the "date of receipt by the Board" and confirms that it is governed by the date of filing in OH CDMS unless an exemption under 2.1.2 is granted (which was not in this case and none of which permit email):

> **4.5 Date of Receipt by the Board**
>
> The timeliness of a filing is determined based on the date of receipt by the Board. The date of receipt is presumed to be:
>
> A. The date of filing in OH CDMS as evidenced by the Confirmation of Correspondence generated by the system; or
>
> B. If the filing is permitted pursuant to an exemption under Rule 2.1.2, the date of receipt is:

[13] (Emphasis added.) Board Rule 3.2 has had this exact language in it since August 29, 2018.
[14] The May 15, 2023 email replies are included in the records *only* as exhibits to the Requests for Reinstatement filed in OH CDMS.

> • The date of delivery to the Board as evidenced by the courier's tracking bill for documents transmitted by a nationally-recognized next-day courier. . . . See 42 C.F.R. § 405.1801(a)(2)(i).
>
> • The date stamped "received" by the Board on documents submitted by regular mail, hand delivery, or couriers not recognized as a national next-day courier. See 42 C.F.R. § 405.1801(a)(2)(ii).

As the Provider's representative, Board Rule 5.2 specifies that Mr. Carlson is responsible for being familiar with and complying with Board rules and procedure and warns that failure to carry out these responsibilities will not be considered good cause for failure to comply with a filing deadline:

> **5.2 Responsibilities**
>
> The case representative is responsible for *being familiar with the following rules and procedures for litigating before the Board*:
>
> • The Board's governing statute at 42 U.S.C. § 1395oo;
> • The Board's governing regulations at 42 C.F.R. Part 405, Subpart R; and
> • *These Rules*, which include any relevant Orders posted at https://www.cms.gov/Regulations-and-Guidance/ReviewBoards/PRRBReview/PRRB-Instructions (see Rule 1.1).
>
> Further, the case representative is responsible for:
>
> • Ensuring his or her contact information is current with the Board, including a current email address and phone number;
> • *Meeting the Board's deadlines*; and
> • *Responding timely to correspondence or requests from the Board* or the opposing party.
>
> *Failure of a case representative to carry out his or her responsibilities is not considered by the Board to be good cause for failing to meet any deadlines*. Withdrawal of a case representative or the recent appointment of a new case representative will also not be considered good cause for delay of any deadlines or proceedings.[15]

In this regard, the Board notes that Mr. Carlson has been a provider representative for cases before the Board for over a decade and, thus, has experience and is required to be familiar with the Board Rules, including the revisions made across that period of time.[16]

Further, the Board suspects that the alleged reply-to-all emails included in Mr. Carlson's filing may have been modified because autogenerated emails from the Board are *not* issued directly from

[15] (Italics emphasis added.)
[16] *See* Board Rule 5.2, quoted above.

"prrb_ohcdms@cms.hhs.gov" (as Mr. Carlson's filing would suggest).[17] Rather, they are *autogenerated* from "noreply@salesforce.com < noreply@salesforce.com> On Behalf Of CMS PRRB_OHCDMS."[18] To document this, the Board has included as Exhibit A, a copy of the autogenerated email (without attachment) that was sent to Mr. Carlson in both Case Nos. 12-0453GC and 12-0452GC on May 12, 2023. Regardless, as discussed above, the email was not (and could not be considered) a proper filing as set forth in the Board Rules. Finally, the Board notes that prrb_ohcdms@cms.hhs.gov is an unmonitored email address that is used relative to all OH CDMS notifications to parties for purposes of Board Rules 2.2.2, 3.4, and 4.5. Similarly, if he had a general inquiry for the Board (*i.e.*, not a filing/submission in a case), he should have sent an email to PRRB@cms.hhs.gov or called 410-796-2671 (note the Board's telephone number is included in its letterhead for all issuances including the May 12, 2023 CIRP Group Status Requests at issue).[19]

The Board recognizes that, in the May 15, 2023 reply-to-all email, Mr. Carlson states, "I was unable to respond to these emails through www.sei.cms.gov apparently because the group was not fully formed." The portal to OH CDMS is at www.sei.cms.gov. As such, this statement confirms Mr. Carlson was able to access OH CDMS but it is unclear how he tried to "respond" or what issue he was having. The Board is puzzled by his statement since the filing of his response could easily be done using the "Other Case Correspondence" feature (similar to what he did to file his June 19, 2023 reinstatement request[20]). The Board notes that the deadline was not until several weeks later on Monday June 12, 2023[21] but Mr. Carlson did not attempt to resolve his identified issue by contacting the OH CDMS help desk as directed by Board Rules 2.1.1 and 2.1.3 (*see* above excerpts). Under Board Rule 2.1.3, Mr. Carlson does not qualify for an extension on the filing deadline until June 19, 2023 (*i.e.*, the date he *belatedly* filed his response) because his June 19, 2023 reinstatement request wholly fails to meet any of the requirements stated in the Rule. More specifically, the reinstatement request failed to: (a) properly describe the technical issue; (b) describe his efforts to resolve the issue; (c) identify the OH CDMS Help Desk ticket number opened to address the issue; and (d) provide the response from the Help Desk confirming that the issue had been resolved to document that the filing is made in OH CDMS *within 24 hours* of that Help Desk confirmation. Here, it appears that there it was simply administrative error or oversight because, as noted above, Mr.

---

[17] For example, at the bottom of page 1 of Mr. Carlson's June 19, 2023 filing, it shows the email history with the email to which the reply-to-all was allegedly selected; however no "From" email address is listed but rather is shown simply as: "From 'PRRB'". Similarly, at the top of page 2, is an alleged autogenerated email received from OH CDMS showing the following address from which the email was allegedly sent as: "From: 'PRRB' <prrb_ohcdms@cms.hhs.gov>".

[18] The Board staff have received emails from representatives forwarding an email received from noreply@salesforce.com on behalf of PRRB <noreply@salesforce.com>, and the forwarded email continues to show the "noreply@salesforce.com on behalf of PRRB <prrb_ohcdms@cms.hhs.gov>" or "noreply@salesforce.com on behalf of PRRB."

[19] As stated on the Board's home webpage, '[q]uestions about the PRRB may be directed to PRRB@cms.hhs.gov or 410-786-2671." https://www.cms.gov/medicare/regulations-guidance/provider-reimbursement-review-board The Board also includes this email address and phone number for the Board contact purposes on the first page of Board Rules. https://www.cms.gov/files/document/current-prrb-rules-v-31-board-order-no-2-november-1-2021.pdf It is this email that the Board monitors for general inquires (not filings). However, Mr. Carlson did not email this email address.

[20] In the June 19, 2023 email that is the first page of the June 19, 2023 filing, Mr. Carlson notes that "I'm also attempting to scan and copy this email and their related previous emails for an additional submission/request through sei.cms.gov." The June 19, 2023 email has a time of 4:45 pm PDT and Mr. Carlson then apparently had no issues in doing the described scanning/copying, and then making the filing ***in OH CDMS*** (as described there) roughly 30 minutes later using the "Other Case Correspondence" feature at 8:14 pm EDT (*i.e.*, 5:14 pm PDT) on June 19, 2023.

[21] As the 30-day deadline fell on Sunday, June 11, 2023, the deadline is moved to the next business day, *i.e.*, Monday, June 12, 2023.

Carlson had no problems filing his June 19, 2023 reinstatement request in response to the Board's June 16, 2023 dismissal.[22]

Finally, Mr. Carlson should have known *not* to email the Board and that an email is *not* (and cannot be) considered a filing. The Board takes administrative notice that it *previously* specifically instructed Mr. Carlson to come into compliance with the mandatory electronic filing requirement. In correspondence dated February 18, 2022 involving 29 group cases,[23] Mr. Carlson was previously advised, ***in each of those cases***, that he must comply with the mandatory OH CDMS electronic filing requirements and warned that failure to do so could result in dismissal:

> In setting the above deadline, the Group Representative should be aware that effective November 1, 2021, the Board's Rules require that all filings must be submitted to the Board electronically through OH CDMS unless an exemption granted under Board Rule 2.1.2 applies. In this regard, on June 16, 2021, Board Alert 21 and Board Order No. 1 were issued by the Board to give the provider community more than 120 days' notice of this new requirement:
>
> > Effective November 1, 2021, ***all*** *submissions* to the Board for new or pending appeals (e.g., appeal requests, correspondence, position papers) ***must*** *be filed electronically* using the Office of Hearings Case and Document Management System ("OH CDMS"), unless the Board grants an exemption.
>
> Concurrent with this notice, and effective for any filings made on or after November 1, 2021, the Board published revised Board Rules to implement this new requirement at Board Rule 2.1.1.3 As explained in Board Rule 2.1.1, OH CDMS is a web-based portal for parties to enter and maintain their cases and to correspond with the Board. Access to a specific case is limited to the parties of that case and the parties' designated representatives.
>
> Notwithstanding, it has come to the Board's attention that the Group Representative has recently failed to comply with the mandatory electronic filing requirement in another matter and continues to not be a registered user in the Office of Hearings Case & Document Management System ("OH CDMS"). ***The Board reminds the Group Representative*** *of his obligation to comply with Board Rules including Board Rule 2.1.1 governing mandatory electronic filing and that failure to comply may result in remedial*

[22] *See supra* note 22.
[23] This notice was include in all of the following 29 group cases: 97-2983G, 98-0212G, 99-3523GC, 99-3524GC, 99-3526GC, 99-3527GC, 99-3529GC, 99-3578GC, 02-2168G, 02-2169G, 02-2170GC, 02-2171GC, 02-2172GC, 02-2173G, 02-2175GC, 02-2177GC, 06-1749GC, 07-1710GC, 07-1725GC, 08-0131G, 08-0281G, 09-0025GC, 09-0026GC, 09-0421GC, 09-0422GC, 09-1764GC, 10-1311G, 10-1312G, 10-1376GC.

> *action such as dismissal*. Instructions on how to register to become a user of OH CDMS, can be found at https://www.cms.gov/Regulations-andGuidance/Review-Boards/PRRBReview/PRRB-Instructions.
>
> *Further, be advised that the above-noted filing deadline is **firm**, and the Board specifically **exempts** it from the Board Alert 19 suspension of filing deadlines*. As a result, failure of the Group Representative to timely file in compliance with Board Rule 2.1.1 without a Board-approved extension may result in dismissal or other remedial action pursuant to 42 C.F.R. § 405.1868(b).[24]

At the time, Mr. Carlson was not yet a registered user in OH CDMS and, as such, the Board's February 18, 2022 letter directed Mr. Carlson to links providing instruction on how to become a registered OH CDMs user. Accordingly, following the Board February 18, 2022 letters, Mr. Carlson did go through the process to become a registered OH CDMS user and, in those 29 group cases, complied with the February 18, 2022 directive by timely making the requisite filing in OH CDMS on March 14, 2022.[25] Further, Mr. Carlson made a subsequent filing on November 30, 2022 using OH CDMS in these same 29 cases. Thus, Carlson has demonstrated both that he is an OH CDMS user and knows how to properly file within OH CDMS. Notwithstanding, Mr. Carlson failed to make a proper and timely filing in the instant cases.

Based on the above, the Board hereby denies Mr. Carlson's request for reinstatement finding that he is at fault and has failed to establish good cause under Board Rule 47 as the cause for the late filing appears to be administrative error. In summary, the Board notes the following:

1. These 2 CIRP group cases are not fully formed and, ***for roughly 9 ½ years***, there has been no activity on the part of Mr. Carlson (*e.g.*, there were no updates and no participants added).[26]

2. Mr. Carlson failed to properly and timely respond to two separate Board "CIRP Group Status Requests" issued on May 21, 2020 and on May 12, 2023 in both Case No. 12-0453GC and 12-0452GC. Each Status Request noted it had been 10 years since any provider was added ***and*** *specified that "[f]ailure to submit a timely response to this request will result in the dismissal of the case*."[27] However, no response was timely filed in OH CDMS per Board Rule 2.1.1 (mandatory electronic filing) and 4.5(A) (date of Board receipt).

3. Emails to the Board are ***not*** accepted by the Board and ***not*** considered a filing under Board Rules but rather filings must be made electronically *using OH CDMS* per Board Rule 2.1:

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[24] (Emphasis in original but footnotes omitted.)
[25] Specifically, a response was due within 30 days from February 18, 2022 in these 29 cases and Mr. Carlson timely filed his response in OH CDMS on March 14, 2022 *as a registered user of OH CDMS.*
[26] In both cases, the last filing was made in November 2014.
[27] NOTE—Alert 23 and Board Order 3 notified providers and representative that Alert 19 had been revoked effective December 7, 2022 and, thus, was not in effect when the Board issued the May 12, 2023 CIRP Group Status Request. Further, Mr. Carlson's June 20, 2023 Reinstatement Request does not claim any reliance on Alert 19 nor does he dispute his obligation to respond to the May 12, 2023 status request issued in both CIRP group cases.

- Through Board Alerts 20 and 21, Mr. Carlson was given advance notice and copy of the OH CDMS mandatory electronic filing requirement and notified that this requirement as effective November 1, 2021. Thus, OH CDMS mandatory electronic filing has been in effect for *over 2½ years now*.

- No exemption to the mandatory electronic filing requirement was granted under Board Rule 2.1.2 and the June 19, 2023 reinstatement request does not provide any basis for such an exemption.

- Since August 29, 2018, Board Rule 3.2 has warned that "The Board does ***not*** accept appeals or other correspondence submitted by email or fax."[28]

- Board Rule 2.1.1 states: "For any technical system issues, please contact the OH CDMS Help Desk at 1-833-783-8255 or email helpdesk_ohcdms@cms.hhs.gov." In addition, as previously noted, the Board's website states: "Questions about the PRRB may be directed to PRRB@cms.hhs.gov or 410-786-2671." However, no such assistance was sought. Similarly, neither May 15, 2023 reply-to-all email nor the June 19, 2023 reinstatement request present any technical issues that would qualify as good cause under Board Rule 2.1.3 to extend the Board-set deadline due to technical difficulties. Indeed, Mr. Carlson apparently had no issue filing the June 19, 2023 reinstatement request in OH CDMS.[29]

4. Mr. Carlson was familiar with the OH CDMS mandatory electronic filing requirement because:

   - By letters dated February 18, 2022 issued in 29 different group cases, the Board ordered Mr. Carlson to come into compliance with the OH CDMs mandatory electronic filing requirement and provided information on how he could become a registered user. The Board further warned that failure to comply with the requirement could result in dismissal.

   - On or around March 14, 2022, Mr. Carlson became a register user of OH CDMS and made multiple electronic filings using OH CDMS on and after that date.

   - As Mr. Carlson has been a provider representative for cases before the Board for over a decade, he has experience and familiarity with Board Rules as required by Board Rule 5.2 and should be familiar both with the OH CDMs mandatory electronic filing requirement in Board Rule 2.1 and the fact that the Board does ***not*** accept any email filings per Board Rules 2.1 and 3.2.

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[28] (Emphasis in original.)
[29] *See supra* note 22 (explaining how it is clear that Mr. Carlson had no problems filing the June 19, 2023 reinstatement request using the "Other Case Correspondence" feature in OH CDMS).

Accordingly, pursuant to its authority under 42 C.F.R. § 405.1868(b) and consistent with the May 12, 2023 CIRP Group Status Request, Alert 23, Board Order No. 3, and Board Rules 2.1, 3.2, and 47, the Board **denies** the request for reinstatement and Case Nos. 12-0453GC and 12-0452GC remain closed.

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

For the Board:

9/15/2023

X Clayton J. Nix

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

Enclosures – Exhibit A – Print Out of May 12, 2023 email to Mr. Carlson issued in both Case Nos. 12-0453GC and 12-0452GC (without attachment)

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
7500 Security Boulevard
Mail Stop: B1-01-31
Baltimore, MD 21207
410-786-2671

Via Electronic Delivery

Venus Marin Bautista
Director of Strategic Planning and Reimbursement
Huntington Memorial Hospital
100 W. California Blvd.
Pasadena, CA 91105

RE: ***Request for Reconsideration***
Huntington Memorial Hospital (Prov. No. 05-0438)
FYE 12/31/2010
Case No. 15-2600

Dear Ms. Bautista,

The Provider Reimbursement Review Board ("Board") has reviewed the letter requesting reconsideration ("Request for Reconsideration") submitted by Huntington Memorial Hospital ("Provider") on July 21, 2023. The decision of the Board is set forth below.

Pertinent Facts:

On May 12, 2015, the Provider Reimbursement Review Board ("Board") received an Individual Appeal Request from Huntington Memorial Hospital ("the Provider") challenging a Notice of Program Reimbursement ("NPR") dated November 10, 2014, for fiscal year ending December 31, 2010. In the original appeal, the Provider included multiple issues such as Medicare Bad Debt, Medicare Disproportionate Share Hospital payments, and Rehab LIP payments. The Medicare Bad Debt issue remained the sole issue in the case until the Board's dismissal on July 10, 2023.

Prior to the Board's July 10, 2023dismissal, the Board issued a Notice of Hearing and Critical Due Dates on February 13, 2023, which set a due date of July 7, 2023 for the filing of Final Position Paper ("FPP") from the Provider. The Notice of Hearing also informed the Provider of the Board's authority to close the case for failure to meet the July 7, 2023 deadline. As the Provider failed to file its FPP by that deadline, the Board dismissed this case on July 10, 2023.

On July 21, 2023, the Board received a Reconsideration Request from the Provider informed the Board that it was in the midst of an administrative resolution process for this case and, as such, was seeking reinstatement and additional time to this process. In the Request, the Provider simply states that they have been working with the Medicare Contractor to administratively resolve the remaining issue. However, the Provider did not include the missing FFP and states that it has no intention of filing FPP or pursuing a hearing. As such, any fault associated with failing to include copies of the FPP/record of MAC's agreement to administratively resolve the issue with the Request rest with the Provider.

Statutory and Regulatory Background

Pursuant to Board Rule 27.1, filing of final position papers remains mandatory for appeals filed prior to August 29, 2018. Rule 19.2 specifies that:

> [T]he final position paper remains a required filing, and failure to timely file the final position papers may result in dismissal of the case. ***Exception:*** If, before the final position paper deadline, a provider files a withdrawal request, or the parties file a fully executed Administrative Resolution withdrawing the case, and the Board has not yet officially sent notice acknowledging closure of the case, the parties are not expected to file final position papers as the withdrawal is self-effectuating (see Rule 46).

In addition, under 42 C.F.R. § 405.1885(a)(1), the Board may reopen its decision with respect to specific findings on matters at issue in the decision. A request from a provider to reopen a Board decision must be made within three (3) years of the decision.[1] Jurisdiction for reopening a Board decision rests exclusively with the Board.[2]

Similarly, the Board's rules allow for reinstatement of a case upon a written motion by the provider made within three (3) years of date of the Board's decision to dismiss the case. The request must set out the reasons for reinstatement, and the Rules provide that the Board will not reinstate a case if the provider was at fault.[3] The Board may reinstate a case dismissed for failing to comply with Board Procedures if the provider demonstrates good cause. Generally, administrative oversight is not considered good cause. If the dismissal was for failure to include some type of filing, the Request for Reinstatement must include a copy of the filing to be considered by the Board.[4]

Board's Decision:

The Provider has filed the Request for Reconsideration; however, it provides no explanation that could constitute "good cause" for failing to comply with Board procedures and, in fact, does not even provide documentation of MAC's agreement to the administrative resolution of the issues. Indeed, the request simply asserts that the Provider has been working with the MAC to administratively resolve the remaining issues and a need for reinstatement to complete this resolution process. Finally, the Provider has failed to include the missing FPP filing with its reinstatement request which as Board Rule 46.3 makes clear is a *prerequisite* to Board consideration of this reinstatement:

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[1] 42 C.F.R. § 405.1885(b)(2).
[2] 42 C.F.R. § 405.1885(c).
[3] PRRB Rule 47.1.
[4] PRRB Rule 47.3.

> If the dismissal was for failure to file with the Board a required position paper, . . . then the motion for reinstatement must, as a prerequisite, include the required filing before the Board will consider the motion."

Instead, the Provider makes clear it has no intention in filing its FPP. As previously noted, administrative oversight is not considered good cause. Accordingly, the Board hereby denies Provider's Request for Reinstatement.

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

Board Members Participating:

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

For the Board:

9/15/2023

X Clayton J. Nix

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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

RE: ***Board Decision – SSI Percentage (Provider Specific), Medicaid Eligible Day & UCC Payment Distribution Pool***
Longview Regional Medical Center (45-0702)
FYE: 09/30/2016
Case Number 19-1446

Dear Mr. Summar,

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

Background:

A. Procedural History for Case No. 19-1446

On February 25, 2019, Longview Regional Medical Center submitted a request for hearing from a Notice of Program Reimbursement ("NPR") dated September 4, 2018. The hearing request included the following issues:

- Issue 1: Disproportionate Share Hospital (DSH) Payment Supplemental Security Income (SSI) Percentage- Provider Specific
- Issue 2: Disproportionate Share Hospital (DSH) Payment Supplemental Security Income (SSI) Percentage[1]
- Issue 3: DSH- Medicaid Eligible Days
- Issue 4: Uncompensated Care ("UCC") Distribution Pool
- Issue 5: 2 Midnight Census IPPS Payment Reduction[2]

As the Provider is commonly owned by Community Health Systems ("CHS"), the Provider transferred issues 2 and 5 to common issue related party ("CIRP") group appeals for CHS. As a result of these transfers, three issues remain pending in the appeal: Issue 1 – SSI (Provider Specific), Issue 3 – Medicaid Eligible Days, and Issue 4 – UCC Distribution Pool.

[1] The Provider transferred this issue to Case No. 19-1409GC on September 24, 2019.
[2] The Provider transferred this issue to Case No. 19-1410GC on September 24, 2019.

On May 17, 2019, the MAC filed a Jurisdictional Challenge over Issue 1- DSH SSI Provider Specific, Issue 4-Uncompensated Care Distribution, and Issue 5- 2 Midnight Census IPPS Payment Reduction.

On October 15, 2019, the Provider filed its preliminary position paper. As part of this filing the Provider promised that "the Medicaid eligible days listing [was] being sent under separate cover."

As no such listing was filed or sent, on December 13, 2019, the Medicare Contractor requested that the Provider's representative submit the listing and supporting documentation within 45 days. However, the Provider did not file a response within that time frame.

On February 19, 2020, the Medicare Contractor filed its preliminary position paper.

On January 6, 2023, the Medicare Contractor filed its second request for the Provider's representative to submit the Medicaid eligible days listing with supporting documentation within 30 days. Again, the Provider's representative failed to file a response within that time frame.

Accordingly, due to the non-responsiveness of the Provider, on July 4, 2023, the Medicare Contractor filed a Motion to Dismiss Issue 3- DSH Medicaid Eligible Days. Significantly, the Provider did not respond to the MAC's Jurisdictional Challenge or Motion to Dismiss. Pursuant to Board Rule 44.4.3: "Providers must file a response within 30 days of the Medicare contractor's jurisdictional challenge. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

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

The Provider's appeal request describes Issue 1 – DSH SSI Percentage (Provider Specific) issue as follows:

> The Provider contends that the MAC did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the MAC's calculation of how the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations.
>
> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.

> The Provider contends that the SSI percentage issued by CMS is flawed.
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[3]

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

> **Statement of the Issue:**
>
> Whether the Secretary properly calculated the Provider's [DSH]/[SSI] percentage, and whether CMS should be required to recalculate the SSI percentages using a denominator based solely upon covered and paid for Medicare Part A days, or alternatively, expand the number of the SSI percentage to include paid/covered/entitled as well as unpaid/non-covered/eligible SSI days?
>
> **Statement of the Legal Basis:**
>
> The Provider(s) contend(s) that the MAC's determination of Medicare Reimbursement for their DSH payments are not in accordance with the Medicare statute 42 U.S.C. §1395ww(d)(5)(F)(vi). The Provider(s) further contend(s) that the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") and used by the MAC to settle their Cost Report incorporates a new methodology inconsistent with the Medicare statute.
>
> The Providers challenge their SSI percentages based on the following reasons:
>
> 1. Availability of MEDPAR and SSA Records;
> 2. Paid days vs. eligible days;
> 3. Not in agreement with provider's records;

[3] Provider's Request for Hearing, Issue Statement (Feb. 25, 2019)

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

On October 15, 2019, the Provider filed its preliminary position paper. The following is the Provider's complete position on Issue 1 set forth therein:

> **Calculation of the SSI Percentage**
>
> **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 Texas and the Provider that does not support the SSI percentage issued by CMS.
>
> The Provider has worked with the State of Texas and has learned similar to L*oma Linda Community Hospital v. Dept of Health and Human Services*, No. CVT94- 0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records.
>
> The Provider is seeking the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR"), HHS/HCFAIOIS, 09-07-009, which was published in the Federal Register on August 18, 2000, from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of SSI percentage. *See 65 Fed. Reg. 50,548 (2000).* The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction.

Medicare Contractor's Contentions

On July 4, 2023, the Medicare Contractor filed a Motion to Dismiss the Medicaid Eligible Days issue arguing that the Provider has effectively abandoned the issue by failing to furnish

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

documentation in support of its claim for additional Medicaid Eligible Days or describe why such documentation was and continues to be unavailable. The Motion outlines the Board's Rules which require a Provider to submit supporting documentation with its appeal or otherwise explain why it is unavailable, and what steps are being taken to obtain it. The Medicare Contractor also points to 42 C.F.R. § 412.106(b)(4)(iii) and § 413.24(c), which places the burden on the Provider with regard to furnishing this documentation. Finally, the Motion notes that the Provider's Preliminary Paper stated that an eligibility listing was being sent under separate cover. The Medicare Contractor claims that no listing has ever been provided in the 52 months since the appeal was filed, notwithstanding subsequent requests on December 13, 2019 and January 6, 2023 by the MAC for that documentation. The MAC requests the Board to dismiss the additional Medicaid Eligible Days issue because the Provider has failed to furnish documentation in support of its claim. Additionally, the MAC states it intends to file a jurisdictional challenge over issue 1.[5]

Provider's Response

The Provider did not file a response to the Motion to Dismiss (nor any of the earlier request filed on December 13, 2019 and January 6, 2023). Board Rule 44.4.3 specifies, "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

Board Analysis and Decision:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2018), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

A. SSI Percentage (Provider Specific)

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

1. First Aspect of Issue 1

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

[5] MAC's Motion to Dismiss.

The Board finds that the first aspect of Issue 1 (the DSH/SSI (Provider Specific) issue) in this appeal is duplicative of the DSH/SSI (Systemic Errors) issue that was directly filed into Case No. 19-1409GC. The first aspect of Issue 1 in the present appeal concerns "whether the Medicare Administrative Contractor used the correct [SSI] percentage in the [DSH] Calculation."[6] 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)."[7] 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."[8] The DSH systemic issues filed into Case No. 19-1409GC, similarly alleges that the Medicare Contractor and CMS improperly calculated the DSH/SSI Percentage, the DSH/SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F).

Thus, the Board finds that the first aspect of Issue 1 in this appeal is duplicative of the group issue in Case No. 19-1409GC, for this same provider and fiscal year. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (Mar. 1, 2013), the Board dismisses this aspect of the DSH/SSI (Provider Specific) issue.

In making this finding, the Board further notes that CMS regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, is pursuing that issue as part of the group under Case No. 19-1409GC. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[9] 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) in its appeal request of how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 19-1409GC.

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

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[6] Individual Appeal Request, Issue 1.
[7] *Id.*
[8] *Id.*
[9] 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).

it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" in its Preliminary Position Paper and include *all* exhibits.

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

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

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

https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH.[10] This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows: "DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[11]

Accordingly, the Board must find that Issues 1 and the group issue in Group 19-1409GC are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (2015), the Board dismisses this component of the DSH/SSI (Provider Specific) issue. As an alternative basis the Board dismisses Issue 1 for failure of the Provider to properly brief the issue in its position paper in compliance with Board Rules.

2. Second Aspect of Issue 1

The second aspect of the DSH SSI Percentage (Provider Specific) issue—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—must be dismissed for lack of jurisdiction and as premature. Under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting 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 the Provider's DSH SSI Percentage realignment as such there is no "determination" to appeal and the appeal of this issue is otherwise premature.

B. DSH- Medicaid Eligible Days

According to its Appeal Request filed on February 25, 2019, the Provider asserts that all Medicaid eligible days were not included in the calculations of the DSH calculations for FY 2016. The Provider states Issue 3 as:

> **Statement of the Issue**
>
> Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.
>
> **Statement of the Legal Basis**
>
> The Provider contends the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.

[10] (Last accessed Nov. 21, 2022.)
[11] (Emphasis added.)

> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.[12]

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

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

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

However, when Community Health Systems ("CHS") filed the February 25, 2019, appeal request, CHS did not indicate that there were issues with accessing information underlying the adjustment to its Medicaid eligible days.

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

> (b) *Position papers*. . . . (2) The Board has the discretion to extend the deadline for submitting a position paper. **Each position paper must set forth the relevant facts and arguments regarding** the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and **the merits of the provider's Medicare payment claims for each remaining issue.**
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. **Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board** through a schedule applicable to a specific case or through general instructions.[13]

So essentially, the regulations require the parties to fully brief the merits of each issue in their position paper (including the relevant facts and legal arguments) and specify that the Board has

[12] Provider's Appeal Request (Feb. 25, 2019).
[13] (Bold emphasis added.)

discretion about setting the time frame for the submission of exhibits supporting the merits of the appeal.

The Board has issues Rules to implement c. Board Rule 27.2 (2018) specifies that "[t]he final position paper should address each remaining issue" and that "[t]he ***minimum*** requirements for the position paper narrative and exhibits are the ***same*** as those outlined for preliminary position papers at Rule 25."[14] Board Rule 25 (2018) gives the following instruction on the content of position papers:

> Rule 25 Preliminary Position Papers
>
> **COMMENTARY:**
>
> Under the PRRB regulations effective August 21, 2008, all issues will have been identified within 60 days of the end of the appeal filing period. The Board will set deadlines for the first position paper generally at eight months after filing the appeal request for the provider, twelve months for the Medicare contractor, and fifteen months for the provider's response. *Therefore, preliminary position papers are expected to present fully developed positions of the parties and, therefore, require analysis well in advance of the filing deadline.*
>
> **25.1 Content of Position Paper Narrative**
>
> The text of the position papers must include the elements addressed in the following sub-sections.
>
> **25.1.1 Provider's Position Paper**
>
> A. Identify any issues that were raised in the appeal but are already resolved (whether by administrative resolution, agreement to reopen, transfer, withdrawal, dismissal, etc.) and require no further documentation to be submitted.
>
> B. For each issue that has not been fully resolved, state the material facts that support the provider's claim.
>
> C. Identify the controlling authority (e.g., statutes, regulations, policy, or case law) supporting the provider's position.
>
> D. Provide a conclusion applying the material facts to the controlling authorities.

[14] (Bold emphasis added.)

****

25.2 Position Paper Exhibits

24.2.1 General

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

25.2.2 Unavailable and Omitted Documents

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

25.2.3 List of Exhibits

Parties must attach a list of the exhibits exchanged with the position paper.

25.3 Filing Requirements to Board

Parties should file with the Board a complete preliminary position paper with a fully developed narrative (Rule 23.1), all exhibits (Rule 23.2), a listing of exhibits, and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. Any issue appealed, but not briefed by the Provider in its position paper will be considered withdrawn

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

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

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

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

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

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

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

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

- upon failure of the provider or group to comply with Board procedures,
- if the Board is unable to contact the provider or representative at the last known address, or
- upon failure to appear for a scheduled hearing.

On October 15, 2019, the Provider filed their preliminary position paper in which it promised that it would be sending the eligibility listing under separate cover.[15] The position paper did not identify how many Medicaid eligible days remained in dispute in this case. Specifically, the Provider's complete briefing of this issue in its position paper is as follows:

> **Calculation of Medicaid Eligible Days**
>
> Specifically, the Provider disagrees with the MAC's determination of the computation of the disproportionate patient percentage set forth at 42 C.F.R. § 412.106(b)(4) of the Secretary's Regulations.
>
> The Sixth Circuit Court of Appeals, in *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.*, 19 F.3d 270 (6th Cir. 1994), held that all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage when the DSH adjustment is calculated. Similar decisions were rendered by the Fourth, Eighth and Ninth Circuits: *Cabell Huntington Hospital, Inc. v. Shalala*, 101 F.3d 984 (4th Cir. 1996); *Deaconess Health Services Corp. v. Shalala*, 83 F.3d 1041 (8th Cir. 1996), *aff'g* 912 F. Supp. 478 (E.D. Mo. 1995); and *Legacy Emanuel Hospital and Health Center v. Shalala*, 97 F.3d 1261 (9th Cir. 1996).
>
> The Centers for Medicare and Medicaid Services ("CMS", formerly HCFA) acquiesced in the above decisions and issued HCFA Ruling 97-2, which in pertinent part reads as follows:
>
> > [T]he Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to include all inpatient hospital days of service for patients who were eligible on that day for medical assistance under a state Medicaid plan in the Medicaid fraction,

[15] Provider's Preliminary Position Paper (October 15, 2019).

> whether or not the hospital received payment for these inpatient hospital services.
>
> Based on the Listing of Medicaid Eligible Days being sent under separate cover, the Provider contends that the total number of days reflected in its' [*sic*] 2016 cost report does not reflect an accurate number of Medicaid eligible days, as required by HCFA Ruling 97-2 and the pertinent Federal Court decisions.

In its Motion to Dismiss, the MAC asserts that the Provider has failed to submit a list of additional Medicaid eligible days. While the Calculation Support filed with their appeal notes a net impact of $31,000, with an increase in days, it is unclear whether this amount continues to be in dispute as of the Provider's filing of the position paper. Moreover, the MAC asserts that the Provider neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2.

Notably, the Provider has not included a list of additional Medicaid eligible days with its preliminary position paper or submitted such list under separate cover notwithstanding filing formal requests for the listing with supporting documentation on December 13, 2019 and January 6, 2023. The MAC thus asserts that the Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it cannot produce those documents, as required by the regulations and the Board Rules.[16]

The Board concurs with the Medicare Contractor that the Provider is required to identify and provide documentation to prove what additional Medicaid Eligible days are at issue and to which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rule 25. Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. § 412.106(b)(iii) and 405.1853(b)(2)-(3) and Board Rules 25.2.1 and 25.2.2 related to the submission of documentary evidence required to support its claims or describe why said evidence is unavailable as well as failed to fully develop the merits of the Medicaid eligible days issue because CHS has failed to identify any specific Medicaid eligible days at issue and failed to produce a listing of the specific days at issue (much less any supporting documentation for those days.)[17] Further, pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed" [18] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. In this regard, the Board notes that the Provider represented in its preliminary position paper filed on October 15, 2019, that "the Listing of Medicaid Eligible days [are] being sent under separate cover."[19] This was suggestive that a listing had been completed and

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[16] *See also* Board's jurisdictional decision in *Lakeland Regional Health* (Case No. 13-2953, 11/20/2019), in which the Board found a Provider essentially abandoned its appeal by filing a position paper that failed to set forth the merits of its claim, explain why the agency's calculation was wrong, and identifying missing documents to support its claim and to explain why those documents remained unavailable.
[17] Board Rule 25, of which 25.2.1 and 25.2.2 are a part, is applicable to final position papers via Board Rule 27.2.
[18] (Emphasis added.)
[19] Provider Preliminary Position Paper at 8.

was imminent. However, no such listing has ever been received by either the Board or the Medicare Contractor notwithstanding the Provider's representation that such a listing was available and ready and notwithstanding the Medicare Contractor's formal requests for that listing filed on December 13, 2019 and January 6, 2023. The Provider even failed to respond to the Medicare Contractor's Motion to Dismiss this issue. Indeed, without any days identified in the position paper filing (or even thereafter), the Board must assume that there are no days in dispute and that the actual amount in dispute is $0 for this issue.

The Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of Board Rules 25.2.1 and 25.2.2 and 42 C.F.R. §§ 412.106(b)(iii) and 405.1853(b)(2)-(3) related to identifying the days in dispute and the submission of documentary evidence required to support its claims or describe why said evidence is unavailable, which the Provider has failed to do. The Board takes administrative notice that it has made similar dismissal in other cases involving CHS providers.[20] Notwithstanding, CHS failed to include the Medicaid eligible days listing with its preliminary position paper or even file a copy following the MAC's Motion to Dismiss. Accordingly, the Board hereby dismisses the DSH Payment – Medicaid Eligible Days issue.

C. UCC Distribution Pool

The Board finds that the Provider previously filed appeals of this issue in the FFY 2015 and FFY 2016 Federal Register appeals of the same issue, and those appeals were previously adjudicated by the Board. The Provider was included in the appeal request in both Case Nos. 15-1134GC (appealing from the Fed. Reg. dated Aug. 22, 2014) and 16-0769GC (appealing from the Fed. Reg. dated Aug. 17, 2015). Both CIRP Group appeals were dismissed as the Board found it did not have jurisdiction over the DSH UCC payment issue because jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2). Accordingly, the Board hereby dismisses Issue 4 as a prohibited duplicate appeal of a common issue that was previously pursued as part of a CIRP group in violation of 42 C.F.R. § 405.1837(b)(1) and Board Rule 4.6. Regardless, the Board would otherwise dismiss Issue 4 since 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2) preclude Board review of Issue 4.

Decision

In summary, based on the record before it, the Board hereby dismisses:

1. The DSH Payment/SSI Percentage (Provider Specific) issue from appeal because it is duplicative of the issue in PRRB Case No. 19-1409GC and there is no final determination

[20] Examples of CHS individual provider cases which the Board dismissed for failure of the Provider to provide a listing of Medicaid eligible days include, but are not limited to: Case No. 22-0676 (dismissed by Board letter dated December 7, 2022 based on a MAC July 13, 2022 request for dismissal of the Medicaid eligible days issue for failure to file Medicaid eligible days listing with the preliminary position paper); Case No. 21-0317 (dismissed by Board letter dated April 3, 2023 based on a October 12,2021 final position paper request citing the Provider's failure to file the Medicaid eligible days listing with the preliminary position paper or under separate cover; and Case No. 18-0283 (dismissed by Board letter dated March 28, 2023 based on a MAC January 9, 2023 request for dismissal of the Medicaid eligible days issue for failure to file Medicaid eligible days listing with the preliminary position paper).

from which the Provider can appeal the SSI realignment portion of the issue and the Provider failed to properly develop the issue to establish it as a separate and distinct issue in compliance with Board Rules and 42 C.F.R. § 405.1853(b)(2);

2. The DSH – Medicaid Eligible Days issue because the Provider failed to meet the Board requirements for preliminary position papers for this issue as described at 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(iii) and Board Rule 25; and

3. The UCC Distribution Pool issue as the Board does not have jurisdiction because 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2) preclude administrative and judicial review of certain aspects of the UCC payment calculation.

In making these dismissals, the Board notes that the Provider failed to respond to the relevant Jurisdictional Challenge and Motion to Dismiss.

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

Board Members:

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

For the Board:

9/15/2023

X Clayton J. Nix

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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RE: ***Board Dismissal of SSI Percentage (Provider Specific) & Medicaid Eligible Days Issues***
Navarro Regional Hospital (Provider No. 45-0447)
FYE 12/31/2017
Case No. 21-1513

Dear Mr. Summar and Mr. Lamprecht,

The Provider Reimbursement Review Board ("Board") has reviewed the documentation in the above referenced appeal. The decision of the Board is set forth below.

Background:

A. *Procedural History for Case No. 21-1513*

On January 12, 2021, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end December 31, 2017.

On July 9, 2021, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained three (3) issues:

1. DSH Payment/SSI Percentage (Provider Specific)
2. DSH/SSI Percentage (Systemic Errors)[1]
3. DSH Payment – Medicaid Eligible Days

As the Provider is commonly owned by Community Health Systems, Inc. (hereinafter "Community Health") and, thereby, subject to the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1), the Provider transferred Issue 2 to a Community Health group on February 9, 2022. As a result, the remaining issues in this appeal are Issue 1 DSH Payment/SSI Percentage (Provider Specific) and Issue 3 DSH Payment – Medicaid Eligible Days.

On February 25, 2022, the Provider filed its preliminary position paper. As part of this filing the Provider promised that "the Medicaid eligible days listing [was] being sent under separate cover."

[1] On February 9, 2022, this issue was transferred to PRRB Case No. 20-0997GC.

As no such listing was filed or sent, on April 5, 2022, the Medicare Contractor requested that the Provider's representative submit the listing and supporting documentation within 45 days. However, the Provider did not file a response within that time frame.

On May 31, 2022, the Medicare Contractor filed a jurisdictional challenge requesting the dismissal of Issue 1 DSH SSI. Again, the Provider did not file a response even though a response was due within 30 days under Board Rules.

On June 9, 2022, the Medicare Contractor filed its preliminary position paper.

On January 6, 2023, the Medicare Contractor filed a Final Request for the Medicaid Eligible Days Listing in connection with Issue 3 and requested a response within 30 days. On July 4, 2023, the Medicare Contractor filed its Motion to Dismiss Issue 3 as the Provider failed to file any response even though a response was due within 30 days under Board Rules. To date, the Provider has yet to respond.

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

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

> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> . . .
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[2]

As the Provider is commonly owned by Community Health, the Provider transferred its Issue 2 – DSH – SSI Percentage to the CIRP group under 20-0997GC, CHS CY 2017 DSH SSI Percentage CIRP Group, on February 9, 2022. The Group Issue Statement in Case No. 20-0997GC reads, in part:

> **Statement of the Issue:**
>
> Whether the Secretary properly calculated the Provider's [DSH]/[SSI] percentage, and whether CMS should be required to

[2] Issue Statement at 1 (July 9, 2021).

> recalculate the SSI percentages using a denominator based solely upon covered and paid for Medicare Part A days, or alternatively, expand the numerator of the SSI percentage to include paid/covered/entitled as well as unpaid/non-covered/eligible SSI days?
>
> **Statement of the Legal Basis**
>
> The Provider(s) contend(s) that the MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). The Provider(s) contend(s) that the SSI percentages calculated by [CMS] and used by the MAC to settle their Cost Reports incorporates a new methodology inconsistent with the Medicare statute.
>
> The Providers challenge their SSI percentages based on the following reasons:
>
> 1. Availability of MEDPAR and SSA records,
> 2. Paid days vs. Eligible days,
> 3. Not in agreement with provider's records,
> 4. Fundamental problems in the SSI percentage calculation,
> 5. Covered days vs. Total days and
> 6. Failure to adhere to required notice and comment rulemaking procedures.[3]

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $15,000.

On February 25, 2022, the Provider filed its preliminary position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Provider Specific**
>
> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation based on the Provider's Fiscal Year End (December 31).
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.

[3] Group Issue Statement, Case No. 20-0997GC.

> Similar to *Loma Linda Community Hospital v. Dept of Health and Human Services*, No. CV-94-0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records. However, at this time, the Provider has been unable to analyze the Medicare Part A data because it has not yet received the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR"), HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000 from CMS. *See* 65 Fed. Reg. 50,548 (2000). Upon release of the complete MEDPAR data, the Provider will seek to reconcile its' records with that of CMS, and identify patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS based on the Federal Fiscal Year End (September 30) when it determined the Provider's SSI. *See Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).[4]

C. Filings Concerning the Jurisdictional Challenge

1. MAC's Contentions

Issue 1 – DSH Payment/ SSI Percentage (Provider Specific)

The MAC argues that the Board lacks jurisdiction over the DSH – SSI Percentage (Provider Specific) issue for two reasons. First, the MAC argues that the appeal is premature:

> The decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election. It is not a final contractor determination. A hospital must make a formal request to CMS in order to receive a realigned SSI percentage. Once the hospital elects to use its own fiscal year end, it is bound by that decision, regardless of reimbursement impact.
>
> . . .
>
> The Provider's appeal is premature. To date the Provider has not requested to have its SSI percentage realigned in accordance with 42 C.F.R. § 412.106(b)(3). Thus, the Provider has not exhausted all available remedies for this issue. The MAC requests that the Board dismiss this issue consistent with recent jurisdictional decisions.[5]

[4] Provider's Preliminary Position Paper at 8-9 (Feb 25, 2022).
[5] Jurisdictional Challenge at 6-7 (May 31, 2022).

In addition, the MAC argues the DSH – SSI Percentage (Provider Specific) issue and the DSH – SSI Percentage (Systemic Errors) issue are considered the same issue by the Board.[6]

Issue 3 – DSH Payment – Medicaid Eligible Days

In its July 4, 2023 Motion to Dismiss, the MAC argued that the Provider abandoned Issue 3, the DSH – Medicaid Eligible Days issue, because it has not submitted a list of the Medicaid eligible days at issue in this case and has not fully addressed the issue in its February 25, 2022 preliminary position paper in violation of Board Rule 25.3. The MAC notes that it specifically requested this listing from the Provider on 2 different dates: April 5, 2022 and January 6, 2023. However, the Provider never responded to those requests. The MAC then requested the Board make the following findings and Order the following:

a. That the Provider has failed to furnish documentation in supports of its claim for additional Medicaid Eligible Days or describe why such documentation was and continues to be unavailable.
b. That the Provider has made affirmative statements in its Preliminary Position Paper that it was submitting such supporting documentation to the MAC.
c. That the Provider's failure to furnish such documentation (or describe why such documentation is unavailable is in violation of PRRB Rules 7, 27.2, 25.2.1 and 25.2.2.[7]
d. That the Provider has effectively abandoned its claim for additional Medicaid Eligible Days. . .[8]

Accordingly, the MAC requested that the Board dismiss the Medicaid eligible days issue.

2. Provider's Jurisdictional Response

The Board Rules require that Provider Responses to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[9] The Provider has not filed a response to the Jurisdictional Challenge or Motion to Dismiss and the time for doing so has elapsed. Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record." Similarly, Board Rule 44.3 specifies with respect to motions that "[u]nless the Board imposes a different deadline, an opposing party may send a response, with relevant supporting documentation, within 30 days from the date that the motion was sent to the Board and opposing party."

[6] *Id*. at 4-6.
[7] PRRB Rules v. 2.0 (Aug. 2018).
[8] Motion to Dismiss at 5 (May 16, 2023).
[9] Board Rule 44.4.3, v. 3.1 (Nov. 2021).

Board Analysis and Decision:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2018), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

A. DSH Payment/SSI Percentage (Provider Specific)

The Board finds that it does not have jurisdiction over the DSH Payment/SSI Percentage (Provider Specific) issue. The jurisdictional analysis for Issue No. 1 has two relevant aspects to consider: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, and 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

1. First Aspect of Issue 1

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

The DSH – 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 Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[11] The Provider argues that "its' SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[12]

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 20-0997GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds the DSH Payment/SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 20-0997GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by

[10] Issue Statement at 1.
[11] *Id.*
[12] *Id.*

PRRB Rule 4.6[13], the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

In making this finding, the Board further notes that CMS regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, is pursuing that issue as part of the group under Case 20-0997GC. 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. 20-0997GC.

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 20-0997GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with the Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" in its Preliminary Position Paper and include *all* exhibits.

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

> **25.2.2 Unavailable and Omitted Documents**
>
> If documents necessary to support your position are still unavailable, identify the missing documents, explain why the documents remain unavailable, state the efforts made to obtain the documents, and explain when the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.

The Board further notes that the Provider only cites to the 2000 Federal Register but additional issuances and developments on the availability of data underlying the SSI fraction, such MEDPAR data, have occurred. For example, as noted in the FY 2006 IPPS Final Rule, "[b]eginning with cost reporting periods that include December 8, 2004 (within one year of the

[13] PRRB Rules v. 2.0 (Aug. 2018).
[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).

date of enactment of Pub. L. 108–173), we will arrange to furnish, consistent with the Privacy Act, MedPAR LDS data for a hospital's patients eligible for both SSI and Medicare at the hospital's request, regardless of whether there is a properly pending appeal relating to DSH payments. *We will make the information available for either the Federal fiscal year or, if the hospital's fiscal year differs from the Federal fiscal year, for the* ***months included in the 2 Federal fiscal years that encompass the hospital's cost reporting period***. Under this provision, *the hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year*. The data set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year." Further highlighting the perfunctory nature of the briefing is the fact that providers *can* obtain certain data used to calculate their DSH SSI ratios directly from the Centers for Medicare and Medicaid Services ("CMS") and in some cases on a self-service basis as explained on the following webpage:

> https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH.[15]
> This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows: "DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[16]

Accordingly, *based on the record before it*, the Board finds that the remaining issue in the instant appeal and the group issue from Group Case 20-0997GC are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

2. Second Aspect of Issue 1

The second aspect of the DSH Payment/SSI Percentage (Provider Specific) issue—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—is dismissed by the Board.

The Board finds that, under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." Without this written request, the Medicare Contractor cannot issue a final determination from which the Provider can be dissatisfied with for appealing purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding DSH SSI Percentage realignment. Therefore, the Board finds that it lacks jurisdiction in this aspect of the appeal.

[15] Last accessed February 24, 2023.
[16] Emphasis added.

B. DSH Payment – Medicaid Eligible Days

According to its Appeal Request, the Provider asserts that all Medicaid eligible days were not included in the calculations of the DSH calculation. The Provider states Issue 3 as:

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

The Provider failed to include a list of additional Medicaid eligible days they expect to be included in their Medicaid percentage and DSH computations, with their appeal request.

The Provider's preliminary position paper indicated that it would be sending the eligibility listing under separate cover.[18]

Board Rule 7.3.2 states:

> **No Access to Data**
>
> If the Provider elects not to claim an item on the cost report because, through no fault of its own, it did not have access to the underlying information to determine whether it was entitled to payment, describe the circumstances why the underlying information was unavailable upon the filing of the cost report.

[17] Individual Appeal Request, Issue 3.
[18] Provider's Preliminary Position Paper at 8.

Moreover, the Provider neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2.

Notably, the Provider has not included a list of additional Medicaid eligible days with its preliminary position paper or submitted such list under separate cover. The Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it cannot produce those documents, as required by the regulations and the Board Rules.[19]

42 C.F.R. § 405.1853 addresses position papers and specifies in pertinent part:

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. *Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board through a schedule applicable to a specific case or through general instructions*.[20]

With regard to the filing of an individual appeal, Board Rule 7 (Support for Appealed Final Determination, Issue-Related Information and Claim of Dissatisfaction) (Aug. 2018) 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,[21] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[22] This requirement is consistent with 42 C.F.R. § 405.1853(b)(3).

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

[20] (Emphasis added).

[21] The minimum requirements for Final Position Paper narratives and exhibits is the same as those for Preliminary Position Papers. *See* Board Rule 27.2.

[22] (Emphasis added).

Similarly, consistent with that regulation, Board Rule 25.2.2 provides the following instruction on the content of position papers as it relates to unavailable documentation/exhibits:

> *If documents necessary to support your position are still unavailable,* then provide the following information in the position papers:
>
> 1. Identify the missing documents;
> 2. Explain why the documents remain unavailable;
> 3. State the efforts made to obtain the documents; and
> 4. Explain when the documents will be available.
>
> Once the documents become available, promptly forward them to the Board and the opposing party.[23]

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.

[23] (Emphasis added).

The Board concurs with the Medicare Contractor that the Provider is required to identify and provide documentation to prove what additional Medicaid Eligible days are at issue and to which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rule 25. Further, pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[24] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. Based on the record before the Board, the Board finds that the Provider has failed to provide a listing or other supporting documentation for the Medicaid Eligible Days issue as required by the controlling regulations and Board Rules. Nor has the Provider provided any explanation as to why the documentation was absent or what is being done to obtain it consistent with Board Rule 25.2.2. Indeed, without any days identified in the position paper filing, the Board assumes that there are no days in dispute and that the amount in dispute is $0 for this issue.

Further, pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[25] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. The Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of Board Rules 25.2.1 and 25.2.2 related to identifying the days in dispute and the submission of documentary evidence required to support its claims or describe why said evidence is unavailable, which the Provider has failed to do.[26]

The Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of Board Rules 25.2.1 and 25.2.2 and 42 C.F.R. §§ 412.106(b)(iii) and 405.1853(b)(2)-(3) related to identifying the days in dispute and the submission of documentary evidence required to support its claims or describe why said evidence is unavailable, which the Provider has failed to do. The Board takes administrative notice that it has made similar dismissal in other cases involving CHS providers.[27] Notwithstanding, CHS failed to include the Medicaid eligible days listing with its preliminary position paper or even file a copy following the MAC's Motion to Dismiss.

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[24] (Emphasis added).
[25] (Emphasis added).
[26] Board Rule 25, of which 25.2.1 and 25.2.2 are a part, is applicable to final position papers via Board Rule 27.2.
[27] Examples of CHS individual provider cases which the Board dismissed for failure of the Provider to provide a listing of Medicaid eligible days include, but are not limited to: Case No. 22-0676 (dismissed by Board letter dated December 7, 2022 based on a MAC July 13, 2022 request for dismissal of the Medicaid eligible days issue for failure to file Medicaid eligible days listing with the preliminary position paper); Case No. 21-0317 (dismissed by Board letter dated April 3, 2023 based on a October 12,2021 final position paper request citing the Provider's failure to file the Medicaid eligible days listing with the preliminary position paper or under separate cover; and Case No. 18-0283 (dismissed by Board letter dated March 28, 2023 based on a MAC January 9, 2023 request for dismissal of the Medicaid eligible days issue for failure to file Medicaid eligible days listing with the preliminary position paper).

****

In summary, the Board hereby dismisses the DSH Payment/SSI Percentage (Provider Specific) issue from this appeal as it is duplicative of the issue in Case No. 20-0997GC and there is no final determination from which the Provider can appeal the SSI realignment portion of the issue. The Board also dismisses the DSH Payment - Medicaid Eligible Days issue as the Provider failed to meet the Board requirements for position papers for this issue in compliance with 42 C.F.R. §§ 412.106(b)(iii) and 405.1853(b)(2)-(3) and Board Rule 25. As no issues remain pending, the Board hereby closes Case No. 21-1513 and removes it from the Board's docket.

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

Board Members Participating:

Clayton J. Nix, Esq.
Robert A. Evarts, Esq.
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For the Board:

9/15/2023

X Clayton J. Nix

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Expedited Judicial Review Determination***
Hartford Health CY 2019 Capital DSH CIRP Group
Case No. 22-1254GC

Dear Ms. Goldsmith:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' July 7, 2023 consolidated request for expedited judicial review ("EJR")[1] in the above-referenced group appeal.[2] The decision with respect to EJR is set forth below.

Issue

In this group case, the Providers are challenging:

> [T]he validity of the regulation at 42 C.F.R. § 412.320(a)(1)(iii), which bars hospitals that are geographically urban and reclassify as rural under 42 C.F.R. § 412.103 from receiving a capital disproportionate share hospital ("DSH") add-on payment, known as the capital DSH adjustment. The Providers challenge the validity of 42 C.F.R. § 412.320(a)(1)(iii) on a number of grounds including that the regulation (a) is inconsistent with the controlling Medicare statute, (b) was adopted in violation of the Administrative Procedure Act, and (c) is arbitrary and capricious.[3]

[1] The consolidated EJR request also included one other group case, Case No. 23-0698GC (entitled "Corewell Health FFY 2018 Capital DSH CIRP Group") for which the Board issued a decision under separate cover on August 9, 2023.
[2] Hartford Health is a parent organization with multiple hospitals and is subject to the mandatory CIRP group regulations at 42 C.F.R. § 405.1837(b)(1) as it relates to the common issue in Case No. 22-1254GC for the year 2019. As Hartford Health designated the CIRP group fully formed, they are prohibited from pursuing this same issue for the same year in any other appeal (whether as part of an individual provider appeal or a group appeal) as explained in § 405.1837(e)(1): "When the Board has determined that a group appeal brought under paragraph (b)(1) . . . is fully formed, absent an order from the Board modifying its determination, no other provider under common ownership or control may appeal to the Board the issue that is the subject of the group appeal with respect to a cost reporting period that falls within the calendar year(s) covered by the group appeal."
[3] Request for Expedited Judicial Review, 1 (July 7, 2023) ("EJR Request").

Background:

Under the inpatient prospective payment system ("IPPS"), Medicare pays hospitals predetermined rates for patient discharges and this system is comprised of two parts, one for operating costs ("operating IPPS") as set forth at § 1395ww(d); and one for capital costs ("capital IPPS") as set forth at 42 U.S.C. § 1395ww(g). The primary objective of IPPS is to create incentives for hospitals to operate efficiently, while providing adequate compensation to hospitals.[4] This case focuses on the capital IPPS.

A. Geographic Reclassification

In 1989, Congress created the Medicare Geographic Classification Review Board ("MGCRB") which implemented a geographic reclassification system in which IPPS hospitals can be reclassified to a different wage index area[5] for purposes of receiving a higher payment rate if they meet certain criteria related to proximity and average hourly wage.[6] This includes an IPPS hospital reclassifying from a rural to an urban labor market, or vice versa.

B. Operating DSH Adjustment Under Operating IPPS

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under operating IPPS.[7] Under the operating IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[8]

The statute governing operating IPPS contains a number of provisions that adjust reimbursement based on hospital-specific factors.[9] One of the adjustments is the hospital-specific Disproportionate Share Hospital ("DSH") adjustment as set forth at 42 U.S.C. § 1395ww(d)(5)(F), which requires the Secretary to provide an adjustment (*i.e.*, an increase in the operating IPPS payment) to hospitals that serve a significantly disproportionate number of low-income patients.[10]

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[4] Daniel R. Levinson, Department of Health and Human Services, Office of the Inspector General, *Significant Vulnerabilities Exist in the Hospital Wage Index System for Medicare Payments*, 1 (Nov. 2018), *available at* https://oig.hhs.gov/oas/reports/region1/11700500.pdf (last visited June 27, 2023) ("*Significant Vulnerabilities*").
[5] *See* https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/wageindex.html (42 U.S.C. § 1395ww(d)(3)(E) requires that, as part of the methodology for determining prospective payments to hospitals, the Secretary must adjust the standardized amounts "for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level." This adjustment factor is the wage index. The Secretary currently defines hospital geographic areas (labor market areas) based on the definitions of Core-Based Statistical Areas ("CBSAs") established by the Office of Management and Budget and announced in December 2003. The wage index also reflects the geographic reclassification of hospitals to another labor market area, such as rural to urban or vice versa, in accordance with sections 1395ww(d)(8)(B) and 1395ww(d)(10).).
[6] Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, 103 Stat. 2106, 2154 (1989). *See also Significant Vulnerabilities* at 4-5.
[7] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[8] *Id.*
[9] *See* 42 U.S.C. § 1395ww(d)(5).
[10] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.

A hospital may qualify for a DSH adjustment to its operating IPPS payments based on its disproportionate patient percentage ("DPP").[11] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.[12]

The DSH adjustment provided under operating IPPS is ***not*** at issue in this case. The DSH adjustment is relevant because certain standards set forth in 42 U.S.C. § 1395ww(d)(5)(F) for the DSH adjustment, the Secretary adopted for purposes of capital IPPS.

C. Capital DSH Adjustment Under Capital IPPS

A hospital's *capital* costs are paid separately under capital IPPS (*i.e.*, separate and apart from payment for a hospital's *operating* costs under the operating IPPS). Specifically, on December 22, 1987, Congress enacted the Omnibus Budget Reconciliation Act of 1987 ("OBRA-87") and OBRA-87 § 4006(b) required the Secretary to establish the capital IPPS for cost reporting periods beginning in FY 1992.[13] OBRA-87 § 4006(b) was codified at 42 U.S.C. § 1395ww(g) which states, in pertinent part:

> **(g) Prospective payment for capital-related costs; return on equity capital for hospitals**
>
> (1)(A) Notwithstanding section 1395x(v) of this title, instead of any amounts that are otherwise payable under this subchapter with respect to the reasonable costs of subsection (d) hospitals and subsection (d) Puerto Rico hospitals for capital-related costs of inpatient hospital services, the Secretary *shall,* for hospital cost reporting periods beginning on or after October 1, 1991, *provide for payments for such costs* in accordance with a prospective payment system established by the Secretary. . . .
>
> (B) Such system— (i) shall provide for (I) a payment on a per discharge basis, and (II) an appropriate weighting of such payment amount as relates to the classification of the discharge;
>
> (ii) *may provide for an adjustment to take into account variations in the relative costs of capital and construction for the different types of facilities or areas in which they are located*;
>
> (iii) may provide for such exceptions (including appropriate exceptions to reflect capital obligations) as the Secretary determines to be appropriate, and

[11] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I), (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[12] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv), (vii)-(xiii); 42 C.F.R. § 412.106(d).
[13] Pub. L. 100-203, § 4006(b), 101 Stat. 1330, 1330-52 (1987).

> (iv) may provide for suitable adjustment to reflect hospital occupancy rate.
>
> (C) In this paragraph, the term ''capital-related costs'' has the meaning given such term by the Secretary under subsection (a)(4) as of September 30, 1987, and does not include a return on equity capital.[14]

Significantly, the statute governing capital IPPS does not specifically mandate or address the use of a capital DSH adjustment. Rather, it specifies generally that the Secretary "may provide for an adjustment to account variations in relative costs." As described below, the Secretary exercised his discretion to establish the c*apital* DSH adjustment at issue in this case which is limited in that it ***only*** applies to *urban* hospitals with 100 or more beds and that serve low income patients.[15]

1. Initial Implementation of Capital IPPS and the Capital DSH Adjustment

The Secretary published a final rule on August 30, 1991 to establish the capital IPPS.[16] In implementing the capital IPPS, the Secretary recognized that he had discretion on whether to apply many of the adjustments statutorily required under operating IPPS to capital IPPS:

> We are persuaded by the argument advanced by some commenters, including ProPAC, that in the long run the ***same*** adjustments should be applied to capital and operating payments and that the level of the adjustments should be determined by examining combined operating and capital costs. ProPAC recommended that the unified adjustments be calculated within two years. However, we believe that it would be most appropriate to implement these adjustments with respect to the capital prospective payment systems from the outset. *While the payment adjustments for the operating prospective payment system are determined by the Act (and therefore cannot be modified by the rulemaking process),* ***we have the latitude to develop adjustments based on combined costs for the capital prospective payment system***.
>
> We do not believe that it would be appropriate to use the current operating payment adjustments in the capital prospective payment system either permanently or on an interim basis until legislation is enacted changing the operating adjustments to the level appropriate for total costs. This is because the levels of the operating payment adjustments for serving a disproportionate share of low income patients (DSH) and for indirect medical education costs (IME)

[14] (Underline and italics emphasis added.)
[15] 42 C.F.R. § 412.320(a)(1). *See also* MedPAC, *Hospital Acute Inpatient Services Payment System: Payment Basics*, 2 (rev. Nov. 2021), *available at* https://www.medpac.gov/wp-content/uploads/2021/11/medpac_payment_basics_21_hospital_final_sec.pdf (last visited Aug. 1, 2023).
[16] 56 Fed. Reg. 43358 (Aug. 30, 1991).

> exceed the levels supported by empirical analysis. We believe the payment adjustments should be empirically supported and should reflect only the higher Medicare costs associated with teaching activity and treating low income patients.[17]

The Secretary did adopt a limited DSH adjustment to capital IPPS for urban hospitals with more than 100 beds. The proposal was described as follows:

> In the proposed rule, our regression results indicated that for urban hospitals with more than 100 beds, the disproportionate share percentage of low income patients has an effect on capital costs per case. We proposed that urban hospitals with 100 or more beds would receive an additional payment equal to $((1 + DSHP)^{0.4176} - 1))$, where DSHP is the disproportionate share patient percentage. There would be no minimum disproportionate share patient percentage required to qualify for the payment adjustment. A hospital would receive approximately a 4.2 percent increase in payments for each 10 percent increase in its disproportionate share percentage. This formula is similar to the one used for the indirect medical education adjustment under the operating prospective payment system.
>
> Since we did not find a disproportionate share effect on the capital costs of urban hospitals with fewer than 100 beds or on rural hospitals, we did not propose to make a disproportionate share adjustment to the capital payment to these hospitals.[18]

In adopting his proposal, the Secretary gave the following justification:

> *Comment*: Many commenters believe that the disproportionate share patient percentage of 30 percent needed to qualify for the special exceptions payment under the proposal is too restrictive. Most of these commenters supported the use of 20.2 percent as the patient threshold percentage since that is the patient percentage above which operating disproportionate share payments become more generous. Some believe that any hospital that received DSH payments under the operating system should be eligible for the special exception.
>
> *Response*: In the final rule, we are providing that urban hospitals with 100 or more beds and a disproportionate share patient percentage of 20.2 percent or higher will be eligible to receive exceptions payments based on a higher minimum payment level than other hospitals. For FY 1992, the minimum payment level is

[17] *Id.* at 43369-70 (emphasis added).
[18] *Id* at 43377.

> 80 percent. Urban hospitals with 100 or more beds that receive disproportionate share payments under § 412.106(C)(2) would also be eligible for the higher minimum payment level. We are not extending the special protection to other hospitals that receive disproportionate share payments under the operating prospective payment system. In urban areas, we believe that our criteria properly focuses on those hospitals that serve a large disproportionate share population. Other urban hospitals receiving disproportionate share payments tend to serve fewer low income patients either because of their smaller size (i.e., under 100 beds) or lower disproportionate share patient percentage. **In rural areas, we believe the more relevant criteria for determining whether a hospital should receive special payment protection is whether the hospital represents the sole source of care reasonably available to Medicare beneficiaries**.[19]

In response to comments, the Secretary rejected expanding the application of the capital DSH adjustment to rural hospitals with 500 or more beds:

> As part of our regression analysis for this final rule, we examined the relationship between total cost per case and disproportionate share patient percentages for rural hospitals with at least 500 beds, and found no statistically significant relationship. As a result, we are not implementing any disproportionate share adjustment to prospective payments for capital for these hospitals. Hospitals that qualify for additional operating disproportionate share payments under section 1886(d)(5)(F)(i)(II) of the Act will be deemed to have a disproportionate patient percentage equivalent to that which would generate their operating disproportionate share payment, using the formula for urban hospitals with at least 100 beds. For discharges occurring on or after October 1, 1991, these hospitals qualify for an operating adjustment of 35 percent, which is equivalent to having a disproportionate share patient percentage of 65.4. Urban hospitals with more than 100 beds that qualify for additional operating disproportionate share payments under section 1866(d)(5)(F)(i)(II) of the Act will be deemed to qualify for additional capital disproportionate share payments as well at the level consistent with their deemed disproportionate share patient percentage. The disproportionate share adjustment factor for these hospitals is 14.16 percent. The additional capital disproportionate share payments to these hospitals will be made at the same time that the additional operating disproportionate share payments are, that is, as the result of the application by these hospitals for payments under § 412.106(b)(l)(ii) of the regulations.[20]

[19] *Id.* at 43409-10 (bold and underline emphasis added).
[20] *Id.* at 43377.

Similarly, in response to comments, the Secretary rejected expanding the application of the capital DSH adjustment to other classes of hospitals such as "[a]ll small urban hospitals, hospitals with high Medicare usage, rural hospitals, rural hospitals with at least 100 beds, rural referral centers, or those hospitals with high 'total government' usage":

> In developing the capital disproportionate share adjustment for this final rule, we examined the relationship between the disproportionate share patient percentage and total costs per case for each class of hospital that is currently receiving an operating payment adjustment. We believe that only those hospitals that merit the adjustment according to our regression analysis should receive additional capital payments for serving low income patients. The regression results did not indicate any significant relationship between total costs per case and disproportionate share patient percentage for any of the special groups mentioned above.[21]

In response to comments, the Secretary also looked at setting a threshold DSH percentage to qualify for a capital DSH adjustment but rejected that alternative approached based upon the following explanation:

> We examined closely the possibility of using a disproportionate share patient percentage threshold in our total cost regression analysis. We were unable to find any threshold level of disproportionate share percentage below which no payment adjustment was merited, or a threshold above which a higher adjustment was merited. As a result, we believe that it is most equitable to make a capital disproportionate share payment to all qualifying hospitals with a positive patient percentage, rather than penalize some hospitals that have a higher cost of treating low income patients but whose patient percentage is below the artificial level we would set.[22]

Further, in response to comments, the Secretary rejected not providing *any* capital DSH adjustment based on the explanation:

> We disagree with the commenter. The regression analyses show that serving low income patients (as defined in section 1886(d)(5)(F)(vi) of the Act) results in higher Medicare capital and total costs per case *for urban hospitals with at least 100 beds*. We believe that it is appropriate for Medicare's payment to recognize these higher Medicare patient care costs.[23]

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[21] *Id.* at 43378.
[22] *Id.* at 43379.
[23] *Id.* (Emphasis added.)

Finally, the Secretary addressed how MGCRB reclassifications, in certain circumstances, affect whether an IPPS hospital qualifies for the capital DSH adjustment:

> *Comment*: Many commenters sought clarification of the effect of reclassification by the Medicare Geographic Classification Review Board (MGCRB) on eligibility for capital disproportionate share payments.
>
> *Response*: Any hospital that is reclassified to an urban area by the MGCRB for purposes of its standardized amount is considered to be urban for all prospective payment purposes other than the wage index. As such, if any hospital reclassified by the MGCRB to an urban area for purposes of the standardized amount has at least 100 beds, it would be eligible for capital disproportionate share payments. We note that a rural hospital reclassified for purposes of the wage index only is still considered a rural hospital, and as such, will not be eligible for capital disproportionate share payments.[24]

The resulting regulations governing capital IPPS were codified at 42 C.F.R. Part 412, Subpart M (§§ 412.300 to 412.374). The regulation governing the capital DSH adjustment was codified at § 412.320 which, at initial implementation, stated:

> **§ 412.320 Disproportionate share adjustment factor.**
>
> (a) *Criteria for classification*. A hospital is classified as a "disproportionate share hospital" for the purposes of capital prospective payments if the hospital is located, for purposes of receiving payment under § 412.63(a), in an urban area, has 100 or more beds as determined in accordance with § 412.105(b) and serves low-income patients, as determined under § 412.106(b), or if the hospital meets the criteria in § 412.106(c)(2).
>
> (b) *Payment adjustment factor*. (1) <u>If a hospital meets the criteria in paragraph (a) of this section for a disproportionate share hospital for purposes of capital prospective payments</u>, the disproportionate share payment adjustment factor equals [e raised to the power of (.2025 X the hospital's disproportionate patient percentage as determined under § 412.106(b)(5)), —1], where e is the natural antilog of 1.
>
> (2) If a hospital meets the criteria in § 412.106(c)(2) for purposes of inpatient hospital operating prospective payments, the disproportionate share adjustment factor equals 14.16 percent.[25]

[24] *Id.*
[25] *Id*. at 43452-53.

2. Reclassification of Certain IPPS Urban Hospitals as Rural for Purposes of Operating IPPS Pursuant to BBRA § 401 and Impact on Capital IPPS Adjustments

On November 29, 1999, Congress enacted the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 ("BBRA") and BBRA § 401 amended 42 U.S.C. § 1395ww(d)(8) to require that certain urban IPPS hospitals be reclassified as rural *for purposes of operating IPPS* if an application is submitted to the MGCRB and certain criteria are met.[26] IPPS hospitals reclassified per BBRA § 401 are often referred to as "§ 401 hospitals."

On August 1, 2000, the Secretary published the interim final rule to, in part, implement BBRA § 401 and stated in the preamble that a hospital reclassified as rural pursuant to § 401 is treated as rural for ***all*** purposes under operating IPPS, including the DSH adjustment for operating IPPS:

> *A hospital that is reclassified as rural* under section 1886(d)(8)(E) of the Act, as added by section 401(a) of Public Law 106–113, ***is treated as rural for all purposes*** *of payment under the Medicare inpatient hospital prospective payment system* (section 1886(d) of the Act), *including* standardized amount (§§ 412.60 et seq.), wage index (§ 412.63), and ***disproportionate share calculations*** (§ 412.106) as of the effective date of the reclassification.[27]

On August 1, 2000, the Secretary also published the FY 2001 IPPS Final Rule which included the following discussion on the effect of reclassification of a hospital from urban to rural pursuant to BBRA § 401:

> In the May 5, 2000 proposed rule, we indicated that we are concerned that section 1886(d)(8)(E) might create an opportunity for some urban hospitals to take advantage of the MGCRB process by first seeking to be reclassified as rural under section 1886(d)(8)(E) (and receiving the benefits afforded to rural hospitals) and in turn seek reclassification through the MGCRB back to the urban area for purposes of their standardized amount and wage index and thus also receive the higher payments that might result from being treated as being located in an urban area. ***That is, we were concerned that some hospitals might inappropriately seek to be treated as being located in a rural area for some purposes and as being located in an urban area for other purposes***. In light of the Conference Report language noted above discussing the House bill and what appears to be the potential for inappropriately inconsistent treatment of the same hospital on the other hand, in the May 5 proposed rule, we solicited public comment on this issue, and indicated that we might impose a limitation on such MGCRB reclassifications in this final rule for FY 2001, if such action appears warranted. We also sought specific

[26] BBRA, Pub. L. 106-113, App. F, § 401, 113. Stat. 1501A-321, 1501A-369 (1999).
[27] 65 Fed. Reg. 47026, 47030 (Aug. 1, 2000) (emphasis added).

comments on how such a limitation, if any, should be imposed and provided several examples and alternatives.

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Consistent with the statutory language, we are providing that a hospital reclassified as rural under section 1886(d)(8)(E) of the Act will be treated as being located in a rural area for purposes of section 1886(d) of the Act, and cannot subsequently be reclassified under the MGCRB process to an urban area (in order to be treated as being located in an urban area for certain purposes under section 1886(d) of the Act).

This policy is consistent not only with the statutory language but also with the policy considerations underlying the MGCRB process. The MGCRB process permits a hospital to be reclassified from one geographic area to another if it is significantly disadvantaged by its geographic location and would be paid more appropriately if it were reclassified to another area. We believe that it would be illogical to permit a hospital that applied to be reclassified from urban to rural under section 1886(d)(8)(E) of the Act because it was disadvantaged as an urban hospital to then utilize a process that was established to enable hospitals significantly disadvantaged by their rural or small urban location to reclassify to another urban location. *If an urban hospital applies under section 1886(d)(8)(E) of the Act in order to be treated as being located in a rural area, then it would be anomalous at best for the urban hospital to subsequently claim that it is significantly disadvantaged by the rural status for which it applied and should be reclassified to an urban area.*

Furthermore, permitting hospitals the option of seeking rural reclassification under section 1886(d)(8)(E) of the Act for certain payment advantages, coupled with the ability to pursue a subsequent MGCRB reclassification back to an urban area, could have implications beyond those originally envisioned under Public Law 106–113. In particular, we are concerned about the potential interface between rural reclassifications under section 401 and section 407(b)(2) of Public Law 106– 113, which authorizes a 30-percent expansion in a rural hospital's resident full-time equivalent count for purposes of Medicare payment for the indirect costs of medical education (IME) under section 1886(d)(5)(B) of the Act. (Reclassification from urban to rural under section 1886(d)(8)(E) of the Act can affect IME payments to a hospital, which are made under section 1886(d)(5)(B) of the Act, but not payments for the direct costs of GME, which are made under section 1886(h) of the Act.)

> Congress clearly intended hospitals that become rural under section 1886(d)(8)(E) of the Act to receive some benefit as a result. For example, some hospitals currently located in very large urban counties are in fact fairly small, isolated hospitals. Some of these hospitals will now be able to be designated a rural hospital and become eligible to be designated a critical access hospital.
>
> ****
>
> We are not permitting hospitals redesignated as rural under section 1886(d)(8)(E) of the Act to be eligible for subsequent reclassification by the MGCRB, and are revising the regulations governing MGCRB reclassifications (§ 412.230) accordingly.
>
> ****
>
> *We wish to emphasize that urban to rural reclassification under section 1886(d)(8)(E) of the Act is entirely voluntary*. ***Each hospital anticipating that it may qualify under this provision should determine the impact of Medicare payment policies if it were to reclassify***. As discussed above, we believe that our policies here are consistent with the Secretary's broad authority under section 1886(d)(10) of the Act, the statutory language in section 1886(d)(8)(E) of the Act, as well as our understanding of the intent underlying the description of the House bill in the Conference Report.[28]

Thus, both the August 1, 2000 interim final rule and the FY 2001 IPPS Final Rule confirmed that urban hospitals reclassified as rural pursuant to BBRA § 401 would be treated as rural for all purposes of operating IPPS, including DSH adjustments. The Secretary memorialized this policy in regulation at 42 C.F.R. § 412.103 (2000) which states in pertinent part:

> **§ 412.103 Special treatment: Hospitals located in urban areas and that apply for reclassification as rural**.
>
> (a) *General criteria*. A prospective payment hospital that is located in an urban area (as defined in § 412.62(f)(1)(ii)) may be reclassified as a rural hospital if it submits an application in accordance with paragraph (b) of this section and meets any of the following conditions:
>
> 1) The hospital is located in a rural census tract of a Metropolitan Statistical Area (MSA) as determined under the most recent version of the Goldsmith Modification as determined by the Office of Rural Health Policy (ORHP) of the Health Resources and Services Administration which is available via the ORHP website at http://www.nal.usda.gov/orph or from the U.S. Department of

[28] 65 Fed. Reg. 47054, 47087-89 (Aug. 1, 2000).

> Health and Human Services, Health Resources and Services Administration, Office of Rural Health Policy, 5600 Fishers Lane, Room 9–05, Rockville, MD 20857.
>
> (2) The hospital is located in an area designated by any law or regulation of the State in which it is located as a rural area, or the hospital is designated as a rural hospital by State law or regulation.
>
> (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.[29]

Neither the August 1, 2000 interim final rule nor the FY 2001 IPPS Final Rule explicitly discussed the impact on capital DSH adjustments under capital IPPS. However, through operation of the cross-reference in 42 C.F.R. § 412.320(a) to § 412.63(a) in the phrase "the hospital is located, for purposes of receiving payment under § 412.63(a), in an urban area", it would appear that hospitals reclassified from urban to rural were ***not*** eligible for capital DSH adjustments under capital IPPS. In this regard, the Board notes that, following the 2000 rulemaking process, § 412.63(a)-(b) (2001) read, in pertinent part:

> (a) *General rule*. (1) HCFA determines a national adjusted prospective payment rate for inpatient operating costs for each inpatient hospital discharge in a Federal fiscal year after fiscal year 1984 involving inpatient hospital services of a hospital in the United States subject to the prospective payment system, and determines a regional adjusted prospective payment rate for operating costs for such discharges in each region, for which payment may be made under Medicare Part A.
>
> (2) **Each such rate is determined for hospitals located in urban <u>or</u> rural areas** within the United States and within each such region respectively, **as described in paragraphs (b)** through (g) of this section.
>
> (b) *Geographic classifications*. (1) For purposes of this section, the definitions set forth in § 412.62(f) apply, **except that**, effective January 1, 2000, **a hospital reclassified as rural may mean** a reclassification that results from a geographic redesignation as set forth in § 412.62(f)(1)(iv) or **a reclassification that results from an urban hospital applying for reclassification as rural as set forth in § 412.103**.[30]

[29] *Id*. at 47048.
[30] *Id.* at 47047 (Bold and underline emphasis added.)

The specific reference in § 412.63(b) to urban to rural reclassifications made under § 412.103 makes clear that capital DSH adjustments would not apply to hospitals reclassified from urban to rural pursuant to BBRA § 401 which as noted above was implemented at § 412.103.

3. Changes to Operating IPPS Required by MMA § 401 and Their Effect on Capital IPPS

On December 8, 2003, Congress enacted the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 ("MMA") and MMA § 401 to equalize operating IPPS payments between urban and rural hospitals.[31] Specifically, § 401 specifies that, beginning with FY 2004, all IPPS hospitals are paid on the basis of the large urban standardized amount under operating IPPS.

The Office of Management and Budget publishes information on core-based statistical areas ("CBSAs") and the Secretary has used this information for purposes of defining labor market areas for use in the wage index for operating IPPS.[32] On June 6, 2003, OMB announced the new CBSAs, comprised of metropolitan statistical areas ("MSAs") and the new Micropolitan Areas based on Census 2000 data.[33]

On August 11, 2004, the Secretary published the FY 2005 IPPS Final Rule and this rule finalized revisions to the operating IPPS regulations to both implement MMA § 401 as well as adopt OMB's new CBSA designations.[34] With respect to implementing MMA § 401, the Secretary revised 42 C.F.R. § 412.63 to apply only to years through 2004 and added a new § 412.64 to implement MMA § 401 for federal rates for FYs 2005 forward. Specifically, § 412.64 reads in pertinent part:

> **§ 412.64 Federal rates for inpatient operating costs for Federal fiscal year 2005 and subsequent fiscal years.**
>
> (a) *General rule*. CMS determines a national adjusted prospective payment rate for inpatient operating costs for each inpatient hospital discharge in Federal fiscal year 2005 and subsequent fiscal years involving inpatient hospital services of a hospital in the United States subject to the prospective payment system for which payment may be made under Medicare Part A.
>
> (b) *Geographic classifications*. (1) For purposes of this section, the following definitions apply:
>
> (i) The term region means one of the 9 metropolitan divisions comprising the 50 States and the District of Columbia, established by the Executive Office of Management and Budget for statistical and reporting purposes.

[31] Pub. L. 108–173
[32] 69 Fed. Reg. 48916, 49026-27 (Aug. 11, 2004).
[33] *Id.*
[34] 69 Fed. Reg. 48916 (Aug. 11, 2004).

(ii) The term *urban area* means—

(A) A Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget; or

(B) The following New England counties, which are deemed to be parts of urban areas under section 601(g) of the Social Security Amendments of 1983 (Public Law 98–21, 42 U.S.S. 1395ww (note)): Litchfield County, Connecticut; York County, Maine; Sagadahoc County, Maine; Merrimack County, New Hampshire; and Newport County, Rhode Island.

(C) The term *rural area* means any area outside an urban area.

(D) The phrase *hospital reclassified as rural* means a hospital located in a county that, in FY 2004, was part of an MSA, but was redesignated as rural after September 30, 2004, as a result of the most recent census data and implementation of the new MSA definitions announced by OMB on June 6, 2003.

(2) For hospitals within an MSA that crosses census division boundaries, the MSA is deemed to belong to the census division in which most of the hospitals within the MSA are located.

(3) For discharges occurring on or after October 1, 2004, a hospital located in a rural county adjacent to one or more urban areas is deemed to be located in an urban area and receives the Federal payment amount for the urban area to which the greater number of workers in the county commute if the rural county would otherwise be considered part of an urban area, under the standards for designating MSAs if the commuting rates used in determining outlying counties were determined on the basis of the aggregate number of resident workers who commute to (and, if applicable under the standards, from) the central county or central counties of all adjacent MSAs. These EOMB standards are set forth in the notice of final revised standards for classification of MSAs published in the Federal Register on December 27, 2000 (65 FR 82228), announced by EOMB on June 6, 2003, and available from CMS, 7500 Security Boulevard, Baltimore, Maryland 21244.

(4) For purposes of this section, any change in an MSA designation is recognized on October 1 following the effective date of the change. Such a change in MSA designation may occur as a result

> of redesignation of an MSA by the Executive Office of Management and Budget.[35]

Significantly, § 412.64 does not reference the provisions of § 412.103 regarding the urban-to-rural reclassifications, as was previously found in § 412.63(b)(1).

The Secretary also amended 42 C.F.R. § 412.320(a). As previously noted, § 412.320(a) originally only referenced § 412.63: "A hospital is classified as a 'disproportionate share hospital' for the purposes of capital prospective payments if the hospital is located, *for purposes of receiving payment under § 412.63(a)*, in an urban area."[36] As a result of the FY 2005 IPPS Final Rule, § 412.320(a) was updated to reference § 412.64 as it relates to FYs 2005 forward:

> **§ 412.320 Disproportionate share adjustment factor.**
>
> (a) *Criteria for classification*. A hospital is classified as a ''disproportionate share hospital'' for the purposes of capital prospective payments <u>if either of the following conditions is met</u>:
>
> (1) The hospital is located in an urban area, has 100 or more beds as determined in accordance with § 412.105(b), and serves low-income patients as determined under § 412.106(b).
>
> (i) For discharges occurring on or before September 30, 2004, the payment adjustment under this section is based on a hospital's location, for the purpose of receiving payment, under § 412.63(a).
>
> (ii) <u>For discharges occurring on or after October 1, 2004, the payment adjustment under this section is based on the geographic classifications specified under § 412.64</u>.[37]

Again, as previously noted, § 412.64 does not reference the provisions of § 412.103 regarding the urban-to-rural reclassifications, as was previously found in § 412.63(b)(1).

Finally, in the preamble to the FY 2005 IPPS Final Rule, the Secretary included the following discussion on the impact of the new CBSAs on geographic reclassifications:

> Currently, the large urban location adjustment under § 412.316(b) and the DSH adjustment for certain urban hospitals under § 412.320 for payments for capital-related costs rely on the existing geographic classifications set forth at § 412.63. Because we proposed to adopt OMB's new CBSA designations for FY 2005 and thereafter, under proposed new § 412.64, we proposed to revise § 412.316(b) and § 412.320(a)(1) to specify that, for

[35] *Id.* at 49242. *See also id.* at 49103 (discussing implementation of MMA § 401).
[36] (Emphasis added.)
[37] 42 C.F.R. § 412.320 (2004) (underline emphasis added). *See also* 69 Fed. Reg. at 49250.

> discharges on or after October 1, 2004, the payment adjustments under these sections, respectively, would be based on the geographic classifications at proposed new § 412.64.
>
> ****
>
> The commenter is correct that as a result of the implementation of the new MSA definitions, hospitals that had previously been located in a large urban area under the current MSA definitions, but will now be located in another urban or rural area under the new MSA definitions will no longer qualify for certain payment adjustments that they previously qualified for under the prior MSA definitions, including the 3-percent large urban add-on payment adjustment at § 412.312(b)(2)(ii) and § 412.316(b). As discussed previously, in the May 18, 2004 proposed rule, we solicited comments on the effect of the equalization of the operating IPPS standardized amount. Specifically, we discussed that rural and other urban hospitals that were previously eligible to receive the large urban add-on payment adjustment (and DSH payment adjustment) under the IPPS for capital-related costs if they reclassified to a large urban area for the purpose of the standardized amount under the operating IPPS, will no longer be reclassified and, therefore, will not be eligible to receive those additional payments under the IPPS for capital-related costs beginning in FY 2005. As we noted previously, we received no comments on that clarification.
>
> ****
>
> As previously discussed, we proposed and adopted as final our policy that, beginning in FY 2005 and thereafter, only those hospitals geographically located in a large urban area (as defined in revised § 412.63(c)(6)) will be eligible for the large urban add-on payment adjustment provided under § 412.312(b)(2)(ii) and § 412.316(b). *Similarly, beginning in FY 2005 and thereafter, to receive capital IPPS DSH payments under § 412.320, a hospital will need to be geographically located in an urban area (as defined in new § 412.64) and meet all other requirements of § 412.320.* Accordingly, we are adopting our proposed revisions as final without change.[38]

4. August 18, 2006 Revisions to the Capital DSH Adjustment

In the FY 2007 Proposed IPPS Rule, the Secretary[39] announced that he was proposing technical changes to 42 C.F.R. §§ 412.316(b) and 412.320(a)(1) to clarify that hospitals reclassified as rural under § 412.103 are not eligible for the large urban add-on payment or for the capital DSH adjustment. These proposed changes reflected the historic policy that hospitals reclassified as rural under § 412.103 also would be considered rural under the capital IPPS. Since the genesis of

[38] 69 Fed. Reg. 48916, 49187-88 (Aug. 11, 2004).
[39] of the Department of Health and Human Services.

the capital IPPS in FY 1992, the same geographic classifications used under the operating IPPS also have been used under the capital IPPS.[40]

The Secretary believed that these proposed changes and clarifications were necessary because the agency's capital IPPS regulations had been updated to incorporate the Office of Management and Budget's ("OMB's") new CBSA definitions for IPPS hospital labor market areas beginning in FY 2005.[41]

In the FY 2007 IPPS Final Rule published on August 18, 2006, the Secretary finalized these technical changes to 42 C.F.R. §§ 412.316(b) and 412.320(a)(1) to clarify that hospitals reclassified as rural under § 412.103 are not eligible for the large urban add-on payment or for the capital DSH adjustment:

> These changes were proposed to reflect our historic policy that hospitals reclassified as rural under § 412.103 also are considered rural under the capital PPS. Since the genesis of the capital PPS in FY 1992, the same geographic classifications used under the operating PPS also have been used under the capital PPS.
>
> These changes and clarifications are necessary because we inadvertently made an error when we updated our capital PPS regulations to incorporate OMB's new CBSA definitions for IPPS hospital labor market areas beginning in FY 2005. In the FY 2005 IPPS final rule (69 FR 49187 through 49188), in order to incorporate the new CBSA designations and the provisions of the newly established § 412.64, which incorporated the CBSA-based geographic classifications, we revised § 412.316(b) and § 412.320 to specify that, effective for discharges occurring on or after October 1, 2004, the capital PPS payment adjustments are based on the geographic classifications under § 412.64. However, § 412.64 does not reference the provisions of § 412.103 regarding the urban-to-rural reclassifications, as was previously found in § 412.63(b)(1).
>
> We believe that this error must be corrected in order to maintain our historic policy for treating urban-to-rural hospital reclassifications under the operating PPS the same for purposes of the capital PPS. Therefore, we proposed to specify under §§ 412.316(b)(2) and (b)(3) and 412.320(a)(1)(ii) and (a)(1)(iii) that, for discharges on or after October 1, 2006, hospitals that are reclassified from urban to rural under § 412.103 would be considered rural.[42]

In adopting these changes, the Secretary noted that it did not receive any public comments on the proposed change as published in the proposed rule published on May 17, 2006.[43]

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[40] 71 Fed. Reg. 23995, 24122 (Apr. 25, 2006).
[41] *Id.*
[42] *Id.*
[43] *Id.*

As a result of the FY 2007 IPPS Final Rule, the regulation, subparagraph (iii) was added to 42 C.F.R. § 412.320(a)(1) so that revised § 412.320(a) read, in pertinent part:

> (a) *Criteria for classification*. A hospital is classified as a "disproportionate share hospital" for the purposes of capital prospective payments if either of the following conditions is met:
>
> (1) The hospital is located in an urban area, has 100 or more beds as determined in accordance with § 412.105(b), and serves low-income patients as determined under § 412.106(b).
>
> (i) For discharges occurring on or before September 30, 2004, the payment adjustment under this section is based on a hospital's location, for the purpose of receiving payment, under § 412.63(a).
>
> (ii) For discharges occurring on or after October 1, 2004, the payment adjustment under this section is based on the geographic classifications specified under § 412.64, except as provided for in paragraph (a)(1)(iii) of this section.
>
> **(iii) For purposes of this section, the geographic classifications specified under § 412.64 apply, except that, effective for discharges occurring on or after October 1, 2006, for an urban hospital that is reclassified as rural as set forth in § 412.103, the geographic classification is rural.[44]**

5. *Litigation Challenging the Validity of 42 C.F.R. § 412.320(a)(1)(iii) as Added by the FY 2007 IPPS Final Rule*

The validity of 42 C.F.R. § 412.320(a)(1)(iii) was addressed in *Toledo Hosp. v. Becerra* ("*Toledo*"),[45] wherein the hospital made the following contentions:

> Toledo Hospital contends that the Secretary's 2006 rulemaking is arbitrary and capricious and thus unreasonable for two principal reasons. First, it charges the Secretary with misrepresenting the regulatory history in claiming that the 2006 Rule merely restored a previously implemented policy. Second, the hospital argues that the Secretary failed to "take into account" relative costs of capital for various hospital types and areas of location, as subsection (g) requires.[46]

In *Toledo*, U.S. District Court for the District of Columbia ("D.C. District Court") outlined the legislative history surrounding the creation of the MGCRB in 1989 which, as noted above, can

[44] (Bold emphasis added.)
[45] 2021 WL 4502052 (D.D.C. 2021).
[46] *Id.* at *8 (citations omitted).

redesignate IPPS hospitals to different labor market areas in order to receive a different wage reimbursement rate.[47] The Court also noted how Congress enacted legislation in 1999[48] allowing IPPS hospitals to reclassify from an urban labor market area to a rural one for various reasons. Thus, a geographically urban hospital can be classified as rural, but then redesignate itself back into an urban labor market area for the purposes of fixing its wage index.[49] The Court also noted the separate IPPS payment for a hospital's *capital* costs at 42 U.S.C. § 1395ww(g) (compared to the IPPS payment for *operating* costs), as well as the capital IPPS adjustments found at 42 C.F.R. § 412.320 for large urban hospitals (the capital DSH payment).[50] The Court explained that, following the 2006 rulemaking, a geographically urban hospital which reclassifies as rural under § 401 loses its eligibility for the capital DSH adjustment.[51]

The appellants in *Toledo* were geographically located in an urban labor market area, but applied to the Secretary (and were approved) to reclassify as rural under § 401. The appellants thereafter applied to the MGCRB to reclassify their wage index to an urban labor market area. The appellants' Medicare Contractor later denied their requests for capital DSH adjustments due to their § 401 rural reclassifications. Before the D.C. District Court, the hospitals argued that 42 C.F.R. § 412.320(a)(1)(iii) violated the plain language of the Medicare Act and that it was promulgated in an arbitrary and capricious manner.[52]

The D.C. District Court rejected the argument that the capital DSH policy in 42 C.F.R. § 412.320(a)(1)(iii) violated the Medicare Act on its face, finding that the Secretary was not prohibited from treating § 401 reclassified hospitals as rural for operating PPS purposes while denying urban status for the purposes of the capital DSH adjustment.[53] The Court next examined, however, whether the Secretary's decision to do so was reasonable. The D.C. District Court made the following findings:

1. "if the Secretary had any policy concerning Section 401 reclassifications before 2006, he never announced such a policy, much less explained the basis for it."[54]

2. The Secretary's decision to not provide a capital DSH adjustment was arbitrary because:

    - "The Secretary has not put forth evidence that the agency took these costs into account, either in 1991, 2000, 2004, or 2006."[55]

    - "[T]he record does not show that the Secretary articulated a consistent policy of treating these reclassified hospitals as rural for capital DSH adjustment purposes, he

[47] *Id.* at *2.
[48] 42 U.S.C. § 1395ww(d)(8)(E). *See* Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, § 401, Pub. L. No. 106-113, 113 Stat. 1501 (1999). Since the amendment was made via § 401 of this legislation, a hospital which receives the new rural reclassification is often referred to a "§ 401" hospital.
[49] *Toledo* at *3.
[50] *Id.* at *3-4.
[51] *Id.* at *4.
[52] *Id.* at *5.
[53] *Id.* at *6-8.
[54] *Id.* at *11.
[55] *Id.*

cannot fall back on any purported general policy of using operating PPS geographic classifications for capital PPS reimbursements."[56]

- "The Secretary also has not explained, even as a general matter, why classification uniformity outweighs the value of more accurate cost reimbursements. *Cf. Anna Jacques Hosp*., 797 F.3d at 1161 (upholding Secretary's regulation where the Secretary explained why 'added precision' 'would not justify the added complication') (quotation omitted)."[57]

- "The agency cannot 'entirely fail[ ] to consider' the "relevant data" and the factors that Congress directed it to review. *State Farm*, 63 U.S. at 43. Here, the Secretary did not perform a cost analysis to determine whether reclassified rural hospitals should receive a capital DSH adjustment, nor did he take costs into account at all."[58]

Notwithstanding these findings, the D.C. District Court declined to vacate 42 C.F.R. § 412.320(a)(1)(iii) because "vacatur of a rule is not an appropriate remedy on review of an adjudication."[59] Instead, the Court remanded the case to the Medicare Contractor for a redetermination on the appellants' eligibility for a capital DSH adjustment.[60]

Providers' EJR Request

As background, each of the Providers is an acute care hospital paid by Medicare pursuant to the inpatient and capital prospective payment systems. During the years under appeal, the hospitals were all geographically located in urban areas, operated more than 100 beds, served low-income patients and, for all or part of the year, received § 401 rural reclassifications pursuant to 42 C.F.R. § 412.103.[61]

The Providers are challenging the validity of 42 C.F.R. § 412.320(a)(1)(iii), which states that urban hospitals may qualify for capital DSH payments unless, on or after October 1, 2006, the urban hospital is reclassified as rural. The Providers assert that this regulation is inconsistent with the underlying operating PPS statute, in particular, 42 U.S.C. § 1395ww(d)(8)(B), which states that hospitals that have undergone a rural reclassification are rural only for purposes of this subsection 1395ww(d). The capital DSH provisions are found at 42 U.S.C. § 1395ww(g), an entirely different section of the statute, and therefore a rural reclassification under the subsection (d) operating PPS provisions does not apply for subsection (g) capital PPS purposes.[62]

The Providers believe that the promulgation of 42 C.F.R. § 412.320(a)(1)(iii) is, therefore, beyond the authority granted under 42 U.S.C. §§ 1395ww(d)(8)(B) and 1395ww(g), and the regulation must be found invalid.[63] The Providers assert that the Secretary has implicitly acknowledged that

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[56] *Id.*
[57] *Id.*
[58] *Id.* at *11-12.
[59] *Id.* at *12.
[60] *Id.*
[61] EJR Request at 7.
[62] *Id.* at 1, 7.
[63] *See id.* at 7.

he cannot apply rural status for hospitals that have undergone a rural reclassification to payment provisions outside of subsection (d), and provides as an example, that the Secretary has stated with respect to direct graduate medical education ("GME") that no adjustment to the direct GME cap are available for urban hospitals that have reclassified as rural because subsection (d) reclassification "affects only payments under section 1886(d) of the Act . . . [and] payment for direct GME are made under section 1886(h) of the Act."[64] Further, the regulation fails to take into account any variation in cost based on location, as the capital PPS statute permits at 42 U.S.C. § 1395ww(g)(1)(B)(ii).[65]

The Providers assert that the Secretary's adoption of the regulation was arbitrary and capricious and violates the Administrative Procedure Act because he failed to establish that the adoption of the exception to the capital DSH adjustment, for providers that reclassified as rural, took into account variations in the relative costs of capital and construction for the different types of facilities or areas in which they are located.[66]

Though 42 C.F.R. § 412.320(a)(1)(iii) has not been vacated, the Providers argue that the merits of their position were adopted by the D.C. District Court in *Toledo*.[67] Further, the Providers contend that the Secretary has conceded the issue prospectively in his most recently proposed inpatient prospective payment rule in which the Secretary, in response to *Toledo*, proposed to amend 42 C.F.R. § 412.320(a)(1)(iii), as follows:

> For purposes of this section, the geographic classifications specified under § 412.64 apply, except that, effective for discharges occurring on or after October 1, 2006, *and before October 1, 2023*, for an urban hospital that is reclassified as rural as set forth in § 412.103, the geographic classification is rural.[68]

Thus, the Providers contend, if the rule is finalized, for discharges on or after October 1, 2023, "hospitals reclassified as rural under § 412.103 will no longer be considered rural for purposes of determining eligibility for capital DSH payments" and therefore will be eligible for capital DSH.[69] However, the Providers explain that "while the Fiscal Year 2024 [] proposed rule would revise 42 C.F.R. § 413.20(a)(1)(iii) in accordance with the *Toledo* decision for discharges on or after October 1, 2023, such changes, even if finalized, would not impact the Providers as the years at issue in this request are outside the scope of the proposed amendments."[70]

The Providers further contend that since the Board is bound by the regulation being challenged,[71] namely, the validity of 42 C.F.R. § 412.320(a)(1)(iii), it lacks the authority to decide the legal

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[64] *Id.* at 8, citing 70 Fed. Reg. 47278, 47437 (Aug. 12, 2005).
[65] *Id.*
[66] *Id.* at 8-9.
[67] *Id.* at 9, 11-12.
[68] *Id.* at 9-10, *citing* Medicare Proposed Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals Policy Changes and Fiscal Year 2024 Rates, 88 Fed. Reg. 26,658, 27,307 (May 1, 2023) (emphasis added).
[69] *Id.* at 10, *citing* 88 Fed. Reg. at 27,058.
[70] *Id.* at 11-12, *citing* 88 Fed. Reg. at 27,058-59.
[71] *See* 42 C.F.R. § 405.1867.

question presented in the Providers' EJR Request. Since the additional criteria for EJR have also been met, the Providers request the Board grant the request.[72]

Board Decision

Pursuant to 42 U.S.C. § 1395oo(f)(1) and the regulation at 42 C.F.R.§ 405.1842(f)(1), the Board is required to grant an EJR request if it determines that: (i) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (ii) the Board lacks the authority to decide a 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 & Related Claims Filing Requirements

In the November 13, 2015 Final Outpatient Prospective Payment Rule,[73] the Secretary finalized new cost reporting regulations related to the substantive reimbursement requirement of an appropriate cost report claim.[74] The Secretary revised the Medicare cost reporting regulations in 42 C.F.R. part 413, subpart B, by requiring a provider to include an appropriate claim for a specific item in its Medicare cost report *beginning on or after January 1, 2016* in order to receive or potentially qualify for Medicare payment for the specific item. If the provider's cost report does not include an appropriate claim for a specific item, the Secretary stated that payment for the item will not be included in the Notice of Program Reimbursement ("NPR") issued by the Medicare Contractor or in any decision or order issued by a reviewing entity (as defined in 42 C.F.R. § 405.1801(a)) in an administrative appeal filed by a provider. In addition, the Secretary revised the appeals regulations in 42 C.F.R. part 405, subpart R, by eliminating the requirement that a provider must include an appropriate claim for a specific item in its cost report in order to meet the "dissatisfaction" requirement in 42 U.S.C. § 1395oo(a)(1)(A)[75] for jurisdiction before the Board (hereinafter the "claim-specific dissatisfaction requirement"), which is effective for cost reports beginning on or after January 1, 2016.

1. Jurisdiction Over Provider No. 07-0024, Backus Hospital

On July 27, 2023, the Medicare Contractor filed a jurisdictional challenge to the Board's jurisdiction over Provider No. 07-0024, Backus Hospital, contending that the hospital failed to claim reimbursement for the specific issue in dispute, *i.e.*, capital DSH costs, on its as-filed cost report. The Medicare Contractor argues that the Provider did not claim any capital DSH payments on its submitted Medicare cost report nor did the Medicare Contractor make an adjustment to the settled cost report for capital DSH. Specifically, the Medicare Contractor contends that:

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[72] EJR Request at 10, 12.
[73] 80 Fed. Reg. 70298, 70551-70580 (Nov. 13, 2015).
[74] *Id.* at 70555.
[75] 42 U.S.C. § 1395oo(a) specifies that "[a]ny provider of services which has filed a required cost report . . may obtain a hearing with respect to such cost report . . . ***if*** – (1) *such provider* – (A) (i) *is* ***dissatisfied*** with a final determination of the organization service as its [Medicare contractor] as to the amount of total program reimbursement due the provider …." (Emphasis added.)

> [a]s can be seen from the as-filed and settled cost reports (Exhibit C-3), the Provider was designated as urban for the entire cost report year and had more than 100 beds. The Provider could have received a capital DSH payment for the current year; however, the Provider answered "N" for Title XVIII on line 45 of Worksheet S-2, Part I. Based on this response, capital DSH was not calculated on Worksheet L. There were no audit adjustments to change this line prior to the initial settlement. Provider error, not regulations, resulted in no capital DSH payment for the current year.[76]

The Medicare Contractor argues that the Board found it lacked jurisdiction to review an *unclaimed* cost in a prior appeal (PRRB Case No. 06-1705, The Mount Sinai Hospital FYE 12/31/1998)[77] that the Medicare Contractor contends has similar circumstances as the instant case. The provider in that case failed to claim the additional rotations for previously claimed residents and residents not in approved programs it sought on appeal. The Board declined to hear the appeal of the additional rotations for previously claimed residents, residents not in approved programs, and residents not previously claimed, as unclaimed costs when reimbursement of those costs was not precluded by a specific law, regulation, CMS Ruling or manual instruction. The Board found that it did not have jurisdiction over these issues not claimed or not properly reported on the cost report where the failure to claim was due to inadvertence rather than futility.[78]

In its response, Provider Backus Hospital explains that it is located geographically in an urban area, and reclassified from urban to rural status effective October 1, 2016, pursuant to 42 C.F.R. § 412.103(a)(3).[79] The Provider further explains that a copy of CMS' determination letter was sent to the Medicare Contractor, and that CMS and the Medicare Contractor's knowledge that Backus Hospital reclassified as rural is further supported in the CMS wage index files and table for the applicable year.[80] Accordingly, Backus Hospital contends that it did not claim payment for capital DSH on its fiscal year ending September 30, 2019 ("FY '19") cost report as 42 C.F.R. § 412.320(a)(1)(iii) prohibited hospitals such as Backus Hospital who were geographically urban but reclassified to rural from this payment during the year at issue.[81] While Backus Hospital acknowledges that it "*inadvertently* entered that it was an urban rather than a rural hospital on its FY '19 filed cost report," Backus Hospital notes that despite knowledge that Backus Hospital was reclassified as a rural hospital, the Medicare Contractor did not adjust or revise this entry on the finalized cost report.[82] The Medicare Contractor also left as unchanged the hospital's indication that the hospital was not entitled to capital DSH payments and the hospital's claim of "0" payment for capital DSH.[83]

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[76] MAC Jurisdictional Challenge at 2-3 (July 27, 2023).
[77] *See id.* at Exhibit C-6 (copy of the Board's determination letter dated Aug. 17, 2015).
[78] *Id.* at 3-4.
[79] Provider's Response to Jurisdictional Challenge at 2 (Aug. 18, 2023), *citing* Exhibit P-1.
[80] *Id.* at 2-3, *citing* Exhibit P-2 (screenshots of the documents).
[81] *Id.* at 3.
[82] *Id.* (citing Exhibit C-3) (emphasis added).
[83] *Id.* at 3-4.

Backus Hospital contends that it stated on its as-filed cost report that it was not entitled to a capital DSH payment and claimed an amount of zero (0) in capital DSH payments, and argues that the hospital's erroneous identification of itself as an urban rather than a rural hospital is irrelevant.[84] The Provider argues that consistent with the court decisions of *Bethesda Hosp. Ass'n v. Bowen*, 485 U.S. 399 (1988) and *Banner Heart Hospital v. Burwell*, 201 F. Supp. 3d 131 (D.D.C. 2016), if a hospital is appealing an issue for which the Medicare Contractor is not permitted to grant payment, then the hospital does not need to include a claim for the cost on its cost report, as an allowable cost or protested amount, in order to confer jurisdiction on the Board.[85]

Backus Hospital asserts that the instant case is distinguishable from the underlying facts in the Board's prior determination for The Mount Sinai Hospital that was cited by the Medicare Contractor. Specifically, the provider in that prior case failed to report on its cost report the residents it wished to be included in its indirect medical education and direct graduate medical education payment determinations, which if it would have done so, Medicare rules would have permitted payment for those residents.[86] In that case, the Board found it did not have jurisdiction under 42 U.S.C. 1395oo(a) over the issues, and declined to exercise discretion under 1395oo(d), to address items and services not claimed or not properly reported on the cost report where failure to claim was due to inadvertence rather than futility. By contrast, in the instant case, Backus Hospital was not permitted to be paid capital DSH pursuant to the Medicare regulation at 42 C.F.R. § 412.320(a)(1)(iii), which prohibits payment of capital DSH to geographically urban hospitals that are reclassified as rural.[87] Backus Hospital asserts that it would have been futile for it to claim capital DSH on its cost report.[88] In summary, Backus Hospital asserts that the Board should have jurisdiction over its appeal.

On review of the administrative record, the Board finds that it has jurisdiction over Backus Hospital under the facts of this particular case. As stated above, the Secretary revised the appeals regulations in 42 C.F.R. part 405, subpart R, by *eliminating* the "dissatisfaction" requirement (*i.e.*, the requirement that a provider must include an appropriate claim for November 13, 2015 final rule:

> As explained below, we are finalizing various revisions to the cost reporting regulations and the provider appeals regulations. These final revisions will apply, on a prospective only basis, to provider cost reporting periods beginning on or after the effective date of this final rule, and to provider appeals regarding provider cost reporting periods that begin on or after the effective date of this final rule [*i.e.*, January 1, 2016].
>
> ****
>
> As a result of our elimination, in the FY 2015 IPPS/LTCH PPS final rule, of the dissatisfaction requirement for Board jurisdiction over

[84] *Id.* at 8.
[85] *Id.*
[86] *Id.* at 8-9.
[87] *Id.* at 9.
[88] *Id.* at 9.

> appeals based on untimely contractor reimbursement determinations, providers no longer have to submit an appropriate cost report claim *as a requirement for Board **jurisdiction** over such appeals*. Our proposal to eliminate the requirement under § 405.1835(a)(1) of an appropriate cost report claim *in order to meet the "dissatisfied" **jurisdictional** provision in section 1878(a)(1)(A) of the Act* would make uniform this aspect of *Board **jurisdiction*** over both appeals of timely final contractor and Secretary determinations and appeals based on untimely final contractor determinations. Specifically, an appropriate cost report claim would no longer be required *for Board **jurisdiction** over appeals of timely final contractor and Secretary determinations* just as the same jurisdictional requirement, of an appropriate cost report claim, was previously eliminated (in the FY 2015 IPPS/LTCH PPS final rule) for appeals based on untimely final contractor determinations.[89]

Accordingly, claim-specific or issue-specific dissatisfaction has no bearing *on Board **jurisdiction*** over that claim/issue for cost reporting period beginning on or after January 1, 2016; rather, the substantive claim requirements at 42 C.F.R. § 413.24(j) are applicable to the instant case in which the cost report is for fiscal year ending in 2019. Consequently, any concerns about "claiming" the specific item at issue on appeal on the cost report fall into the realm of substantive claim issues, (which are discussed below) and not in the realm of jurisdiction. Here, the Board finds it has jurisdiction over Backus as a participant in this group and that Backus met the claims filing requirements for a Board hearing because: (1) Backus timely filed its appeal within 180 days of the issuance of its final determination as required by 42 C.F.R. § 405.1835; (2) the issue in the EJR request was included as part of Backus' appeal and transferred to the this CIRP group; and (3) the Board is not precluded by regulation or statute from reviewing the issue.[90]

2. Jurisdiction Over the Remaining Two Participants

The remaining two participants that comprise this group appeal have filed appeals involving thir respective FY 2019. Because they involve fiscal years that began ***after*** January 1, 2016, the claim-specific "dissatisfaction" requirement is not applicable *for jurisdiction before the Board*.

Based on its review of the administrative record, the Board finds that the two providers remaining in this group appeal filed their appeals within 180 days of the issuance of their respective final determination as required by 42 C.F.R. § 405.1835, or more than twelve months after the submission of their amended cost report and a final determination has not yet been issued under 42 C.F.R. § 405.1835(c)(1). The remaining providers each appealed the issue in the EJR request, and the Board is not precluded by regulation or statute from reviewing the issue. Further, the amount in controversy meets the $50,000 amount in controversy requirement for a group appeal pursuant to 42 C.F.R. § 405.1837(a)(3). In summary, the Board has jurisdiction over these two providers as well.

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[89] 80 Fed. Reg. at 70558, 70564 (emphasis added).

[90] While the Provider's position essentially applies the rationale of CMS Ruling 1727-R, that Ruling is not applicable to cost reporting periods beginning on or after January 1, 2016 since the claim/issue specific dissatisfaction requirement is no longer a requirement for Board jurisdiction for cost reporting period beginning on or after January 1, 2016.

B. Compliance with the Reimbursement Requirement of an Appropriate Cost Report Claim Pursuant to 42 C.F.R. § 405.1873 (Cost Reports Beginning on or After January 1, 2016)

For cost report periods beginning on or after January 1, 2016, the regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 are applicable. The regulation, § 413.24(j), specifies that, in order for a specific item to be eligible for potential reimbursement, the provider must include an appropriate cost report claim for that specific item:

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

In conjunction with the regulation above, 42 C.F.R. § 405.1873(a) addresses when the Board must examine a provider's compliance with § 413.24(j):

> (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.[91]

These regulations are applicable to the cost reporting periods under appeal for the three participants in this group appeal, which have cost reporting periods ending after December 31, 2016. The regulation at § 405.1873(b) sets out certain procedures that must be followed in the event a party questions whether the cost report included an appropriate claim for a specific item under appeal. *In such situations where a party raises that question*, the regulation requires the Board to give the parties an adequate opportunity to submit factual evidence and legal arguments regarding whether the provider's cost report included an appropriate claim for the specific item under appeal, and upon receipt of the factual evidence or legal argument (if any), the Board must review the evidence and argument and prepare written specific findings of fact and conclusions of law on the question of whether the provider's cost report complied with the cost report claim requirements of § 413.24(j).

The Board interprets the regulation at 42 C.F.R. § 405.1873 to only require the Board to review a provider's "compliance"[92] 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.[93]

On July 12, 2023, the Medicare Contractor responded to the EJR request, and informed the Board that it will be filing a substantive claim challenge. Thereafter, on July 24, Federal Specialized Services ("FSS"), on behalf of the Medicare Contractor, filed a substantive claim challenge to all three Providers in this group case, and asserted that appropriate cost report claims for the item under appeal, *i.e.* Capital Disproportionate Share, were not made by those three Providers.[94] Specifically, FSS contends that the Providers did not claim reimbursement for the Capital DSH issue in their cost report in accordance with Medicare policy nor did the Providers self-disallow the specific item in the Providers' cost reports as a protested amount. Further, FSS asserts that none of the exceptions at § 413.24(j)(3)(i)-(iii) applies.[95]

The three Providers filed a combined response to the Medicare Contractor's Substantive Claim Challenges on August 17, 2023. The Provider Hartford Hospital, Provider No. 07-0025, argues

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[91] (Bold emphasis added.)
[92] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."
[93] *See* 42 C.F.R. § 405.1873(a).
[94] MAC's Substantive Claim Challenge (July 24, 2023).
[95] *Id.*

that, contrary to FSS' assertions, it did meet the substantive claim requirements.[96] However, with respect to the two remaining providers, Backus Hospital and The Hospital of Central Connecticut (Provider No. 07-0035), those two Providers acknowledge that they neither claimed capital DSH as an allowable cost nor claimed it as a protest item on their cost reports, instead self-disallowing the issued based on the Medicare Contractor being bound by the regulation at 42 C.F.R. § 412.320(a)(1)(iii) (the regulation that is in dispute).[97]

1. Backus Hospital and The Hospital of Central Connecticut

Since a party to the appeal has questioned, pursuant to § 405.1873(a), whether an appropriate claim was made,[98] the Board finds that there is a regulatory obligation for the Board to affirmatively, on its own, review the appeal documents to determine whether an appropriate claim was made by the three Providers in this appeal. However, the two Providers listed above have conceded that they did not comply with § 413.24(j) and, as such, this noncompliance is *undisputed*. Therefore, pursuant to 42 C.F.R. § 405.1873(d)(2), the Board finds in its specific findings of facts and conclusions of law that those two Providers, Backus Hospital and The Hospital of Central Connecticut, failed to make a substantive claim pursuant to 42 C.F.R. § 413.24(j)(1)-(2), and notes that this is undisputed as the Providers/Group Representative have acknowledged this fact.

2. Hartford Hospital

On review of the evidence submitted and the parties' arguments, the Board finds that Hartford Hospital made an appropriate claim on its cost report. The evidence submitted shows that the Provider filed its cost report, answering "Y" on its Worksheet S-2 in response to the question of being eligible for capital DSH (Worksheet S-2, Part I, Line 45, Column 2).[99] The Medicare Contractor's adjustment #7 clearly changes the Provider's filed answer of "Y" (that it does qualify for capital DSH payment) to "N."[100] This answer drives the calculation of the cost reporting software. If it is answered "Y," capital DSH payments are calculated on Worksheet L, but if it is answered "N," no payment is calculated. Thus, while the Provider claimed $748,389 as capital DSH on its Worksheet L, Part I, Line 11,[101] because the adjustment on Worksheet S-2 changed the answer regarding eligibility for capital DSH to "N," that adjustment eliminated any submitted payment for capital DSH on Worksheet L, thereby reducing the claimed capital DSH amount to zero (0). In summary, the Board concludes that the Provider claimed the capital DSH at issue as an allowable cost on its cost report, thereby meeting the substantive claim requirement at 42 C.F.R. § 413.24(j)(1).

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

While two Providers, Backus Hospital and The Hospital of Central Connecticut, admit that they did not protest the capital DSH issue on their cost reports, the two Providers assert that the self-disallowance regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 are invalid insofar as these

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[96] Provider's Response to the Substantive Claim Challenge and Second EJR Request at 1 (Aug. 17, 2023).
[97] *Id.* at 2.
[98] 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."
[99] MAC's Substantive Claim Challenge, Exhibit C-1 at 31.
[100] *Id.* at 36.
[101] *Id.* at 32.

regulations would limit the Board's authority to order payment to providers that have not claimed a particular cost on their cost report as an allowable cost or as a protested amount. The Group Representative requested a second EJR in this particular case over the validity of 42 C.F.R. §§ 413.24(j) and 405.1873 (in addition to the capital DSH issue discussed above).[102]

In the second EJR request, the Providers argue that the regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 contravene the Board's authority set forth in 42 U.S.C. § 1395oo. They note that nowhere in the statute is there a requirement that a provider must include a claim for a specific cost on its cost report before payment related to that cost can be addressed by the Board. 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.[103]

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 . . .) that it is without authority to decide the question." The Providers note that while the validity of these regulatory provisions was not at issue when the Providers filed their appeal, the Medicare Contractor raised this issue in its substantive claim challenge, and the Board's Rules entitle the Providers to respond, including in the context of an EJR filing, citing Board Rule 44.5.2. Further, the Providers argue that because the Medicare Contractor argues that the substantive claim regulatory provisions prevent the Providers from receiving additional reimbursement for the capital DSH payment, the validity of these substantive claim regulatory provisions stems from the Providers' appeal of the capital DSH regulation and is integral to the resolution of the capital DSH issue.[104]

Per 42 C.F.R. § 405.1842(a)(1), "a provider [has] 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 Providers' challenge to the validity of 42 C.F.R. §§ 413.24(j) and 405.1873 is relevant to the matter at issue in this group appeal. Since there is no factual dispute regarding the two Providers' (Backus Hospital and The Hospital of Central Connecticut) lack of compliance with 42 C.F.R. § 413.24(j), the Board is able to reach consideration of the Providers' challenge to the validity of 42 C.F.R. §§ 413.24(j) and 405.1873. Further, since 42 C.F.R. § 405.1867 requires that the Board comply with the requirements of the statute and regulations, the Board lacks the authority to eliminate the regulatory provisions that create the self-disallowance requirements in §§ 413.24(j) and 405.1873, which is the remedy the Providers are seeking. Consequently, EJR is appropriate on this issue and the Board grants the Providers' (Backus Hospital and The Hospital of Central Connecticut) EJR request on this challenge.[105]

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[102] Provider's Response and EJR Request at 1, 8-11.
[103] *Id.*
[104] *Id.* at 13-14.
[105] The Board recognizes that: (1) as this challenge relates only to 2 of the 3 participants in the group, it does not apply to the full group; and (2) 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

D. Board's Analysis Regarding the Appealed Issue

The Providers in this case are challenging the application of 42 C.F.R. § 412.320(a)(1)(iii), which states in effect that urban hospitals may qualify for Capital DSH payments unless, on or after October 1, 2006, the urban hospital is reclassified as rural. The Providers contend that this regulation is inconsistent with the enabling statute, 42 U.S.C. § 1395ww(d)(8)(B), which concerns rural status. The Providers contend that §1395ww(d)(8)(B) specifically notes that the hospitals that have undergone a rural reclassification are rural only for "purposes of this subsection [1395ww(d)]." Additionally, the Providers assert that the Capital DSH provisions are found at 42 U.S.C. § 1395ww(g), not § 1395ww(d), and, accordingly, the literal wording of the rural reclassification statutory provision identifies that rural status does not reach the Capital DSH calculation. The Providers maintain that the promulgation of 42 C.F.R. § 412.320(a)(1)(iii) is, therefore, beyond the authority granted under 42 U.S.C. § 1395ww(d)(8)(B), and the regulation must be found invalid.

The Board finds that, pursuant to 42 C.F.R. § 405.1867, it must comply all the provisions of Title XVIII of the Act and regulations issued thereunder, including the challenged regulation, 42 C.F.R. § 412.320(a)(1)(iii). Moreover, 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.

Accordingly, the Board concludes that it lacks the authority to grant the relief sought by the Providers, *i.e.,* to reverse or otherwise invalidate 42 C.F.R. § 412.320(a)(1)(iii). Consequently, the Board hereby grants the Providers' request for EJR for the issue and federal fiscal year under dispute.

E. Board's Decision Regarding the EJR Requests

The Board finds that:

1) For the subject year, it has jurisdiction over both the capital DSH issue for all 3 participants and the challenge to the validity of 42 C.F.R. §§ 413.24(j) and 405.1873 for the two participant raising that challenge (Backus Hospital and The Hospital of Central Connecticut), and the Providers in this group appeal are entitled to a hearing before the Board;

2) As all 3 participants appealed cost reports with cost reporting periods beginning after January 1, 2016, they are each subject to the substantive claim cost reporting requirements at 42 C.F.R. § 413.24(j) and the Medicare Contractor timely raised a substantive claim challenge[106]

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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 of this challenge is available to these 2 participants.

[106] As explained at 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."

under 42 C.F.R. § 1873(a) for all 3 participants resulting in the following findings of the Board:

a. Hartford Hospital (Prov. No. 07-0025) met the substantive claim cost reporting requirements in § 413.24(j); and

b. It is undisputed that neither Backus Hospital (Prov. No. 07-0024) nor The Hospital of Central Connecticut (Prov. No. 07-0035) met the substantive claim cost reporting requirements in § 413.24(j);

3) Based upon the Providers' assertions regarding 42 C.F.R. § 412.320(a)(1)(iii), as well as the assertions regarding the validity of 42 C.F.R. §§ 413.24(j) and 405.1873, there are no findings of fact for resolution by the Board;

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

5) It is without the authority to decide the legal questions of whether 42 C.F.R. § 412.320(a)(1)(iii), as promulgated in the FY 2007 IPPS Final Rule, is substantively or procedurally valid ***and***, in connection with the participants Backus Hospital and The Hospital of Central Connecticut, whether the regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 are valid.

Accordingly, the Board finds that the question of the validity of 42 C.F.R. § 412.320(a)(1)(iii) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' EJR request for the capital DSH issue for the subject year. The Board also finds that the question of the validity of the substantive claim regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the two Providers' (Backus Hospital and The Hospital of Central Connecticut) EJR request for this issue for the subject year.

The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. As there are no issues remaining in this group appeal, the Board hereby closes it and removes it from the Board's docket.

Board Members Participating:

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

For the Board:

9/15/2023

X Clayton J. Nix

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

Enclosure: Schedule of Providers

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Expedited Judicial Review Determination***
Banner Health CY 2018 Capital DSH CIRP Group
Case No. 23-0928GC

Dear Ms. Goldsmith:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' September 5, 2023 request for expedited judicial review ("EJR") in the above-referenced group appeal.[1] The decision with respect to EJR is set forth below.

Issue

In this group case, the Providers are challenging:

> [t]he validity of the regulation at 42 C.F.R. § 412.320(a)(1)(iii), which bars hospitals that are geographically urban and reclassify as rural under 42 C.F.R. § 412.103 from receiving a capital disproportionate share hospital ("DSH") add-on payment, known as the capital DSH adjustment. The Providers challenge the validity of 42 C.F.R. § 412.320(a)(1)(iii) on a number of grounds including that the regulation (a) is inconsistent with the controlling Medicare statute, (b) was adopted in violation of the Administrative Procedure Act, and (c) is arbitrary and capricious.[2]

Background

Under the inpatient prospective payment system ("IPPS"), Medicare pays hospitals predetermined rates for patient discharges and this system is comprised of two parts, one for operating costs ("operating IPPS") as set forth at § 1395ww(d); and one for capital costs

[1] As Banner Health is the parent organization of multiple hospitals, it is subject to the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1) as it relates to the common issue in Case No. 23-0928GC for the year 2018. As Banner Health designated the CIRP group fully formed, they are prohibited from pursuing this same issue for the same year in any other appeal (whether as part of an individual provider appeal or group appeal) as explained in § 405.1837(e)(1): "When the Board has determined that a group appeal brought under paragraph (b)(1) . . . is fully formed, absent an order from the Board modifying its determination, no other provider under common ownership or control may appeal to the Board the issue that is the subject of the group appeal with respect to a cost reporting period that falls within the calendar year(s) covered by the group appeal."

[2] Request for Expedited Judicial Review, 1 (Sept. 5, 2023) ("Request for EJR").

("capital IPPS") as set forth at 42 U.S.C. § 1395ww(g). The primary objective of IPPS is to create incentives for hospitals to operate efficiently, while providing adequate compensation to hospitals.[3] This case focuses on the capital IPPS.

A. Geographic Reclassification

In 1989, Congress created the Medicare Geographic Classification Review Board ("MGCRB") which implemented a geographic reclassification system in which IPPS hospitals can be reclassified to a different wage index area[4] for purposes of receiving a higher payment rate if they meet certain criteria related to proximity and average hourly wage.[5] This includes an IPPS hospital reclassifying from a rural to an urban labor market, or vice versa.

B. Operating DSH Adjustment Under Operating IPPS

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under operating IPPS.[6] Under the operating IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[7]

The statute governing operating IPPS contains a number of provisions that adjust reimbursement based on hospital-specific factors.[8] One of the adjustments is the hospital-specific Disproportionate Share Hospital ("DSH") adjustment as set forth at 42 U.S.C. § 1395ww(d)(5)(F), which requires the Secretary to provide an adjustment (*i.e.*, an increase in the operating IPPS payment) to hospitals that serve a significantly disproportionate number of low-income patients.[9]

A hospital may qualify for a DSH adjustment to its operating IPPS payments based on its disproportionate patient percentage ("DPP").[10] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.[11]

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[3] Daniel R. Levinson, Department of Health and Human Services, Office of the Inspector General, *Significant Vulnerabilities Exist in the Hospital Wage Index System for Medicare Payments*, 1 (Nov. 2018), *available at* https://oig.hhs.gov/oas/reports/region1/11700500.pdf (last visited Sept. 13, 2023) ("*Significant Vulnerabilities*").
[4] *See* https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/wageindex.html (42 U.S.C. § 1395ww(d)(3)(E) requires that, as part of the methodology for determining prospective payments to hospitals, the Secretary must adjust the standardized amounts "for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level." This adjustment factor is the wage index. The Secretary currently defines hospital geographic areas (labor market areas) based on the definitions of Core-Based Statistical Areas ("CBSAs") established by the Office of Management and Budget and announced in December 2003. The wage index also reflects the geographic reclassification of hospitals to another labor market area, such as rural to urban or vice versa, in accordance with sections 1395ww(d)(8)(B) and 1395ww(d)(10).).
[5] Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, 103 Stat. 2106, 2154 (1989). *See also Significant Vulnerabilities* at 4-5.
[6] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[7] *Id.*
[8] *See* 42 U.S.C. § 1395ww(d)(5).
[9] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[10] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[11] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).

The DSH adjustment provided under operating IPPS is ***not*** at issue in this case. The DSH adjustment is relevant because certain standards set forth in 42 U.S.C. § 1395ww(d)(5)(F) for the DSH adjustment, the Secretary adopted for purposes of capital IPPS.

C. Capital DSH Adjustment Under Capital IPPS

A hospital's *capital* costs are paid separately under capital IPPS (*i.e*., separate and apart from payment for a hospital's *operating* costs under the operating IPPS). Specifically, on December 22, 1987, Congress enacted the Omnibus Budget Reconciliation Act of 1987 ("OBRA-87") and OBRA-87 § 4006(b) required the Secretary to establish the capital IPPS for cost reporting periods beginning in FY 1992.[12] OBRA-87 § 4006(b) was codified at 42 U.S.C. § 1395ww(g) which states, in pertinent part:

> **(g) Prospective payment for capital-related costs; return on equity capital for hospitals**
>
> (1)(A) Notwithstanding section 1395x(v) of this title, instead of any amounts that are otherwise payable under this subchapter with respect to the reasonable costs of subsection (d) hospitals and subsection (d) Puerto Rico hospitals for capital-related costs of inpatient hospital services, the Secretary *shall,* for hospital cost reporting periods beginning on or after October 1, 1991, *provide for payments for such costs* in accordance with a prospective payment system established by the Secretary. . . .
>
> (B) Such system— (i) shall provide for (I) a payment on a per discharge basis, and (II) an appropriate weighting of such payment amount as relates to the classification of the discharge;
>
> (ii) *may provide for an adjustment to take into account variations in the relative costs of capital and construction for the different types of facilities or areas in which they are located*;
>
> (iii) may provide for such exceptions (including appropriate exceptions to reflect capital obligations) as the Secretary determines to be appropriate, and
>
> (iv) may provide for suitable adjustment to reflect hospital occupancy rate.
>
> (C) In this paragraph, the term ''capital-related costs'' has the meaning given such term by the Secretary under subsection (a)(4)

[12] Pub. L. 100-203, § 4006(b), 101 Stat. 1330, 1330-52 (1987).

> as of September 30, 1987, and does not include a return on equity capital.[13]

Significantly, the statute governing capital IPPS does not specifically mandate or address the use of a capital DSH adjustment. Rather, it specifies generally that the Secretary "may provide for an adjustment to account variations in relative costs." As described below, the Secretary exercised his discretion to establish the c*apital* DSH adjustment at issue in this case which is limited in that it ***only*** applies to *urban* hospitals with 100 or more beds and that serve low income patients.[14]

1. Initial Implementation of Capital IPPS and the Capital DSH Adjustment

The Secretary published a final rule on August 30, 1991 to establish the capital IPPS.[15] In implementing the capital IPPS, the Secretary recognized that he had discretion on whether to apply many of the adjustments statutorily required under operating IPPS to capital IPPS:

> We are persuaded by the argument advanced by some commenters, including ProPAC, that in the long run the ***same*** adjustments should be applied to capital and operating payments and that the level of the adjustments should be determined by examining combined operating and capital costs. ProPAC recommended that the unified adjustments be calculated within two years. However, we believe that it would be most appropriate to implement these adjustments with respect to the capital prospective payment systems from the outset. *While the payment adjustments for the operating prospective payment system are determined by the Act (and therefore cannot be modified by the rulemaking process),* ***we have the latitude to develop adjustments based on combined costs for the capital prospective payment system***.
>
> We do not believe that it would be appropriate to use the current operating payment adjustments in the capital prospective payment system either permanently or on an interim basis until legislation is enacted changing the operating adjustments to the level appropriate for total costs. This is because the levels of the operating payment adjustments for serving a disproportionate share of low income patients (DSH) and for indirect medical education costs (IME) exceed the levels supported by empirical analysis. We believe the payment adjustments should be empirically supported and should reflect only the higher Medicare costs associated with teaching activity and treating low income patients.[16]

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[13] (Underline and italics emphasis added.)
[14] 42 C.F.R. § 412.320(a)(1). *See also* MedPAC, *Hospital Acute Inpatient Services Payment System: Payment Basics*, 2 (rev. Nov. 2021), *available at* https://www.medpac.gov/wp-content/uploads/2021/11/medpac_payment_basics_21_hospital_final_sec.pdf (last visited Sept. 13, 2023).
[15] 56 Fed. Reg. 43358 (Aug. 30, 1991).
[16] *Id.* at 43369-70 (emphasis added).

The Secretary did adopt a limited DSH adjustment to capital IPPS for urban hospitals with more than 100 beds. The proposal was described as follows:

> In the proposed rule, our regression results indicated that for urban hospitals with more than 100 beds, the disproportionate share percentage of low income patients has an effect on capital costs per case. We proposed that urban hospitals with 100 or more beds would receive an additional payment equal to $((1 + DSHP)^{0.4176} - 1))$, where DSHP is the disproportionate share patient percentage. There would be no minimum disproportionate share patient percentage required to qualify for the payment adjustment. A hospital would receive approximately a 4.2 percent increase in payments for each 10 percent increase in its disproportionate share percentage. This formula is similar to the one used for the indirect medical education adjustment under the operating prospective payment system.
>
> Since we did not find a disproportionate share effect on the capital costs of urban hospitals with fewer than 100 beds or on rural hospitals, we did not propose to make a disproportionate share adjustment to the capital payment to these hospitals.[17]

In adopting his proposal, the Secretary gave the following justification:

> *Comment*: Many commenters believe that the disproportionate share patient percentage of 30 percent needed to qualify for the special exceptions payment under the proposal is too restrictive. Most of these commenters supported the use of 20.2 percent as the patient threshold percentage since that is the patient percentage above which operating disproportionate share payments become more generous. Some believe that any hospital that received DSH payments under the operating system should be eligible for the special exception.
>
> *Response*: In the final rule, we are providing that urban hospitals with 100 or more beds and a disproportionate share patient percentage of 20.2 percent or higher will be eligible to receive exceptions payments based on a higher minimum payment level than other hospitals. For FY 1992, the minimum payment level is 80 percent. Urban hospitals with 100 or more beds that receive disproportionate share payments under § 412.106(C)(2) would also be eligible for the higher minimum payment level. We are not extending the special protection to other hospitals that receive disproportionate share payments under the operating prospective

[17] *Id* at 43377.

> payment system. In urban areas, we believe that our criteria properly focuses on those hospitals that serve a large disproportionate share population. Other urban hospitals receiving disproportionate share payments tend to serve fewer low income patients either because of their smaller size (i.e., under 100 beds) or lower disproportionate share patient percentage. **In rural areas, we believe the more relevant criteria for determining whether a hospital should receive special payment protection is whether the hospital represents the sole source of care reasonably available to Medicare beneficiaries**.[18]

In response to comments, the Secretary rejected expanding the application of the capital DSH adjustment to rural hospitals with 500 or more beds:

> As part of our regression analysis for this final rule, we examined the relationship between total cost per case and disproportionate share patient percentages for rural hospitals with at least 500 beds, and found no statistically significant relationship. As a result, we are not implementing any disproportionate share adjustment to prospective payments for capital for these hospitals. Hospitals that qualify for additional operating disproportionate share payments under section 1886(d)(5)(F)(i)(II) of the Act will be deemed to have a disproportionate patient percentage equivalent to that which would generate their operating disproportionate share payment, using the formula for urban hospitals with at least 100 beds. For discharges occurring on or after October 1, 1991, these hospitals qualify for an operating adjustment of 35 percent, which is equivalent to having a disproportionate share patient percentage of 65.4. Urban hospitals with more than 100 beds that qualify for additional operating disproportionate share payments under section 1866(d)(5)(F)(i)(II) of the Act will be deemed to qualify for additional capital disproportionate share payments as well at the level consistent with their deemed disproportionate share patient percentage. The disproportionate share adjustment factor for these hospitals is 14.16 percent. The additional capital disproportionate share payments to these hospitals will be made at the same time that the additional operating disproportionate share payments are, that is, as the result of the application by these hospitals for payments under § 412.106(b)(l)(ii) of the regulations.[19]

Similarly, in response to comments, the Secretary rejected expanding the application of the capital DSH adjustment to other classes of hospitals such as "[a]ll small urban hospitals, hospitals with high Medicare usage, rural hospitals, rural hospitals with at least 100 beds, rural referral centers, or those hospitals with high 'total government' usage":

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[18] *Id.* at 43409-10 (bold and underline emphasis added).
[19] *Id.* at 43377.

> In developing the capital disproportionate share adjustment for this final rule, we examined the relationship between the disproportionate share patient percentage and total costs per case for each class of hospital that is currently receiving an operating payment adjustment. We believe that only those hospitals that merit the adjustment according to our regression analysis should receive additional capital payments for serving low income patients. The regression results did not indicate any significant relationship between total costs per case and disproportionate share patient percentage for any of the special groups mentioned above.[20]

In response to comments, the Secretary also looked at setting a threshold DSH percentage to qualify for a capital DSH adjustment but rejected that alternative approached based upon the following explanation:

> We examined closely the possibility of using a disproportionate share patient percentage threshold in our total cost regression analysis. We were unable to find any threshold level of disproportionate share percentage below which no payment adjustment was merited, or a threshold above which a higher adjustment was merited. As a result, we believe that it is most equitable to make a capital disproportionate share payment to all qualifying hospitals with a positive patient percentage, rather than penalize some hospitals that have a higher cost of treating low income patients but whose patient percentage is below the artificial level we would set.[21]

Further, in response to comments, the Secretary rejected not providing *any* capital DSH adjustment based on the explanation:

> We disagree with the commenter. The regression analyses show that serving low income patients (as defined in section 1886(d)(5)(F)(vi) of the Act) results in higher Medicare capital and total costs per case *for urban hospitals with at least 100 beds*. We believe that it is appropriate for Medicare's payment to recognize these higher Medicare patient care costs.[22]

Finally, the Secretary addressed how MGCRB reclassifications, in certain circumstances, affect whether an IPPS hospital qualifies for the capital DSH adjustment:

> *Comment*: Many commenters sought clarification of the effect of reclassification by the Medicare Geographic Classification Review

[20] *Id.* at 43378.
[21] *Id.* at 43379.
[22] *Id.* (Emphasis added.)

> Board (MGCRB) on eligibility for capital disproportionate share payments.
>
> *Response*: Any hospital that is reclassified to an urban area by the MGCRB for purposes of its standardized amount is considered to be urban for all prospective payment purposes other than the wage index. As such, if any hospital reclassified by the MGCRB to an urban area for purposes of the standardized amount has at least 100 beds, it would be eligible for capital disproportionate share payments. We note that a rural hospital reclassified for purposes of the wage index only is still considered a rural hospital, and as such, will not be eligible for capital disproportionate share payments.[23]

The resulting regulations governing capital IPPS were codified at 42 C.F.R. Part 412, Subpart M (§§ 412.300 to 412.374). The regulation governing the capital DSH adjustment was codified at § 412.320 which, at initial implementation, stated:

> **§ 412.320 Disproportionate share adjustment factor.**
>
> (a) *Criteria for classification*. A hospital is classified as a "disproportionate share hospital" for the purposes of capital prospective payments if the hospital is located, for purposes of receiving payment under § 412.63(a), in an urban area, has 100 or more beds as determined in accordance with § 412.105(b) and serves low-income patients, as determined under § 412.106(b), or if the hospital meets the criteria in § 412.106(c)(2).
>
> (b) *Payment adjustment factor*. (1) <u>If a hospital meets the criteria in paragraph (a) of this section for a disproportionate share hospital for purposes of capital prospective payments</u>, the disproportionate share payment adjustment factor equals [e raised to the power of (.2025 X the hospital's disproportionate patient percentage as determined under § 412.106(b)(5)), —1], where e is the natural antilog of 1.
>
> (2) If a hospital meets the criteria in § 412.106(c)(2) for purposes of inpatient hospital operating prospective payments, the disproportionate share adjustment factor equals 14.16 percent.[24]

2. Reclassification of Certain IPPS Urban Hospitals as Rural for Purposes of Operating IPPS Pursuant to BBRA § 401 and Impact on Capital IPPS Adjustments

On November 29, 1999, Congress enacted the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 ("BBRA") and BBRA § 401 amended 42 U.S.C. § 1395ww(d)(8) to

[23] *Id.*
[24] *Id*. at 43452-53.

require that certain urban IPPS hospitals be reclassified as rural *for purposes of operating IPPS* if an application is submitted to the MGCRB and certain criteria are met.[25] IPPS hospitals are reclassified per BBRA § 401 are often referred to as "§ 401 hospitals."

On August 1, 2000, the Secretary published the interim final rule to, in part, implement BBRA § 401 and stated in the preamble that a hospital reclassified as rural pursuant to § 401 is treated as rural for ***all*** purposes under operating IPPS, including the DSH adjustment for operating IPPS:

> *A hospital that is reclassified as rural* under section 1886(d)(8)(E) of the Act, as added by section 401(a) of Public Law 106–113, ***is treated as rural for all purposes*** *of payment under the Medicare inpatient hospital prospective payment system* (section 1886(d) of the Act), *including* standardized amount (§§ 412.60 et seq.), wage index (§ 412.63), and ***disproportionate share calculations*** (§ 412.106) as of the effective date of the reclassification.[26]

On August 1, 2000, the Secretary also published the FY 2001 IPPS Final Rule which included the following discussion on the effect of reclassification of a hospital from urban to rural pursuant to BBRA § 401:

> In the May 5, 2000 proposed rule, we indicated that we are concerned that section 1886(d)(8)(E) might create an opportunity for some urban hospitals to take advantage of the MGCRB process by first seeking to be reclassified as rural under section 1886(d)(8)(E) (and receiving the benefits afforded to rural hospitals) and in turn seek reclassification through the MGCRB back to the urban area for purposes of their standardized amount and wage index and thus also receive the higher payments that might result from being treated as being located in an urban area. ***That is, we were concerned that some hospitals might inappropriately seek to be treated as being located in a rural area for some purposes and as being located in an urban area for other purposes***. In light of the Conference Report language noted above discussing the House bill and what appears to be the potential for inappropriately inconsistent treatment of the same hospital on the other hand, in the May 5 proposed rule, we solicited public comment on this issue, and indicated that we might impose a limitation on such MGCRB reclassifications in this final rule for FY 2001, if such action appears warranted. We also sought specific comments on how such a limitation, if any, should be imposed and provided several examples and alternatives.
>
> ****
>
> Consistent with the statutory language, we are providing that a hospital reclassified as rural under section 1886(d)(8)(E) of the Act

[25] BBRA, Pub. L. 106-113, App. F, § 401, 113. Stat. 1501A-321, 1501A-369 (1999).
[26] 65 Fed. Reg. 47026, 47030 (Aug. 1, 2000) (emphasis added).

will be treated as being located in a rural area for purposes of section 1886(d) of the Act, and cannot subsequently be reclassified under the MGCRB process to an urban area (in order to be treated as being located in an urban area for certain purposes under section 1886(d) of the Act).

This policy is consistent not only with the statutory language but also with the policy considerations underlying the MGCRB process. The MGCRB process permits a hospital to be reclassified from one geographic area to another if it is significantly disadvantaged by its geographic location and would be paid more appropriately if it were reclassified to another area. We believe that it would be illogical to permit a hospital that applied to be reclassified from urban to rural under section 1886(d)(8)(E) of the Act because it was disadvantaged as an urban hospital to then utilize a process that was established to enable hospitals significantly disadvantaged by their rural or small urban location to reclassify to another urban location. *If an urban hospital applies under section 1886(d)(8)(E) of the Act in order to be treated as being located in a rural area, then it would be anomalous at best for the urban hospital to subsequently claim that it is significantly disadvantaged by the rural status for which it applied and should be reclassified to an urban area.*

Furthermore, permitting hospitals the option of seeking rural reclassification under section 1886(d)(8)(E) of the Act for certain payment advantages, coupled with the ability to pursue a subsequent MGCRB reclassification back to an urban area, could have implications beyond those originally envisioned under Public Law 106–113. In particular, we are concerned about the potential interface between rural reclassifications under section 401 and section 407(b)(2) of Public Law 106– 113, which authorizes a 30-percent expansion in a rural hospital's resident full-time equivalent count for purposes of Medicare payment for the indirect costs of medical education (IME) under section 1886(d)(5)(B) of the Act. (Reclassification from urban to rural under section 1886(d)(8)(E) of the Act can affect IME payments to a hospital, which are made under section 1886(d)(5)(B) of the Act, but not payments for the direct costs of GME, which are made under section 1886(h) of the Act.)

Congress clearly intended hospitals that become rural under section 1886(d)(8)(E) of the Act to receive some benefit as a result. For example, some hospitals currently located in very large urban counties are in fact fairly small, isolated hospitals. Some of these hospitals will now be able to be designated a rural hospital and become eligible to be designated a critical access hospital.

****

> We are not permitting hospitals redesignated as rural under section 1886(d)(8)(E) of the Act to be eligible for subsequent reclassification by the MGCRB, and are revising the regulations governing MGCRB reclassifications (§ 412.230) accordingly.
>
> ****
>
> *We wish to emphasize that urban to rural reclassification under section 1886(d)(8)(E) of the Act is entirely voluntary*. ***Each hospital anticipating that it may qualify under this provision should determine the impact of Medicare payment policies if it were to reclassify***. As discussed above, we believe that our policies here are consistent with the Secretary's broad authority under section 1886(d)(10) of the Act, the statutory language in section 1886(d)(8)(E) of the Act, as well as our understanding of the intent underlying the description of the House bill in the Conference Report.[27]

Thus, both the August 1, 2000 interim final rule and the FY 2001 IPPS Final Rule confirmed that urban hospitals reclassified as rural pursuant to BBRA § 401 would be treated as rural for all purposes of operating IPPS, including DSH adjustments. The Secretary memorialized this policy in regulation at 42 C.F.R. § 412.103 (2000) which states in pertinent part:

> **§ 412.103 Special treatment: Hospitals located in urban areas and that apply for reclassification as rural**.
>
> (a) *General criteria*. A prospective payment hospital that is located in an urban area (as defined in § 412.62(f)(1)(ii)) may be reclassified as a rural hospital if it submits an application in accordance with paragraph (b) of this section and meets any of the following conditions:
>
> 1) The hospital is located in a rural census tract of a Metropolitan Statistical Area (MSA) as determined under the most recent version of the Goldsmith Modification as determined by the Office of Rural Health Policy (ORHP) of the Health Resources and Services Administration which is available via the ORHP website at http://www.nal.usda.gov/orph or from the U.S. Department of Health and Human Services, Health Resources and Services Administration, Office of Rural Health Policy, 5600 Fishers Lane, Room 9–05, Rockville, MD 20857.
>
> (2) The hospital is located in an area designated by any law or regulation of the State in which it is located as a rural area, or the hospital is designated as a rural hospital by State law or regulation.

[27] 65 Fed. Reg. 47054, 47087-89 (Aug. 1, 2000).

> (3) The hospital would qualify as a rural referral center as set forth in § 412.96, or as a sole community hospital as set forth in § 412.92, if the hospital were located in a rural area.[28]

Neither the August 1, 2000 interim final rule nor the FY 2001 IPPS Final Rule explicitly discussed the impact on capital DSH adjustments under capital IPPS. However, through operation of the cross-reference in 42 C.F.R. § 412.320(a) to § 412.63(a) in the phrase "the hospital is located, for purposes of receiving payment under § 412.63(a), in an urban area", it would appear that hospitals reclassified from urban to rural were ***not*** eligible for capital DSH adjustments under capital IPPS. In this regard, the Board notes that, following the 2000 rulemaking process, § 412.63(a)-(b) (2001) read, in pertinent part:

> (a) *General rule*. (1) HCFA determines a national adjusted prospective payment rate for inpatient operating costs for each inpatient hospital discharge in a Federal fiscal year after fiscal year 1984 involving inpatient hospital services of a hospital in the United States subject to the prospective payment system, and determines a regional adjusted prospective payment rate for operating costs for such discharges in each region, for which payment may be made under Medicare Part A.
>
> (2) **Each such rate is determined for hospitals located in urban or rural areas** within the United States and within each such region respectively, **as described in paragraphs (b)** through (g) of this section.
>
> (b) *Geographic classifications*. (1) For purposes of this section, the definitions set forth in § 412.62(f) apply, **except that**, effective January 1, 2000, **a hospital reclassified as rural may mean** a reclassification that results from a geographic redesignation as set forth in § 412.62(f)(1)(iv) or **a reclassification that results from an urban hospital applying for reclassification as rural as set forth in § 412.103**.[29]

The specific reference in § 412.63(b) to urban to rural reclassifications made under § 412.103 makes clear that capital DSH adjustments would not apply to hospitals reclassified from urban to rural pursuant to BBRA § 401 which as noted above was implemented at § 412.103.

3. Changes to Operating IPPS Required by MMA § 401 and Their Effect on Capital IPPS

On December 8, 2003, Congress enacted the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 ("MMA") and MMA § 401 to equalize operating IPPS payments between urban and rural hospitals.[30] Specifically, § 401 specifies that, beginning with FY 2004,

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[28] *Id*. at 47048.
[29] *Id.* at 47047 (Bold and underline emphasis added.)
[30] Pub. L. 108–173

all IPPS hospitals are paid on the basis of the large urban standardized amount under operating IPPS.

The Office of Management and Budget publishes information on core-based statistical areas ("CBSAs") and the Secretary has used this information for purposes of defining labor market areas for use in the wage index for operating IPPS.[31] On June 6, 2003, OMB announced the new CBSAs, comprised of metropolitan statistical areas ("MSAs") and the new Micropolitan Areas based on Census 2000 data.[32]

On August 11, 2004, the Secretary published the FY 2005 IPPS Final Rule and this rule finalized revisions to the operating IPPS regulations to both implement MMA § 401 as well as adopt OMB's new CBSA designations.[33] With respect to implementing MMA § 401, the Secretary revised 42 C.F.R. § 412.63 to apply only to years through 2004 and added a new § 412.64 to implement MMA § 401 for federal rates for FYs 2005 forward. Specifically, § 412.64 reads in pertinent part:

> **§ 412.64 Federal rates for inpatient operating costs for Federal fiscal year 2005 and subsequent fiscal years.**
>
> (a) *General rule*. CMS determines a national adjusted prospective payment rate for inpatient operating costs for each inpatient hospital discharge in Federal fiscal year 2005 and subsequent fiscal years involving inpatient hospital services of a hospital in the United States subject to the prospective payment system for which payment may be made under Medicare Part A.
>
> (b) *Geographic classifications*. (1) For purposes of this section, the following definitions apply:
>
> (i) The term region means one of the 9 metropolitan divisions comprising the 50 States and the District of Columbia, established by the Executive Office of Management and Budget for statistical and reporting purposes.
>
> (ii) The term *urban area* means—
>
> (A) A Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget; or
>
> (B) The following New England counties, which are deemed to be parts of urban areas under section 601(g) of the Social Security Amendments of 1983 (Public Law 98–21, 42 U.S.S. 1395ww (note)): Litchfield County, Connecticut; York County, Maine;

[31] 69 Fed. Reg. 48916, 49026-27 (Aug. 11, 2004).
[32] *Id.*
[33] 69 Fed. Reg. 48916 (Aug. 11, 2004).

> Sagadahoc County, Maine; Merrimack County, New Hampshire; and Newport County, Rhode Island.
>
> (C) The term *rural area* means any area outside an urban area.
>
> (D) The phrase *hospital reclassified as rural* means a hospital located in a county that, in FY 2004, was part of an MSA, but was redesignated as rural after September 30, 2004, as a result of the most recent census data and implementation of the new MSA definitions announced by OMB on June 6, 2003.
>
> (2) For hospitals within an MSA that crosses census division boundaries, the MSA is deemed to belong to the census division in which most of the hospitals within the MSA are located.
>
> (3) For discharges occurring on or after October 1, 2004, a hospital located in a rural county adjacent to one or more urban areas is deemed to be located in an urban area and receives the Federal payment amount for the urban area to which the greater number of workers in the county commute if the rural county would otherwise be considered part of an urban area, under the standards for designating MSAs if the commuting rates used in determining outlying counties were determined on the basis of the aggregate number of resident workers who commute to (and, if applicable under the standards, from) the central county or central counties of all adjacent MSAs. These EOMB standards are set forth in the notice of final revised standards for classification of MSAs published in the Federal Register on December 27, 2000 (65 FR 82228), announced by EOMB on June 6, 2003, and available from CMS, 7500 Security Boulevard, Baltimore, Maryland 21244.
>
> (4) For purposes of this section, any change in an MSA designation is recognized on October 1 following the effective date of the change. Such a change in MSA designation may occur as a result of redesignation of an MSA by the Executive Office of Management and Budget.[34]

Significantly, § 412.64 does not reference the provisions of § 412.103 regarding the urban-to-rural reclassifications, as was previously found in § 412.63(b)(1).

The Secretary also amended 42 C.F.R. § 412.320(a). As previously noted, § 412.320(a) originally only referenced § 412.63: "A hospital is classified as a 'disproportionate share hospital' for the purposes of capital prospective payments if the hospital is located, *for purposes*

[34] *Id.* at 49242. *See also id.* at 49103 (discussing implementation of MMA § 401).

of receiving payment under § 412.63(a), in an urban area."[35] As a result of the FY 2005 IPPS Final Rule, § 412.320(a) was updated to reference § 412.64 as it relates to FYs 2005 forward:

> **§ 412.320 Disproportionate share adjustment factor.**
>
> (a) *Criteria for classification*. A hospital is classified as a ''disproportionate share hospital'' for the purposes of capital prospective payments if either of the following conditions is met:
>
> (1) The hospital is located in an urban area, has 100 or more beds as determined in accordance with § 412.105(b), and serves low-income patients as determined under § 412.106(b).
>
> (i) For discharges occurring on or before September 30, 2004, the payment adjustment under this section is based on a hospital's location, for the purpose of receiving payment, under § 412.63(a).
>
> (ii) For discharges occurring on or after October 1, 2004, the payment adjustment under this section is based on the geographic classifications specified under § 412.64.[36]

Again, as previously noted, § 412.64 does not reference the provisions of § 412.103 regarding the urban-to-rural reclassifications, as was previously found in § 412.63(b)(1).

Finally, in the preamble to the FY 2005 IPPS Final Rule, the Secretary included the following discussion on the impact of the new CBSAs on geographic reclassifications:

> Currently, the large urban location adjustment under § 412.316(b) and the DSH adjustment for certain urban hospitals under § 412.320 for payments for capital-related costs rely on the existing geographic classifications set forth at § 412.63. Because we proposed to adopt OMB's new CBSA designations for FY 2005 and thereafter, under proposed new § 412.64, we proposed to revise § 412.316(b) and § 412.320(a)(1) to specify that, for discharges on or after October 1, 2004, the payment adjustments under these sections, respectively, would be based on the geographic classifications at proposed new § 412.64.
>
> ****
>
> The commenter is correct that as a result of the implementation of the new MSA definitions, hospitals that had previously been located in a large urban area under the current MSA definitions, but will now be located in another urban or rural area under the new MSA definitions will no longer qualify for certain payment

[35] (Emphasis added.)
[36] 42 C.F.R. § 412.320 (2004) (underline emphasis added). *See also* 69 Fed. Reg. at 49250.

> adjustments that they previously qualified for under the prior MSA definitions, including the 3-percent large urban add-on payment adjustment at § 412.312(b)(2)(ii) and § 412.316(b). As discussed previously, in the May 18, 2004 proposed rule, we solicited comments on the effect of the equalization of the operating IPPS standardized amount. Specifically, we discussed that rural and other urban hospitals that were previously eligible to receive the large urban add-on payment adjustment (and DSH payment adjustment) under the IPPS for capital-related costs if they reclassified to a large urban area for the purpose of the standardized amount under the operating IPPS, will no longer be reclassified and, therefore, will not be eligible to receive those additional payments under the IPPS for capital-related costs beginning in FY 2005. As we noted previously, we received no comments on that clarification.
>
> ****
>
> As previously discussed, we proposed and adopted as final our policy that, beginning in FY 2005 and thereafter, only those hospitals geographically located in a large urban area (as defined in revised § 412.63(c)(6)) will be eligible for the large urban add-on payment adjustment provided under § 412.312(b)(2)(ii) and § 412.316(b). *Similarly, beginning in FY 2005 and thereafter, to receive capital IPPS DSH payments under § 412.320, a hospital will need to be geographically located in an urban area (as defined in new § 412.64) and meet all other requirements of § 412.320.* Accordingly, we are adopting our proposed revisions as final without change.[37]

4. August 18, 2006 Revisions to the Capital DSH Adjustment

In the FY 2007 Proposed IPPS Rule, the Secretary[38] announced that he was proposing technical changes to 42 C.F.R. §§ 412.316(b) and 412.320(a)(1) to clarify that hospitals reclassified as rural under § 412.103 are not eligible for the large urban add-on payment or for the capital DSH adjustment. These proposed changes reflected the historic policy that hospitals reclassified as rural under § 412.103 also would be considered rural under the capital IPPS. Since the genesis of the capital IPPS in FY 1992, the same geographic classifications used under the operating IPPS also have been used under the capital IPPS.[39]

The Secretary believed that these proposed changes and clarifications were necessary because the agency's capital IPPS regulations had been updated to incorporate the Office of Management and Budget's ("OBM's") new CBSA definitions for IPPS hospital labor market areas beginning in FY 2005.[40]

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[37] 69 Fed. Reg. 48916, 49187-88 (Aug. 11, 2004).
[38] of the Department of Health and Human Services.
[39] 71 Fed. Reg. 23995, 24122 (Apr. 25, 2006).
[40] *Id.*

In the FY 2007 IPPS Final Rule published on August 18, 2006, the Secretary finalized these technical changes to 42 C.F.R. §§ 412.316(b) and 412.320(a)(1) to clarify that hospitals reclassified as rural under § 412.103 are not eligible for the large urban add-on payment or for the capital DSH adjustment:

> These changes were proposed to reflect our historic policy that hospitals reclassified as rural under § 412.103 also are considered rural under the capital PPS. Since the genesis of the capital PPS in FY 1992, the same geographic classifications used under the operating PPS also have been used under the capital PPS.
>
> These changes and clarifications are necessary because we inadvertently made an error when we updated our capital PPS regulations to incorporate OMB's new CBSA definitions for IPPS hospital labor market areas beginning in FY 2005. In the FY 2005 IPPS final rule (69 FR 49187 through 49188), in order to incorporate the new CBSA designations and the provisions of the newly established § 412.64, which incorporated the CBSA-based geographic classifications, we revised § 412.316(b) and § 412.320 to specify that, effective for discharges occurring on or after October 1, 2004, the capital PPS payment adjustments are based on the geographic classifications under § 412.64. However, § 412.64 does not reference the provisions of § 412.103 regarding the urban-to-rural reclassifications, as was previously found in § 412.63(b)(1).
>
> We believe that this error must be corrected in order to maintain our historic policy for treating urban-to-rural hospital reclassifications under the operating PPS the same for purposes of the capital PPS. Therefore, we proposed to specify under §§ 412.316(b)(2) and (b)(3) and 412.320(a)(1)(ii) and (a)(1)(iii) that, for discharges on or after October 1, 2006, hospitals that are reclassified from urban to rural under § 412.103 would be considered rural.[41]

In adopting these changes, the Secretary noted that it did not receive any public comments on the proposed change as published in the proposed rule published on May 17, 2006.[42]

As a result of the FY 2007 IPPS Final Rule, the regulation, subparagraph (iii) was added to 42 C.F.R. § 412.320(a)(1) so that revised § 412.320(a) read, in pertinent part:

> (a) *Criteria for classification*. A hospital is classified as a "disproportionate share hospital" for the purposes of capital prospective payments if either of the following conditions is met:

[41] *Id.*
[42] *Id.*

> (1) The hospital is located in an urban area, has 100 or more beds as determined in accordance with § 412.105(b), and serves low-income patients as determined under § 412.106(b).
>
> (i) For discharges occurring on or before September 30, 2004, the payment adjustment under this section is based on a hospital's location, for the purpose of receiving payment, under § 412.63(a).
>
> (ii) For discharges occurring on or after October 1, 2004, the payment adjustment under this section is based on the geographic classifications specified under § 412.64, except as provided for in paragraph (a)(1)(iii) of this section.
>
> **(iii) For purposes of this section, the geographic classifications specified under § 412.64 apply, except that, effective for discharges occurring on or after October 1, 2006, for an urban hospital that is reclassified as rural as set forth in § 412.103, the geographic classification is rural.[43]**

5. *Litigation Challenging the Validity of 42 C.F.R. § 412.320(a)(1)(iii) as Added by the FY 2007 IPPS Final Rule*

The validity of 42 C.F.R. § 412.320(a)(1)(iii) was addressed in *Toledo Hosp. v. Becerra* ("*Toledo*"),[44] wherein the hospital made the following contentions:

> Toledo Hospital contends that the Secretary's 2006 rulemaking is arbitrary and capricious and thus unreasonable for two principal reasons. First, it charges the Secretary with misrepresenting the regulatory history in claiming that the 2006 Rule merely restored a previously implemented policy. Second, the hospital argues that the Secretary failed to "take into account" relative costs of capital for various hospital types and areas of location, as subsection (g) requires.[45]

In *Toledo*, U.S. District Court for the District of Columbia ("D.C. District Court") outlined the legislative history surrounding the creation of the MGCRB in 1989 which, as noted above, can redesignate IPPS hospitals to different labor market areas in order to receive a different wage reimbursement rate.[46] The Court also noted how Congress enacted legislation in 1999[47] allowing IPPS hospitals to reclassify from an urban labor market area to a rural one for various reasons. Thus, a geographically urban hospital can be classified as rural, but then redesignate itself back into

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[43] (Bold emphasis added.)
[44] 2021 WL 4502052 (D.D.C. 2021).
[45] *Id.* at *8 (citations omitted).
[46] *Id.* at *2.
[47] 42 U.S.C. § 1395ww(d)(8)(E). *See* Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, § 401, Pub. L. No. 106-113, 113 Stat. 1501 (1999). Since the amendment was made via § 401 of this legislation, a hospital which receives the new rural reclassification is often referred to a "§ 401" hospital.

an urban labor market area for the purposes of fixing its wage index.[48] The Court also noted the separate IPPS payment for a hospital's *capital* costs at 42 U.S.C. § 1395ww(g) (compared to the IPPS payment for *operating* costs), as well as the capital IPPS adjustments found at 42 C.F.R. § 412.320 for large urban hospitals (the capital DSH payment).[49] The Court explained that, following the 2006 rulemaking, a geographically urban hospital which reclassifies as rural under § 401 loses its eligibility for the capital DSH adjustment.[50]

The appellants in *Toledo* were geographically located in an urban labor market area, but applied to the Secretary (and were approved) to reclassify as rural under § 401. The appellants thereafter applied to the MGCRB to reclassify their wage index to an urban labor market area. The appellants' Medicare Contractor later denied their requests for capital DSH adjustments due to their § 401 rural reclassifications. Before the D.C. District Court, the hospitals argued that 42 C.F.R. § 412.320(a)(1)(iii) violated the plain language of the Medicare Act and that it was promulgated in an arbitrary and capricious manner.[51]

The D.C. District Court rejected the argument that the capital DSH policy in 42 C.F.R. § 412.320(a)(1)(iii) violated the Medicare Act on its face, finding that the Secretary was not prohibited from treating § 401 reclassified hospitals as rural for operating PPS purposes while denying urban status for the purposes of the capital DSH adjustment.[52] The Court next examined, however, whether the Secretary's decision to do so was reasonable. The D.C. District Court made the following findings:

1. "if the Secretary had any policy concerning Section 401 reclassifications before 2006, he never announced such a policy, much less explained the basis for it."[53]

2. The Secretary's decision to not provide a capital DSH adjustment was arbitrary because:

    - "The Secretary has not put forth evidence that the agency took these costs into account, either in 1991, 2000, 2004, or 2006."[54]

    - "[T]he record does not show that the Secretary articulated a consistent policy of treating these reclassified hospitals as rural for capital DSH adjustment purposes, he cannot fall back on any purported general policy of using operating PPS geographic classifications for capital PPS reimbursements."[55]

    - "The Secretary also has not explained, even as a general matter, why classification uniformity outweighs the value of more accurate cost reimbursements. *Cf. Anna Jacques Hosp*., 797 F.3d at 1161 (upholding Secretary's regulation where the

[48] *Toledo* at *3.
[49] *Id.* at *3-4.
[50] *Id.* at *4.
[51] *Id.* at *5.
[52] *Id.* at *6-8.
[53] *Id.* at *11.
[54] *Id.*
[55] *Id.*

Secretary explained why 'added precision' 'would not justify the added complication') (quotation omitted)."[56]

- "The agency cannot 'entirely fail[ ] to consider' the "relevant data" and the factors that Congress directed it to review. *State Farm*, 63 U.S. at 43. Here, the Secretary did not perform a cost analysis to determine whether reclassified rural hospitals should receive a capital DSH adjustment, nor did he take costs into account at all."[57]

Notwithstanding these findings, the D.C. District Court declined to vacate 42 C.F.R. § 412.320(a)(1)(iii) because "vacatur of a rule is not an appropriate remedy on review of an adjudication."[58] Instead, the Court remanded the case to the Medicare Contractor for a redetermination on the appellants' eligibility for a capital DSH adjustment.[59]

Providers' Request for EJR

As background, each of the Providers is an acute care hospital paid by Medicare pursuant to the inpatient and capital prospective payment systems. During the years under appeal, the hospitals were all geographically located in urban areas, operated more than 100 beds, served low-income patients and received § 401 rural reclassifications pursuant to 42 C.F.R. § 412.103.[60]

The Providers are challenging the validity of 42 C.F.R. § 412.320(a)(1)(iii), which states that urban hospitals may qualify for capital DSH payments unless, on or after October 1, 2006, the urban hospital is reclassified as rural. The Providers assert that this regulation is inconsistent with the underlying operating PPS statute, in particular 42 U.S.C. § 1395ww(d)(8)(B), which states that hospitals that have undergone a rural reclassification are rural only for purposes of this subsection 1395ww(d). The capital DSH provisions are found at 42 U.S.C. § 1395ww(g), an entirely different section of the statute, and therefore a rural reclassification under the subsection (d) operating PPS provisions does not apply for subsection (g) capital PPS purposes.[61]

The Providers believe that the promulgation of 42 C.F.R. § 412.320(a)(1)(iii) is, therefore, beyond the authority granted under 42 U.S.C. §§ 1395ww(d)(8)(B) and 1395ww(g), and the regulation must be found invalid.[62] The Providers assert that the Secretary has implicitly acknowledged that he cannot apply rural status for hospitals that have undergone a rural reclassification to payment provisions outside of subsection (d), and provides as an example, that the Secretary has stated with respect to direct graduate medical education ("GME") that no adjustment to the direct GME cap are available for urban hospitals that have reclassified as rural because subsection (d) reclassification "affects only payments under section 1886(d) of the Act . . . [and] payment for direct GME are made under section 1886(h) of the Act."[63] Further, the

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[56] *Id.*
[57] *Id.* at *11-12.
[58] *Id.* at *12.
[59] *Id.*
[60] Request for EJR at 7.
[61] *Id.* at 1, 7.
[62] *See id.* at 7.
[63] *Id.* at 8, citing 70 Fed. Reg. 47278, 47437 (Aug. 12, 2005).

regulation fails to take into account any variation in cost based on location, as the capital PPS statute permits at 42 U.S.C. § 1395ww(g)(1)(B)(ii).[64]

The Providers assert that the Secretary's adoption of the regulation was arbitrary and capricious and violates the Administrative Procedure Act because he failed to establish that the adoption of the exception to the capital DSH adjustment, for providers that reclassified as rural, took into account variations in the relative costs of capital and construction for the different types of facilities or areas in which they are located.[65]

Though 42 C.F.R. § 412.320(a)(1)(iii) has not been vacated, the Providers argue that the merits of their position were adopted by the D.C. District Court in *Toledo*.[66] Further, the Providers contend that the Secretary adopted the FY 2024 hospital IPPS proposed rule in which the Secretary, in response to *Toledo*, proposed to amend 42 C.F.R. § 412.320(a)(1)(iii). Specifically, effective for discharges occurring on or after October 1, 2023, an urban hospital that is reclassified as rural under § 412.103 will no longer be considered rural for purposes of determining capital DSH eligibility. Instead, for purposes of § 412.320, the geographic classifications specified under § 412.64 will apply.[67] However, the Providers explain that for the period under appeal, CMS and its contractors will continue to apply the 2006 regulation, denying capital DSH to the Providers for this period.[68]

The Providers further contend that since the Board is bound by the regulation being challenged,[69] namely, the validity of 42 C.F.R. § 412.320(a)(1)(iii), it lacks the authority to decide the legal question presented in the Providers' Request for EJR. Since the additional criteria for EJR have also been met, the Providers request the Board grant the request.[70]

Board Decision

Pursuant to 42 U.S.C. § 1395oo(f)(1) and the regulation at 42 C.F.R.§ 405.1842(f)(1), the Board is required to grant an EJR request if it determines that: (i) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (ii) the Board lacks the authority to decide a 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

In the November 13, 2015 Final Outpatient Prospective Payment Rule,[71] the Secretary finalized new cost reporting regulations related to the substantive reimbursement requirement of an

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[64] *Id.*
[65] *Id.* at 8-9.
[66] *Id.* at 9, 11-12.
[67] *Id.* at 9-10, *citing* Medicare Program: Hospital IPPS Fiscal Year 2024 Payment Rates & Policy Changes, 88 Fed. Reg. 58,640, 59,117, 59,334 (Aug. 28, 2023).
[68] *Id.* at 11-12, *citing* 88 Fed. Reg. at 27,058-59.
[69] *See* 42 C.F.R. § 405.1867.
[70] Request for EJR at 10-12.
[71] 80 Fed. Reg. 70298, 70551-70580 (Nov. 13, 2015).

appropriate cost report claim.[72] The Secretary revised the Medicare cost reporting regulations in 42 C.F.R. part 413, subpart B, by requiring a provider to include an appropriate claim for a specific item in its Medicare cost report *beginning on or after January 1, 2016* in order to receive or potentially qualify for Medicare payment for the specific item. If the provider's cost report does not include an appropriate claim for a specific item, the Secretary stated that payment for the item will not be included in the Notice of Program Reimbursement ("NPR") issued by the Medicare Contractor or in any decision or order issued by a reviewing entity (as defined in 42 C.F.R. § 405.1801(a)) in an administrative appeal filed by a provider. In addition, the Secretary revised the appeals regulations in 42 C.F.R. part 405, subpart R, by eliminating the requirement that a provider must include an appropriate claim for a specific item in its cost report in order to meet the dissatisfaction requirement for jurisdiction before the Board (hereinafter the "claim-specific dissatisfaction requirement"), again, for cost reports beginning on or after January 1, 2016. As all of the participants in these three cases have fiscal years that began after January 1, 2016, the claim-specific dissatisfaction requirement is not applicable.

The participants that comprise the group appeal have filed appeals involving fiscal year ending in 2018. All of the participants have appealed from an original NPR. Based on its review of the record, the Board finds that all of the providers in the group appeal filed their appeals within 180 days of the issuance of their respective final determinations as required by 42 C.F.R. § 405.1835. The providers each appealed the issue in the EJR request, and the Board is not precluded by regulation or statute from reviewing the issue. Finally, the amount in controversy meets the $50,000 amount in controversy requirement for a group appeal pursuant to 42 C.F.R. § 405.1837(a)(3) in the cases at issue. Therefore, the Board has jurisdiction over the providers.

B. Compliance with the Reimbursement Requirement of an Appropriate Cost Report Claim Pursuant to 42 C.F.R. § 405.1873 (Cost Reports Beginning on or After January 1, 2016)

For cost report periods beginning on or after January 1, 2016, the regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 are applicable. The regulation, § 413.24(j), specifies that, in order for a specific item to be eligible for potential reimbursement, the provider must include an appropriate cost report claim for that specific item:

> (j) **Substantive reimbursement requirement of an appropriate cost report claim**—
>
> (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

[72] *Id.* at 70555.

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

In conjunction with the regulation above, 42 C.F.R. § 405.1873(a) addresses when the Board must examine a provider's compliance with § 413.24(j):

> (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.[73]

These regulations are applicable to the cost reporting period under appeal, which ends after December 31, 2016. The regulation at § 405.1873(b) sets out certain procedures that must be followed in the event a party questions whether the cost report included an appropriate claim for a specific item under appeal. *In such situations where a party raises that question*, the regulation requires the Board to give the parties an adequate opportunity to submit factual evidence and legal arguments regarding whether the provider's cost report included an appropriate claim for the specific item under appeal, and upon receipt of the factual evidence or legal argument (if any), the

[73] (Bold emphasis added.)

Board must review the evidence and argument and prepare written specific findings of fact and conclusions of law on the question of whether the provider's cost report complied with the cost report claim requirements of § 413.24(j).

The Board interprets the regulation at 42 C.F.R. § 405.1873 to only require the Board to review a provider's "compliance"[74] with the reimbursement requirement of an appropriate cost report claim for the specific item under appeal (and the supporting factual evidence and legal argument) ***if*** a party to the appeal questions whether there was an appropriate claim made.[75] Board Rule 42.4[76] provides that if the Medicare Contractor opposes an EJR request filed by a provider or group of providers, which includes a Substantive Claim Challenge,[77] then it must file its response within five (5) business days of the filing of the EJR request. Five (5) business days have passed since the Providers filed the EJR request, and the Medicare Contractor has not filed a response or a Substantive Claim Challenge.

As such, since no party to the appeal has questioned, pursuant to § 405.1873(a), whether an appropriate claim was made, the Board finds 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 need not include any findings regarding compliance with the substantive claim requirements and may proceed to rule on the EJR request pursuant to 42 C.F.R. § 405.1873(d).

C. Board's Analysis Regarding the Appealed Issue

The Providers in this case are challenging the application of 42 C.F.R. § 412.320(a)(1)(iii), which states in effect that urban hospitals may qualify for Capital DSH payments unless, on or after October 1, 2006, the urban hospital is reclassified as rural. The Providers contend that this regulation is inconsistent with the enabling statute, 42 U.S.C. § 1395ww(d)(8)(B), which concerns rural status. The Providers contend that §1395ww(d)(8)(B) specifically notes that the hospitals that have undergone a rural reclassification are rural only for "purposes of this subsection [1395ww(d)]."

In addition, the Providers assert that, as the Capital DSH provisions are found at 42 U.S.C. § 1395ww(g) (and not § 1395ww(d)), the literal wording of the rural reclassification statutory provision identifies that rural status does not reach the Capital DSH calculation. The Providers maintain that the promulgation of 42 C.F.R. § 412.320(a)(1)(iii) is, therefore, beyond the authority granted under 42 U.S.C. § 1395ww(d)(8)(B), and the regulation must be found invalid.

The Board finds that, pursuant to 42 C.F.R. § 405.1867, it must comply all the provisions of Title XVIII of the Act and regulations issued thereunder, including the challenged regulation, 42 C.F.R. § 412.320(a)(1)(iii). Moreover, 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

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[74] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."
[75] *See* 42 C.F.R. § 405.1873(a).
[76] 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."
[77] *See also* Board Rules 44.5.2 and 44.6.

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.

Accordingly, the Board concludes that it lacks the authority to grant the relief sought by the Providers, *i.e.,* to reverse or otherwise invalidate 42 C.F.R. § 412.320(a)(1)(iii). Consequently, the Board hereby grants the Providers' request for EJR for the issue and federal fiscal year under dispute.

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 all of the participants in the group appeal are entitled to a hearing before the Board;

2) The review process in 42 C.F.R. § 405.1873(a)-(b) has not been triggered, and therefore, there are no findings regarding whether the Providers' cost reports included appropriate claims for the specific item at issue in this appeal;

3) Based upon the participants' assertions regarding 42 C.F.R. § 412.320(a)(1)(iii), there are no findings of fact for resolution by the Board;

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

5) It is without the authority to decide the legal question of whether 42 C.F.R. § 412.320(a)(1)(iii), as promulgated in the FY 2007 IPPS Final Rule, is substantively or procedurally valid.

Accordingly, the Board finds that the question of the validity of 42 C.F.R. § 412.320(a)(1)(iii) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' EJR request for the issue and the subject 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 this care, the Board hereby closes the case.

Board Members Participating:

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

For the Board:

9/22/2023

X Clayton J. Nix

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

Enclosures: Schedule of Providers

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Richard Morris
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Plano, TX 75074

RE: ***Notice of Dismissal***
El Campo Memorial Hospital (Prov. No. 45-0694)
FYE 03/31/2014
Case No. 18-1869

Dear Mr. Morris,

The Provider Reimbursement Review Board ("Board" or "PRRB") received El Campo Memorial Hospital's ("Provider") Individual Appeal Request on September 20, 2018. On October 16, 2018, the Board sent the parties a Case Acknowledgement and Critical Due Dates letter setting the Provider's Preliminary Position Paper due date to May 18, 2019, and the Medicare Contractor's Preliminary Position Paper due date to September 15, 2019.

On May 1, 2019, the Provider filed its Preliminary Position Paper. On September 13, 2019, the Medicare Contractor filed its Preliminary Position Paper. On April 19, 2023, the Board issued a Notice of Hearing to the parties scheduling the hearing in Case No. 18-1869 for October 6, 2023, and scheduling the Provider's Final Position Paper due date on July 8, 2023, the Medicare Contractor's Final Position paper due date on August 7, 2023, and the Provider's optional Responsive Brief and Witness Lists due date on September 6, 2023.[1] On August 4, 2023, the Medicare Contractor filed a Final Position Paper stating that it would rely on its previously submitted Preliminary Position Paper. The Provider did not file a Final Position Paper.[2]

On August 22, 2023, Board staff sent an email to the parties (to their respective email addresses of record[3]) asking for an update on the case and whether the parties would be coming in for the live hearing scheduled for October 6, 2023. On August 28, 2023, a follow up email was sent to the parties asking the parties to respond by September 1, 2023, as no response was received from the parties.

On September 1, 2023, a follow-up email was sent to the Medicare Contractor requesting a response. On that same date, the Medicare Contractor's representative, Joseph Bauers, responded

[1] Pursuant to Board Rule 27, the parties were not required to file Final Position Papers but only complete Preliminary Position Papers (see Rule 25.3). Final Position Papers are "optional" for new appeals filed on or after August 29, 2018.
[2] However, the Provider was not required to do so as the Final Position Paper filing was optional per Board Rule 27.
[3] *See* Board Rules 5.2 and 5.3.

advising "Scott Berends is the FSS attorney assigned to this appeal, and he is copied on this message. On behalf of FSS, we will attend the live hearing on October 6, 2023." Again, the Provider did not respond to Board staff's inquiry.

Board Rule 5.2 (Nov. 2021) addresses the Case Representative's responsibilities which include maintaining current contact information and timely responding to Board correspondence/requests:

> **5.2 Responsibilities**
>
> The case representative is responsible for being familiar with the following rules and procedures for litigating before the Board:
>
> • The Board's governing statute at 42 U.S.C. § 1395oo;
> • The Board's governing regulations at 42 C.F.R. Part 405, Subpart R; and
> • These Rules, which include any relevant Orders posted at https://www.cms.gov/Regulations-and-Guidance/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.

Board Rule 5.3 (Nov. 2021) addresses Board communications with Case Representatives:

> **5.3 Communications with Providers**
>
> The Board's communications will be sent to the case representative via email to the case representative's email address on file with the Board (see Rule 5.2). The Board will address notices only to the official case representative.

Board Rule 4.1 and 41.2 (Nov, 2021) permits dismissal or closure of a case on the Board's own motion:

> **4.1 General Requirements**
>
> The Board will dismiss appeals that fail to meet the timely filing requirements and/or jurisdictional requirements.
>
> **41.2 Own Motion**
>
> The Board may dismiss a case or an issue on its own motion:
>
> • if it has a reasonable basis to believe that the issues have been fully settled or abandoned,
>
> • upon failure of the provider or group to comply with Board procedures or filing deadlines (see 42 C.F.R. § 405.1868),
>
> • 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.

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.

Based on the following, the Board has a reasonable basis to believe the Provider has abandoned the remaining issue in the appeal (Medicare Dependent Hospital Volume Decrease Adjustment):

- The lack of response from the Provider's Representative to Board inquiries,
- The failure of the Provider to comply with Board filing deadlines (*e.g.*, it failed to file its Witness List by the September 6, 2023 deadline pursuant to the April 19, 2023 Notice of Hearing which specifies that, by September 6, 2023, "[e]ach party ***must*** file either a witness list or a statement that the party does not intend to call any witnesses"[4]),
- The Board's inability to contact the Provider Representative at the last known contact, in light of the upcoming hearing date of October 6, 2023,

[4] (Emphasis added.)

- The phone number on file for the Provider Representative is not in service,
- The Provider's last filing/activity was more than 4 years ago on May 1, 2019 (when the Provider filed its Preliminary Position Paper).

As such, the Board hereby dismisses Case No. 18-1869 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 Participating:

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

For the Board:

9/22/2023

X Clatyon J. Nix

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

cc: Wilson Leong, Federal Specialized Services
Michael Redmond, Novitas Solutions, Inc.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

James Ravindran
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RE: ***Jurisdictional Decision***
Tacoma General Allenmore Hospital (Prov. No. 50-0129)
FYE 12/31/2009
Case No. 19-2240

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board" or "PRRB") received Tacoma General Allenmore Hospital's ("Provider") Individual Appeal Request on appeal on August 16, 2019, appealing from a Revised Notice of Program Reimbursement ("revised NPR") dated February 18, 2019 and a second revised NPR dated April 30, 2019 for fiscal year ("FY") 2009. The decision of the Board is set forth below.

Procedural History:

On August 16, 2019, the Provider filed an individual appeal with the Board, appealing a *revised* NPR dated February 18, 2019 for FY 2009. The individual appeal contained the following issues:

- Issue 1: DSH- SSI Fraction/Medicare Managed Care Part C Days
- Issue 2: DSH- SSI Fraction/Dual Eligible Days

On September 30, 2019 the Provider filed a request to add another *revised* NPR dated April 30, 2019 for FY 2009, appealing with the ***same*** two issues.

- Issue 3: DSH- SSI Fraction Medicare Managed Care Part C Days
- Issue 4: DSH- SSI Fraction/Dual Eligible Days

On March 31, 2020, the Provider filed its Preliminary Position Paper ("PPP") and, shortly later on May 26, 2020, it filed a supplemental PPP. On August 11, 2020, the MAC filed its PPP.

Board Decision:

The Code of Federal Regulations at 42 C.F.R. § 405.1885 (2015) permit a Medicare Contractor to reopen an NPR and issue a *revised* NPR:

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

Additionally, 42 C.F.R. § 405.1889 (2015)[1] explains the effect of a *revised* NPR and a provider right to appeal a *revised* NPR:

> (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.

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

> (a) Right to hearing on final contractor determination. A provider . . . has a right to a Board hearing, as a single provider appeal, with respect to a final contractor or Secretary determination for the provider's cost reporting period, if –
>
> (1) The provider is dissatisfied with the contractor's final determination of the total amount of reimbursement due the provider, as set forth in the contractor's written notice specified under § 405.1803. Exception: If a final contractor determination 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)).

[1] *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).

> (2) The amount in controversy (as determined in accordance with § 405.1839) must be $10,000 or more.
>
> (3) Unless the provider qualifies for a good cause extension under § 405.1836, the date of receipt by the Board of the provider's hearing request must be no later than 180 days after the date of receipt by the provider of the final contractor or Secretary determination.

A. Dismissal of the February 18, 2019 Revised NPR

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[.]"[2] In this case, the Provider appealed from two *revised* NPRs that adjusted the SSI percentage, specifically, Audit Adjustment Nos. 4 and 6.[3]

The Provider's ***first*** Notice of Reopening is dated March 30, 2016 and serves as the catalyst for the February 18, 2019 revised NPR under appeal stated. The Provider requested this reopening "to revise the SSI percentage and Allowable Disproportion Share percentage using the SSI percentage recalculated by CMS for both operating and capital DSH payment purposes in accordance with 42 C.F.R. §412.106(b)(3)."[4] Through the reference to §412.106(b)(3), it is clear that the Provider was requesting that its SSI percentage be realigned from the federal fiscal year to its fiscal year.

Accordingly, on March 30, 2016, the Medicare Contractor issued a Notice of Reopening to "recalculate[e] . . . the SSI percentage on the basis of [the Provider's] cost reporting period instead of Federal fiscal year."

It was not until February 18, 2019, that the Medicare Contractor acted on the reopening and issued the revised NPR. The accompanying Audit Adjustment Report confirms at Audit Adjustment Nos. 4 and 6 that the revised NPR was issued "to adjust the SSI% and the Disproportionate Share Amount based on the latest CMS Letter of SSI% Realignment."[5]

When a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[6] The reopening in this case was a result of the Provider's request to realign their SSI percentage from the federal fiscal year end to their individual cost reporting fiscal year end. The audit adjustments associated with the revised NPR under appeal clearly revised the SSI percentage in order to realign it from a federal fiscal year to the provider's respective fiscal year. The Board has consistently found that it does not have jurisdiction over revised NPRs that were issued as a result of a provider's request for realignment of its SSI percentage.

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[2] 42 C.F.R. § 405.1889(b)(1).
[3] Provider Preliminary Position Paper at 3
[4] Provider's Appeal , Tab 1-(3) MAC's Notice of Reopening of Cost Report.
[5] MAC Exhibit C-2
[6] 42 C.F.R. § 405.1889(b)(1).

As noted in 42 C.F.R. § 412.106(b)(2), CMS gathers data to be used in the SSI fraction on a month-by-month basis:

> (2) *First computation: Federal fiscal year*. **For each month** of the Federal fiscal year in which the hospital's cost reporting period begins, CMS -
>
> (i) Determines the number of patient days that -
>
> (A) Are associated with discharges occurring **during each month**; and
>
> (B) Are furnished to patients who **during that month** were entitled to both Medicare Part A (including Medicare Advantage (Part C)) and SSI, excluding those patients who received only State supplementation;
>
> (ii) Adds the results for the whole period; and
>
> (iii) Divides the number determined under paragraph (b)(2)(ii) of this section by the total number of days that -
>
> (A) Are associated with discharges that occur during that period; and
>
> (B) Are furnished to patients entitled to Medicare Part A (including Medicare Advantage (Part C)).[7]

The data matching process by which CMS gathers this *monthly* data is described in the FY 2011 IPPS Final Rule.[8] As described in the Federal Register, under the realignment process, CMS calculates the SSI fraction using the *previously-gathered* data for the months included in the published SSI fractions for 2 Federal fiscal years that encompass the hospital's cost reporting period:

1. *75 Fed. Reg. 50042, 50279 (Aug. 16, 2010)*.—"[W]e publish these [SSI fraction] data for every hospital based on the Federal fiscal year but, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived *from the data match process* ***for the two Federal fiscal years that spanned the hospital's cost reporting period***."[9]

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

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."[10]

Accordingly, the realignment process does not change any of the data underlying the realigned SSI fraction (*e.g*., Part C days or Part A days or Dual Eligible Days) because that data had been previously gathered on a month-by-month basis and *there is no need for CMS to rerun the data matching process* in order to effectuate a realignment (*i.e*., realigning the SSI fraction from the federal fiscal year to the provider's fiscal year). 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 February 18, 2019 determination was only being reopened to include realigned SSI percentages. Since the only matters specifically revised in the February 18, 2019 revised NPR 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 February 18, 2019 revised NPR appeal of the DSH Part C days issue or the Dual Eligible Days issue. In making this ruling, the Board notes that its application of 42 C.F.R. § 405.1889(b) has been upheld by courts on review.[11]

B. Dismissal of the April 30, 2019 Revised NPR

The 2nd Notice of Reopening dated April 5, 2019, which relates to the September 30, 2019 revised NPR. The Audit Adjustment Report accompanying the revised NPR confirms at Audit Adjustment 4 and 5 that it was issued: "to adjust the SSI ratio based on the final SSI ratio provided *from the Settlement Agreement* and amend the Disproportionate Share Adjustment to

[10] (Emphasis added.)
[11] *See St. Mary's of Mich. V. Azar*, No. 18-01790, 2020 WL 4049912 (D.D.C. July 20, 2020); *McLaren Flint v. Azar*, 464 F. Supp. 3d 1 (D.D.C. 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).

account for the change in the SSI ratio."[12] Additionally, both adjustments state "Title XVIII, Hospital, Line 4.00 Percentage of SSI recipient patient days to Medicare Part A patient days."

Significantly, the Provider did not submit a copy of the referenced "Settlement Agreement" or any other information describing what data was revised by the "Settlement Agreement", and how that "Settlement Agreement" impacted the SSI ratio, much less dual eligible days or Part C days. The information relative to the "Settlement Agreement" is critical to understanding the scope of the reopening and revisions made. Accordingly, the Board finds that the Provider has failed to document that the April 30, 2019 revised NPR adjusted the Part C Days and Dual Eligible Days issues.

Regardless, the Board has alternative bases to dismiss the April 30, 2019 revised NPR appeal. The Board notes that the revised NPR was made to execute the referenced "Settlement Agreement" and that the "Settlement Agreement" presumable ***resolved*** a dispute between the Provider and the Medicare Contractor. As such, it is unclear how the Provider would have any basis to appeal that revised NPR since § 405.1889 makes clear that a revised NPR is a separate and distinct determination and any appeal rights are limited to "[o]nly those matters that are specifically revised in [the revised NPR]."

Based on the above reasons, the Board finds that, pursuant to 42 C.F.R. § 405.1889(b) (as referenced in 42 C.F.R. 405.1835(a)), it does not have jurisdiction over each of the issues in the instant appeal of the April 30, 2019 revised NPR. Moreover, as a separate basis for dismissal, the Board finds that the Provider failed to comply with its obligation in 42 C.F.R. § 405.1835(b)(1) to include in its appeal request "[a] demonstration that the provider satisfies the requirements for a Board hearing as specified in paragraph (a) of this section."

Conclusion:

The Board finds that it lacks jurisdiction over the Issues 1 and 2 because the February 18, 2019 revised NPR was issued *only* to re-align the SSI from the federal fiscal year to the provider's cost reporting period. Neither Part C days nor Dual Eligible days were revised as part of that revised NPR. The Provider does not have the right to appeal the February 18, 2019 revised NPR under 42 C.F.R. § 405.1889(b) (as referenced in 42 C.F.R. § 405.1835(a)(1)).

Additionally, the Board finds it lack jurisdiction over Issues 3 and 4 because the record fails to document that either Dual Eligible Days or Part C Days were revised as part of the April 30, 2019 revised NPR and the Provider's SSI percentage was not changed. The Provider does not have the right to appeal under 42 C.F.R. § 405.1889(b) (as referenced in 42 C.F.R. § 405.1835(a)(1)) and the Provider also failed to comply with its obligation in 42 C.F.R. § 405.1835(b)(1) to include in its appeal request "[a] demonstration that the provider satisfies the requirements for a Board hearing as specified in paragraph (a) of this section."

[12] Provider's Final Determination Added, Tab 1-(3) MAC's Notice of Reopening of Cost Report (emphasis added).

Since the Board does not have jurisdiction over any of the issues in this appeal, the Board hereby closes the case and removes it from its docket.[13] 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:

9/26/2023

X Clayton J. Nix

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

cc: Wilson C. Leong, Esq. Federal Specialized Services
John Bloom, Noridian Healthcare Solutions (J-F)

[13] Even if the Board were to find jurisdiction, it would need to review whether the Provider has complied with its mandatory common issue relate party ("CIRP") group obligations under 42 C.F.R. § 405.1837(b)(1) and (e)(1) and Board Rules because, such a review might result in one or more of the issues being subject to dismissal and/or other remedial action. In this regard, the Board notes that: (a) the Provider is part of a health care chain, MultiCare Health System ("MultiCare") and, accordingly, is subject to the mandatory CIRP group rules at 42 C.F.R. § 405.1837(b)(1); (b) issues common to a health care chain arising in a particular year must be pursued as part of a CIRP group per § 405.1837(b)(1); (c) the Part C issues at Issues 1 and 3 and the Dual Eligible Days issues at Issue 2 and 4 are common group issues; and (d) Board Rule 4.7.3 specifies that transfers from individual appeals to group are expected to be effectuated *prior to* the submission of PPPs but no such transfers were made prior to the Provider filing its PPP on March 31, 2020.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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RE: ***EJR Determination and Dismissal of Duplicative Cases***
Select Medical Corporation 2011 – 2019 Dual Eligible Bad Debts CIRP Groups
Case Nos. 13-0122GC, *et al.* (*see* attached listing of 18 group cases)

Dear Messrs. Healy & Lau:

The Provider Reimbursement Review Board ("Board") has reviewed the above-referenced eighteen (18) group appeals for Select Medical Corporation ("Select") and the Request for Expedited Judicial Review ("EJR") filed on September 15, 2023. The decision of the Board is set forth below.

Statutory Background:

As part of the Fiscal Year ("FY") 2021 IPPS Final Rule, CMS codified the "must bill" policy and deemed it effective for cost reports ***before***, on, *or* after the effective date of its implementation (*i.e.*, October 1, 2021).[1] Hence, it is to be applied *retroactively* to cost reports *before* October 1, 2021 (*i.e.*, the effective date of the must bill codification). Specifically, the regulation at issue is 42 C.F.R. § 413.89(e)(2)(iii) which as amended states:

> (iii) *Indigent dual-eligible beneficiaries (**including qualified Medicare beneficiaries**)*. Providers may deem Medicare beneficiaries indigent or medically indigent when such individuals have also been determined eligible for Medicaid under a State's Title XIX Medicaid program as either categorically needy individuals or medically needy individuals. To be considered a reasonable collection effort for dual-eligible beneficiaries:
>
> **(A) When a State permits a Medicare provider's Medicaid enrollment for the purposes of processing a beneficiary's claim, to determine the State's liability for the beneficiary's Medicare cost sharing, the provider—**
>
> (1) Must determine whether the State's Title XIX Medicaid Program (or a local welfare agency, if applicable) is responsible to pay all or

[1] *Id.* at 58989, 58900.

a portion of the beneficiary's Medicare deductible or coinsurance amounts;

(2) Must submit a bill to its Medicaid/Title XIX agency (or to its local welfare agency) to determine the State's cost sharing obligation to pay all or a portion of the applicable Medicare deductible and coinsurance;

(3) Must submit the Medicaid remittance advice received from the State to its Medicare contractor;

(4) Must reduce allowable Medicare bad debt by any amount that the State is obligated to pay, either by statute or under the terms of its approved Medicaid State plan, regardless of whether the State actually pays its obligated amount to the provider; and

(5) May include the Medicare deductible or coinsurance amount, or any portion thereof that the State is not obligated to pay, and which remains unpaid by the beneficiary, as an allowable Medicare bad debt.

(**B) When, through no fault of the provider, a provider does not receive a Medicaid remittance advice** because the State does not permit a Medicare provider's Medicaid enrollment for the purposes of processing a beneficiary's claim, **or because the State does not generate a Medicaid remittance advice, the provider—**

(1) **Must submit** to its contractor, all of the following auditable and verifiable documentation:

(i) The State's Medicaid notification stating that the State has no legal obligation to pay the provider for the beneficiary's Medicare cost sharing.

(ii) A calculation of the amount the State owes the provider for Medicare cost sharing.

(iii) Verification of the beneficiary's eligibility for Medicaid for the date of service;

(2) Must reduce allowable Medicare bad debt by any amount the State is obligated to pay, regardless of whether the State actually pays its obligated amount to the provider; and

(3) May include the Medicare deductible or coinsurance amount, or any portion thereof that the State is not obligated to pay, and which

> remains unpaid by the beneficiary, as an allowable Medicare bad debt.[2]

The preamble to the FY 2021 IPPS Final Rule describes this regulation as follows:

> After consideration of the public comments we received, we are finalizing our proposal to codify *our longstanding Medicare must bill bad debt policy* with respect to QMB dual eligible beneficiaries ***to require that the provider must bill the State for the QMB's Medicare cost sharing*** *and submit the resulting Medicaid RA the provider receives to Medicare to evidence the State's Medicare cost sharing liability,* so that any State Medicare cost sharing liability can be deducted from the Medicare bad debt reimbursement. *We are also codifying an alternate Medicaid RA documentation policy so that, in limited circumstances, providerscan comply with the must bill policy and still evidence a State's cost sharing liability (or absence thereof) for dual eligible beneficiaries* ***when a State does not process a Medicare crossoverclaim and issue a Medicaid RA to providers***. In this regard, we arecodifying that to be considered a reasonable collection effort for dual eligible beneficiaries when alternative documentation to the Medicaid remittance advice is submitted, a provider must submit all of the following: (1) The State Medicaid notification evidencingthat the State has no obligation to pay the beneficiary's Medicare cost sharing or notification evidencing the provider's inability to enroll in Medicaid for purposes of processing a crossover cost sharing claim, (2) documentation setting forth the State's liability, or lack thereof, for the Medicare cost sharing, and (3) documentation verifying the beneficiary's eligibility for Medicaidfor the date of service. *These policies are effective for cost reporting periods beginning* ***before****, on and after* ***the effective dateof this final rule***.[3]

The Secretary has insisted that CMS has the statutory authority to *retroactively* codify these policies for dual eligible beneficiaries because it is merely clarifying longstanding requirements.[4]

Procedural Background:

As discussed below, the instant EJR Request covers eighteen (18) different Common Issue Related Part ("CIRP") group appeals covering nine (9) different fiscal years from 2011 to 2019. For each fiscal year, there is a CIRP group taken from each participant's Notice of Program Reimbursement ("NPR") and a CIRP group taken from the FY 2021 IPPS Final Rule published in the Federal Register. The cases are broken down as follows:

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[2] (Bold and underline emphasis added.)
[3] 85 Fed. Reg. at 59003-04 (emphasis added). *See also* id. (stating: "when a State does not process a Medicare crossover claim and issue a Medicaid RA, the provider could obtain, and submit to its Medicare contractor, some form of alternative documentation to evidence a state's Medicare cost sharing liability (or absence thereof)." (emphasis added)).
[4] *Id.* at 58902.

Fiscal Year	NPR CIRP Group	Federal Register ("FR") CIRP Group
2011	13-0122GC	21-1061GC
2012	13-2602GC	21-1062GC
2013	14-3729GC	21-1063GC
2014	17-1219GC	21-1064GC
2015	17-1220GC	21-1065GC
2016	17-2240GC	21-1066GC
2017	19-0123GC	21-1067GC
2018	20-0584GC	21-1068GC
2019	21-0329GC	21-1069GC

A. The NPR Appeals

1. *FY 2011 NPR CIRP Group – Case No. 13-0122GC*

On December 5, 2012, the Board received a request to form a group appeal to establish the Select FY 2011 CIRP group under Case No. 13-0122GC. The Common Issue identified was:

> [Whether the Medicare contractor] improperly applied the CMS must bill policy for bad debt to hospitals which were not Medicaid participating.
>
> All of the providers in this group appeal are hospitals that participate in the Medicare program, but do not participate in the Medicaid program. Because the providers do not have Medicaid provider numbers, they were not able to bill the state Medicaid program and receive remittance advice ("RAs") showing that Medicaid would not pay for Medicare cost sharing amounts of dual eligibles (beneficiaries of both the Medicare and Medicaid programs). The Intermediary has refused to accept any alternative documentation of the beneficiaries' Medicaid eligibility, or otherwise allow the bad debt without Medicaid RAs. The Intermediary denied Medicare bad debt reimbursement to the providers for dual eligible Medicare cost sharing amounts because the providers could not provide RAs from the state Medicaid program. The providers challenge these adjustments because they violate the statutory prohibition on cost-shifting at 42 U.S.C. § 1395x(v)(1)(A) and CMS regulations on bad debt at 42 C.F.R. § 413.89.[5]

The CIRP Group at issue in that appeal involved long term care hospitals ("LTCHs") owned by Select Medical Corporation across 26 states that claimed bad debts related to dual eligibles (*i.e.*, Medicare beneficiaries who were also eligible for a state Medicaid program). The dual eligible

[5] Initial Request for Hearing – Group Appeal, 2 (Dec. 2, 2012) (Case No. 13-1022GC).

bad debts at issue involve 24 different state Medicaid programs in which the Select LTCHs were not enrolled as a Medicaid provider. The Medicare Contractors for these providers denied the dual eligible bad debt claims at issue because they involved dual eligibles and the Select LTCHs failed to obtain remittance advices ("RAs") from the relevant state Medicaid program to document their bad debt claims.[6]

On June 26, 2019, the Board issued a D-Decision for Case No. 13-0122GC:

- *Select Medical 2011 Dual Eligible Medicare Bad Debts CIRP Group v. Novitas Solutions, Inc.*, PRRB Dec. 2019-D29 (June 26, 2019).

The Board ultimately ***affirmed*** the Medicare Contractors' denial of claims for states where the Providers did not obtain an RA but chose not to enroll in the state Medicaid programs. Conversely, the Board ***reversed*** the Medicare Contractors' denial of claims for states where the Providers did not obtain an RA but were unable to enroll in the state Medicaid programs.[7]

However, on August 29, 2019, the Administrator vacated the Board's decision and remanded Case No. 13-1022GC back to the Board for further development.[8] The Administrator noted that both the CMS Center for Medicare ("CM") and the Select LTCHs dispute the factual findings made by the Board regard the opportunity to enroll in several state Medicaid programs. Specifically, the CM disputes the Board's findings related to Alabama, Mississippi, and Pennsylvania, while the Select Medical LTCHs dispute the Board's findings related to Arkansas and North Carolina. In addition, the Select Medical LTCHs claim that the Board did not specifically address out-of-state provider claims.[9]

On January 31, 2020, the Board reopened Case No. 13-1022GC pursuant to the Administrator's Decision and Order and requested the Providers supplement the record, as needed, ***within 60 days*** (*i.e.,* by Tuesday March 31, 2020) to ensure that the information needed to address the Administrator's concerns is included therein. Specifically, for each state under appeal (in particular, Alabama, Mississippi, Pennsylvania, Arkansas, and North Carolina), the Parties were to ensure that the record in Case No. 13-1022GC is complete regarding whether each of the relevant Select Medical LTCHs had an opportunity to enroll in the respective Medicaid programs. The Parties were also to address and include in Case No. 13-1022GC any supplemental documents, information, or arguments related to the Medicare Contractor's adjustments to the dual eligible bad debts for out-of-state beneficiary claims. Finally, the Parties were to enhance the record for Case No. 13-1022GC regarding the enrollment of LTCHs in the relevant state Medicaid programs.[10]

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[6] PRRB Dec. 2019-D29 at 2-3.
[7] *Id.* at 13-14.
[8] *Select Medical 2011 Dual Eligible Medicare Bad Debts CIRP Grp. v. Novitas Solutions, Inc.*, Adm'r Dec. 2019-D29 at 1 (Aug. 29, 2019).
[9] *Id.* at 25.
[10] *I.e.*, the Parties were to clarify and supplement the record, as appropriate, on whether the issue, at least in some instances, with enrollment was related to the Providers' type of license or whether it was the type of payment sought (non-DRG/Acute care payment) and whether a LTCH could choose to be enrolled as an acute care hospital for cross over claim payments in a State's Medicaid program.

Notwithstanding the Board's January 31, 2020 Scheduling Order, the Board has no record of either party supplement the record for Case No. 13-1022GC pursuant to the Board's Order (either in hard-copy or electronically in OH CDMS).[11] The parties were supposed to supplement the record by March 31, 2023, which overlaps with when the office shut down for COVID. However, the Board has no record of any hard copies being delivered or any electronic filings being made in Case No. 13-1022GC. ***Nor*** was this required supplementation of the record in Case No. 13-1022GC discussed in the instant EJR Request. Rather, the EJR Request refers to the comments submitted for FY 2012-2017 cases after the Board's OMEJR notice, and then generically assert that 2011 (and 2018/2019) involve all the same facts and Medicaid programs.[12] Accordingly, there are gaps in the record for Case No. 13-1022GC and the parties must cure them as set forth below.

In reviewing EJR request as it relates to this case, it has come to the Board's attention that the Providers had appealed the Administrator's decision to the U.S. District Court for the District of Columbia ("D.C. District Court"). Following the Board's reopening and issuance of the Scheduling Order, the Providers failed to respond. Notwithstanding, the Board understands that, on May 26, 2020, the DC District Court affirmed the Administrator's remand noting:

> How *Select Specialty Hosp.—Denver, Inc*., which held that CMS could not apply the must-bill policies at issue here to certain non-Medicaid participating providers without going through notice-and-comment procedures, applies to this case depends in part on facts the PRRB is to develop on remand. *See* 391 F. Supp. at 70 (summarizing the holding). *Select Specialty Hosp.—Denver, Inc.*, drew legally significant distinctions among providers who were and were not permitted to enroll in state Medicaid programs and providers who did and did not enroll where permitted. *Id*. at 69. The Administrator's remand order instructed PRRB to "further develop[] . . . the record" on related issues, including "the enrollment status of LTCHs in States where the Providers claim they were not allowed to enroll." CMS Decision at 28. Review in this Court before the PRRB has a chance to finalize its work is not an option.[13]

While the Board is aware that it issued Alert 19 shortly before the March 31, 2020 filing deadline, the Board is aware that a similar request was made in the FY 2012 through 2017 cases and that the parties responded to the request in those cases. However, they failed to do so in this case. As discussed below, under separate cover, the Board will issue a Scheduling Order requiring the parties to cure this defect.

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[11] Office of Hearing Case Management System (the Board's electronic filing system).
[12] *See* EJR Request at 18.
[13] *Select Specialty Hosps., Inc. v. Azar*, No. 19-2591, 2020WL2735616 (D.D.C. May 26, 2020).

2. *FY 2012-2017 NPR CIRP Groups* – *Case Nos. 13-2602GC, 14-3729GC, 17-1219GC, 17-1220GC, 17-2240GC, 19-0123GC*

On August 5, 2013 and July 2, 2014, Select filed its requests to form the CIRPgroup appeals for FYs 2012 and 2013, respectively. Similarly, on December 7, 2016, Select filed its requests to form the CIRP group appeals for FYs 2014 and 2015. Finally, on September 8, 2017 and October 2, 2018, Select filed its requests to form the CIRP group appeals for FYs 2016 and 2017, respectively. The Issue Statement for each these NPR CIRP group appeals was identical to the issue statement in the FY 2011 NPR CIRP Group.[14]

On April 29, 2019, the Provider's Representative filed a Motion to Consolidate Groups or Hear Cases Concurrently for the CIRP group cases for FYs 2012 through 2016[15] based on its assertion that they involve the same provider chain as well as the same legal issue and controlling facts. On the same day, the Board issued a Notice of Consolidated Hearing and Critical Due Dates effectively granting the request. Consistent with this notice, the parties briefed the FYs 2012-16 group cases.[16] On October 17, 2019, the parties requested a hearing on the record.[17] On November 19, 2019, the Board granted this request. On December 18, 2019, the Medicare Contractor submitted a Supplemental Position Paper, to which the Providers filed a Response on December 19, 2019.

As discussed above, on August 29, 2019, the Administrator vacated the Board's decision in Case No. Case No. 13-1022GC for FY 2011 and remand it back to the Board for further development. In light of this remand and the fact that the FY 2012 to 2017 appeals involved the same issue, the Board issued an own motion EJR request for information ("RFI") on December 20, 2019 requiring the parties to supplement the record to address the concerns raised in the Administrator's remand order, namely "further development of the record with respect to out-of-state claims and also for the enrollment status of LTCHs in States where the Providers claim they were not allowed to enroll, and any other matter that advance the understanding of the issues in this case." On February 18, 2020, both parties filed responses to this request for information (note this response did *not* include Case No. 13-0122GC).[18]

Based on these responses to the Board's RFI, **on April 20, 2020, the Board notified the parties that a hearing on the record was no longer appropriate for these cases because "this is a complex case with multiple legal and factual details that are in dispute . . ."**[19] On May 29, 2020, Select filed an Unopposed Motion to Consolidate FY 2017 with Other FY 2012-16 Group Cases for Hearing. On July 22, 2020, the Board granted that request to hold a consolidated hearing for the FY 2012 to FY 2017 NPR CIRP Groups.

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[14] Initial Request for Hearing – Group Appeal, 1-2 (Aug. 5, 2013) (Case No. 13-2602GC).
[15] Case Nos. 13-2602GC, 14-3729GC, 17-1219GC, 17-1220GC, and 17-2240GC.
[16] The Provider filed a Final Position Paper ("FPP") on August 14, 2019; the Medicare Contractor filed an FPP on September 11, 2019; the Provider filed an Optional Responsive Position Paper on October 10, 2019.
[17] Stipulations of Fact were submitted on November 1, 2019.
[18] The Provider filed a Reply to the Medicare Contractor's filing on March 3, 2020.
[19] Though no formal request to do so is in the record, Case No. 19-0123GC was added to this group of consolidated cases via a new Notice of Hearing issued July 31, 2020.

Consistent with the Board notices, the parties filed revised FPPs for FYs 2012 through 2017.[20] Following those filings, on December 31, 2020, the Board issued a Request for Comments in consideration of granting EJR on its own motion. The Board's request was based on the August 22, 2019 *Select Specialty*[21] decision from the U.S. District Court for the District of Columbia and the subsequent, contradictory, and retroactive revisions to the bad debt regulations issued in the FY 2021 IPPS/LTCH PPS Final Rule.[22] The Board reasoned that the two different, contradicting authorities may preclude it from providing the relief sought by the Providers (*i.e.*, following the ruling in *Select Specialty* since that would require disregarding the retroactive regulation).

On January 29, 2021, the Providers filed their comments, arguing that, even under the amended, retroactive must-bill regulations, nothing has altered the rationale in 2019 *Select Specialty* that the policy violates 42 U.S.C. § 1395hh(a)(2) because it failed to provide prior notice and opportunity for comment before applying the must-bill requirements.[23] They further argue that they are ***not*** seeking the Board to declare the must-bill policy in the amended regulations invalid. The Providers agree that some aspects of a must-bill policy are acceptable, but object to the must-bill policy that made billing Medicaid and obtaining a valid Medicaid RA a requirement for ***non-Medicaid-participating providers*** to be reimbursed by Medicare for their dual eligible bad debts.[24] The Providers argue the Board has the authority to disregard the regulation's explicit statement of retroactive applicability in the specific context of their appeal since the court in *Select Specialty*, prior to the regulation being amended, ruled that the policy could not be applied retroactively.[25] In the event that the Board disagrees with this, they request the appeals be certified for EJR.[26]

On February 1, 2021, the Medicare Contractor filed its Comments and Objections to the Board's Notice of Own Motion EJR. It argues that the 2021 regulation was not raised in the Providers' appeal requests and is therefore inappropriate for EJR consideration.[27] The Medicare Contractor notes that the validity of the 2021 IPPS/LTCH Final Rule was not raised by the Providers until their supplemental/reply brief, and that at the time the appeals were filed in these cases, the 2021 rule did not exist. Since challenging the validity of the 2021 Final Rule is a second issue (which is

[20] The Provider filed a Revised FPP on September 18, 2020; The Medicare Contractor filed a Consolidated Revised FPP on October 19, 2020; the Provider filed a Revised Reply Brief on November 19, 2020.
[21] *Select Specialty Hosp.-Denver, Inc. v. Azar*, 391 F. Supp. 3d 53 (D.D.C. 2019).
[22] 85 Fed. Reg. 58432 (Sept. 18, 2020).
[23] Providers' Comments in Support of Expedited Judicial Review, 1 (Jan. 29, 2021).
[24] *Id.* at 3.
[25] *See, e.g., id.* at 3 ("The Board need only apply the Medicare Act's notice-and-comment requirement and prohibition on retroactive rulemaking to conclude that CMS's amended bad debt regulation cannot be applied retroactively to prevent reimbursement of the Providers' dual eligible bad debts."), 13 ("Even with the amended regulation, the Providers believe that the Board is still bound by the District Court's rationale because the amended bad debt regulation violates the Medicare Act's notice-and-comment rulemaking requirement and its prohibition on retroactive rulemaking.").
[26] *Id.* at 3-4, 14. The Providers also argued that the Medicare Contractors' adjustments violate the bad debt moratorium in the Medicare Act, 42 U.S.C. § 1395f note, because CMS's invalid change in bad debt policy as to Select Medical's non-Medicaid-participating providers occurred in 2007, during the moratorium. *Id.* at 20.
[27] Comments and Objections to the Board's Notice of Own Motion EJR, 2 (Feb. 1, 2021).

not permitted in group appeals) that was not timely added, the Medicare Contractor argues the Board lacks jurisdiction to consider it.[28]

The Medicare Contractor also notes that a number of Providers in these appeals were, in fact, able to enroll in their respective Medicaid programs and obtain RAs. For these Providers, the Medicare Contractor claims that it is not clear how the 2021 Final Rule should be applied. It also claims that the Board is bound by the new, amended regulations and should simply apply them retroactively as directed by the regulations themselves, then allow the Providers to challenge the regulations on appeal to the district court.[29] The Medicare Contractor concludes that a hearing on this case is premature because the amended regulations allow for alternative documentation, so the Board should remand or otherwise give the parties the opportunity to explore whether different documentation could resolve the case.[30] It claims that the Board has ruled on the same bad debt issue appealed by the Providers in the past, and nothing in the 2021 Final Rule precludes the Board's review in this case.[31]

3. FY 2018 NPR CIRP Group[32]

The Board received a request to form a group appeal on January 8, 2020. The Common Issue identified was identical to the issue statement in the FY 2011-2017 NPR CIRP Groups.[33] The group was fully formed on October 8, 2021 and the full Schedule of Providers was submitted on November 18, 2021. Both parties have submitted Preliminary Position Papers.

4. FY 2019 NPR CIRP Group[34]

The Board received a request to form a group appeal on December 6, 2020. The Common Issue identified was identical to the issue statement in the FY 2011-2018 NPR CIRP Groups.[35] The group was fully formed on April 20, 202 and the Provider filed, pursuant to Board Rule 20 (Nov. 2021), a certification that the group is fully populated in OH CDMS on May 9, 2022. Both parties have submitted Preliminary Position Papers.

B. FY 2011-2019 FR CIRP Group Appeals[36]

To prevent any jurisdictional issues from delaying resolution of the above referenced FY 2011-2019 **NPR** CIRP Group appeals, the same Providers filed separate group appeal requests for FYs 2011 through 2019 on March 15, 2021 to directly challenge the application of CMS's final rule, the FY 2021 IPPS/LTCH PPS Final Rule, 85 Fed. Reg. 58432 (Sept. 18, 2020) to FYs 2011 through

[28] *Id.* at 3.
[29] *Id.* at 4.
[30] *Id.* at 4-5.
[31] *Id.* at 5.
[32] Case No. 20-0584GC.
[33] Initial Request for Hearing – Group Appeal, 1 (Jan. 8, 2020) (Case No. 20-0584GC).
[34] Case No. 21-0329GC.
[35] Initial Request for Hearing – Group Appeal, 1 (Dec. 6, 2020) (Case No. 21-0329GC).
[36] Case Nos. 21-1061GC, 21-1062GC, 21-1063GC, 21-1064GC, 21-1065GC, 21-1066GC, 21-1067GC, 21-1068GC, 21-1069GC.

2019. Specifically, these appeals challenge the retroactive application of the must-bill and Medicaid RA requirements, and the new alternative documentation provision, to the amended Medicare bad debt regulation at 42 C.F.R. § 413.89(e)(2)(iii). These are the same provisions of the amended bad debt regulation that the Providers challenged in their Revised Final Position Paper and Revised Reply Brief filed in the FY 2011-2019 **NPR** CIRP Groups.[37] The new **FR** CIRP group appeals are:

- Select Medical CY 2011 Retroactive Must-Bill Reg. CIRP Group, Case No. 21-1061GC
- Select Medical CY 2012 Retroactive Must-Bill Reg. CIRP Group, Case No. 21-1062GC
- Select Medical CY 2013 Retroactive Must-Bill Reg. CIRP Group, Case No. 21-1063GC
- Select Medical CY 2014 Retroactive Must-Bill Reg. CIRP Group, Case No. 21-1064GC
- Select Medical CY 2015 Retroactive Must-Bill Reg. CIRP Group, Case No. 21-1065GC
- Select Medical CY 2016 Retroactive Must-Bill Reg. CIRP Group, Case No. 21-1066GC
- Select Medical CY 2017 Retroactive Must-Bill Reg. CIRP Group, Case No. 21-1067GC
- Select Medical CY 2018 Retroactive Must-Bill Reg. CIRP Group, Case No. 21-1068GC
- Select Medical CY 2019 Retroactive Must-Bill Reg. CIRP Group, Case No. 21-1069GC

The Providers ***timely*** filed these nine (9) new FR CIRP group appeals *within 180 days of CMS's publication* of the FY 2021 IPPS/LTCH PPS Final Rule in the Federal Register. The Providers have already notified the Board and the Medicare Contractor that these new groups are complete.

As stated in the Statement of the Issue filed with each new group appeal:

> These are the same legal arguments regarding the amended bad debt regulation that were raised in the Providers' pending appeals before the PRRB. However, the Medicare Contractors in the pending appeals have objected to the Providers' challenge to the amended regulation at 42 C.F.R. § 413.89(e)(2)(iii) (2020). The Providers take the position that their challenge to this recently amended regulation before the Board because CMS promulgated the amended regulation while their existing appeals were pending before the Board. However, the Providers file this new appeal based on the Federal Register Notice to preserve their right to challenge the amended regulation, in the event that the Board (or other reviewing authority) determines that the Board lacks jurisdiction to review the Providers' challenge to the amended regulation in the pending group appeal for the same year.

C. EJR Request for All Eighteen (18) CIRP Groups (i.e.*, for both the NPR CIRP groups and the FR CIRP Groups*)

As noted above, the Board issued a D-Decision for FY 2011 **NPR** CIRP Group, but the case was subsequently remanded to and reopened by the Board. The Board has also requested comments on

[37] *See* Providers' Revised Final Position paper, pgs. 130-31; Providers' Revised Reply Brief, pgs. 12-24.

granting an Own Motion EJR for the FY 2012-2017 **NPR** CIRP Groups. On September 15, 2023, the Providers requested EJR in all of the eighteen CIRP groups – both the 9 NPR CIRP groups and the 9 FR CIRP Groups.

The Providers reiterate their position that the rationale set forth in the *Select Specialty* decision relating to the FY 2005 – 2010 cases is controlling and binding on the Board, despite the subsequent retroactive amendments to the controlling bad debt regulations.[38] They claim that there is no current challenge sought against the must bill policy, as adopted in the amended regulation. Rather, they object to "the change in the must-bill policy in 2007 that made billing Medicaid and obtaining a valid Medicaid RA requirements for non-Medicaid participating providers to be reimbursed by Medicare for their dual eligible bad debts[,]" which was already deemed invalid in *Select Specialty*.[39] In the event that the Board disagrees, the Providers request EJR be granted and *contend that* ***no further factual development*** is necessary in any of the FY 2011 – 2019 CIRP group cases (NPR or FR based).[40]

The Providers also contend there are no *disputed* facts material to the resolution of the Providers' appeals.[41] They rely on the *Select Specialty* decision regarding the same Providers' FY 2005-2010 cases challenging the same bad debts policy which made a number of factual findings about the policy – they also argue that this District Court decision is binding on the Board. They also rely on the Stipulations submitted for the FY 2012-2017 [*sic* 2016] **NPR** CIRP Groups[42] which agree on a number of undisputed facts.[43] The Providers insist that the disagreement in these cases is whether the must bill policy applies to non-Medicaid-participating providers. They also ague that the new, retroactive bad debt regulation was improperly amended and contradicts the District Court's holding in *Select Specialty*. Finally, the Providers claim the FY 2011, FY 2018, and FY 2019 **NPR** CIRP Groups concern the same providers and state Medicaid programs, so the facts are the same and no material facts are in dispute.[44]

Significantly, the Providers also set forth a number of arguments on which it states that the Board should rule. In particular, they contend that the Board should find that the new provisions of the amended bad debt regulation (that apply the must-bill and Medicaid RA requirements retroactively) are inconsistent with the District Court's decision in *Select Specialty*, and/or the Medicare Act's notice-and-comment rulemaking requirement, the Medicare Act's prohibition on retroactive rulemaking, or the Medicare Act's bad debt moratorium.[45] If the Board determines that it does not have the authority to rule in this fashion, however, the Providers request EJR over the cases.

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[38] Provider's Request for Expedited Judicial Review, 3-5 (Sept. 15, 2023) ("EJR Request").
[39] *Id.* at 5.
[40] *Id.* at 5-6.
[41] *Id.* at 15.
[42] *Id.* at 16. *See also* Providers' Revised Final Position Paper, Exhibit P-164 (Sept. 18, 2020) (copy of Stipulations (Nov. 1, 2019) (FY 2012-2016 NPR CIRP Groups)).
[43] EJR Request at 17.
[44] *Id.* at 17-18.
[45] *Id.* at 22-29.

On September 21, 2023, the Medicare Contractor filed a response entitled "Request for Extension of Time to Respond to Providers' EJR Request." However, the filing briefly responds to the Providers' EJR Request, and does ***not*** actually make a *request for extension of time*. Rather, it reiterates previously made arguments:

> namely: (1) the Board lacks procedural jurisdiction over the challenge to the 2021 IPPS Final Rule in the original cases; (2) the Board can grant findings or decisions that do not necessitate overturning or refusing to follow a statute or regulation because the matters can be remanded to the MAC to explore alternate forms of documentation; and (3) by Providers' own admission, multiple providers were able to enroll in their various Medicaid programs and, accordingly, remittance advices were available.

The Medicare Contractor generally incorporated their responses to the Board's December 2020 own motion EJR request for comments, and requests the Board deny EJR.

Decision of the Board:

The Medicare statute at 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R. § 405.1842(f)(1), require the Board to grant expedited judicial review 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. General Jurisdiction

Pursuant to 42 U.S.C. § 1395oo(a), 42 C.F.R. § 405.1837 and 42 C.F.R. § 405.1835(a), a provider has a right to a Board hearing for specific items claimed for a cost reporting period covered by a final determination if it has preserved its right to claim dissatisfaction with the amount of Medicare payment for the specific item(s) at issue, 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. In each of these cases each Provider requested a hearing within 180 days after receipt of its NPR and/or the Federal Register, and the $50,000 amount in controversy requirement for a group appeal has been met.

Further, all of the Providers in the **NPR** CIRP Groups protested dual eligible bad debt amounts on their FY 2011 to FY 2019 Medicare cost reports.

Likewise, in the **FR** CIRP Groups, the Providers have all timely appealed from the FY 2021 IPPS Final Rule; however, as described below, these FR CIPR Groups are prohibited duplicate appeals and the Board does not have jurisdiction over them.

B. Board Finding on the EJR Request

1. *Dismissal of the FY 2011-2019* ***FR*** *CIRP Groups*

In the issue statements for the FY 2011-2019 FR CIRP appeals, the Providers acknowledge that: (1) "[t]hese are the same legal arguments regarding the amended bad debt regulation that were raised in the Providers' pending appeals before the PRRB"; ***and*** (2) these FR CIRP Groups were *only* filed "to preserve their right to challenge the amended regulation, in the event that the Board (or other reviewing authority) determines that the Board lacks jurisdiction to review the Providers' challenge to the amended regulation in the pending group appeal for the same year."

The Board finds that the Provider's appeal requests for the FY 2011-2019 **NPR** CIRP Groups clearly concern the "must bill" policy and clearly challenge that policy by stating therein that the policy violates the statutory prohibition on cost-shifting and CMS regulations on bad debt.[46] The Medicare Contractor readily asserts in its comments regarding EJR that the retroactive regulations both codify the "must bill" policy and retroactively apply to the Provider's FYs at issue here; and that the Board is bound to apply those regulations retroactively to these FYs.[47] Accordingly, it is within the Provider's right to challenge, *as part of the FY 2011-2019 NPR CIRP Groups*, the retractive application of those regulations which otherwise codify on a retroactive basis the "must bill" policy that it is challenging.

Based on the foregoing, the Board finds that the FY 2011-2019 **FR** CIRP Groups appeals are duplicative of the FY 2011-2019 **NPR** CIRP Group appeals since they concern the same issue, providers, and fiscal years. The Providers admit they are duplicates and were filed only "to preserve their right to challenge the amended regulation, in the event that the Board (or other reviewing authority) determines that the Board lacks jurisdiction to review the Providers' challenge to the amended regulation." Board Rule 4.6 (Nov. 2021) prohibits duplicate filings, and Board Rule 4.6.2 (Same Issue from Multiple Determinations) provides that "[a]ppeals of the same issue from distinct determinations covering the same time period must be pursued in a single appeal." Similarly, 42 C.F.R. §§ 405.1837(b)(1) and (e)(1) makes clear that health care chain can pursue an issue common to the chain for a particular year ***in only one CIRP group.*** As a result, the Board hereby dismisses all nine (9) the FY 2011-2019 FR CIRP Groups because they are prohibited duplicates of the FY 2011-2019 NPR CIRP Groups.

As an alternative basis for dismissal, the Board notes that the final rule appealed (FY 2021 IPPS Final Rule), on its own, would not be a valid appealable final determination for the issue appealed for FYs 2011 to 2019 under 42 U.S.C. § 1395oo(a)(1). The final rule codified retroactive bad debt policies but determined no reimbursement (whether retrospectively or prospectively). Bad debts are reimbursed on a case-by-case determination, meaning that the policies must be applied to specific bad debts in order for there to be a reimbursement impact and that case-by-case determination is made through the cost reporting process and is not "computed" under subsection (d). Indeed, a factor in such case-by-case reimbursement determinations is the provider's written bad debt collections policy in effect during the relevant period.

[46] Provider's appeal requests.
[47] Comments and Objections to Notice of Board's Own Motion EJR, 4 (Feb. 1, 2021).

Based on the above, the Board hereby **dismisses** the FY 2011 to 2019 **FR** CIRP Groups (*i.e.*, Case Nos. 13-2602GC, 14-3729GC, 17-1219GC, 17-1220GC, 17-2240GC, 19-0123GC) because they are prohibited duplicates in violation of 42 C.F.R. §§ 405.1837(b)(1) and (e)(1) and Board Rule 4.6 and because the FY 2021 IPPS Final Rule is not an appealable final determination. Accordingly, the Board also **denies** the EJR request as it relates to the FY 2011 to 2019 **FR** CIRP Groups.

2. *FY 2011-2019 **NPR** CIRP Groups*

The Board's notice of potential own-motion EJR for the FY 2012-2017 cases identified the regulation at issue in the FY 2011-2019 NPR Groups as 42 C.F.R. § 413.89(e)(2)(iii) as the FY 2021 IPPS/LTCH PPS Final Rule retroactively codified the "must bill" policy into that regulation. The Provider agrees with the Board's proposed own-motion EJR and has requested EJR for all nine NPR cases concerning FYs 2011-2019.

Upon review, the Board has determined that there are material factual issues in dispute that must be resolved and these cases are not ripe for consideration of EJR (whether on motion from the Board or by request from the Providers).[48] In this regard, based on the record in these cases, it is not clear, for example, that: (1) each of the participating Providers were unable to enroll in the relevant Medicaid programs as an in-state provider (and as relevant as an out-of-state provider) and obtain an RA for each of the FYs in each state involved in these group appeals in connection with both the in-state and out-of-state claims at issue; or (2) whether each of the participating Providers with regard to the relevant state Medicaid program(s) during each of the relevant fiscal years at issue may have qualified under the exception at 42 C.F.R. § 413.89(e)(2)(iii)(B) (2020).[49] Indeed, the Board notes that the applicability of the exception under § 413.89(e)(2)(iii)(B) (2020) to any of the Providers for any of the years is not discussed nor potential distinctions with out-of-state provider claims discussed notwithstanding the record development required in FY 2011 by the Administrator's remand on this point. The Providers' EJR request does not comply with the requirement in Board Rule 42.3 requiring the EJR request to "[d]emonstrate that there are no factual issues in dispute."[50]

Pursuant to 42 C.F.R. § 405.1867, the Board must comply with Title XVIII of the Act and its supporting regulations and this includes, but is not limited to, 42 C.F.R. § 413.89(e)(2)(iii) as

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[48] *See* Board's Review of Information Received, 2 (Apr. 20, 2020) (denying request for record hearing for FY 2012-2016 NPR CIRP Groups) ("this is a complex case with multiple legal and factual details that are in dispute and need development through the hearing setting.").

[49] *See also infra* note 60.

[50] The Providers' EJR request makes broad brush stoke claims about there being no factual disputes but fails to give any thoughtful analysis back up their assertions to "[d]emonstrate[] that there are no factual disputes" for ***each*** of the cases/years The material facts in each of these cases can vary by year, by state Medicaid program, by provider, and by the nature of claim (*e.g.*, in state versus out of state) and some thoughtful discussion is needed, particularly in light of the Administrator's remand order for FY 2011 which is one of the cases covered by this EJR request, and the fact that, if the Providers qualify under the exception at § 413.89(e)(2)(iii)(B) (2020), then any controversy regarding the validity of the retroactive bad debts (as alleged in the EJR request) would become moot as it would not be reached. Indeed, the Board has no record of the Providers filing a formal response to the Administrator's remand order in Case No. 13-0122GC for FY 2011.

retroactively codified pursuant to the FY 2021 IPPS/LTCH PPS Final Rule. The Providers allege this regulation (as codified by the FY 2021 IPPS/LTCH PPS Final Rule) should not apply retroactively to the FYs in each of these group appeals. The Providers challenge both procedural and substantive validity of the retroactive codification of the must bill policy.[51] They argue that the policy is procedurally invalid based on a lack of appropriate notice and comment rulemaking, and cite *Select Specialty* in support. They argue that the policy is substantively invalid because it violates the Bad Debt Moratorium.

The Board recognizes that the Medicare Contractor has raised objections to the Board's own motion EJR and the Providers' EJR Request concerning the retroactive bad debt regulations by asserting that EJR is inappropriate. The Provider's appeal requests for the FYs in the NPR CIRP Group Appeals clearly concern the "must bill" policy and clearly challenge that policy by stating therein that the policy violates the statutory prohibition on cost-shifting and CMS regulations on bad debt.[52] The Medicare Contractor readily asserts, in its comments regarding EJR, that the retroactive regulations both codify the "must bill" policy and retroactively apply to the Provider's FYs at issue; and that the Board is bound to apply those regulations retroactively to those FYs.[53] Accordingly, it is within the Provider's right to challenge the retractive application of those regulations which otherwise codify on a retroactive basis the "must bill" policy that it is challenging and which the Board is otherwise bound to apply *to the Providers FYs 2011-2019* per 42 C.F.R. § 405.1867.[54]

In making this finding, the Board notes that the fact that the retroactive regulations were not considered in the determinations at issue, in and of itself, has no bearing on the Board's jurisdiction over the "specific matter" appealed for FYs 2011 to 2019. 42 C.F.R. § 405.1869(a) confirms that the Board has the authority to modify a Medicare Contractor determination and 42 C.F.R. § 405.1867 confirms the Board is bound by the retroactive regulation. In this regard, the final rule adopting the retroactive regulations does not specifically preclude the application of the retroactive regulation to pending appeals because it is apparent that the Secretary's position is he was clarifying and codifying "longstanding" policies which pre-date the Bad Debt Moratorium and of which providers should have been aware.[55] The codification of those "longstanding" policies into binding regulations does not change their applicability in this appeal. Rather, it merely affects the nature of the Board's authority to consider those policies and changes the nature of the Providers' challenge to those policies.

The Board recognizes that, prior litigation, has addressed the Secretary's must bill policy. For example, the D.C. District Court holding in *Select Specialty* contradicts the amended regulations at 42 C.F.R. § 413.89; however, this is a district court case and, as such, is not binding on the Board and, in similar circumstances, the Board has not applied *res jucata* (*i.e.*, issue preclusion or collateral estoppel) because the legal question of issue preclusion, as posed, does not itself

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[51] Providers' Comments in Support of Expedited Judicial Review, 14-20 (Jan. 29, 2021).
[52] Provider's appeal requests.
[53] Comments and Objections to Notice of Board's Own Motion EJR, 4 (Feb. 1, 2021).
[54] Further, contrary to the Medicare Contractor's assertion, a plain reading of Board Rule 42.1 demonstrates that it does not bar the Board's own-motion EJR.
[55] *See, e.g.,* 85 Fed. Reg. at 59002, 58994.

entail a legal *challenge* to or legal question under "the provisions of Title XVIII of the Act and regulations issued thereunder" and, as such, necessarily falls *outside the scope of the Board's authority* to grant EJR in the first instance (as well as the scope of the Board hearing proceedings). Moreover, the decision pre-dates and is superseded by the amended regulations. Further, *as the DC District Court noted the above 2019 quote affirming the Administrator's the remand of FY 2011*,[56] the Board has factual disputes to resolve that may distinguish these cases for those in its earlier Court decision since that decision involved years earlier where the material facts and law may differ. Finally, in contrast, *subsequent to the 2019 district court decision*, the U.S. Circuit Court of Appeals for the D.C. Circuit recently reviewed and upheld the must bill policy.[57] Regardless of these decisions, pursuant to 42 C.F.R. § 405.1867, the Board "***must*** comply with all provisions of Title XVIII of the [Social Security] Act and *the regulations thereunder*."[58]

As described above, the Board finds that, for the nine (9) NPR CIRP Groups[59]: (1) the retroactive bad debt regulations are part of the issue appealed; (2) the Providers' EJR request failed to comply with the requirement in Board Rule 42.3 that the EJR request "[d]emonstrate that there are no factual issues in dispute"; and (3) there are still *material* facts in dispute and in need of development (consistent with the August 29, 2019 Administrator's remand order and the May 26, 2020 decision of the D.C. District Court upholding that remand and, as such, that the cases are not ripe for EJR.[60] Based on these findings, the Board **denies** the request for EJR for the FY 2011 to FY 2019 NPR CIRP Group cases. Finally, the Board recognizes that it has an open notice of consideration of own motion EJR in the NPR CIRP groups for FYs 2012 through 2017 and hereby **withdraws** that notice for the same reasons it is denying the Providers' EJR request for FYs 2011 through 2019.

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[56] *See supra* n.19 and accompanying text.
[57] *New Lifecare Hospitals of NC v. Becerra*, 7 F.4th 1215 (D.C. Cir. 2021).
[58] 42 C.F.R. § 405.1867 (emphasis added).
[59] Case Nos. 13-0122GC, 13-2602GC, 14-3729GC, 17-1219GC, 17-1220GC, 17-2240GC, 19-0123GC, 20-0584GC, and 21-0329GC.
[60] For example, as noted in the Administrator's remand for FY 2011 at 25, "CM disputes certain of these findings (in particular for Alabama, Mississippi and Pennsylvania) and the Provider disputes certain of these findings (in particular Arkansas and North Carolina), for which the further fact finding and or clarification is best addressed by the Board. In addition, the Providers have pointed out that the Board did not specifically address the out-of-state provider claims, which is best directly addressed by the Board in the first instance." (Footnote omitted.) Similarly, the Providers' stipulations entered only in some of the FY 2011-2019 NPR CIRP Group cases only pertain to FYs 2012 to 2016 or to years *prior to* those at issue in the FY 2011 to 2019 NPR CIRP Group cases. Moreover, the Board notes that there may be a material legal difference between situations where a law and/or regulation prevents or bars an LTCH provider from enrolling in a state Medicaid (whether as an LTCH or simply an acute care hospital) ***and*** situations where a state has a "practice" of not permitting an LTCH provider to enroll in a state Medicaid program. Similarly, law, regulations, and practices for enrolling an out-of-state provider in a state Medicaid program may differ from those governing in-state providers and, as such, the record may need to reflect exactly which state Medicaid programs that the Providers are alleging did not permit them to enroll as *out-of-state* providers to ensure the record is appropriately developed regarding out-of-state provider enrollment. Further, there appears to be material factual issues for the Board to resolve regarding whether any of the Providers qualify under the exception at 42 C.F.R. § 413.89(e)(2)(iii)(B) (2020) during any of the years at issue. Similarly, there may be questions related to qualified Medicare beneficiaries ("QMB") for which Medicare had cost sharing, to the extent the bad debt claims at issue for any of the years involves QMBs, because the cost-sharing obligations of a state Medicaid program may be different for a QMB than for a Medicaid-enrolled beneficiary. *See also supra* note 50.

****

In summary, the Board dismisses the 9 **FR** CIRP Groups cases for FYs 2011 to 2019[61] because they are prohibited duplicate of the 9 **NPR** CIRP Groups and are not based on an appealable final determination. Accordingly, the Board also **denies** the EJR request for the 9 **FR** CIRP Groups.

The Board **denies** the Providers' request for EJR for the 9 **NPR** CIRP Group cases for FYs 2011 to 2019[62] because the Providers' EJR request failed to comply with the requirement in Board Rule 42.3 and, in each of these cases, there are material facts in dispute and need of development. As such, these cases are not ripe for consideration of EJR. Similarly, the Board **withdraws** its notice of consideration of own motion EJR in the **NPR** CIRP groups for FYs 2012 to 2017 for the same reasons.

Finally, the Board will issue, shortly under separate cover,[63] a Scheduling Order related to record development in the **NPR** CIRP group for FYs 2011 and related to ensuring the OH CDMS record is complete in *each* case consistent with the August 29, 2019 Administrator's remand order in Case No. 13-0122GC and the D.C. District Court decision upholding that remand.

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For the Board:

9/27/2023

X Clayton J. Nix

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

cc: Michael Redmond, Novitas Solutions, Inc.
Wilson Leong, Esq., FSS

[61] Case Nos. 21-1061GC, 21-1062GC, 21-1063GC, 21-1064GC, 21-1065GC, 21-1066GC, 21-1067GC, 21-1068GC, and 21-1069GC.
[62] Case Nos. 13-0122GC, 13-2602GC, 14-3729GC, 17-1219GC, 17-1220GC, 17-2240GC, 19-0123GC, 20-0584GC, and 21-0329GC.
[63] At the time this determination is being issued, there is the potential for a government furlough/shutdown beginning October 1, 2023. To the extent that occurs and the Board it subject to a furlough beginning October 1, 2023, then these issuances will occur shortly *after* the Board resumes normal operations.

LISTING OF CIRP GROUP CASES

1. The NPR CIRP Groups

13-0122GC - Select Medical 2011 Dual Eligible Medicare Bad Debts CIRP Group
13-2602GC - Select Medical 2012 Dual Eligible Medicare Bad Debts CIRP Group
14-3729GC - Select Medical 2013 Dual Eligible Medicare Bad Debts CIRP Group
17-1219GC - Select Medical 2014 Dual Eligible Medicare Bad Debts CIRP Group
17-1220GC - Select Medical 2015 Dual Eligible Medicare Bad Debts CIRP Group
17-2240GC - Select Medical 2016 Dual Eligible Medicare Bad Debts CIRP Group
19-0123GC - Select Medical CY 2017 Dual Eligible Medicare Bad Debts CIRP Group
20-0584GC - Select Medical CY 2018 Dual Eligible Medicare Bad Debts CIRP Group
21-0329GC - Select Medical CY 2019 Dual Eligible Medicare Bad Debts CIRP Group

2. The FR CIRP Groups

21-1061GC - Select Medical CY 2011 Retroactive Must-Bill Regulation CIRP Group
21-1062GC - Select Medical CY 2012 Retroactive Must-Bill Regulation CIRP Group
21-1063GC - Select Medical CY 2013 Retroactive Must-Bill Regulation CIRP Group
21-1064GC - Select Medical CY 2014 Retroactive Must-Bill Regulation CIRP Group
21-1065GC - Select Medical CY 2015 Retroactive Must-Bill Regulation CIRP Group
21-1066GC - Select Medical CY 2016 Retroactive Must-Bill Regulation CIRP Group
21-1067GC - Select Medical CY 2017 Retroactive Must-Bill Regulation CIRP Group
21-1068GC - Select Medical CY 2018 Retroactive Must-Bill Regulation CIRP Group
21-1069GC - Select Medical CY 2019 Retroactive Must-Bill Regulation CIRP Group

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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RE: ***Board Decision***
LifePoint 2013 IPPS Hospital Medicare/Medicaid Medicare Advantage Day CIRP
PRRB Case No. 15-3178GC

Dear Ms. Griffin,

The Provider Reimbursement Review Board ("Board") has reviewed the documents in the above-referenced common issue related party ("CIRP") group appeal and, hereby, dismisses three providers. The decision of the Board is set forth below.

Pertinent Facts:

On August 6, 2015, the Providers established this CIRP group appeal was established on August 6, 2015, initially appealing to challenge the inclusion of Part C Days in the SSI fraction. On July 11, 2017, the Board consolidated the Medicaid Fraction group under Case No. 15-3179GC (challenging the exclusion of Part C days from the Medicaid fraction) into this appeal.[1] As a result, this CIRP group encompasses both the SSI and Medicaid fractions Part C days issues.

A. Sumner Regional Medical Center (44-0003)

Sumner Regional Medical Center (Prov. No. 44-0003) was added to the appeal via direct add on February 16, 2018, and is also appealing from a revised NPR dated July 21, 2017. On December 14, 2015, the Provider submitted a reopening request to the MAC to realign its SSI percentage from the federal fiscal year to its fiscal year as demonstrated by the following excerpt:

> As provided in Medicare regulation 42 CFR § 412.106(b)(3), "if a hospital prefers that CMS use its cost reporting period instead of the Federal fiscal year" for the *first computation* (also referred to

[1] These two CIRP groups were companion cases where both CIRP groups related to Part C days but one CIRP group related to the Medicare fraction (requesting exclusion of Part C days) and the other to the Medicaid fraction (requesting inclusion of Part C days). However, the Board considers these as one issue because, D.C. Circuit explained in *Allina Health Servs. v. Sebelius* ("*Allina*"), 746 F.3d 1102, 1108 (D.C. Cir. 2014), "*the **statute** unambiguously requires* that Part C days be counted in one fraction or the other (a Part C-enrolled individual is either eligible for Medicare Part A, or not)." (Emphasis added.) Accordingly, there are no separate Medicare or Medicaid fraction issues since Part C days must be counted in one fraction or the other (*i.e.*, excluding them from one means they must be counted in the other).

> as the SSI ratio) of the hospital's disproportionate patient percentage, it must furnish to CMS, thorough its intermediary, a written request including the hospital's name, provider number and cost reporting period end date.
>
> We are hereby requesting to use the cost reporting period ending 4/30/2013 for Sumner Regional Medical Center, provider number 44-0003, for the *first computation* (SSI ratio) of the hospital's disproportionate patient percentage.

The MAC issued the NOR on June 21, 2017 which stated that the cost report was being reopened, in pertinent part, "To update the SSI and Medicare DSH Percentages in accordance with 42 CFR 412.106(d)(4), CMS Pub. 15-2, 4030.10."

B. St. Mary's Regional Medical Center (04-0041)

St. Mary's Regional Medical Center (04-0041) was added to the appeal via direct add on April 18, 2019, and is appealing from a revised NPR dated October 23, 2018. As shown in the following excerpt, the Provider submitted a Request for Reopening on March 12, 2018 in order to include additional Medicaid eligible days in the numerator of the Medicaid fraction:

> The disproportionate share adjustment requires an update to correct the number of Medicaid eligible days and for recent CMS policy changes directed through CMS Ruling 97-2 and other clarifications.

The Provider was unable to locate the Notice of Reopening issued by the MAC. The Provider's Audit Adjustment Report explains, in Audit Adjustment Nos. 5 and 6 that the revised NPR was issued "To adjust to include the allowable *additional Medicaid days*" and "To adjust the hospital DSH payment percentage to include *the allowable additional Medicaid days*."

Board Decision:

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

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

Additionally, 42 C.F.R. § 405.1889 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.[2]

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

> (a) *Right to hearing on final contractor determination*.
> A provider . . . has a right to a Board hearing, as a single provider appeal, with respect to a final contractor or Secretary determination for the provider's cost reporting period, if -
>
> (1) The provider is dissatisfied with the contractor's final determination of the total amount of reimbursement due the provider, as set forth in the contractor's written notice specified under § 405.1803. **Exception**: If a final contractor determination is reopened under § 405.1885, **any review by the Board must be limited solely to those matters that are specifically revised in the contractor's revised final determination** (§§ 405.1887(d), 405.1889(b), and the "Exception" in § 405.1873(c)(2)(i)).
>
> (2) The amount in controversy (as determined in accordance with § 405.1839) must be $10,000 or more.
>
> (3) Unless the provider qualifies for a good cause extension under § 405.1836, the date of receipt by the Board of the provider's hearing request must be no later than 180 days after the date of receipt by the provider of the final contractor or Secretary determination.[3]

[2] 42 C.F.R. § 405.1889(b).
[3] (Emphasis added).

The Board finds that it does not have jurisdiction over the Part C Days issue in this appeal for Sumner Regional Medical Center (44-0003) or St. Mary's Regional Medical Center (04-0041).

A. Sumner Regional Medical Center (04-0003)

The Board finds that it does not have jurisdiction over Sumner Regional Medical Center's *revised* NPR appeal because the revised NPR was issue as a result of the Provider's request for realignment of its SSI percentage. Thus, the provider does not have the right to appeal the revised NPR 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[.]"[4] The reopenings in this case were a result of the Providers' request to realign their SSI percentages from the federal fiscal year end to their individual cost reporting fiscal year end. More specifically, the realignment process (as described in the Federal Register) does not change any of the underlying data that is gathered on a month-by-month basis since CMS does not rerun the data matching process in order to effectuate a realignment.[5] In other words, the determination was only being reopened to include the realigned SSI percentage and CMS' realignment process (as described in the Federal Register) does ***not*** entail re-running of the data matching process that the Provider is trying to appeal (much less revise any of the Part C days included in the underlying month-by-month data). Since the only matter specifically revised in Sumner Regional Medical Center's revised NPR was the adjustment related to realigning the SSI percentage from federal fiscal year to the Provider's fiscal year, the Provider does not have a right to appeal under 42 C.F.R. §§ 405.1889(b) and 405.1835(a)(1) for the Part C Days issue. In making this ruling, the Board notes that its application of 42 C.F.R. § 405.1889(b) has been upheld by courts on review.[6]

---

[4] 42 C.F.R. § 405.1889(b)(1).

[5] CMS describes the matching process that it uses as part of the FY 2011 IPPS final rule published on August 16, 2010. *See* 75 Fed. Reg. 50042, 50275-85 (Aug. 16, 2010). However, CMS does not utilize or re-run the data match process when it issues a realigned SSI percentage. Rather, when CMS conducts the realignment process, all of the underlying data which has already been gathered on a month-by-month basis through that data matching process remains the same. The realigned SSI percentage simply reflects a different 12-month time period being used. *See* 42 C.F.R. § 412.106(b)(2) (noting that CMS gathers data on a month-by-month basis). 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 based on the provider's cost reporting period instead of the September 30 FFY. *See also* 75 Fed. Reg. 50042, 50279 (Aug. 16, 2010) (stating: "The SSI fractions are generally based on the Federal fiscal year; however, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived from the data match process for the two Federal fiscal years that spanned the hospital's cost reporting period.); 70 Fed. Reg. 47278, 47439 (Aug. 12, 2005) (stating: "Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period, and *the hospital* ***must accept*** *the resulting DSH percentage for that year, whether or not it is a more favorable number than the DSH percentage based on the Federal fiscal year*." (emphasis added)).

[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).

The Board further notes that Sumner Regional Medical Center is not prejudiced by the Board's dismissal of its *revised* NPR appeal, because it is also participating in this CIRP group based on the appeal of its November 19, 2015 *original* NPR. As a result, Sumner Regional Medical Center will remain a participant in this CIRP group based on its original NPR appeal.

B. St. Mary's Regional Medical Center (04-0041)

Last, the Board finds that it does not have jurisdiction over St. Mary's Regional Medical Center because the Provider's revised NPR did not specifically adjust the Part C days issue under appeal in this group. The Provider's revised NPR was issued for additional Medicaid eligible days, and therefore did not include an adjustment to the SSI percentage and/or Part C days. 42 C.F.R. § 405.1889 explains that the Board has jurisdiction from revised NPRs for "those matters that are specifically revised;" as the Part C days issue was not specifically revised, the Board finds that it does not have jurisdiction over St. Mary's Regional Medical Center's revised NPR appeal.

Conclusion

The Board finds that it does not have jurisdiction over the Part C Days issue in this appeal for the revised NPR appeals of Sumner Regional Medical Center (44-0003) or St. Mary's Regional Medical Center (04-0041) and hereby dismisses these Providers' revised NPR appeal from Case No. 15-3178GC. The remaining Providers in PRRB Case 15-3178GC will be remanded pursuant to CMS Ruling 1739-R under separate cover. In the regard, the Board again notes that Sumner Regional Medical Center continues to participate in this group based on its appeal of its *original* NPR.

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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For the Board:

9/27/2023

X Clayton J. Nix

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DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

James Ravindran
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RE: ***Board Decision***
Lock Haven Hospital (Provider Number 39-0071)
FYE: 06/30/2016
Case Number: 19-0136

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the documentation in Case No. 19-0136 pursuant to a jurisdictional challenge filed by the Medicare Administrative Contractor ("MAC"). The Board's decision is set forth below.

Background

Procedural History for Case No. 19-0136

On April 12, 2018, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end June 30, 2016.

On October 10, 2018, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained six (6) issues:

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

The DSH – SSI Percentage (Provider Specific), issue is the last issue pending in the appeal.

[1] On May 30, 2019, this issue was transferred to PRRB Case No. 19-1503GC.
[2] On August 23, 2023, the Provider withdrew this issue.
[3] On August 21, 2023, the Provider withdrew this issue.
[4] On May 30, 2019, this issue was transferred to PRRB Case No. 19-1504GC.
[5] This issue was withdrawn on May 29, 2019.

A. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 19-1503GC

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

> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> . . .
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[6]

On May 15, 2019, the Provider submitted its preliminary position paper to the MAC. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Provider Specific**
>
> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation based on the Provider's Fiscal Year End (June 30).
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.
>
> Similar to *Loma Linda Community Hospital v. Dept of Health and Human Services*, No. CV-94-0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records. However, at this time, the Provider has been unable to analyze the Medicare Part A data because it has not yet received the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR"), HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000 from CMS. *See* 65 Fed. Reg. 50,548 (2000). Upon release of the complete MEDPAR data, the Provider will seek to reconcile its' records with that of CMS, and identify patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage

[6] Issue Statement at 1 (Oct. 10, 2018).

> determined by CMS based on the Federal Fiscal Year End (September 30) when it determined the Provider's SSI. *See Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).[7]

MAC's Contentions

Issue 1 – DSH – SSI Percentage (Provider Specific)[8]

The MAC argues that the Board lacks jurisdiction over the DSH – SSI Percentage (Provider Specific) issue for two reasons. First, the MAC argues that the appeal is premature:

> The decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election. It is not a final intermediary determination. A hospital must make a formal request to CMS in order to receive a realigned SSI percentage. Once the hospital elects to use its own fiscal year end, it is bound by that decision, regardless of reimbursement impact.
>
> . . .
>
> The Provider's appeal is premature. To date, the Provider has not requested to have its SSI percentage realigned in accordance with 42 C.F.R. § 412.106(b)(3). Thus, the Provider has not exhausted all available remedies for this issue. The MAC requests that the Board dismiss this issue consistent with recent jurisdictional decisions.[9]

In addition, the MAC argues the DSH – SSI Percentage (Provider Specific) issue and the DSH – SSI Percentage (Systemic Errors) issue are considered the same issue by the Board.[10]

Provider's Jurisdictional Response

The Provider did not file a response to the Jurisdictional Challenge, and the time to do so has passed.

Analysis and Recommendation

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2018), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in

[7] MAC's Motion to Dismiss, Ex. C-1 at 8-9 (Feb. 23, 2023).
[8] The MAC also challenged jurisdiction over the Medicaid eligible days and UCC issue, however the Provider has since withdrawn those issues.
[9] Jurisdictional Challenge at 6 (Feb. 7, 2019).
[10] *Id*. at 4-5.

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

A. DSH – SSI Percentage (Provider Specific)

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

1. *First Aspect of Issue 1*

The Board finds that the Provider's Preliminary Position Paper failed to comply with Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers.

In making this finding, the Board notes that CMS regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, the Provider has failed to explain how this argument is ***specific to this provider***, as the issue statement asserts. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[11] Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors are specific to this provider.

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

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

> 25.2.2 Unavailable and Omitted Documents If documents necessary to support your position are still unavailable, then provide the following information in the position papers:

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

> 1. Identify the missing documents;
> 2. Explain why the documents remain unavailable;
> 3. State the efforts made to obtain the documents; and
> 4. Explain when the documents will be available.
>
> Once the documents become available, promptly forward them to the Board and the opposing party. Common examples of unavailable documentation include pending discovery requests, pending requests filed under the federal Freedom of Information Act (also known as FOIA requests), or similar requests for information pending with a state Medicaid agency.

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

> https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH.[12]
>
> This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows: "DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[13]

Accordingly, the Board must find that the Provider failed to properly brief the issue in its position paper in compliance with Board Rules.

2. *Second Aspect of Issue 1*

[12] Last accessed February 24, 2023.
[13] 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—must be dismissed as premature. Under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request…" Without this written request, the Medicare Contractor cannot issue a final determination 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 the Provider's DSH SSI Percentage realignment as such there is no "determination" to appeal and the appeal of this issue is otherwise premature.

****

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

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

Board Members Participating:

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Ratina Kelly, CPA

For the Board:

9/27/2023

X Kevin D. Smith, CPA

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Maureen O'Brien Griffin, Esq.
Hall, Render, Killian, Heath & Lyman, P.C.
500 North Meridian Street, Suite 400
Indianapolis, IN 46204

RE: ***Jurisdictional Determination in Part***

LifePoint 2009 Revised NPR DSH SSI Fraction Dual Eligible Days CIRP Group
Case Number: 18-0488GC

Specifically: Parkview Regional Hospital (Provider Number 45-0400) and
Palestine Regional Medical Center (Provider Number 45-0747)

Dear Ms. O'Brien Griffin:

The Provider Reimbursement Review Board ("Board" or "PRRB") has reviewed the subject group appeal and notes an impediment to jurisdiction over two of the participants that appealed from revised Notices of Program Reimbursement ("RNPRs"). A brief procedural history, the pertinent facts regarding the appeals of these Providers and the Board's Determination are set forth below.

Procedural History:

On January 11, 2018, Hall, Render, Killian, Heath & Lyman, P.C. ("Hall Render") filed the "LifePoint 2009 Revised NPR DSH SSI Fraction Dual Eligible Days CIRP Group" under Case No. 18-0488GC.[1] Although the group has not yet been designated to be fully formed, on September 27, 2023, Hall Render requested that the Board expand a later CY 2015 CIRP group in order to allow the transfer of one of the participants in the subject group, Rockdale Medical Center (Prov. No. 11-0091) to be transferred to the expanded CIRP group.[2] Case No. 18-0488GC currently includes three participants that were all directly added to the group from receipt of their final determinations:

[1] According to Hall Render's September 27, 2023 correspondence, Case No. 18-0488GC was one of two groups, the other being Case No. 17-0154GC, which was established after a consolidated hearing was held in 2015. Hall Render indicated that the hospitals in these groups could not have been included in the 2015 hearing because they had not received NPRs or RNPRs with the DSH SSI ratios issued pursuant to CMS Ruling 1498-R. The subject group, included two providers that filed from RNPRs and one, Rockdale Medical Center, that appealed from its original NPR, the issuance of which had been delayed due to a change in ownership.

[2] Hall Render had previously requested the expansion/consolidation with an earlier year CIRP group for CY 2006, under Case No. 17-0154GC. The Board has not yet rendered a determination on that request. If the current request is granted, Hall Render advised that the original November 2, 2021 request could be withdrawn.

- Parkview Regional Hospital ("Parkview"/Prov. No. 45-0400)
- Palestine Regional Medical Center ("Palestine"/Prov. No. 45-0747)
- Piedmont Rockdale Hospital ("Rockdale"/Prov. No. 11-0091)

Pertinent Facts for Parkview, FYE 3/31/2009

Parkview's Reopening Request was dated January 31, 2016. The reopening request referenced 42 C.F.R. § 412.106(b)(3), which indicates:

> [i]f a hospital prefers that CMS use its cost reporting period instead of the Federal fiscal year for the first computation (also referred to as the SSI ratio) of the hospital's disproportionate percentage, "it must furnish to CMS, through its intermediary, a written request . . . .

The Provider requested a recalculation of its SSI ratio based on its cost reporting period rather than the federal fiscal year.

Parkview's Notice of Reopening ("NOR") was dated June 27, 2017. According to the NOR, the cost report was reopened for the following issue:

> "To update the SSI percentage and DSH payment percentage per Provider's request to recalculate the SSI percentage using their cost report Fiscal Year. CMS processed and approved the request using Medicare Provider Analysis and Review (MedPar) data."

Parkview's RNPR was dated July 24, 2017. The Provider referenced audit adjustments 4 and 5. Specifically, audit adjustment 4 was made to ". . .adjust the SSI percentage per CMS release" and audit adjustment 5 was ". . . to adjust allowable DSH."

Pertinent Facts for Palestine, FYE 12/31/2009

Palestine's Reopening Request was dated January 31, 2016. The reopening request referenced 42 C.F.R. § 412.106(b)(3), which indicates:

> [i]f a hospital prefers that CMS use its cost reporting period instead of the Federal fiscal year for the first computation (also referred to as the SSI ratio) of the hospital's disproportionate percentage, "it must furnish to CMS, through its intermediary, a written request . . . .

The Provider requested a recalculation of its SSI ratio based on its cost reporting period rather than the federal fiscal year.

Palestine's Notice of Reopening was dated February 24, 2016. According to the NOR, the Provider's 1/31/2016 request to recalculate the SSI percentage based on the fiscal year was forwarded to CMS.

Palestine's RNPR was dated July 25, 2017. The Provider referenced audit adjustments 4 and 5. Specifically, audit adjustment 4 was made to ". . . adjust the SSI percentage per CMS release" and audit adjustment 5 was ". . . to adjust allowable DSH."

Board Determination:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2015), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final contractor determination, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

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

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

Additionally, 42 C.F.R. § 405.1889 explains the effect of a cost report revision:

> (a) If a revision is made in a Secretary or contractor determination or a decision by a reviewing entity after the determination or decision is reopened as provided in §405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the provisions of §§ 405.1811, 405.1834, 405.1835, 405.1837, 405.1875, 405.1877 and 405.1885 of this subpart are applicable.
>
> (b)(1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.

> (2) Any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision.[3]

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

> (a) *Right to hearing on final contractor determination*.
> A provider . . . has a right to a Board hearing, as a single provider appeal, with respect to a final contractor or Secretary determination for the provider's cost reporting period, if -
>
> (1) The provider is dissatisfied with the contractor's final determination of the total amount of reimbursement due the provider, as set forth in the contractor's written notice specified under § 405.1803. **Exception**: If a final contractor determination is reopened under § 405.1885, **any review by the Board must be limited solely to those matters that are specifically revised in the contractor's revised final determination** (§§ 405.1887(d), 405.1889(b), and the "Exception" in § 405.1873(c)(2)(i)).
>
> (2) The amount in controversy (as determined in accordance with § 405.1839) must be $10,000 or more.
>
> (3) Unless the provider qualifies for a good cause extension under § 405.1836, the date of receipt by the Board of the provider's hearing request must be no later than 180 days after the date of receipt by the provider of the final contractor or Secretary determination.[4]

The Board has determined that it does not have jurisdiction over the SSI Fraction Dual Eligible Days issues that were appealed from the RNPRs for Parkview (Prov. No. 45-0400) and Palestine (Prov. No. 45-0747). The Board finds that the RNPRs for these two Providers were issued as a result of SSI Realignment requests, and the RNPRs did not adjust the SSI Fraction Dual Eligible Days issue.[5] Thus, the Providers do not have the right to appeal under 42 C.F.R. § 405.1889(b) as referenced in § 405.1835(a)(1).

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[3] 42 C.F.R. § 405.1889(b).
[4] (Emphasis added).
[5] It is noted that, in Hall Render's September 27, 2023 "Request to Expand a CIRP Group to Form a Multi-Year CIRP Group" filed in the subject group and Case No. 17-1500GC, Hall Render acknowledged that, if the Board agreed to the expansion of Case No. 7-1500GC to allow the transfer of Rockdale (the original NPR provider), the other two participants (i.e. the RNPR providers: Parkview and Palestine) would be withdrawn.

When a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[6] The reopenings for these Providers were a result of the Providers' requests to realign their SSI percentages from the federal fiscal year end to their individual cost reporting fiscal year ends. Based on the audit adjustments associated with the RNPR under appeal for each Provider, the revision to the SSI percentage was adjusted to realign it from a federal fiscal year to the providers' respective fiscal year. More specifically, the determinations were only reopened to include the realigned SSI percentage where the SSI percentage was realigned from the federal fiscal year to the providers' fiscal year, *and* the realignment process (as described in the Federal Register) does not change any of the underlying data that is gathered on a month-by-month basis since CMS does not rerun the data matching process in order to effectuate a realignment.[7] In other words, the determinations were only being reopened to include the realigned SSI percentages and CMS' realignment process (as described in the Federal Register) does ***not*** entail re-running of the data matching process (much less revise any of the Part C days included in the underlying month-by-month data).[8] Since the only matters specifically revised in the RNPRs for Parkview and Palestine were adjustments related to realigning the SSI percentages from federal fiscal year to the provider fiscal year, the respective Providers do not have a right to appeal under 42 C.F.R. §§ 405.1889(b) and 405.1835(a)(1) for the SSI Fraction Dual Eligible Days issues. 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.[9]

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[6] 42 C.F.R. § 405.1889(b)(1).

[7] CMS describes the matching process that it uses as part of the FY 2011 IPPS final rule published on August 16, 2010. *See* 75 Fed. Reg. 50042, 50275-85 (Aug. 16, 2010). However, CMS does not utilize or re-run the data match process when it issues a realigned SSI percentage. Rather, when CMS conducts the realignment process, all of the underlying data which has already been gathered on a month-by-month basis through that data matching process remains the same. The realigned SSI percentage simply reflects a different 12-month time period being used. *See* 42 C.F.R. § 412.106(b)(2) (noting that CMS gathers data on a month-by-month basis). 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 based on the provider's cost reporting period instead of the September 30 FFY. *See also* 75 Fed. Reg. 50042, 50279 (Aug. 16, 2010) (stating: "The SSI fractions are generally based on the Federal fiscal year; however, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived from the data match process for the two Federal fiscal years that spanned the hospital's cost reporting period.); 70 Fed. Reg. 47278, 47439 (Aug. 12, 2005) (stating: "Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period, and *the hospital* ***must accept*** *the resulting DSH percentage for that year, whether or not it is a more favorable number than the DSH percentage based on the Federal fiscal year*." (emphasis added)).

[8] *See supra* n. 8.

[9] *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 finds that it lacks jurisdiction over Parkview (Prov. No. 45-0400) and Palestine (Prov. No. 45-0747) that appealed from RNPRs because the issue under appeal in the group was not specifically revised in the RNPRs which were the basis for the respective Providers' appeals. 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 case.

The Board will issue a determination in response to Hall Render's request to expand the CY 2015 CIRP group under Case No. 17-1500GC to include CY 2009 and the consolidation of Rockdale under separate cover.

Board Members:

Clayton J. Nix, Esq.
Robert A. Evarts, Esq.
Kevin D. Smith, CPA
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For the Board:

9/28/2023

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Board Determination:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2015), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final contractor determination, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

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> (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 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.
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> (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.

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> (2) The amount in controversy (as determined in accordance with § 405.1839) must be $10,000 or more.
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> (3) Unless the provider qualifies for a good cause extension under § 405.1836, the date of receipt by the Board of the provider's hearing request must be no later than 180 days after the date of receipt by the provider of the final contractor or Secretary determination.[4]

The Board has determined that it does not have jurisdiction over the SSI Fraction Dual Eligible Days issues that were appealed from the RNPRs for Parkview (Prov. No. 45-0400) and Palestine (Prov. No. 45-0747). The Board finds that the RNPRs for these two Providers were issued as a result of SSI Realignment requests, and the RNPRs did not adjust the SSI Fraction Dual Eligible Days issue.[5] Thus, the Providers do not have the right to appeal under 42 C.F.R. § 405.1889(b) as referenced in § 405.1835(a)(1).

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[3] 42 C.F.R. § 405.1889(b).
[4] (Emphasis added).
[5] It is noted that, in Hall Render's September 27, 2023 "Request to Expand a CIRP Group to Form a Multi-Year CIRP Group" filed in the subject group and Case No. 17-1500GC, Hall Render acknowledged that, if the Board agreed to the expansion of Case No. 7-1500GC to allow the transfer of Rockdale (the original NPR provider), the other two participants (i.e. the RNPR providers: Parkview and Palestine) would be withdrawn.

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[6] 42 C.F.R. § 405.1889(b)(1).

[7] CMS describes the matching process that it uses as part of the FY 2011 IPPS final rule published on August 16, 2010. *See* 75 Fed. Reg. 50042, 50275-85 (Aug. 16, 2010). However, CMS does not utilize or re-run the data match process when it issues a realigned SSI percentage. Rather, when CMS conducts the realignment process, all of the underlying data which has already been gathered on a month-by-month basis through that data matching process remains the same. The realigned SSI percentage simply reflects a different 12-month time period being used. *See* 42 C.F.R. § 412.106(b)(2) (noting that CMS gathers data on a month-by-month basis). 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 based on the provider's cost reporting period instead of the September 30 FFY. *See also* 75 Fed. Reg. 50042, 50279 (Aug. 16, 2010) (stating: "The SSI fractions are generally based on the Federal fiscal year; however, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived from the data match process for the two Federal fiscal years that spanned the hospital's cost reporting period.); 70 Fed. Reg. 47278, 47439 (Aug. 12, 2005) (stating: "Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period, and *the hospital* ***must accept*** *the resulting DSH percentage for that year, whether or not it is a more favorable number than the DSH percentage based on the Federal fiscal year*." (emphasis added)).

[8] *See supra* n. 8.

[9] *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 finds that it lacks jurisdiction over Parkview (Prov. No. 45-0400) and Palestine (Prov. No. 45-0747) that appealed from RNPRs because the issue under appeal in the group was not specifically revised in the RNPRs which were the basis for the respective Providers' appeals. 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 case.

The Board will issue a determination in response to Hall Render's request to expand the CY 2015 CIRP group under Case No. 17-1500GC to include CY 2009 and the consolidation of Rockdale under separate cover.

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

Byron Lamprecht
WPS Government Health Administrators
2525 N 117th Avenue, Suite 200
Omaha, NE 68164

RE: ***Board Dismissal of SSI Percentage (Provider Specific) & Medicaid Eligible Days Issues***
Tennova Healthcare Cleveland (Provider No. 44-0185)
FYE 08/31/2015
Case No. 18-1103

Dear Mr. Summar and Mr. Lamprecht,

The Provider Reimbursement Review Board ("Board") has reviewed the documentation in the above referenced appeal. The decision of the Board is set forth below.

Background:

A. *Procedural History for Case No. 18-1103*

On September 27, 2017, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end August 31, 2015.

On March 22, 2018, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained five (5) issues:

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

As the Provider is owned by Community Health Systems, Inc. (hereinafter "CHS") and, thereby, subject to the mandatory Common Issue Related Party ("CIRP") group regulation at 42 C.F.R. § 405.1837(b)(1), the Provider transferred Issues 2, 4, and 5 to CHS groups on November 21, 2018. As a result, the remaining issues in this appeal are Issues 1 and 3.

[1] On June 14, 2019, this issue was transferred to PRRB Case No. 18-0552GC.
[2] On June 14, 2019, this issue was transferred to PRRB Case No. 18-0555GC.
[3] On June 14, 2019, this issue was transferred to PRRB Case No. 18-0554GC.

On April 12, 2018, the Medicare Contractor filed a jurisdictional challenge requesting dismissal of Issue 1 as a prohibited duplicate of Issue 2. Significantly, the Provider failed to file a response pursuant to Board Rule 44.4 (2015) which specifies that "[t]he responding party must file a response within 30 days of the Intermediary's jurisdictional challenge" and that "[f]ailure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

On November 23, 2018, the Provider filed its preliminary position paper and with respect to Issue 3 does not identify any specific Medicaid eligible days at issue but rather promised that "the Medicaid eligible days listing [was] being sent under separate cover." On March 13, 2019, the Medicare Contractor filed its preliminary position paper.

On January 6, 2023, the Medicare Contractor filed a Final Request for the Medicaid Eligible Days Listing in connection with Issue 3 and requested a response within 30 days. However, the Provider did not file any response in OH CDMS.

On July 3, 2023, the Medicare Contractor filed its Motion to Dismiss Issue 3 as the Provider failed to respond or make any filing. Significantly, CHS has not filed any response to the Medicare Contractor Motion to Dismiss which, per Board Rule 44.3 was due within 30 days.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 18-0552GC

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

> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> . . .
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[4]

As the Provider is commonly owned by CHS, the Provider transferred its Issue 2 – DSH – SSI Percentage to the CIRP group under 18-0552GC, QRS CHS 2015 DSH SSI Percentage CIRP Group, on November 21, 2018. The Group Issue Statement in Case No. 18-0552GC reads:

[4] Issue Statement at 1 (Mar. 21, 2018).

Statement of the Issue:

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

Statement of the Legal Basis

The Provider(s) contend(s) that the Lead MAC's determination of Medicare Reimbursement for their DSH payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww(d)(5)(F)(vi). The Provider(s) contend(s) that the SSI percentages calculated by [CMS] and used by the Lead MAC to settle their Cost Report(s) were incorrectly computed.

The Provider also contends that CMS inconsistently interprets the term "entitled" as it is used in the statute. CMS requires SSI payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the denominator. CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days of care) as Medicare Part A days, yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment.

The Provider(s) further contend(s) that the SSI percentages calculated by [CMS] fail to address all the deficiencies as described in *Baystate Medical Center v. Michael O. Leavitt*, 545 F. Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37, 44 (D.D.C. 2008) and incorporate a new methodology inconsistent with 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
6. Covered days vs. Total days[5]

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $43,000.

On November 19, 2018, the Provider filed its preliminary position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Provider Specific**
>
> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation.
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.
>
> Similar to Loma Linda Community Hospital v. Dept of Health and Human Services, No. CV-94- 0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records. However, at this time, the Provider has been unable to analyze the Medicare Part A data because it has not yet received the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR"), HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000 from CMS. *See* 65 Fed. Reg. 50,548 (2000). Upon release of the complete MEDPAR data, the Provider will seek to reconcile its' records with that of CMS, and identify patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS based on the Federal Fiscal Year End (September 30) when it determined the Provider's 551. See Baystate Medical Center v. Leavitt, 545 F. Supp. 2d 20 (D.D.C. 2008).[6]

C. Filings Concerning the Jurisdictional Challenge and Motion to Dismiss - MAC's Contentions

[5] Group Issue Statement, Case No. 18-0552GC.
[6] Provider's Preliminary Position Paper at 8-9 (November 19, 2018)

Issue 1 – DSH Payment/ SSI Percentage (Provider Specific)

The MAC argues that the Board lacks jurisdiction over the DSH – SSI Percentage (Provider Specific) issue for two reasons. First, the MAC argues that the appeal is premature:

> The decision to change the Medicare computation fiscal year end from federal fiscal year end to hospital fiscal year end is a provider election. The provider must send a written request to the intermediary and CMS requesting the change. The change can be made once per cost reporting period.
>
> . . .
>
> There is a distinction between a provider questioning the underlying validity of its SSI percentage (an appealable issue) and the realignment to its cost reporting period (a provider election). The provider cannot appeal the realignment of its SSI percentage or try to leverage its appeal regarding the validity of the SSI percentage by attempting to include realignment to its own fiscal year in a PRRB appeal before exhausting its available remedy of requesting CMS to recalculate the SSI ratio using their fiscal year end.[7]

In addition, the MAC argues the DSH – SSI Percentage (Provider Specific) issue and the DSH – SSI Percentage (Systemic Errors) issue are considered the same issue by the Board.[8]

Issue 3 – DSH Payment – Medicaid Eligible Days

In its July 4, 2023 Motion to Dismiss, the MAC argued that the Provider abandoned Issue 3, the DSH – Medicaid Eligible Days issue, because it has not submitted a list of the Medicaid eligible days at issue in this case and has not fully addressed the issue in its November 25, 2018 preliminary position paper in violation of Board Rule 25.3. The MAC notes that it specifically requested this listing from the Provider on 3 different dates: December 17, 2018; January 31, 2019; and January 6, 2023. However, the Provider never responded to those requests. The MAC then requested the Board make the following findings and Order the following:

a. That the Provider has failed to furnish documentation in supports of its claim for additional Medicaid Eligible Days or describe why such documentation was and continues to be unavailable.
b. That the Provider has made affirmative statements in its Preliminary Position Paper that it was submitting such supporting documentation to the MAC.

[7] Jurisdictional Challenge at 3-4 (Apr. 12, 2018).
[8] *Id*. at 2.

c. That the Provider's failure to furnish such documentation (or describe why such documentation is unavailable is in violation of PRRB Rules 7, 27.2, 25.2.1 and 25.2.2.[9]
d. That the Provider has effectively abandoned its claim for additional Medicaid Eligible Days.[10]

Accordingly, the MAC requested that the Board dismiss the Medicaid eligible days issue.

Board Analysis and Decision:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2018), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

A. DSH Payment/SSI Percentage (Provider Specific)

The Board is dismissing the DSH Payment/SSI Percentage (Provider Specific) issue, as discussed below. The analysis for Issue No. 1 has two relevant aspects to consider: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, and 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

1. First Aspect of Issue 1

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH – SSI Percentage (Systemic Errors) issue that was appealed in PRRB Case No. 18-0552GC.

The Board finds that the first aspect of Issue 1 (the DSH/SSI (Provider Specific) issue) in this appeal is duplicative of the DSH/SSI (Systemic Errors) issue that was directly filed into Case No. 18-0552GC. The first aspect of Issue 1 in the present appeal concerns "whether the [MAC] used the correct [SSI] percentage in the [DSH] Calculation."[11] The Provider's legal basis for this aspect of Issue 1 is simply that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[12] Similarly, the Provider argues that "it[s] SSI percentage published by [CMS] was incorrectly computed . . ." and it ". . . disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[13] The DSH

[9] PRRB Rules v. 2.0 (Aug. 2018).
[10] Motion to Dismiss at 5 (July 3, 2023)
[11] Individual Appeal Request, Issue 1.
[12] *Id.*
[13] *Id.*

systemic issues filed into Case No. 18-0552GC, similarly alleges that the Medicare Contractor and CMS improperly calculated the DSH/SSI Percentage, the DSH/SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F).

Thus, the Board finds that the first aspect of Issue 1 in this appeal is duplicative of the group issue in Case No. 18-0552GC, for this same provider and fiscal year. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (Mar. 1, 2013), the Board dismisses this aspect of the DSH/SSI (Provider Specific) issue.

In making this finding, the Board further notes that CMS regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, is pursuing that issue as part of the group under Case No. 18-0552GC. 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) in its appeal request of how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 18-0552GC.

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 18-0552GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. For example, it alleges that "SSI entitlement of individuals can be ascertained from State records" but fails to explain how it can, explain how that information is relevant, and whether such a review was done for purposes of the year in question.[15] Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with the Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" in its Preliminary Position Paper and include *all* exhibits.

The Board further notes that the Provider only cites to the 2000 Federal Register but additional issuances and developments on the availability of data underlying the SSI fraction, such

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[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] It is also not clear whether this is a systemic issue for CHS providers in the same state subject to the CIRP rules or something that is provider specific. The Provider fails to comply with its obligation under 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rules to fully brief the merits of its issue.

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

> https://www.cms.gov/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh.[16] This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows: "DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[17]

Accordingly, *based on the record before it*,[18] the Board finds that the remaining issue in the instant appeal and the group issue from Group Case 18-0552GC are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue. As an alternative basis the Board dismisses Issue 1 for failure of the Provider to properly brief the issue in its position paper in compliance with Board Rules.

2. Second Aspect of Issue 1

The second aspect of the DSH Payment/SSI Percentage (Provider Specific) issue—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—is dismissed by the Board.

The Board finds that, under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." Without this written request, the Medicare Contractor cannot issue a final determination from which the Provider can be dissatisfied with for appealing purposes. There is nothing in the record to

[16] Last accessed September 6, 2023
[17] Emphasis added.
[18] Again, the Board notes that the Provider failed to respond to the jurisdictional challenge and, per Board Rule 44.4 (2015), the Board must rule based on the record before it.

indicate the Medicare Contractor has made a final determination regarding DSH SSI Percentage realignment. Therefore, the Board finds that it lacks jurisdiction in this aspect of the appeal.

B. DSH Payment – Medicaid Eligible Days

According to its Appeal Request, the Provider asserts that all Medicaid eligible days were not included in the calculations of the DSH calculation. The Provider states Issue 3 as:

> **Statement of the Issue**
>
> Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.
>
> **Statement of the Legal Basis**
>
> The Provider contends that the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.
>
> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.[19]

The Provider failed to include a list of additional Medicaid eligible days they expect to be included in their Medicaid percentage and DSH computations, with their appeal request.

The Provider's preliminary position paper indicated that it would be sending the eligibility listing under separate cover.[20]

Board Rule 7.2 B (July 1, 2015) states:

> **No Access to Data**
>
> If the Provider elects not to claim an item on the cost report because, through no fault of its own, it did not have access to the underlying information to determine whether it was entitled to payment, describe the circumstances why the underlying information was unavailable upon the filing of the cost report.

[19] Individual Appeal Request, Issue 3.
[20] Provider's Preliminary Position Paper at 8.

Moreover, the Provider neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2.

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

42 C.F.R. § 405.1853 addresses position papers and specifies in pertinent part:

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. *Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board through a schedule applicable to a specific case or through general instructions*.[22]

With regard to the filing of an individual appeal, Board Rule 7 (Support for Appealed Final Determination, Issue-Related Information and Claim of Dissatisfaction) (Jul. 2015) 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,[23] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[24] This requirement is consistent with 42 C.F.R. § 405.1853(b)(3).

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

[22] (Emphasis added).

[23] The minimum requirements for Final Position Paper narratives and exhibits is the same as those for Preliminary Position Papers. *See* Board Rule 27.2.

[24] (Emphasis added).

Similarly, consistent with that regulation, Board Rule 25.2.2 provides the following instruction on the content of position papers as it relates to unavailable documentation/exhibits:

> *If documents necessary to support your position are still unavailable,* 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 opposing party.[25]

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.

As stated by the MAC and uncontested by the Provider, when the Provider filed their preliminary position paper it promised that it would be sending the eligibility listing under separate cover. The position paper did not identify how many Medicaid eligible days remained in dispute in this case. While the "Estimated Impact" filed with their appeal notes a net impact of $67,000 based on a generic "estimated" 150-day increase in days, it is unclear whether this amount continues to be in

[25] (Emphasis added).

dispute as of the Provider's filing of the position paper since the Provider failed to identify any specific days at issue in the position paper filing. Moreover, the MAC asserts that the Provider neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2.

Notably, the Provider has not included a list of additional Medicaid eligible days with its preliminary position paper or submitted such list under separate cover even after the MAC submitted a follow up request for the listing on January 6, 2023 in OH CDMS and failing to respond to numerous requests. The MAC thus asserts that the Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it cannot produce those documents, as required by the regulations and the Board Rules.[26]

The Board concurs with the Medicare Contractor that the Provider is required to identify and provide documentation to prove what additional Medicaid Eligible days are at issue and to which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rule 25. Further, pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[27] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. Based on the record before the Board, the Board finds that the Provider has failed to provide a listing or other supporting documentation for the Medicaid Eligible Days issue as required by the controlling regulations and Board Rules. Nor has the Provider provided any explanation as to why the documentation was absent or what is being done to obtain it consistent with Board Rule 25.2.2. Indeed, without any days identified in the position paper filing, the Board must assume that there are no actual days in dispute or that the amount in dispute is $0 for this issue.

Further, pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[28] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. The Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of Board Rules 25.2.1 and 25.2.2 related to identifying the days in dispute and the submission of documentary evidence required to support its claims or describe why said evidence is unavailable, which the Provider has failed to do.[29]

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

The Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of Board Rules 25.2.1 and 25.2.2 and 42 C.F.R. §§ 412.106(b)(iii) and 405.1853(b)(2)-(3) related to identifying the days in dispute and the submission of documentary evidence required to support its claims or describe why said evidence is unavailable, which the Provider has failed to do. The Board takes administrative notice that it has made similar dismissal in other cases involving CHS providers.[30] Notwithstanding, CHS failed to include the Medicaid eligible days listing with its preliminary position paper or even file a copy following the MAC's Motion to Dismiss.

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In summary, the Board hereby dismisses the DSH Payment/SSI Percentage (Provider Specific) issue from this appeal as it is duplicative of the issue in Case No. 18-0552GC and there is no final determination from which the Provider can appeal the SSI realignment portion of the issue and the Provider failed to meet the Board requirements for position papers.

The Board also dismisses Issue 3, DSH Medicaid Eligible Days, as the Provider has failed to meet the Board requirements for position papers for this issue relative to developing the merits of its case and filing supporting exhibits as required under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)- (3) and Board Rules 27.2 and 25. Nor has the Provider provided any timely explanation to the MAC as to why the documentation was absent or what is being done to obtain it, notwithstanding a second request for the documentation and a follow-up Motion to Dismiss for failure to reply.

Further, the Board takes administrative notice that it has made similar dismissal in other cases in which CHS was the designated representative and, notwithstanding, CHS failed to provide the Medicaid eligible days listing with its preliminary position paper or after numerous requests.[31]

As no issues remain pending, the Board hereby closes Case No. 18-1103 and removes it from the Board's docket. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

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[30] *See also* Note 29.

[31] Examples of CHS individual provider cases which the Board dismissed for failure of the Provider to provide a listing of Medicaid eligible days include, but are not limited to: Case No. 22-0676 (dismissed by Board letter dated December 7, 2022 based on a MAC July 13, 2022 request for dismissal of the Medicaid eligible days issue for failure to file Medicaid eligible days listing with the preliminary position paper); Case No. 21-0317 (dismissed by Board letter dated April 3, 2023 based on a October 12, 2021 final position paper request citing the Provider's failure to file the Medicaid eligible days listing with the preliminary position paper or under separate cover; Case No. 18-0283 (dismissed by Board letter dated March 28, 2023 based on a MAC January 9, 2023 request for dismissal of the Medicaid eligible days issue for failure to file Medicaid eligible days listing with the preliminary position paper); and Case No. 19-0650 (dismissed by Board letter dated August 21, 2023 based on a MAC July 3, 2023 request for dismissal of the Medicaid eligible days issue for failure to file Medicaid eligible days listing with the preliminary position paper).

Board Members Participating:

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

For the Board:

9/28/2023

X Clayton J. Nix

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

James Ravindran
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RE: ***Board Decision* – DSH Payment/SSI Percentage (Provider Specific)**
McKenzie-Willamette Medical Center (Provider Number 38-0020)
FYE: 12/31/2015
Case Number: 19-0953

Dear Mr. Ravindran,

The Provider Reimbursement Review Board ("Board") has reviewed the documentation in the above referenced appeal. The decision of the Board with regard to the DSH Payment/SSI Percentage (Provider Specific) issue is set forth below.

Background:

Procedural History for Case No. 19-0953

On July 20, 2018, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end December 31, 2015.

On January 3, 2019, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained six (6) issues:

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

As the Provider is owned by Quorum Health and, thereby, subject to the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1), the Provider transferred Issues 2, 4, and 5 to Quorum

[1] On August 23, 2019, this issue was transferred to PRRB Case No. 18-1333GC.
[2] This issue was withdrawn on September 15, 2023.
[3] On August 23, 2019, this issue was transferred to PRRB Case No. 18-0594GC.
[4] On August 23, 2019, this issue was transferred to PRRB Case No. 18-0595GC.
[5] This issue was withdrawn on September 26, 2023.

Health CIRP groups on August 23, 2019. After withdrawals, Issue 1 is the only remaining issue on appeal.

On August 26, 2019, the Provider filed its preliminary position paper. On December 10, 2019, the Medicare Contractor filed its preliminary position paper.

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

> The Provider contends that its SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> . . .
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[6]

On August 26, 2019, the Provider filed its preliminary position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

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

[6] Issue Statement at 1 (Jan. 3, 2019).

> in the Federal Register on August 18, 2000 from CMS. *See* 65 Fed. Reg. 50,548 (2000). Upon release of the complete MEDPAR data, the Provider will seek to reconcile its' records with that of CMS, and identify patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS based on the Federal Fiscal Year End (September 30) when it determined the Provider's SSI. *See Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).[7]

Board Analysis and Decision:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2018), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

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

1. *First Aspect of Issue 1*

The Board finds that the Provider's Preliminary Position Paper failed to comply with Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers.

In making this finding, the Board notes that CMS regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and the Provider has failed to explain how this argument is ***specific to this provider***, as the issue statement asserts. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[8] Provider's reliance upon 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 are specific to this provider.

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1 and finds that the Provider's Preliminary Position Paper failed to comply with the Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers.

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[7] Provider's Preliminary Position Paper at 8-9 (Aug. 26, 2019).

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

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

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

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

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

https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH.[9]

This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows: "DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[10]

Accordingly, the Board must find that the Provider failed to properly brief the issue in its position paper in compliance with Board Rules.

2. Second Aspect of Issue 1

The second aspect of the DSH SSI Percentage (Provider Specific) issue—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—must be dismissed as premature. Under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request…" Without this written request, the Medicare Contractor cannot issue a final determination with which the Provider can be dissatisfied for appeal purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding the Provider's DSH SSI Percentage realignment and, as such, there is no "determination" to appeal and the appeal of this issue is therefore premature.

Conclusion:

The Board dismisses Issue 1, the DSH Payment/SSI Percentage (Provider Specific) issue, in its entirety from this appeal. As there are no remaining issues on appeal, the case is 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 upon final disposition of the appeal.

[9] Last accessed February 24, 2023.
[10] Emphasis added.

Board Members Participating:

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For the Board:

9/28/2023

X Kevin D. Smith, CPA

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Board Member
Signed by: Kevin D. Smith -A

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Jurisdictional Decision in Whole***
Swedish Medical Center (Prov. No. 50-0027, FYE 12/31/2005)
Case No. 20-0061

Dear Mr. Ravindran and Mr. Lamprecht,

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above-referenced appeal for Swedish Medical Center ("Provider") in response to the MAC's Jurisdictional Challenge of Part C Days issues. The Board's decision is set forth below.

Background:

On September 30, 2019, the Provider filed its Request for Hearing, relating to a *revised* notice of program reimbursement ("revised NPR") dated April 18, 2019.[1] The original cost report was reopened by the MAC in accordance with the Board's remand pursuant to CMS Ruling 1498-R. The provider's appeal request contained the following two issues relating to the disproportionate share hospital ("DSH") adjustment:

Issue 1: DSH – Medicaid Fraction/Medicare Managed Care Part C Days; and
Issue 2: DSH – Medicaid Fraction/Dual eligible Days.[2]

The Medicare Administrative Contractor ("MAC") filed a formal jurisdictional challenge on December 16, 2019, the MAC contends that the Board does not have jurisdiction over either issue because the Medicaid fraction was not adjusted for the MACs revised determination – i.e., the Notice of Correction of Program Reimbursement ("revised NPR"). Accordingly, the PRRB does not have jurisdiction over the issues pursuant to 42 C.F.R. § 405.1887(d) and 42 C.F.R. § 405.1889. As such, the MAC requests that the Board dismiss the issues.

[1] Provider's Request for Appeal (Sep. 30, 2019), PRRB Case No. 20-0061.
[2] *Id.* at Tab 3 (Issue Statement).

Medicare Contractor's Jurisdictional Challenge

The MAC asserts that it did not make an adjustment to Medicaid days on the revised cost report.[3]

The Notice of Reopening was issued pursuant to the Board's remand due to CMS ruling 1498-R, which will "will result in a Revised Notice of program reimbursement that will adjust the SSI ratio from the original .0727 to the agreed upon .0733, which will impact the Disproportionate Share Hospital (DSH) Payment."[4]

The revised NPR did not adjust the Medicaid fraction portion of the disproportionate share payment. In accordance with 42 C.F.R. § 405.1835:

> A provider (but no other individual, entity, or party) has a right to a Board hearing, as a single provider appeal, for specific items claimed for a cost reporting period covered by an intermediary or Secretary determination .... (Emphasis added.)

For both issues under appeal, the Provider points to Audit Adjustment Nos. 5 and 6 as the source of its dissatisfaction and both issues are related to the first computation – *i.e.*, the SSI/Medicare fraction.

Adjustment 5 was proposed "To adjust the cost report to include the SSI Percentage from the TDL Spreadsheet." In this adjustment the MAC increased the percentage of SSI Recipient Days to Medicare Part A patient days from 7.27 to 7.33 (reported on Worksheet E, Part A, line 4.00 and Worksheet L, line 5.00).

Adjustment 6 was proposed "To adjust the Hospital DSH payment percentage to incorporate the SSI Percentage from the TDL Spreadsheet." In this adjustment the MAC increased the allowable DSH Percentage from 13.02 to 13.07 (reported on Worksheet E, Part A, line 4.03).[5]

The adjustments proposed by the MAC (i.e., adjustments 5 and 6) solely impact the Medicare fraction. The adjustments proposed by the MAC did not exclude Part C days or dual eligible Part A days from the Medicaid fraction for the *revised* NPR. Accordingly, the Board does not have jurisdiction over either issue in this case pursuant to 42 C.F.R. § 405.1887(d) and 42 C.F.R. § 405.1889.[6]

Provider's Jurisdictional Response

The Provider filed a response to the MAC's Jurisdictional Challenge on January 7, 2020. The Provider argues that 42 C.F.R. § 405.1835 states that hospitals that are paid under the prospective payment system are entitled to hearings before the Board under this section if: 1) An

[3] MAC's Jurisdictional Challenge, at 4 (Dec. 16, 2019).
[4] *Id*.
[5] *Id*.
[6] *Id*.

intermediary determination has been made with respect to the provider; 2) The provider has filed a written request for a hearing before the Board; and 3) The amount in controversy is $10,000 or more.[7]

MAC adjustment numbers 5 and 6 revised lines 4, and 4.03 on Worksheet E Part A. These lines then impacted the providers' Medicare disproportionate share payment amount found on line 4.04 of Worksheet E Part A.

They continue, arguing that the Provider protected their appeal rights within the 180 days of the Revised NPR dated April 18, 2019, by filing appeals dated September 26, 2019. The provider is dissatisfied with the final determination of the MAC with respect to the SSI issue. The reimbursement impact of the adjustments made by the MAC amounted to $36,646. This amount controversy exceeds the $10,000 threshold. Therefore, the Board has jurisdiction to hear this case, and the Provider argues that all of the jurisdictional requirements have been met.

The Provider further argues that the Ruling 1498-R remand of the underlying appeal required the MAC to utilize CMS' revised SSI percentage based upon the Secretary's revised interpretation of the term "entitled" to benefits under part A which became effective October 1, 2004. The Secretary's revised interpretation of this term eliminated the word 'covered' from 42 CFR 412.106. But, this change in the Medicare disproportionate share regulation however has been vacated by the courts in the *Allina* decisions.[8]

The Provider contends that the Medicare statute at 42 U.S.C. § 1395ww(d)(5)(F)(vi) makes it clear that all patient days of the hospital must be included in either the Medicaid fraction or the SSI fraction of the Medicare disproportionate share payment formula. If all days must be included in either the Medicaid fraction or the SSI fraction, and if days that are not 'covered' by Medicare Part A should not be included in the SSI fraction, these days must be included in the Medicaid fraction. For this reason, the Provider take the position that the Board has jurisdiction over the issues being challenged by the MAC.[9]

Board's Analysis and Decision

The Code of Federal Regulations provides for an opportunity reopening of an NPR and issuance of a revised NPR. 42 C.F.R. § 405.1885 (2011) 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) of this subpart) may be reopened, for 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

[7] Provider's Jurisdictional Challenge Response, at 2 (Jan. 7, 2020).
[8] *Id*.
[9] *Id*.

> that made the decision (as described in § 405.1885(c) of this subpart).

42 C.F.R. § 405.1889 (2011) explains the effect of a cost report revision as well as the scope of the appeal rights associated with that 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 42 C.F.R. §§ 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.

Finally, 42 C.F.R. § 405.1835(a)(1) specifical:

> 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)).

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[.]"[10] In this case, the issue statements in the appeal request for the Part C days and dual eligible Part A days issue are:

Issue 1: "Whether HMO / Medicare Plus Choice / Medicare Managed Care / Medicare Part C / Medicare Advantage ("M4") Days were properly accounted for in the Disproportionate Share Hospital ("DSH") calculation."

Issue 2: "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

[10] 42 C.F.R. § 405.1889(b)(1).

> eligible for both Medicare and Medicaid where Medicare Part A did not make a payment."[11]

The Medicare Contractor contends that the Board does not have jurisdiction over either issue because the *Medicaid* fraction was not adjusted for the MACs revised determination.

Per the 2014 holding of the D.C. Circuit in *Allina Health Servs. v. Sebelius* (746 F.3d 1102, 1108 (D.C. Cir. 2014)) ("*Allina*"),[12] the DSH statute at 42 U.S.C. § 1395ww(d)(5)(F)(vi) "*unambiguously requires*" that Part C days be included in either the SSI fraction or Medicaid fraction.[13] This holding is controlling precedent for the interpretation of 42 U.S.C. § 1395ww(r)(3) because the Providers could bring suit in the D.C. Circuit.[14] Thus, the disposition of the DSH Part C Days – Medicare/SSI Fraction issue dictates the disposition of the DSH Part C Days – Medicaid Fraction issue, as *Allina* indicates Part C days must be counted in one fraction or the other. As such, the Board finds that it has jurisdiction over Issue 1: Medicaid Fraction/Medicare Managed Care Part C Days as the *revised* NPR was to adjust the SSI fraction for Part C Days under CMS Ruling 1498-R which included Part C days in the SSI fraction. Pursuant to Allina, if the Part C days were included in the Medicare fraction, they would be excluded from the Medicaid fraction. Additionally, the Board also finds that Issue 1 is subject to CMS Ruling 1739-R and will address the remand of this issue under separate cover.

The Board finds it lacks jurisdiction over Issue 2: Medicaid Fraction/ Dual Eligible Days because Dual Eligible days in the Medicaid fraction were not covered by the revised NPR as no adjustment was made *to the Medicaid fraction* has no bearing on their inclusion in the Medicaid fraction. To this end the "estimated impact" analysis for Issue 2 included in the appeal request, only estimates reimbursement impact of $14,391 as it relates *to the Medicaid fraction*.[15] The Provider has failed to document that the Medicaid Fraction/Dual Eligible Days issue meets the requirement of 42 C.F.R. § 405.1889. Issue Number 2 is therefore dismissed. The Board also notes that, per 42 C.F.R. § 405.1835(b)(2), an appeal request must include information on each specific item under appeal to explain why, and describe how, the provider is dissatisfied with the

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[1111] (Emphasis added.)
[12] 746 F.3d 1102, 1108 (D.C. Cir. 2014).
[13] Specifically, *Allina* states "the statute unambiguously requires that Part C days be counted in one fraction or the other (a Part C-enrolled individual is either eligible for Medicare Part A, or not)." 746 F.3d at 1108.
[14] The CMS Administrator generally has applied as controlling precedent the law of the Circuit in which the Provider is located. *See, e.g., QRS CHW DSH Labor room Days Groups v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (Apr. 13, 2009), affirming, PRRB Dec. No. 2009-D11 (Feb. 27, 2009); *St. Vincent Mercy Med. Ctr. v. BlueCross BlueShield Ass'n*, Adm'r Dec. (Nov. 17, 2008), *affirming in part and reversing in part*, PRRB Dec. No. 2008-D35 (Sept. 15, 2008). However, in recognizing that providers may file suit with the appropriate District Court either in the Circuit in which they are located or the D.C. Circuit, the Administrator also applies as controlling precedent the law of the D.C. Circuit. *See, e.g., Jordan Hosp. v. Blue Cross Blue Shield Ass'n.*, Adm'r Dec. (Apr. 30, 2007), *vacating*, PRRB Dec. No. 2007-D23 (Feb. 28, 2007).
[15] The Board takes administrative notice that, unlike Part C days, it has found that challenging the inclusion of no-pay Dual Eligible days in the SSI fraction is a separate legal question as highlighted by the fact that the Board requires parties to set up separate groups for the SSI fraction and the Medicaid fraction when a group of provider raises ***both*** issues with the SSI fraction and with the Medicaid fraction. In this respect, the Board takes administrative notice that providers do not always raise issues with both fraction but sometimes only with respect to one of the fractions (i.e., SSI or Medicaid fraction).

specific aspects of the determination at issue, including: "[w]hy the provider believes Medicare payment is incorrect for each disputed item"; "[h]ow and why the provider believes Medicare payment must be determined differently for each disputed item" and "an explanation of the nature and amount of each self-disallowed item, the reimbursement sought for the item, and why the provider self-disallowed the item instead of claiming reimbursement for the item."

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:

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For the Board:

9/29/2023

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services

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RE: ***Determination on Reopening Status of Fully Formed CIRP Group***
Case No. 21-1585GC – Baptist Health Sys. CY 2016 DSH SSI/Medicaid Dual Elig. Days CIRP
Specifically to transfer: Baptist Med. Ctr. Jacksonville (Prov. No. 10-0088, FYE 9/30/2016)
From Case No. 21-0847

Dear Mr. Ravindran and Mr. Pike:

The Provider Reimbursement Review Board (the "Board") is in receipt of correspondence from Quality Reimbursement Services, Inc. ("QRS" or "Group Representative") dated March 23, 2023, in which QRS requests that the Board reopen the status of the subject fully formed common issue related party ("CIRP") group for Baptish Health System ("BHS").[1] According to QRS, the **BHS** CIRP group was "inadvertently" designated to be complete prior to Baptist Medical Center Jacksonville ("BMC Jacksonville") being transferred. QRS indicates BMC Jacksonville is the only remaining member of BHS appealing the DSH SSI/Medicaid Dual Eligible Days for calendar year ("CY") 2016.[2]

Board Determination:

The regulation at 42 C.F.R. § 405.1837(b)(1), requires that commonly owned or controlled providers file group appeals for each common issue of fact, law or rulings (*i.e.*, file common issue related party group appeals ("CIRPs")). *See also* Board Rules 12 and 13 regarding the formation of group appeals (https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/PRRB- Instructions.html). Accordingly, BHS is subject to § 405.1837(b)(1) and must pursue, *in a CIRP group,* any issue that is common to BHS providers for a particular year.

Pursuant to 42 C.F.R. § 405.1837(e)(1), once a CIRP group is fully formed (*as it was here*), no other commonly owned/controlled provider may pursue the CIRP group issue for that year, *absent an order from the Board to reopen that group to permit an additional participant(s) to join the group*:

[1] Case No. 21-1585GC was designated to be fully formed on June 2, 2022, the same date the Providers file a request for expedited judicial review ("EJR").
[2] The Board notes that in its individual appeal, Case No. 21-0847, BMC Jacksonville included the Dual Eligible Days issue as 3 separate issues: Issue #5: Exhausted Medicare Benefits Medicaid Dual Eligible Days; Issue #6: DSH – No Pay Part A Days; and Issue #23: Charged vs. Covered Days (Empire Case). QRS is requesting the transfer of all 3 issues to Case No. 21-1585GC.

> When the Board has determined that a group appeal brought under paragraph (b)(1) of this section is fully formed, *absent an order from the Board modifying its determination*, ***no other provider*** under common ownership or control ***may appeal*** to the Board ***the issue*** that is the subject of the group appeal with respect to a cost reporting period that falls within the calendar year(s) covered by the group appeal.

Accordingly, once a group representative certifies that a CIRP group is fully formed/complete ***and*** then *later* requests joinder of an additional provider to the "fully formed" CIRP group, the Board may exercise its discretion on whether or not to reopen the CIRP group to allow the additional participant. Given that the Board may decline to exercise its discretion to reopen fully-formed CIRP group, *a group representative for a health care system should exercise diligence and care before certifying (on behalf of that health care system) a CIRP group is fully formed and ensure that,* ***prior to*** *making that certification, it both: (a) reviews OH CDMS and its records;* ***and*** *(b) consults with the health care chain*.

As set forth below, the Board has considered the facts in the subject BHS CIRP group case ***denies*** QRS' request to reopen the status of the fully formed CIRP group, Case No. 21-1585GC to allow the transfer of BMC Jacksonville from Case No. 21-0847.

QRS claims it "inadvertently" designated Case No. 21-1585GC to be fully formed on June 2, 2022. However, ***on the same day***, QRS then proceeded to file a request for EJR *and* then, ***only one day later***, on June 3, 2022, QRS proceeded to file litigation in U.S. District Court for the District of Columbia[3] to pursue the merits of their EJR request *without notice to the Board and without a Board ruling on its EJR request*. QRS' fault for its failure to transfer BMC Jacksonville to the subject BHS CIRP group is further highlighted by the facts that: (1) at the time QRS designated the BHS CIRP group to be complete, BMC Jacksonville's individual appeal under Case No. 21-0847 had been pending *for more than a year* (since February 25, 2021); and (2) QRS was well aware that BMC Jacksonville was part of the Baptist Health System ("BHS") as the same provider had been included in other QRS **BHS** CIRP groups.

In its request to reopen the status of the BHS CIRP group, QRS admits that its failure to timely transfer BMC Jacksonville to the BHS CIRP group was an "inadvertent[]" error. Nonetheless, once the BHS CIRP group was designated to be fully formed, QRS effectively *waived* its right to add additional BHS providers to the BHS CIRP group. Furthermore, as noted above, the Board is aware that QRS' filed a Complaint in federal district court ***only one day*** after it had certified the BHS CIRP group was fully formed *and* filed the EJR Request. The regulation at 42 C.F.R. § 405.1842(h)(3) addresses how Provider lawsuits relating to an EJR request affect Board proceedings:

> (3) *Provider lawsuits*. (i) If the provider files a lawsuit seeking judicial review (whether on the basis of the EJR provisions of section 1878(f)(1) of the Act or on some other basis) pertaining to a

[3] *Kings Mountain Hosp. v. Becerra*, Case No. 1:22CV01582 (D.D.C., filed June 3, 2022).

> 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.[4]

This regulation makes clear that the Board is prohibited from taken any further proceedings in Case No. 21-1585GC due to the Providers' lawsuit. Accordingly, the Board **denies** the request to reopen Case No. 21-1585GC due to the § 405.1842(h)(3)(iii) bar on further Board proceedings.

Regardless, even if the Board could act in this case, the Board would still **decline** exercising discretion under 42 C.F.R. § 405.1837(e)(1) to reopen the status of the case because QRS committed clear administrative error in certifying the group was complete and then on the same requesting EJR and then filing its lawsuit the next day in Federal Court. Indeed, the Board is *astonished* that QRS' request to reopen the status of Case No. 21-1585GC failed to discuss or even recognize that it already requested EJR in this case and is pursuing litigation on this case in federal court. It suggests that QRS failed to properly manage both the BHS CIRP group as well as the individual appeal for BMC Jacksonville. *Again, as noted above, a group representative for a health care system should exercise diligence and care before certifying (on behalf of that health care system) a CIRP group is fully formed and ensure that,* ***prior to*** *making that certification, it both: (a) reviews OH CDMS and its records;* ***and*** *(b) consults with the health care chain*.

Finally, in accordance with the CIRP rules discussed herein, because BMC Jacksonville is not permitted to be transferred to the BHS CRIP Group under Case No. 21-1585GC entitled "Baptist Health System CY 2016 DSH SSI/Medicaid Dual Eligible Days CIRP group," the Board is dismissing the following three (3) Dual Eligible Days issues from BMC Jacksonville's individual appeal under Case No. 21-0847:

> Issue #5: Exhausted Medicare Benefits Medicaid Dual Eligible Days;
> Issue #6: DSH – No Pay Part A Days; and
> Issue #23: Charged vs. Covered Days (Empire Case).

The Board is dismissing the above three issues from BMC Jacksonville's individual appeal because the BHS appealed Case No. 21-1585GC to D.C. District Court and *has requested adjudication on the merits of these 3 issues* in the lawsuit filed with that Court. Thus, to the extent BMC Jacksonville wished to pursue these common issues it needed to do so as part of the

[4] (Emphasis added.)

BHS CIRP group appeal under 21-1585GC; however, QRS failed to do so. Pursuant to 42 C.F.R. §§ 405.1837(b)(1) and (e)(1), a BMC hospital may ***not*** *separately*[5] pursue an issue that is already being pursued by BMC for the same year in a CIRP group appeal. Accordingly, since the three FY 2016 issues are being pursued in federal court via the appeal of the 2016 CIRP group under Case No. 21-1585GC,[6] the Board hereby **dismisses** these three issues from Case No. 21-0847 pursuant to 42 C.F.R. §§ 405.1837(b)(1) and (e)(1).

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

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

For the Board:

9/29/2023

X Clayton J. Nix

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

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services
Shaw Seely, Baptist Health System

[5] Whether as part of a different group (CIRP or optional) or in an individual appeal.
[6] In light of the Provider's lawsuit and 42 C.F.R. § 405.1842(h)(3), the Board is concurrently issuing a letter closing the BHS CIRP group under Case No. 21-1585GC and detailing the basis for that closure.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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RE: ***Closure of Group Appeals Pursuant to 42 C.F.R. § 405.1842(h)(3)(iii)***
Case No. 13-3814GC *et al.* (*see* Attached listing marked as Appendix A)

Dear Messrs. Ravindran and Berends:

As the parties are aware, Quality Reimbursement Services, Inc. ("QRS" or "Group Representative"), the Providers' designated representative, filed a *consolidated* request for expedited judicial review ("EJR") on May 26, 2022 involving, in the aggregate, 14 group cases and seventy-three (73) participants. As discussed in further detail *infra*, the Group Representative filed a complaint in the U.S. District Court for the District of Columbia ("D.C. District Court") on May 27, 2022,[1] ***one day after the EJR request was filed with the Board***.

Due to the fact that the groups were formed in late May 2022 and the MAC normally has 60 days following full formation to review for potential jurisdictional challenges (per Board Rule 22), Federal Specialized Services ("FSS"), the Medicare Contractors' representative, filed a request on May 31, 2022 to extend by 60 days the time permitted under Board Rules to review those cases. QRS did *not* file any opposition to FSS' extension request.

On June 17, 2022, the Board issued its first Scheduling Order ("First Scheduling Order") for all 14 group cases in the consolidated EJR request. The First Scheduling Order:

1. Extended the time for FFS to file its response to the EJR request until July 25, 2022.
2. Required FSS' response to include any jurisdictional and/or substantive claim challenges.
3. Required that the Providers file their response by August 25, 2022.
4. Required the Parties' filings address the following issues:

    a. "[A]ddress whether Case Nos. 16-0607GC and 17-0952GC respectively are prohibited duplicates of the Providence CIRP groups for 2013 and 2014 under Case Nos. 16-0605GC and 17-0950GC respectively, for which the Board granted EJR on September 30, 2020."[2]

[1] *Kings Mountain Hosp. v. Becerra*, Case No. 1:22CV01582 (D.D.C., filed June 3, 2022).
[2] In addition, the First Scheduling Order specified: "Both parties should brief as to why the Board should not dismiss the open appeals as duplicative and, if not, whether the EJR request, as currently draft remains applicable to Case Nos. 16-0607GC and 17-0952GC. In their response, the Providers must include, from Case Nos. 16-0607GC and 17-0952GC, a copy of the group issue statement, the September 30, 2020 EJR determination, as well as any

b. "[A]ddress the Board's jurisdiction over Case No. 15-0560GC and whether the portion of that CIRP group that pertains to CY 2007 is a prohibited duplicate of the University of Washington CIRP group for 2007 under Case No. 10-1325GC" and required "the Providers [to] include, from Case No. 10-1325GC, a copy of the group issue statement and August 22, 2016 EJR determination as well as any other relevant documents in support of their position"[3]

c. "[I]dentify the group issue statement for Case Nos. 15-0560GC and 15-0561GC and whether the EJR request falls outside the scope of the group issue statement for those cases" and required "[t]he Providers in their response must include a copy of the group issue statement from Case No. 09-0271GC and any other relevant documentation in support of their position" since the 2 CIRP groups were formed based on bifurcation from Case No. 09-0271GC.[4]

The Scheduling Order further notified the parties that the 30-day period for the Board to rule on an EJR request had not begun and that the Board would notify them when it did begin:

> [A]s jurisdiction is a prerequisite to consideration of an EJR request, this Scheduling Order necessarily affects the 30-day period for the Board's determination of authority required to decide the EJR request. Specifically, this Scheduling Order, "confirm[s] . . . that the 30-day period for the Board to rule on the EJR request has been stayed because the EJR request is incomplete and the Board does not yet have all the information necessary to rule on the EJR request." Further, in issuing this Scheduling Order, the Board is mindful of the Covid-19 pandemic. *Notwithstanding, be advised that the above filing deadlines in this Scheduling Order are* ***firm*** *and the Board is* ***exempting*** *them from the Alert 19 suspension of Board filing deadlines*. The Board will continue its review of the jurisdiction in these appeals, as well as review the Providers' request for EJR, upon receipt of the requested information, or the August 25, 2022 filing deadline, whichever occurs first.[5]

Following the Board's First Scheduling Order, the Providers filed ***no objections*** *or requests for clarification with regard to the Scheduling Order itself*. As a result, the Board and FSS continued to take actions consistent with that Scheduling Order. The Medicare Contractors were required to file, through FSS, any response to the Group Representative's response and the Board's information requests no later than July 25, 2022 (*i.e.*, 38 days after the date of the Order). Similarly, the Provider were required to respond to the Medicare Contractor's filing as

---

other relevant documents in support of their position."

[3] In particular, the Board noted that "The Board's records reflect that, on August 22, 2016, it granted EJR in Case No. 10-1325GC "Univ. of Washington 2007 SSI Covered vs. Total Days CIRP Group."

[4] The Board noted that "it is the Board's understanding that these 2 CIRPs were formed based on bifurcation from Case No. 09-0271GC."

[5] (Emphasis in original and footnotes omitted.)

well as the Board's information requests no later than August 25, 2022 (31 days after the Medicare Contractor's deadline).

The Board issued a Scheduling Order ("Second Scheduling Order") on August 9, 2022 for all 14 group cases in the consolidated EJR request. The Second Scheduling Order noted that the Supreme Court issued a decision in *Becerra v. Empire Health Foundation* ("*Empire*")[6] *after* QRS filed the instant EJR request. Since the *Empire* decision was directly relevant to the issues in the EJR Request, but the request and responses did not discuss the case, the Board exercised its authority under 42 C.F.R. § 405.1842(e)(3) to issue a Scheduling Order requiring QRS to file a response within 28 days (*i.e.*, by September 6, 2022):

1. Giving updates on whether the groups' participants were still pursuing the EJR Request;
2. Requesting withdrawals for each case not being pursued; and
3. Updating, or clarifying as relevant, the EJR request to discuss the impact of *Empire* on the EJR request challenging (whether in whole or in part) the Secretary's policy of including no-pay/exhausted Part A days in the Medicare fraction for each case being pursued.[7]

Following the Board's Second Scheduling Order, the Providers filed ***no objections*** *or requests for clarification with regard to the Second Scheduling Order itself*. As a result, the Board and FSS continued to take actions consistent with that Scheduling Order. The Medicare Contractors were required to file, through FSS, any response to the Group Representative's response no later than 21 days after it was filed.

QRS failed to file a timely response to the First Scheduling Order by the August 25, 2022 filing deadline. However, QRS did file a timely response to the Second Scheduling Order on September 6, 2022 notifying the Board of the litigation it had filed in the D.C. District Court:

> The Administrator of the Centers for Medicare & Medicaid Services ("CMS") was required to notify, and presumably has or will notify, the Board that the Providers have commenced an action in the District Of Columbia District Court in the case of TARZANA PROVIDENCE HEALTH SYSTEM et al v. BECERRA, Case No. 22-01509-TNM attached as Exhibit 1. The Providers served the Secretary of Health and Human Services on August 25, 2022. *Accordingly, the Providers respectfully submit that the Board does* ***not*** *at present* ***possess jurisdiction*** *over the captioned cases*. 42 C.F.R. § 405.1842(h)(3)(iii).[8]

[6] 142 S.Ct. 2354 (2022).
[7] The Board noted this information was necessary for the Board to determine jurisdiction over the groups and underlying participants and, if the Board found the prerequisite jurisdiction (see 42 C.F.R. § 405.1842(b)(1)-(2)), to then rule on the EJR request. *See* 42 C.F.R. § 405.1842(f)(2)(iii).
[8] (Emphasis added and footnote omitted.)

On September 6, 2022, QRS timely filed its response to the Board's Second Scheduling Order. Within its response, QRS notifying the Board that they had "commenced an action in District of Columbia District Court in the case of *TARZANA PROVIDENCE HEALTH SYSTEM et al v. BECERRA, Case No. 22-01509-TNM* attached as Exhibit 1."[9] QRS insisted that "the Board does ***not*** at present *possess jurisdiction* over the captioned cases[] [per] 42 C.F.R. § 405.1842(h)(3)(iii)." It nevertheless argued that the appeals at issue here all included challenges to an alternate issue (whether all patients entitled to SSI, whether or not a payment was received during hospitalization, should be included in the numerator of the DSH Medicare Fraction).

A review of public records confirmed that QRS had filed litigation one-hundred-two (102) days prior to its September 6, 2022 notice to the Board and, more egregiously, just ***one day after the EJR request was filed with the Board***. Specifically, on May 27, 2022, without notice to the Board or the opposing parties in these cases, QRS bypassed the ongoing jurisdictional review process by filing a complaint in the D.C. District Court under Case No. 1:22CV01509 seeking judicial review on the merits of its EJR Request in these 14 group cases. This less than 30 days timing demonstrates that QRS had *no intention* of allowing the Board to process its EJR requests pursuant to 42 U.S.C. § 1395oo(f)(1) and the regulation at 42 C.F.R. § 405.1842 that implemented the statutory provision. QRS' failure to immediately notify the Board and the opposing parties of this litigation filing demonstrates QRS' lack of good faith and the disingenuous nature of its filings before the Board.

QRS' egregious actions in these cases are not new to the Board. To provide context for these cases, and the ongoing malfeasance by QRS, the Board attaches and incorporates a copy of the Board's June 10, 2022 closure letter, in response to QRS initiating federal litigation in connection with the consolidated EJR request QRS filed on January 20, 2022 involving 80 group cases for the same issue with 950+ participants in the aggregate, as **Appendix C**.

Procedural Background:

The Scheduling Orders issued in these cases explained that, per 42 C.F.R. §§ 405.1842(b)(2), (e)(2)(ii), and (e)(3)(ii), "jurisdiction is a prerequisite to consideration of an EJR request" and "the 30-day period for [the Board] responding to the EJR request has not yet commenced for these CIRP group appeals and will not commence until the Board completes its jurisdictional review of these CIRP groups." The Board also explained that a Board finding of jurisdiction is a ***prerequisite*** to any review of an EJR request pursuant to 42 C.F.R. § 405.1842.

The Board's conclusion that the 30-day period had not begun is further supported by 42 C.F.R. § 405.1842(b)(2) which states in pertinent part: "the 30-day period for the Board to make a determination under [42 U.S.C. § 1395oo(f)(1)] does not begin to run until the Board finds jurisdiction to conduct a hearing on the specific matter at issue in the EJR request and notifies the provider that the provider's request is complete." Accordingly, 42 C.F.R. § 405.1842(a)(4)(ii) states that a provider may seek EJR review in federal court without an EJR determination by the Board, "*only if* . . . [t]he Board fails to make a determination of its authority to decide the legal

[9] Curiously, QRS suggest that the Board should have been aware of the litigation filed on May 27, 2022 because the CMS Administrator has an obligation to notify the Board that the Providers in these appeals had commenced the lawsuit. Significantly, QRS did not serve CMS until 90 days later on August 25, 2022 and, only 12 days later it filed this notice with the Board; however, during that 90-day period, QRS did not notify the Board of this litigation.

question no later than 30 days *after* finding jurisdiction over the matter at issue and notifying the provider that the provider's EJR request is complete." Consistent with these regulatory provisions, Board Rule 42.1 states, in pertinent part:

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

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.[10]

Under Board Rule 44.3, if a party intends to respond to a motion, it must do so within 30 days, unless the Board imposes a different deadline. Significantly, QRS did not file any objections to FSS' extension requests in cases 13-3813GC and 13-3814GC. Nor did QRS file any objections to the Scheduling Orders issued in these cases, and in fact requested *additional* time to comply and participate with the Board's June 28, 2022 Scheduling Order.

QRS made clear by filing the Complaint in federal district court on May 27, 2022, that it was bypassing and abandoning the Board's prerequisite jurisdictional review process.

If the Providers were successful on the merits of their claims in federal court, then bypassing the Board's jurisdictional review process could result in millions of dollars being improperly paid. To illustrate this very point, the Board has included as **Appendix C**, a non-exhaustive listing of some of the jurisdictional issues that the Board has identified thus far. The Board expects that additional, material, jurisdictional and/or claim filing issues would be identified if it were to complete the jurisdictional review process.

Board Findings:

The Board must consider the significant impact on the proceedings caused by QRS filing a lawsuit in connection with the above-referenced six (6) group cases.

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

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

> Providers shall also have the right to obtain judicial review of any action of the fiscal intermediary which involves a question of law or

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

> regulations relevant to the matters in controversy whenever the Board determines (on its own motion or at the request of a provider of services as described in the following sentence) that it is without authority to decide the question, by a civil action commenced within sixty days of the date on which notification of such determination is received. ***If a provider of services may obtain a hearing under subsection (a)*** and has filed a request for such a hearing, such provider may file a request for a determination by the Board of its authority to decide the question of law or regulations relevant to the matters in controversy (accompanied by such documents and materials as the Board shall require for purposes of rendering such determination). *The Board shall render such determination in writing within thirty days* ***after the Board receives the request and such accompanying documents and materials***, and the determination shall be considered a final decision and not subject to review by the Secretary.[11]

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**

[11] (Emphasis added.)

> **specific matter at issue** and a determination by the Board that it has no authority to decide the relevant legal question; or
>
> (ii) The Board fails to make a determination of its authority to decide the legal **question no later than 30 days <u>after finding jurisdiction</u> over the matter at issue <u>and</u> notifying the provider that the provider's EJR request is complete**.
>
> (b) *General*—(1) *Prerequisite of Board jurisdiction*. The Board (or the Administrator) **must find that the Board has jurisdiction over the specific matter at issue <u>before</u> the Board may determine its authority to decide the legal question**.
>
> (2) *Initiating EJR procedures*. A provider or group of providers may request the Board to grant EJR of a specific matter or matters under appeal . . . . Under paragraphs (d) and (e) of this section, **a provider may request** a determination of the Board's authority to decide a legal question, but **<u>the 30-day period</u> for the Board to make a determination under section 1878(f)(1) of the Act** [*i.e.*, 42 U.S.C. § 1395oo(f)(1)] **<u>does not begin to run until the Board finds jurisdiction to conduct a hearing</u> on the specific matter at issue in the EJR request <u>and</u> notifies the provider that the provider's request is complete**.[12]

Clearly, when implementing 42 U.S.C. § 1395oo(f)(1) via 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."[13] 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

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[12] (Emphasis added).

[13] 42 C.F.R. § 405.1842(b)(2) (emphasis added). *See also* 69 Fed. Reg. 35716, 35730 (June 25, 2004) (proposed rule explaining: "In proposed § 405.1842(b), we would set forth an overview of the EJR process. We believe that an overview would be helpful given the complexity of the process. In § 405.1842(b)(l), ***we would <u>emphasize</u> that a Board finding that it has jurisdiction*** *over the specific matter at issue* ***is a <u>prerequisite</u>*** *for its determination of its authority to decide the legal question*, and for the ensuing stages of the EJR process. Section 1878(f)(1) of the Act states that a provider may file a request for EJR '[i]f [such] provider of services may obtain a hearing under subsection (a) [which sets forth the jurisdictional requirements for obtaining a Board hearing].' In § 405.1842(b)(2) we would state that the EJR procedures may be initiated in two ways. First, a provider or group of providers may request the Board to grant EJR, or, second, the Board may consider on its own motion whether to grant EJR. We would also state in paragraph (b)(2), ***consistent with*** *the requirement that a Board finding of jurisdiction is a prerequisite of both the provider's ability to obtain EJR and the Board's authority to issue an EJR Decision*, that ***the 30-day time limit*** specified in section 1878(f)(l) of the Act for the Board to act on a provider's complete request ***does not begin to run <u>until the Board has found jurisdiction</u>*** on the specific matter at issue." (emphasis added)).

> 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.[14]

Thus, it is clear that the 30-day clock does not start until ***after*** the Board determines it has jurisdiction over the relevant providers (*as well as* any associated group(s) in which these providers participate) in the appeals underlying an EJR request. Note that the Board's use of the term "stay" (as used in this and prior similar situations) in relation to the 30-day period for responding to the parties' EJR requests, was an inartful use of that term because the Board's intent was to simply notify the parties that the Board had not yet finished its jurisdictional review of the parties' EJR requests and, as such, the 30-day period for the review of the EJR requests had not yet commenced.

The Board notes that the Secretary had a sound basis for issuing 42 C.F.R. § 405.1842(b)(2). The statute itself states that a provider may be authorized to request EJR "***if*** [it] ***may obtain a hearing under subsection (a). . . .***"[15] Thus, as the Court in *Alexandria Hospital v. Bowen* ("*Alexandria*") noted, "the statute itself suggests that an EJR request need not be considered before the Board determines it has jurisdiction over an appeal. Moreover, the legislative history makes clear that in enacting the EJR provision, Congress sought solely to expedite resolution of the *legal* controversies in Medicare reimbursement appeals."[16] 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

[14] (Emphasis added.)
[15] 42 U.S.C. § 1395oo(f)(1) (emphasis added).
[16] *See* H.R. Rep. No. 96–1167, *reprinted in* 1980 U.S. Code Cong. & Ad. News at 5757; *Alexandria Hosp. v. Bowen*, 631 F. Supp. 1237, 1244 (W.D. Va. 1986); *San Francisco General Hosp. v. Shalala,* No. C 98-00916, 1999 WL 717830 (N.D. Cal. Sept. 8, 1999); *Total Care, Inc. v. Sullivan,* 754 F. Supp. 1097 (W.D. N.C. 1991); *Abington Mem'l Hosp. v. Bowen,* Civ. A No. 86-7262, 1988 WL 71367 (E.D. Pa. July 1, 1988); *Good Samaritan Hosp. v. Heckler*, No. CV84-L-459, 1986 WL 68497 (D. Neb. June 27, 1986).

> 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***.[17]

The *Alexandria* Court's conclusions are also supported by the practical considerations involved in the EJR process. If EJR requests were permitted to supersede jurisdictional determinations, there would be only two logical outcomes. The first is that jurisdictional determinations need never be made in cases where EJR requests are filed before a jurisdictional determination is reached by the Board. This would result in fraud, waste and abuse concerns if parties, unable to meet the Board's jurisdictional requirements, could still prevail in federal court, merely by filing an EJR request. The second conclusion is that federal trial courts would be forced to resolve jurisdictional disputes.[18] Not only are the federal trial courts ill-suited for making such determinations, this is a task assigned to the Board, *by statute*.

Significantly, in these fourteen (14) group cases, with seventy-three (73) participants, the Board has not yet completed its jurisdictional review to confirm whether it has jurisdiction to hear all of the providers' disputes raised in the EJR request. The Board stopped this process after it learned that QRS had bypassed the completion of this process on May 27, 2023 even before 30 days had elapsed. Having sufficient time to complete the jurisdictional and substantive claim review[19] process is vital to ensure that the groups, and all of the underlying providers, are properly before the Board both generally and for the issue(s) raised in the EJR request. Further, the jurisdictional and substantive claim review process ensures that the groups, and underlying providers, have complied with the applicable Board regulations and rules (*e.g.*, have not previously withdrawn or been dismissed without being reinstated; are not pursuing a prohibited duplicate appeal of the same issue for the same year; and have complied with the mandatory CIRP group rules). Without a proper jurisdictional review, fraud, waste and abuse concerns arise. Indeed, these concerns are very real and evident in these fourteen (14) group cases as highlighted in **Appendix B**.

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.[20]

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[17] *Alexandria Hosp. v. Bowen*, 631 F. Supp. at 1244.

[18] It is hard to see federal courts deciding jurisdictional issues, including determining whether a case or provider: (a) has been previously withdrawn or dismissed without being reinstated; (b) is pursuing a prohibited duplicate appeal of the same issue for the same year; or (c) has complied with the mandatory CIRP group rules. Indeed, ***subsequent to filing its Complaint on June 3, 2022***, QRS continued to expand the record and take actions in the Board proceedings in these group cases (*e.g.*, indicating in its July 19, 2022 correspondence with the Board that an updated EJR Request would be filed based on the Supreme Court's *Empire* decision) and it is unclear how a federal court is equipped to keep track of those actions and their import when there has been no jurisdictional determination and/or EJR decision in these cases.

[19] 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."

[20] "Indeed, the statute and regulation by their terms do not impose *any* time constraints on the Board's determination of jurisdiction. *See* 42 U.S.C. 1395oo(f)(1); 42 CFR § 405.1842. The Hospitals' proffered interpretation of the regulation is so wildly disconnected from the text as to `warrant[] little attention.'" *St. Francis Medical Center, et al*

QRS' filing of the Complaint in federal district court ***one day after the EJR Request was filed***, without notice to the Board or opposing party, is contemptuous of the Board's authority. It also demonstrates that QRS had no intention of allowing the Board to complete its jurisdictional review, much less the 30-day EJR review period to rule on the EJR request.

B. Effect of QRS' Concurrent Filing of the Complaint on the 6 Group Cases

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

> (3) *Provider lawsuits*. (i) If the provider files a lawsuit seeking judicial review (whether on the basis of the EJR provisions of section 1878(f)(1) of the Act or on some other basis) pertaining to a legal question that is allegedly relevant to a specific matter at 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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> ****
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> (iii) *If the lawsuit is filed before a final EJR request is issued on the legal question*, ***the Board may not conduct any further proceedings*** on the legal question or the matter at issue until the lawsuit is resolved.[21]

This regulation ***bars any further Board proceedings*** in these 6 group cases, including proceedings on *pre-requisite* jurisdictional issues or other procedural issues. Consistent with FRCP 62.1, the Board issues this ruling on a Motion for Relief that is barred by a pending appeal and, as explained below, is deferring further action in these 6 group cases until, or if, the Administrator remands these cases back to the Board.

To confirm the proper application of § 405.1842(h)(3), the Board reviewed the preambles to the proposed rule, dated June 5, 2004,[22] and the May 23, 2008 final rule[23] that promulgated the regulation at 42 C.F.R. § 405.1842(h)(3)(iii). The preamble to the proposed rule described this regulation as follows:

> Proposed § 405.1842(h)(3) would specify the effect that a provider lawsuit would have on the Board's ability to conduct further proceeding on the legal matter at issue. In general, if a provider files a lawsuit on the same legal issue for the same cost year that is currently pending before the Board - that is, the provider goes into

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v. Xavier Becerra, Memorandum Opinion, No. 1:22-cv-1960-RCL, at 8 (D.D.C. Sept. 27, 2023) (*citing Cape Cod Hosp. v. Leavitt*, 565 F. Supp. 2d 137, 141 (D.D.C. 2008)).

[21] (Emphasis added.)

[22] 69 Fed. Reg. 35716 (June 25, 2004).

[23] 73 Fed. Reg. 30190 (May 23, 2008).

> court without waiting for a final administrative decision on EJR, we would seek to have the lawsuit dismissed, and we would prohibit the Board from conducting further proceedings on that issue until the lawsuit is resolved.[24]

The discussion in the final rule includes additional guidance on 42 C.F.R. § 405.1842(h)(3):

> *Comment*: One commenter stated that the proposed rule would provide that, if any allegedly relevant lawsuit was filed before a final EJR decision, the Board would be precluded from conducting any further proceedings on the EJR decision until the lawsuit was resolved, and that it appears that the proposed policy would apply, regardless of the basis for the lawsuit. The commenter suggested that the final rule provide that the Board be required to conduct further proceedings on an EJR decision when the provider subsequently files a lawsuit brought on jurisdictional grounds other than the Social Security Act. If the Board were allowed to grant EJR, the issues jurisdictionally under the Medicare statute could be added to the pending matter in court, thus preserving judicial resources and avoiding multiple lawsuits.
>
> *Response*: The commenter is correct that the proposed policy would apply regardless of the jurisdictional basis for the lawsuit. However, we decline to adopt the commenter's suggestion that we make a distinction based on the jurisdictional basis pleaded in the complaint. **We do not agree that it would be appropriate for the Board or the intermediary to spend its limited resources to spend time on a Board appeal if the provider has filed a complaint that involves a legal matter that is relevant to a legal issue in the Board appeal**. If the court properly has jurisdiction over the appeal, the decision, that it or a higher court renders, may resolve the issue or issues in the Board case, or otherwise inform the Board in reaching a decision, or affect the parties' decision as to whether they should attempt to settle the Board case. On the other hand, where the basis for the court's jurisdiction is defective (which we believe would most likely be the situation when a provider attempts to file a complaint based on a legal issue related to an appeal still pending before the Board), a contrary rule would not discourage providers from filing improper appeals with the court. We believe our proposal to be in line with the general rule practiced by courts that an appeal to a higher court deprives the lower court of jurisdiction to conduct further proceedings until the appeal is resolved by the higher court.[25]

[24] 69 Fed. Reg. at 35732.
[25] 73 Fed. Reg at 30214-15 (bold and underline emphasis added).

Based on the above explanation regarding the intent and purpose for 42 C.F.R. § 405.1842(h)(3)(iii), the Board finds that QRS' concurrent filing of the Complaint in the D.C. District Court on June 3, 2022 prohibits the Board from conducting any further proceedings on the consolidated EJR request for the six cases at issue therein as filed, including any proceedings related to the prerequisite jurisdiction and claims filing requirements.

C. QRS' Actions

The Board finds that QRS' decision to withhold notice from the Board and the opposing parties of its filing of the federal district court litigation is tantamount to bad faith and actively created confusion surrounding the status of these cases at the Board because it ignored the 30-day Board review period as provided at 42 U.S.C. § 1395oo(f)(1) ***and*** *implemented at 42 C.F.R. § 405.1842*. Indeed, QRS' preemptive actions, taken without notice to the Board or the opposing parties, demonstrate that QRS had no intent to exhaust its administrative remedies before the Board. Pursuant to Board Rule 1.3 (Nov. 1, 2022),[26] QRS had a duty to communicate early, and in good faith, with the Board and the opposing parties (in that regard the Secretary is not a party per 42 C.F.R. § 405.1843(b)):

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

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

> **5.2 Responsibilities**
>
> *The case representative is responsible for being familiar with the following rules and procedures* for litigating before the Board:
>
> - The Board's governing statute at 42 U.S.C. § 1395oo;

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

- *The Board's governing regulations at 42 C.F.R. Part 405, Subpart R*; and
- *These Rules*, which include any relevant Orders posted at https://www.cms.gov/Regulations-and-Guidance/ReviewBoards/PRRBReview/PRRB-Instructions (see Rule 1.1).

Further, *the case representative is responsible for*:

- Ensuring his or her contact information is current with the Board, including a current email address and phone number;
- Meeting the Board's deadlines; and
- *Responding timely to correspondence or requests from the Board or the opposing party*.

Failure of a case representative to carry out his or her responsibilities is not considered by the Board to be good cause for failing to meet any deadlines. Withdrawal of a case representative or the recent appointment of a new case representative will also not be considered good cause for delay of any deadlines or proceedings.[27]

Indeed, the following actions (or inactions) by QRS reinforce the Board's finding that QRS has no basis to claim that proceedings before the Board have been exhausted:

1. QRS did not notify the Board, FSS, or the Medicare Contractors, of its opposition to FSS' motion to extend the Medicare Contractor's time to file jurisdictional challenges in these fourteen (14) group cases.

2. QRS failed to promptly and timely notify the Board of its objection to the Board's ruling on the extension, and the associated Scheduling Orders for these fourteen (14) group cases requesting information from both parties. QRS' failure to file and preserve its objection to the Board's ruling and Scheduling Orders (including information requests) violates QRS' obligations under Board Rules 1.3, 5.2, and 44. QRS' failures further deprived the Board of an opportunity to reconsider its ruling and Scheduling Orders and, if necessary, correct or clarify that ruling and/or the Scheduling Orders.[28]

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[27] (Italics emphasis added.) *See also, Baptist Mem'l Hosp.-Golden Triangle v. Sebelius*, 566 F.3d 226, 227 (D.C. Cir. 2009) wherein the Circuit Court affirmed the District Court's granting of summary judgment to the Secretary because the Providers failed to follow Board Rules, stating, "The court therefore granted summary judgment to the Board. Because the Board's procedural rules mean what they say and say what they mean, and because the hospitals did not follow them, we affirm."

[28] While the Board is not bound by the FRCP, the Board refers to them for guidance and notes that the principles of FRCP 46 are similar. FRCP 46 applies to trial-like proceedings and "requires that a party seeking to preserve an objection to the court's ruling must 'make known to the court the action which the party desires the court to take or the party's objection to the action of the court and the grounds therefor.'" *Beach Aircraft Corp. v. Rainey*, 488 U.S. 163 (1988). *See also Cain v. J.P. Productions*, 11 Fed. Appx 714 (9th Cir. 2001). Similarly, the purpose behind Rule 46 is also relevant: "As pointed out in the discussions of Rule 46, the function of an exception was to bring pointedly to the attention of the trial judge the importance of the ruling from the standpoint of the lawyer and to give the trial judge an opportunity to make

3. The Board made known to the parties in these cases its position regarding the 30-day period to respond to the EJR request at issue, based on 42 U.S.C. § 1395oo(f), 42 C.F.R. §§ 405.1842(b)(2), 405.1801(d)(2).[29] Specifically, the Board notified the parties that the Board had the authority to stay the start of the 30-day period. The Board's notice was based on 42 C.F.R. § 405.1842(b)(2) which specifies that jurisdiction is a prerequisite to Board consideration of an EJR request ***and*** that the 30-day period to review the EJR request does ***not*** begin until the Board finds jurisdiction. To that end, the Board issued its First Scheduling Order for these fourteen (14) group cases to memorialize, and effectuate, the necessity to conduct the jurisdictional review process and delay the start of the 30-day period to review the EJR request. QRS failed to notify the Board of its objection to the Scheduling Orders. QRS' failure to timely file any objection violates Board Rules 1.3, 5.2 and 44. Indeed, QRS' actions interfered with the speedy, orderly and fair conduct of Board proceedings and prejudiced the Board by depriving it of an opportunity to reconsider its rulings and, if necessary, correct or clarify them,[30] or take other actions, ***prior to*** QRS filing its May 27, 2022 Complaint. Indeed, QRS' preemptive actions did not even allow completion of the 30-day EJR review deadline, ***as alleged by QRS to be established in 42 U.S.C. § 1395oo(f)(1) (and which QRS alleges in its litigation the Board missed)***, to pass, and, under QRS' strained interpretation that ignores the Secretary's regulations, permitted federal litigation to be pursued.[31]

4. QRS' failure to promptly notify the Board that it had filed the lawsuit in the D.C. District Court violates Board Rule 1.3 and prevented the Board and the Medicare Contractors from understanding the nature of QRS' position relative to the 30-day period specified in 42 U.S.C. § 1395oo(f)(1). The following circumstances make it clear that QRS had an affirmative obligation to notify the Board of the Complaint being filed, and that QRS should have been aware of that affirmative obligation:

   a. The Board, in its First and Second Scheduling Orders issued for these cases (as well as for other cases prior to May 27, 2022 as set forth in **Appendix C**), made clear the Board's position that the 30-day period for responding to the EJR request would not commence until the Board had completed its jurisdictional review and issued its jurisdictional findings.

   b. The Board and the Medicare Contractors were acting in reliance on the authority of those Scheduling Orders.

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further reflection regarding his ruling. Proceedings of Institute, Washington, D.C., 1938, p. 87. In justifying the rule, it was stated 'the exception is no longer necessary, if you have made your point clear to the court below.' Proceedings of Institute, Cleveland, 1938, p. 312. 'But of course it is necessary that a man should not spring a trap on the court * * *, so the rule requires him to disclose the grounds of his objections fully to the court.' Proceedings of Institute, Washington, D.C., 1938, p. 145; see also p. 87." *Bucy v. Nevada Const. Co.*, 125 F.3d 213, 218 (9th Cir. 1942).

[29] The Board's Notice was clear that a Board finding of jurisdiction is a prerequisite to any review of an EJR request citing to 42 C.F.R. §§ 405.1842(b)(2), (e)(2)(ii), (e)(3)(ii).

[30] For example, the Board could have explained how reliance ***solely*** on 42 U.S.C. § 1395oo(f)(1) would be misplaced, given the Secretary's implementation of that statute at 42 C.F.R. § 405.1842 (including in particular § 405.1842(b)(2)) as promulgated in the May 23, 2008 final rule and the Secretary's explanation of that regulation in the June 25, 2004 proposed rule. *See supra* notes 13-18 and accompanying text.

[31] *See supra* note 28 (discussing how the FRCP supports the Board's position).

D. Board Actions

These facts demonstrate that QRS had a duty, pursuant to Board Rule 1.3, "to communicate early and act in good faith [with regard] [] to dealings with the opposing party, the Board, and/or any relevant nonparty." Indeed, QRS' failure to comply with Board Rule 1.3, through prompt notification of the lawsuit on, or about, June 3, 2022, prejudiced the Board, FSS and the Medicare Contractors. Specifically, it interfered with the speedy, orderly and fair conduct of the Board proceedings (on these and other cases) and deprived both the Board, and the Medicare Contractors, of the opportunity to decide whether to delay or cease work on these eight (8) group cases and the underlying 34 participants in favor of other time-sensitive work such as ***other*** EJR requests filed by QRS *and* by other representatives. Indeed, QRS' failure to ***timely*** notify the Board, and the opposing parties, of this lawsuit filed in the D.C. District Court, raises very serious concerns about prejudicial sandbagging by QRS to benefit prior, current and subsequent EJR requests that QRS filed on behalf of other providers ***or*** by other representatives for EJR requests filed for the same issue.[32] The prejudicial sandbagging is highlighted by the facts that:

1. Across the 6-month period from December 20, 2021 to June 30, 2022, record concentrations of EJR requests were filed covering 642 group cases involving 2000+ participants (with the overlay of challenges created by the surge in the Omicron variant of the COVID-19 virus at the beginning of that 6-month period); and

2. 80 percent of these requests were filed by either QRS or another representative, Healthcare Reimbursement Services ("HRS") (specifically QRS filed EJR requests covering 359 cases and HRS filed EJR requests covering 148 cases during this 6-month period).[33]

As a point of reference and context for these serious violations by QRS, the Board has included, at **Appendix C**, a copy of the closure letter it issued in 80 QRS cases that were included in a February 14, 2022 Federal Complaint in the California Central District Court. Finally, this is not an isolated event because it is the Board's understanding that: (1) QRS and HRS jointly filed the Complaint in the California Central District Court on April 20, 2022 establishing Case No. 22-cv-02648 covering 178 cases with 969 participants and did so without completing the jurisdictional review process, much less receiving the Board's jurisdictional decision, and without notice to the

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

[33] It is the Board's understanding that, on February 14, 2022, QRS established the initial ongoing litigation in the California Central District Court covering 80 group cases with 950+ participants in the aggregate, and that QRS and another representative, HRS *joined* the following additional cases to that lawsuit through the Amended Complaint filed on March 30, 2022 (without any notice to the Board or the opposing party). Similar litigation involving other EJR requests filedby QRS has been filed both in California and the District of Columbia. *See infra* notes 30 and 31 and accompanying text.

Board;[34] and (2) QRS filed at least one similar Complaint in the D.C. District Court on May 27, 2022 under Case No. 22-cv-01509.[35]

It is clear the Providers are pursuing the merits of their claims in these fourteen (14) group cases as part of their lawsuit in the D.C. District Court. Pursuant to 42 C.F.R. § 405.1842(h)(3)(iii), the Board is prohibited from further proceedings in these cases. Therefore, the Board must close these cases.[36]

However, the Board cannot permit QRS' reckless and contemptuous disregard for its ***basic*** responsibilities and due diligence as a representative appearing before the Board, its bypassing and abandonment of the jurisdictional review process, and its disregard for the Board's authority, orders and process, to remain unanswered. Accordingly, *if these cases are remanded for further proceedings*, the Board will complete its jurisdictional review and weigh: (a) the severity of QRS' violations of, as well as failure to comply with, Board Rules, regulations and Orders; (b) the prejudice to the Board and the opposing parties; (c) the interference with the speedy, orderly and fair conduct of the Board proceedings (regarding both these cases and others); and (d) the effect on the operations of the Board, when determining what, if any, remedial actions will be taken per 42 C.F.R. § 405.1868.[37] Examples of available remedial actions that the Board may consider to defend its authority resulting from QRS' numerous, egregious regulatory violations and abuses include, but are not limited to:

1. Dismissal of the fourteen (14) group cases and all underlying participants.

2. Dismissal of any group case in which the Board identifies any jurisdictional or material procedural errors occurred, whether by one participant or more.

3. Dismissal of any participant for which there is an open jurisdictional challenge regardless of the merit of such challenge.

These potential actions are well within the Board's authority pursuant to 42 C.F.R. § 405.1868(a)-(b),[38] as confirmed in the preamble to the May 23, 2008 final rule:

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[34] Under separate cover, the Board closed the QRS cases by letters dated September 30, 2022 (Grouping A for Case Nos. 13-3842GC, *et al*.; Grouping B for Case Nos. 17-2150GC, *et al*.; and Grouping C for Case Nos. 18-0037GC, *et al*.) , and the HRS cases dated October 19, 2022 (Grouping A for Case Nos. 14-2400GC, *et al*.; and Grouping B for Case Nos. 15-055G, *et al*.). These closure letters included similar findings as in these QRS group cases.

[35] The Board is addressing the cases impacted by this litigation under separate cover.

[36] As noted in 42 C.F.R. § 405.1837(a), a group appeal may only have "a single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group." Similarly, as explained at 42 C.F.R. § 405.1842(d), "[a] provider (or, in the case of a group appeal, a group of providers) may request a determination by the Board that it lacks the authority to decide a legal question relevant to a specific matter at issue in an appeal." Accordingly, the Board must assume there are no other issues, particularly since: (1) the existence of other issues would necessarily mean that the Board would not have jurisdiction over the group until that defect was cured; and (2) the Providers did not identify any concurrent issues with the filing of the consolidated EJR request but rather claimed therein that the Board had jurisdiction over the groups.

[37] The Board's planned actions are consistent with those planned for QRS as laid out in **Appendix C**.

[38] 42 C.F.R. § 405.1868 states:

> (a) The Board has full power and authority to make rules and establish procedures, not inconsistent with the law, regulations, and CMS Rulings, that are necessary or appropriate to carry out the

> Most of the comments we received on this subject came from providers, and reflect a perceived disparate treatment by the Board when a provider, rather than an intermediary, fails to follow a procedural rule or timeframe set by the Board. We proposed two possible actions by the Board, one applicable to a provider and the other applicable to an intermediary. That is, the worst case scenario for a provider would be a dismissal of the appeal by the Board, while the harshest remedy for an intermediary would be the issuance of a decision by the Board based on the written record established at the point of the intermediary's violation. However, we note that, because providers are the proponents of a case, they are responsible for moving the case forward by meeting all deadlines. Additionally, at section 1878(e) of the Act, the Congress has given the Board authority to make rules and establish procedures to carry out its function. Moreover, we note that the Board will have broad discretion to weigh the particular facts at hand in order to decide whether or not an offense merits remedial action.
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> ****
>
> Again, we are clarifying that the proposed rule did not identify a complete listing of all potential Board sanctions. The Board has the authority to take appropriate action against either party for procedural violations, but appropriate action does not necessarily mean a dismissal or the early issuance of a decision by the Board. We believe that these provisions will alert both parties that the Board has a mechanism in place to effectively stop a delaying tactic, or to redress other procedural violations. As a result, the parties should be less inclined to ignore procedural requirements and, accordingly, be more motivated to meet the deadlines set by the Board.[39]

Pursuant to the above, the Board has broad authority to sanction QRS for its repeated, and ongoing, malfeasance.

E. Board Decision and Order

Based on QRS' misconduct, the Board hereby takes the following actions:

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provisions of section 1878 of the Act and of the regulations in this subpart. The Board's powers include the authority to take *appropriate actions in response to the failure of a party to a Board appeal to comply with Board rules and orders or for inappropriate conduct during proceedings in the appeal*.
(b) If a provider fails to meet a filing deadline or other requirement established by the Board in a rule or order, the Board may -
(1) Dismiss the appeal with prejudice;
(2) Issue an order requiring the provider to show cause why the Board should not dismiss the appeal; or
(3) Take any other remedial action it considers appropriate.
(Emphasis added.)

[39] 73 Fed. Reg. at 30225.

1. Closes the fourteen (14) group cases consistent with 42 C.F.R. § 405.1842(h)(3)(iii); and

2. Suspends the ongoing jurisdictional review process; and

3. Defers consideration of citing QRS for contempt and dismissing these group cases (and/or taking other remedial action to uphold the authority of the Board) based on QRS' numerous, egregious, regulatory violations and abuses until there is an Administrator's Remand Order consistent with 42 C.F.R. § 405.1842(h)(3)(iii) and Federal Rule of Civil Procedure ("FRCP") 62.1.[40]

Accordingly, the Board hereby closes these cases and removes them from the Board's docket. No further proceedings will occur, except upon remand from the Administrator, pursuant to 42 C.F.R. § 405.1877(g)(2).

Board Members Participating:

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

For the Board:

9/29/2023

X Clayton J. Nix

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

Enclosures:
Appendix A – Case List
Appendix B – Interim List of Potential Jurisdictional & Procedural Violations Under Review
Appendix C -- June 10, 2022 Board Letter to QRS Deferring Show Cause Order & Closure of Cases

cc: Dana Johnson, Palmetto GBA c/o National Government Services, Inc.
John Bloom, Noridian Healthcare Solutions
Geoff Pike, First Coast Service Options, Inc.
Wilson Leong, FSS
Jacqueline Vaughn, OAA

[40] FRCP 62.1 is entitled "Indicative Ruling on a Motion for Relief That is Barred by a Pending Appeal." While FRCP 62.1 is not directly applicable to the Board, the procedural developments in these cases are similar those addressed in FRCP 62.1 and the Board looked to it for guidance.

APPENDIX A

Grouping A – List of the 8 Group Cases
Covered by the Request for EJR
Filed on June 2, 2022

14-1309GC QRS DCH 2007 DSH SSI Fraction Dual Eligible Days CIRP Group
14-1336GC QRS DCH 2007 DSH Medicaid Fraction Dual Eligible Days CIRP Group
14-2382GC QRS DCH 2008 DSH SSI Fraction Dual Eligible Days CIRP Group
14-2384GC QRS DCH 2008 DSH Medicaid Fraction Dual Eligible Days CIRP Group
14-2418GC QRS DCH 2009 DSH SSI Fraction Dual Eligible Days CIRP Group
14-2432GC QRS DCH 2009 DSH Medicaid Fraction Dual Eligible Days CIRP Group
14-3259GC QRS Health First 2009 DSH SSI Fraction Dual Eligible Days CIRP Group
14-3263GC QRS Health First 2009 DSH Medicaid Fraction Dual Eligible Days CIRP Group
14-4404GC QRS John C. Lincoln Health Network 2009 Medicaid Fraction/Dual Eligible Days CIRP Grp.
16-0607GC QRS Providence 2013 No Pay Part A CIRP
17-0952GC QRS Providence 2014 No Pay Part A CIRP
15-0560GC QRS UW 10/1/2004 – 2007 Dual Eligible Days CIRP
15-0561GC QRS UW 2008-2009 Dual Eligible Days CIRP
16-2595GC QRS UW Medicine 2006 SSI – Dual Eligible Days CIRP Group

APPENDIX B

INTERIM LIST OF POTENTIAL JURISDICTIONAL, SUBSTANTIVE CLAIM, AND PROCEDURAL VIOLATIONS UNDER REVIEW[41]

The following summary of jurisdictional, substantive claim and procedural concerns and issues is preliminary and highlights the complexity of the jurisdictional review process.[42] This process is *exponentially* more complex when consolidated EJR requests are concurrently filed involving multiple group cases with 36 participants and when many of those cases are older cases (7+ years old).

The Board, through its ongoing review of jurisdiction, and other procedural issues, in these 8 group cases, has identified multiple, ***material*** jurisdictional issues and concerns that were not raised by FSS or the Medicare Contractors. The Board's review is based on the SoPs filed for these cases because, as explained at Board Rule 20.1.1 (Nov. 2021),[43] the SoPs are supposed to contain all relevant jurisdictional documentation for each participant in the group.

At the outset, the Board notes that, On June 17, 2022 (which was within 22 days of the May 26, 2023 EJR request), the Board issued its First Scheduling Order for all 14 group cases requiring the Providers to provide the following information in connection with the Board's then-ongoing jurisdictional review:

- "[A]ddress whether Case Nos. 16-0607GC and 17-0952GC respectively are prohibited duplicates of the Providence CIRP groups for 2013 and 2014 under Case Nos. 16-0605GC and 17-0950GC respectively, for which the Board granted EJR on September 30, 2020."[44]

- "[A]ddress the Board's jurisdiction over Case No. 15-0560GC and whether the portion of that CIRP group that pertains to CY 2007 is a prohibited duplicate of the University of Washington CIRP group for 2007 under Case No. 10-1325GC" and required "the Providers [to] include, from Case No. 10-1325GC, a copy of the group issue statement and August 22, 2016 EJR determination as well as any other relevant documents in support of their position"[45]

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[41] This listing is not exhaustive and only reflects preliminary findings and the Board has not yet completed or finalized its jurisdictional findings in these 36 group cases.

[42] The Board notes that 42 C.F.R. § 405.1840 is entitled "Board Jurisdiction" but it also addresses certain claim filing requirements such as timelines or filing deadlines. For example, whether an appeal was timely is not a jurisdictional requirement but rather is a claim filing requirement as the Supreme Court made clear in *Sebelius v. Auburn Reg. Med. Ctr.*, 568 U.S. 145 (2013). *See also* Board Rule 4.1 ("The Board will dismiss appeals that fail *to meet the timely filing requirements* ***and/or*** *jurisdictional requirements*. Similarly, the Board notes that 42 C.F.R. §§ 405.1835(b) and 405.1837(c) address certain claim filing requirements.

[43] *See also* Board Rule 20.1 (Aug. 2018).

[44] In addition, the First Scheduling Order specified: "Both parties should brief as to why the Board should not dismiss the open appeals as duplicative and, if not, whether the EJR request, as currently draft remains applicable to Case Nos. 16-0607GC and 17-0952GC. In their response, the Providers must include, from Case Nos. 16-0607GC and 17-0952GC, a copy of the group issue statement, the September 30, 2020 EJR determination, as well as any other relevant documents in support of their position."

[45] In particular, the Board noted that "The Board's records reflect that, on August 22, 2016, it granted EJR in Case No. 10-1325GC "Univ. of Washington 2007 SSI Covered vs. Total Days CIRP Group."

- "[I]dentify the group issue statement for Case Nos. 15-0560GC and 15-0561GC and whether the EJR request falls outside the scope of the group issue statement for those cases" and required "[t]he Providers in their response must include a copy of the group issue statement from Case No. 09-0271GC and any other relevant documentation in support of their position" since the 2 CIRP groups were formed based on bifurcation from Case No. 09-0271GC.[46]

The Providers' response was due by August 25, 2022. However, QRS failed to file any response or objection to the Board's request. As such, the Board would need to make jurisdictional rulings on the above cases based on the information before it.

Other issues and concerns identified by the Board (thus far) include, but are not limited to, the following:

1. *Invalid Appeals Due to Failure to Timely Appeal or Provide the Requisite Documentation*.— QRS failed to include sufficient documentation in the SoPs to establish that many of the participants filed timely appeals. As a result, the Board is reviewing dismissal of a significant number of participants for failure to meet the claims filing requirements. For example, for appeals based on the nonissuance of an NPR, 42 C.F.R. § 405.1835(c)(2) specifies that: "[u]nless the provider qualifies for a good cause extension under § 405.1836, the date of receipt by the Board of the provider's hearing request is no later than 180 days after the expiration of the 12 month period for issuance of the final contractor determination (as determined in accordance with paragraph (c)(1) . . .)." In this instance, the appeal must be filed within 12 months of the Medicare Contractor's receipt of the relevant perfected cost report and, as explained at Board Rule 21.2.2, the SoP must contain the following documents to establish that the cost report was, in fact, filed and when that filing occurred:

    - evidence of the Medicare contractor's receipt of the as-filed or amended cost report under appeal, and
    - evidence of the Medicare contractor's acceptance of the as-filed or amended cost report under appeal. (*See* Board Rule 7.5.)[47]

    There are a significant number of participants that appealed from the nonissuance of an NPR, and the Board has identified situations where QRS has failed to include the requisite documentation in the SOP to establish that such appeals were timely. *See, e.g.*, Case Nos. 14-4404GC (the SoP shows at least both participants as having filed untimely appeals). There are also instances where QRS has failed to provide proof of delivery of the appeal request or add issue request (e.g., Case No. 16-0607GC, 17-0952GC, 15-0560GC, 15-0561GC) and, as a result, there is a question of whether the appeal was timely filed in such instances.

[46] The Board noted that "it is the Board's understanding that these 2 CIRPs were formed based on bifurcation from Case No. 09-0271GC."

[47] Board Rule 7.5 specifies the documentation requirements for appeals based on the nonissuance of a final determination and requires such appeals to include: "evidence of the Medicare contractor's receipt of the as-filed or amended cost report under appeal" and "evidence of the Medicare contractor's acceptance of the as-filed or amended cost report under appeal."

2. *Improper Transfer from a Closed Case*.—In Case No. 15-1161GC, the Board is reviewing whether a participant improperly filed a request to transfer from an individual case that had already been closed. If true, the participant would be dismissed as it had no right to transfer from an otherwise closed case.

3. *Unauthorized Representation of Participants*.— The Board reviews the Schedule of Providers to confirm QRS obtained proper ***prior*** authorization from the provider to be a participant in the relevant group.[48,49] This ***prior*** authorization is required to be placed behind Tab H for each participant, as noted by Board Rule 21.9.2, to confirm the participant gave ***prior*** authorization to join the group. The Board is reviewing the SoP to confirm proper authorization.

4. *Participants That Did Not Appeal the Group Issue, Properly Transfer Into the Group or Only Transferred a Portion of the Issue/Issues Covered By the Group*.— A significant number of the participants in these groups arrived by transfer from an individual appeal. For any participant that transfers into a group from an individual appeal, the Board must review whether the individual appeal properly included the issue the provider seeks to transfer. A provider can only transfer an issue that is properly existing in its individual appeal.[50] The Board expects it would identify multiple participants with these types of jurisdictional transfer issues if it were to complete its jurisdictional review. For example, the Medicare Contractor flagged such an issue for one of the participants in Case No. 14-2418GC for the Board to review. Similarly, for Case No. 14-3259GC, the Medicare Contractor has flagged a jurisdictional issue involving a participant revised NPR appeal, claiming that the participant did not have the right to appeal the group issue from that revised NPR per 42 C.F.R. § 405.1889(b). Finally, the Board notes that, in some instances, QRS has failed to provide proof that certain transfer requests included in the SoP were in fact filed (*e.g.*, Case No. 15-0560GC, 15-0561GC).

5. *Reviewing Scope of the EJR Request and Potential Improper Groups*.—In order for the Board to have jurisdiction over a group appeal, the group appeal must contain only one legal question/issue.[51] Pursuant to 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. § 405.1837(a)(1), a

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[48] Per Board Rule 6.4 (Mar.2013, July 2015), "An authorized representative of the Provider must sign the [individual provider] appeal. If the authorized representative is not a Provider employee, attach an Authorization of Representation letter with the Initial Filing on the Provider's letterhead, signed by an owner or officer of the Provider." The Board requires provider-executed letters of representation to be filed *with the appeal* (*i.e.*, to be obtained ***prior to*** taking actions on behalf of the provider) in order to protect providers and health chains from potentially coercive or abusive representation situations, whether in the context of an individual or group appeal.

[49] Per Board Rule 12.4(A) (2015), "The Board will recognize a single Group Representative for all Providers in the group. The Providers filing the initial appeal must appoint the Group Representative by attaching an Authorization of Representation letter on each Provider's letterhead, signed by an owner or officer of the Provider." To this end, the Model Form E (2015) for Direct Add Appeals specifies, "[i]f you are filing as a representative, YOU **MUST** ATTACH A LETTER SIGNED BY THE PROVIDER AUTHORIZING REPRESENTATION UNDER A **TAB LABELED 2**. *See* Rule 5.4." (Emphasis in original.)

[50] The window to add issues to an individual appeal is limited by the regulation at 42 C.F.R. § 405.1835(e) as follows: "After filing a hearing request in accordance with paragraphs (a) and (b), or paragraphs (c) and (d), of this section, a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the Board only if – . . . . (3) The Board receives the provider's request to add issues no later than 60 days after the expiration of the applicable 180-day period prescribed in paragraph (a)(3) or paragraph (c)(2), of this section." *See also* 42 C.F.R. §§ 405.1835(b), 1837(c), & Board Rule 8 for content and specificity requirements for issues being appealed.

[51] *See* 42 C.F.R. §§ 405.1842(a), 405.1842(f); 73 Fed. Reg. 30190, 30212 (May 23, 2008) (in response to comment that

group may only contain one legal issue. In pertinent part, § 405.1837(a)(1) states that "[a] provider . . . has a right to a Board hearing, as part of a group appeal with other providers, with respect to a final contractor or Secretary determination for the provider's cost reporting period, ***only if*** - . . . (2) The matter at issue in the group appeal involves ***a single*** question of fact or ***interpretation*** *of law, regulations, or CMS Rulings* that is common to each provider in the group.[52] The Board is reviewing whether the Providers' consolidated EJR requests are ***improperly*** challenging *multiple* interpretations of law or regulation. In particular, the Board is reviewing whether the EJR request properly includes a challenge to the SSI eligibility codes used to identify the SSI days to be included in the numerator of the Medicare fraction (as embodied in PRRB Dec. No. 2017-D11[53]) in addition to the no-pay Part A days issue (as embodied in the *Empire* litigation decided before the Supreme Court[54]). If true, it raises ***immediate*** jurisdictional problems of whether the additional challenge(s) are *properly* part of the relevant groups[55] and, if true, requires determining: (1) whether each of the participants properly appealed additional issues[56] and, as relevant, whether it requested transfer of those additional issues to the group; (2) if a preliminary position paper was filed, whether the additional was properly briefed in the preliminary position paper in compliance with 42 C.F.R. § 405.1853(b)(2) and Board Rule 25[57]; and (3) whether the additional issues should be bifurcated from the group per 42 C.F.R. § 405.1837(f)(2). A critical aspect of the jurisdictional inquiry entails confirming that any potential bifurcation would not result in prohibited duplicate appeals by the same providers for the same issue and years. The Board has already

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"the Board should have the authority to handle more than one question of fact or law in a group appeal" because "sometimes there is more than one disputed fact or question of law pertaining to a single item on the cost report" where "[a] common example of this is the [DSH] adjustment, which is determined by a combination of calculations, each of which may have more than one element in dispute", the Secretary affirmed that [t]he regulations at § 405.1837(a)(2) . . . specify that a group appeal involve a single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group" and that "[w]hat constitutes an appropriate group appeal issue in a given case will be determined by the Board."). The Board further notes that 42 C.F.R. § 405.1839(b) (underline and bold emphasis added) states the following in relevant part:

> (b) *Group appeals*. (1) In order to satisfy the amount in controversy requirement under § 405.1837(a)(3) of this subpart for a Board hearing as a group appeal, the group must demonstrate that if its appeal were successful, the total program reimbursement for the cost reporting periods under appeal would increase, in the aggregate, by at least $50,000.
> (2) *Aggregation of claims*. (i) For purposes of satisfying the amount in controversy requirement, group members are **not allowed to aggregate claims involving different issues**.
> (A) A group appeal must involve a **single** question of fact or **interpretation** of law, regulations, or CMS Ruling that is common to each provider (as described in § 405.1837(a)(2) of this subpart).

[52] (Emphasis added.)

[53] *Hall Render Optional and CIRP DSH Dual/SSI Eligible Group Appeals – Medicare Fraction v. Wisconsin Physicians Servs.*, PRRB Dec. No. 2017-D11 (Mar. 27, 2017).

[54] *Becerra v. Empire Health Found.*, 142 S. Ct. 2354 (2022), *reversing*, 958 F.3d 873 (9th Cir. 2020).

[55] This includes whether the group appeal request includes the additional issue and whether the final SoP filed in the relevant group establishes that the group meets the $50,000 AiC requirement for each of the additional issues. Per 42 C.F.R. § 405.1839(b), participants in a group are ***not*** permitted to aggregate claims involving different issues for purposes of meeting the $50,000 AiC requirement.

[56] Note that a proper appeal on an issue must include an AiC calculation for that issue. If the Providers were to claim that the group had multiple issues, then each participant would have a separate AiC calculation in the SoP *for* ***each*** *issue*. *See* 42 C.F.R. §§ 405.1839(b), 405.1837(c)(2)(iii). However, the Board's initial impressions are that each participant generally only has ***one*** AiC calculation behind Tab E in the relevant SoP.

[57] 42 C.F.R. § 405.1853(b)(2) and Board Rule 25 require the full briefing of each issue in a position paper filing. Consistent with this regulation and Board Rule 25, Board Rule 25.3 specifies that "[i]f the provider fails to brief an appealed issue in it is position paper, the Board will consider the unbriefed issue abandoned and effectively withdrawn."

> flagged this issue in its letter dated July 22, 2022 and it was in the QRS' response to this inquiry that the Board learned of the litigation that QRS filed bypassing completion of the Board's administrative review process.

Notwithstanding the above jurisdictional issues and concerns, QRS made clear, with the June 3, 2022 filing of the Amended Complaint in federal district court, that it was bypassing and abandoning the Board's jurisdictional review process (as discussed above).

APPENDIX C

June 10, 2022 Board Letter to QRS
Deferring Show Cause Order and Closure of Cases
Pursuant to 42 C.F.R. § 405.1842(h)(3)(iii)
Due to QRS Filing in California Central District Court

(35 pages)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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James Ravindran
Quality Reimbursement Services, Inc.
150 N. Santa Anita Avenue, Suite 570A
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RE: ***Deferring Show Cause Order & Closure of Cases***
Case No. 09-1903GC, *et al.* (*see* attached list of 80 group cases[1])

Dear Mr. Berends and Ravindran:

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

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

[2] *See supra* note 1.

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

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

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

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

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

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

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

Procedural Background

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

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

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

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

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

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

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

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

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

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

[17] (Emphasis in original.)

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

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

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

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

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

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

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[18] *See supra* note 3.

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

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

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

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

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

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

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

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

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

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

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

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

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

Board Findings and Ruling:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. *Prohibited Duplicate Appeals*

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

2. *Providers With No Appeal Rights*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4. Prohibited Participation of CIRP Providers in Optional Groups

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

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

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

5. *Unauthorized Representation of Participants*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[93] 42 C.F.R. § 405.1868 states:

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

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

(1) Dismiss the appeal with prejudice;

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

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

(Emphasis added.)

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

* * * * *

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

Board Members Participating:

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For the Board:

6/10/2022

X Clayton J. Nix

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

Enclosures: List of Groups

cc: Bill Tisdale, Novitas Solutions
Judith Cummings, CGS
Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators
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Wilson Leong, FSS
Jacqueline Vaughn, OAA

[94] 73 Fed. Reg. at 30225.
[95] *See supra* note 92.

LIST OF 80 GROUP CASES

09-1903GC	BHCS 07 DSH Dual Eligible Days
13-1419G	QRS 2006 DSH SSI Fraction Denominator/Dual Eligible Group
13-1440G	QRS 2006 DSH Medicaid Fraction/Dual Eligible Group
13-1720GC	Scott & White 2008 Medicaid Fraction Dual Elig Days CIRP Group
13-1722GC	Scott & White 2008 DSH SSI Fraction Dual Elig Days CIRP Group
13-2678G	QRS 2007 DSH Medicaid Fraction Dual Eligible Days Group (2)
13-2693G	QRS 2008 DSH Medicaid Fraction Dual Eligible Days Group
13-2901GC	QRS BJC 2007 DSH SSI Fraction Dual Eligible Days CIRP Group
13-2903GC	QRS Novant 2007 SSI Fraction Dual Eligible Days CIRP Group
13-2904GC	QRS Novant 2007 Medicaid Fraction Dual Eligible Days CIRP Group
13-3061GC	QRS WFHC 2009 Medicaid Fraction Dual Eligible CIRP Group
13-3191GC	QRS Novant 2006 DSH Dual Eligible Days
13-3942G	QRS 2009 DSH Medicaid Fraction/Dual Eligible Days Group
13-3944G	QRS 2009 DSH SSI Fraction/Dual Eligible Days Group
14-1171G	QRS 2008 DSH SSI Fraction Dual Eligible Days Group
14-1174G	QRS 2007 DSH SSI Fraction Dual Eligible Days Group
14-1816G	QRS 2010 DSH SSI Fraction Dual Eligible Days Group
14-1818G	QRS 2010 DSH Medicaid Fraction Dual Eligible Days Group
14-2217GC	QRS Novant 2009 DSH Medicaid Fraction Dual Eligible Days CIRP Group
14-3306G	QRS 2011 DSH Medicaid Fraction Dual Eligible Days Group
14-3308G	QRS 2011 DSH SSI Fraction Dual Eligible Days Group
15-0018G	QRS 2012 DSH Medicaid Fraction/Dual Eligible Days Group
15-1067G	QRS 2006 DSH Medicaid Fraction Dual Eligible Days Group (2)
15-1147G	QRS 2006 DSH SSI Fraction Dual Eligible Days Group (2)
15-1152GC	QRS Novant 2010 DSH Medicaid Fraction Dual Eligible Days CIRP Group
15-1419G	QRS 2012 DSH SSI Fraction Dual Eligible Days Group
15-2385G	QRS 2010 DSH SSI Fraction Dual Eligible Days Group II
15-2386G	QRS 2010 DSH Medicaid Fraction Dual Eligible Days Group II
15-3031G	QRS 2011 DSH Medicaid Fraction Dual Eligible Days Group 2
15-3039G	QRS 2011 DSH SSI Fraction Dual Eligible Days Group 2
15-3073GC	QRS Progressive Acute Care 2011 DSH Medicaid Fraction/Dual Eligible Days
16-0091GC	HRS DCH 2010 DSH SSI Fraction Dual Eligible Days CIRP Group
16-0092GC	HRS DCH 2010 Medicaid Fraction Dual Eligible Days CIRP Group
16-1142G	QRS 2013 DSH SSI Fraction Dual Eligible Days Group
16-1145G	QRS 2013 DSH Medicaid Fraction Dual Eligible Days Group
16-1750G	QRS 2012 DSH SSI/Medicaid Dual Eligible Days Group II
17-0867G	QRS 2014 DSH SSI/Medicaid Dual Eligible Days Group
17-1405G	QRS 2013 DSH SSI Fraction Dual Eligible Days Group (2)
17-1406G	QRS 2013 DSH Medicaid Fraction Dual Eligible Days Group (2)
17-1409G	QRS 2005 DSH SSI Fraction Dual Eligible Days Group
17-1412G	QRS 2005 DSH Medicaid Fraction Dual Eligible Days Group
17-1426G	QRS 2006 DSH SSI Fraction Dual Eligible Days Group 3

17-1427G	QRS 2006 DSH Medicaid Fraction Dual Eligible Days Group
18-0270G	QRS 2007 DSH SSI Fraction Dual Eligible Days Group (3)
18-0730G	QRS 2011 DSH SSI Fraction Dual Eligible Days Group III
18-1259G	QRS 2014 DSH SSI Fraction Dual Eligible Days Group 2
18-1260G	QRS 2014 DSH Medicaid Fraction Dual Eligible Days Group 2
18-1405G	QRS 2015 DSH Medicaid Fraction Dual Eligible Days Group
18-1408G	QRS 2015 DSH SSI Fraction Dual Eligible Days Group
18-1738GC	AHMC Healthcare CY 2012 DSH Medicaid Fraction Dual Eligible Days CIRP
19-0012GC	AHMC Healthcare CY 2015 DSH SSI Fraction Dual Eligible Days CIRP Group
19-0014GC	AHMC Healthcare CY 2015 DSH Medicaid Fraction Dual Eligible Days CIRP
19-0164GC	AHMC Healthcare CY 2013 DSH Medicaid Fraction Dual Eligible Days CIRP Group
19-0195GC	Houston Methodist CY 2014 DSH SSI Fraction Dual Eligible Days CIRP Group
19-0235GC	Houston Methodist CY 2014 DSH Medicaid Fraction Dual Eligible Days CIRP
19-0270GC	Mercy CY 2016 DSH SSI Fraction Dual Eligible Days CIRP Group
19-0272GC	Mercy CY 2016 DSH Medicaid Fraction Dual Eligible Days CIRP Group
19-0534G	QRS CY 2011 DSH Medicaid Fraction Dual Eligible Days (3) Group
19-0704G	QRS CY 2012 DSH SSI Fraction Dual Eligible Days (3) Group
19-0706G	QRS CY 2012 DSH Medicaid Fraction Dual Eligible Days (3) Group
19-2131GC	Hartford Health CY 2015 DSH SSI Fraction Dual Eligible Days CIRP Group
19-2134GC	Hartford Health CY 2015 DSH Medicaid Fraction Dual Eligible Days CIRP
19-2513G	QRS CY 2016 DSH SSI Fraction Dual Eligible Days Group
19-2515G	QRS CY 2016 DSH Medicaid Fraction Dual Eligible Days Group
19-2594G	QRS CY 2015 DSH SSI Fraction Dual Eligible Days (2) Group
19-2596G	QRS CY 2015 DSH Medicaid Fraction Dual Eligible Days (2) Group
20-0107G	QRS CY 2013 DSH SSI Fraction Dual Eligible Days (3) Group
20-0112G	QRS CY 2013 DSH Medicaid Fraction Dual Eligible (3) Group
20-0209G	QRS CY 2010 DSH SSI Fraction Dual Eligible Days (3) Group
20-0211G	QRS CY 2010 DSH Medicaid Fraction Dual Eligible (3) Group
20-0244G	QRS CY 2007 DSH Medicaid Fraction Dual Eligible Days (4) Group
20-0248G	QRS CY 2006 DSH SSI Fraction Dual Eligible Days (4) Group
20-0250G	QRS CY 2006 DSH Medicaid Fraction Dual Eligible Days (4) Group
20-0367G	QRS CY 2005 DSH SSI Fraction Dual Eligible Days (2) Group
20-0368G	QRS CY 2005 DSH Medicaid Fraction Dual Eligible Days (2) Group
20-0409GC	AHMC Healthcare CY 2016 DSH SSI Fraction Dual Eligible Days CIRP Group
20-0411GC	AHMC Healthcare CY 2016 DSH Medicaid Fraction Dual Eligible Days CIRP
20-1511G	QRS CY 2014 DSH SSI Fraction Dual Eligible Days (2) Group
20-1513G	QRS CY 2014 DSH Medicaid Fraction Dual Eligible Days (2) Group
20-1655G	QRS CY 2007 DSH SSI Fraction Dual Eligible Days (4) Group

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Closure of Group Appeals Pursuant to 42 C.F.R. § 405.1842(h)(3)(iii)***
Case No. 13-3814GC *et al.* (*see* Attached listing marked as Appendix A)

Dear Messrs. Ravindran and Berends:

As the parties are aware, Quality Reimbursement Services, Inc. ("QRS" or "Group Representative"), the Providers' designated representative, filed a *consolidated* request for expedited judicial review ("EJR") on June 2, 2022 involving, in the aggregate, eight (8) group cases and thirty four (34) participants. As discussed in further detail *infra*, the Group Representative filed a complaint in the U.S. District Court for the District of Columbia ("D.C. District Court") on June 3, 2022,[1] ***one day after the EJR request was filed with the Board***. Two cases[2] were dismissed by the Board on July 22, 2022.

Due to the fact that the EJR request was filed concurrently with two cases'[3] Schedules of Providers ("SOPs"), Federal Specialized Services ("FSS"), the Medicare Contractors' representative, requested an extension of time to review those two cases on June 16, 2022. QRS did not oppose FSS' extension request.

The Board issued a Scheduling Order ("Scheduling Order") on June 28, 2022 for all eight group cases in the consolidated EJR request. The Scheduling Order noted that the Supreme Court issued a decision in *Becerra v. Empire Health Foundation* ("*Empire*")[4] *after* QRS filed the instant EJR request. Since the *Empire* decision was directly relevant to the issues in the EJR Request, but the request and responses did not discuss the case, the Board exercised its authority under 42 C.F.R. § 405.1842(e)(3) to issue a Scheduling Order requiring QRS to file a response within 21 days (*i.e.*, by July 19, 2022):

1. Giving updates on whether the groups' participants were still pursuing the EJR Request;
2. Requesting withdrawals for each case not being pursued; and

[1] *Kings Mountain Hosp. v. Becerra*, Case No. 1:22CV01582 (D.D.C., filed June 3, 2022).
[2] PRRB Case Nos. 13-3813GC and 15-1162GC.
[3] PRRB Case Nos. 13-3813GC and 13-3814GC.
[4] 142 S.Ct. 2354 (2022).

3. Updating, or clarifying as relevant, the EJR request to discuss the impact of *Empire* on the EJR request challenging (whether in whole or in part) the Secretary's policy of including no-pay/exhausted Part A days in the Medicare fraction for each case being pursued.[5]

Following the Board's Scheduling Order, the Providers filed ***no objections*** *or requests for clarification with regard to the Scheduling Order itself*. As a result, the Board and FSS continued to take actions consistent with that Scheduling Order. The Medicare Contractors were required to file, through FSS, any response to the Group Representative's response no later than 21 days after it was filed.

The Group Representative filed a response to the Scheduling Order on July 19, 2022. It noted that all cases were pursuing EJR and none would be withdrawn. It noted that, in light of the *Empire* decision, it intended to submit an updated EJR Request to focus on new arguments related to the Medicare Fraction. On July 22, 2022, the Board issued a Denial of EJR Requests and Scheduling Order. It noted that QRS' July 19 response was incomplete and sought additional time to brief *Empire* along with its new issue focusing on the numerator of the Medicare Fraction. The Board found that QRS failed to brief the *Empire* decision as required by the Board's Scheduling Order and denied the request for additional time to do so. The Board also denied the EJR Requests for all eight (8) cases, noting that group cases can only contain one issue and to the extent that QRS was attempting to identify or brief a new issue, the group cases would need to be bifurcated. Finally, since the new issue being pursued pertains to the numerator of the Medicare fraction, the Board dismissed cases 13-3813GC and 15-1162GC which only related to the Medicaid fraction.

For the remaining six (6) cases, the Board noted that QRS needed to request bifurcation in order to pursue any new issues no later than August 22, 2022. It noted that any bifurcation requests would need to include: (i) the original group issue statement with an explanation of how the new issue was included therein; (ii) an explanation of how any new issues had not been abandoned in filings made in each CIRP group case; (iii) an explanation of how each amount in controversy calculation contemplated the issue decided in *Empire* and any newly sought issues; and (iv) for participants who were transferred from individual appeals, an explanation of how it included any newly sought issues in its original appeal request.

On August 22, 2022, QRS timely filed its response to the Board's Scheduling Order. Within its response, QRS obliquely notified the Board that they had commenced an action in federal court and served the Secretary of Health and Human Services on August 18, 2022. It insisted that the Board now lacked jurisdiction to dismiss or take any action in these cases as a result of its federal court filing. It nevertheless argued that the appeals at issue here all included challenges to an alternate issue (whether all patients entitled to SSI, whether or not a payment was received during hospitalization, should be included in the numerator of the DSH Medicare Fraction).

A review of public records confirmed that QRS had filed litigation eighty (80) days prior to its August 22, 2022 notice to the Board and, more egregiously, just ***one day after the EJR request was filed with the Board***. Specifically, on June 3, 2022, without notice to the Board or the opposing

[5] The Board noted this information was necessary for the Board to determine jurisdiction over the groups and underlying participants and, if the Board found the prerequisite jurisdiction (see 42 C.F.R. § 405.1842(b)(1)-(2)), to then rule on the EJR request. See 42 C.F.R. § 405.1842(f)(2)(iii).

parties in these cases, QRS bypassed the ongoing jurisdictional review process by filing a complaint in the D.C. District Court under Case No. 1:22CV01582 seeking judicial review on the merits of its EJR Request in these eight group cases. This less-than-30-days timing demonstrates that QRS had *no intention* of allowing the Board to process its EJR requests pursuant to 42 U.S.C. § 1395oo(f)(1) and the regulation at 42 C.F.R. § 405.1842 that implemented the statutory provision. QRS' failure to immediately notify the Board and the opposing parties of this litigation filing demonstrates QRS' lack of good faith and the disingenuous nature of its filings before the Board.

QRS' egregious action in these cases is not new to the Board. To provide context for these cases, and the ongoing malfeasance by QRS, the Board attaches and incorporates a copy of the Board's June 10, 2022 closure letter, in response to QRS initiating federal litigation in connection with the consolidated EJR request QRS filed on January 20, 2022 involving 80 group cases for the same issue with 950+ participants in the aggregate, as **Appendix C**.

Procedural Background:

The Scheduling Orders issued in these cases explained that, per 42 C.F.R. §§ 405.1842(b)(2), (e)(2)(ii), and (e)(3)(ii), "jurisdiction is a prerequisite to consideration of an EJR request" and "the 30-day period for [the Board] responding to the EJR request has not yet commenced for these CIRP group appeals and will not commence until the Board completes its jurisdictional review of these CIRP groups." The Board also explained that a Board finding of jurisdiction is a ***prerequisite*** to any review of an EJR request pursuant to 42 C.F.R. § 405.1842.

The Board's conclusion that the 30-day period had not begun is further supported by 42 C.F.R. § 405.1842(b)(2) which states in pertinent part: "the 30-day period for the Board to make a determination under [42 U.S.C. § 1395oo(f)(1)] does not begin to run until the Board finds jurisdiction to conduct a hearing on the specific matter at issue in the EJR request and notifies the provider that the provider's request is complete." Accordingly, 42 C.F.R. § 405.1842(a)(4)(ii) states that a provider may seek EJR review in federal court without an EJR determination by the Board, "*only if* . . . [t]he Board fails to make a determination of its authority to decide the legal question no later than 30 days *after* finding jurisdiction over the matter at issue and notifying the provider that the provider's EJR request is complete." Consistent with these regulatory provisions, Board Rule 42.1 states, in pertinent part:

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

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.[6]

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

Under Board Rule 44.3, if a party intends to respond to a motion, it must do so within 30 days, unless the Board imposes a different deadline. Significantly, QRS did not file any objection to FSS' extension requests in cases 13-3813GC and 13-3814GC. Nor did QRS file any objection to the Scheduling Orders issued in these cases, and in fact requested *additional* time to comply and participate with the Board's June 28, 2022 Scheduling Order.

QRS made clear by filing the Complaint in federal district court on June 3, 2022, that it was bypassing and abandoning the Board's prerequisite jurisdictional review process.

If the Providers were successful on the merits of their claims in federal court, then bypassing the Board's jurisdictional review process could result in millions of dollars being improperly paid. To illustrate this very point, the Board has included as **Appendix C**, a non-exhaustive listing of some of the jurisdictional issues that the Board has identified thus far. The Board expects that additional, material, jurisdictional and/or claim filing issues would be identified if it were to complete the jurisdictional review process.

Board Findings:

The Board must consider the significant impact on the proceedings caused by QRS filing a lawsuit in connection with the above-referenced six (6) group cases.

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

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

> Providers shall also have the right to obtain judicial review of any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines (on its own motion or at the request of a provider of services as described in the following sentence) that it is without authority to decide the question, by a civil action commenced within sixty days of the date on which notification of such determination is received. ***If a provider of services may obtain a hearing under subsection (a)*** and has filed a request for such a hearing, such provider may file a request for a determination by the Board of its authority to decide the question of law or regulations relevant to the matters in controversy (accompanied by such documents and materials as the Board shall require for purposes of rendering such determination). *The Board shall render such determination in writing within thirty days* ***after the Board receives the request and such accompanying documents and materials***, and the determination shall be considered a final decision and not subject to review by the Secretary.[7]

[7] (Emphasis added.)

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

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

> **the Board to make a determination under section 1878(f)(1) of the Act** [*i.e.*, 42 U.S.C. § 1395oo(f)(1)] **does not begin to run until the Board finds jurisdiction to conduct a hearing on the specific matter at issue in the EJR request and notifies the provider that the provider's request is complete**.[8]

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."[9] 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.[10]

Thus, it is clear that the 30-day clock does not start until ***after*** the Board determines it has jurisdiction over the relevant providers (*as well as* any associated group(s) in which these providers participate) in the appeals underlying an EJR request. Note that the Board's use of the term "stay" (as used in this and prior similar situations) in relation to the 30-day period for responding to the parties' EJR requests, was an inartful use of that term because the Board's intent was to simply notify the parties that the Board had not yet finished its jurisdictional review of the parties' EJR requests and, as such, the 30-day period for the review of the EJR requests had not yet commenced.

The Board notes that the Secretary had a sound basis for issuing 42 C.F.R. § 405.1842(b)(2). The statute itself states that a provider may be authorized to request EJR "***if*** [it] ***may obtain a hearing***

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[8] (Emphasis added).

[9] 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)).

[10] (Emphasis added.)

under subsection (a). . . ."[11] Thus, as the Court in *Alexandria Hospital v. Bowen* ("*Alexandria*") noted, "the statute itself suggests that an EJR request need not be considered before the Board determines it has jurisdiction over an appeal. Moreover, the legislative history makes clear that in enacting the EJR provision, Congress sought solely to expedite resolution of the *legal* controversies in Medicare reimbursement appeals."[12] 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***.[13]

The *Alexandria* Court's conclusions are also supported by the practical considerations involved in the EJR process. If EJR requests were permitted to supersede jurisdictional determinations, there would be only two logical outcomes. The first is that jurisdictional determinations need never be made in cases where EJR requests are filed before a jurisdictional determination is reached by the Board. This would result in fraud, waste and abuse concerns if parties, unable to meet the Board's jurisdictional requirements, could still prevail in federal court, merely by filing an EJR request. The second conclusion is that federal trial courts would be forced to resolve jurisdictional disputes.[14] Not only are the federal trial courts ill-suited for making such determinations, it is a task assigned to the Board, *by statute*.

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[11] 42 U.S.C. § 1395oo(f)(1) (emphasis added).
[12] *See* H.R. Rep. No. 96–1167, *reprinted in* 1980 U.S. Code Cong. & Ad. News at 5757; *Alexandria Hosp. v. Bowen*, 631 F. Supp. 1237, 1244 (W.D. Va. 1986); *San Francisco General Hosp. v. Shalala,* No. C 98-00916, 1999 WL 717830 (N.D. Cal. Sept. 8, 1999); *Total Care, Inc. v. Sullivan,* 754 F. Supp. 1097 (W.D. N.C. 1991); *Abington Mem'l Hosp. v. Bowen,* Civ. A No. 86-7262, 1988 WL 71367 (E.D. Pa. July 1, 1988); *Good Samaritan Hosp. v. Heckler*, No. CV84-L-459, 1986 WL 68497 (D. Neb. June 27, 1986).
[13] *Alexandria Hosp. v. Bowen*, 631 F. Supp. at 1244.
[14] 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

Significantly, in the 6 remaining group cases,[15] the Board has not yet completed its jurisdictional review to confirm whether it has jurisdiction to hear all of the providers' disputes raised in the EJR request. The Board stopped this process after it learned that QRS had bypassed the completion of this process even before 30 days had elapsed. Having sufficient time to complete the jurisdictional and substantive claim review[16] process is vital to ensure that the groups, and all of the underlying providers, are properly before the Board both generally and for the issue(s) raised in the EJR request. Further, the jurisdictional and substantive claim review process ensures that the groups, and underlying providers, have complied with the applicable Board regulations and rules (*e.g.*, have not previously withdrawn or been dismissed without being reinstated; are not pursuing a prohibited duplicate appeal of the same issue for the same year; and have complied with the mandatory CIRP group rules). Without a proper jurisdictional review, fraud, waste and abuse concerns arise. Indeed, these concerns are very real and evident in these eight (8) group cases as highlighted in **Appendix B**.

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.[17] QRS' filing of the Complaint in federal district court ***one day after the EJR Request was filed***, without notice to the Board or opposing party, is contemptuous of the Board's authority. It also demonstrates that QRS had no intention of allowing the Board to complete its jurisdictional review, much less the 30-day EJR review period to rule on the EJR request.

B. Effect of QRS' Concurrent Filing of the Complaint on the 6 Group Cases

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

> (3) *Provider lawsuits*. (i) If the provider files a lawsuit seeking judicial review (whether on the basis of the EJR provisions of section 1878(f)(1) of the Act or on some other basis) pertaining to a legal question that is allegedly relevant to a specific matter at issue in a Board appeal to which the provider is a party and that is

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same issue for the same year; or (c) has complied with the mandatory CIRP group rules. Indeed, ***subsequent to filing its Complaint on June 3, 2022***, QRS continued to expand the record and take actions in the Board proceedings in these group cases (*e.g.*, indicating in its July 19, 2022 correspondence with the Board that an updated EJR Request would be filed based on the Supreme Court's *Empire* decision) and it is unclear how a federal court is equipped to keep track of those actions and their import when there has been no jurisdictional determination and/or EJR decision in these cases.

[15] The Board dismissed 2 cases (*see supra* note 2) and, to the extent those cases were remanded for reinstatement, then the Board would similarly need to complete the jurisdictional review process in these 2 cases.

[16] 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."

[17] "Indeed, the statute and regulation by their terms do not impose *any* time constraints on the Board's determination of jurisdiction. *See* 42 U.S.C. 1395oo(f)(1); 42 CFR § 405.1842. The Hospitals' proffered interpretation of the regulation is so wildly disconnected from the text as to `warrant[] little attention.'" *St. Francis Medical Center, et al v. Xavier Becerra*, Memorandum Opinion, No. 1:22-cv-1960-RCL, at 8 (D.D.C. Sept. 27, 2023) (*citing Cape Cod Hosp. v. Leavitt*, 565 F. Supp. 2d 137, 141 (D.D.C. 2008)).

> allegedly not within the Board's authority to decide, the Office of the Attorney Advisor must promptly provide the Board with written notice of the lawsuit and a copy of the complaint.
>
> ****
>
> (iii) *If the lawsuit is filed before a final EJR request is issued on the legal question*, ***the Board may <u>not</u> conduct any further proceedings*** on the legal question or the matter at issue until the lawsuit is resolved.[18]

This regulation ***bars any further Board proceedings*** in these 6 group cases, including proceedings on *pre-requisite* jurisdictional issues or other procedural issues. Consistent with FRCP 62.1, the Board issues this ruling on a Motion for Relief that is barred by a pending appeal and, as explained below, is deferring further action in these 6 group cases until, or if, the Administrator remands these cases back to the Board.

To confirm the proper application of § 405.1842(h)(3), the Board reviewed the preambles to the proposed rule, dated June 5, 2004,[19] and the May 23, 2008 final rule[20] that promulgated the regulation at 42 C.F.R. § 405.1842(h)(3)(iii). The preamble to the proposed rule described this regulation as follows:

> Proposed § 405.1842(h)(3) would specify the effect that a provider lawsuit would have on the Board's ability to conduct further proceeding on the legal matter at issue. In general, if a provider files a lawsuit on the same legal issue for the same cost year that is currently pending before the Board - that is, the provider goes into court without waiting for a final administrative decision on EJR, we would seek to have the lawsuit dismissed, and we would prohibit the Board from conducting further proceedings on that issue until the lawsuit is resolved.[21]

The discussion in the final rule includes additional guidance on 42 C.F.R. § 405.1842(h)(3):

> *Comment*: One commenter stated that the proposed rule would provide that, if any allegedly relevant lawsuit was filed before a final EJR decision, the Board would be precluded from conducting any further proceedings on the EJR decision until the lawsuit was resolved, and that it appears that the proposed policy would apply, regardless of the basis for the lawsuit. The commenter suggested that the final rule provide that the Board be required to conduct further proceedings on an EJR decision when the provider subsequently files a lawsuit brought on jurisdictional grounds other than the Social

[18] (Emphasis added.)
[19] 69 Fed. Reg. 35716 (June 25, 2004).
[20] 73 Fed. Reg. 30190 (May 23, 2008).
[21] 69 Fed. Reg. at 35732.

> Security Act. If the Board were allowed to grant EJR, the issues jurisdictionally under the Medicare statute could be added to the pending matter in court, thus preserving judicial resources and avoiding multiple lawsuits.
>
> *Response*: The commenter is correct that the proposed policy would apply regardless of the jurisdictional basis for the lawsuit. However, we decline to adopt the commenter's suggestion that we make a distinction based on the jurisdictional basis pleaded in the complaint. **We do not agree that it would be appropriate for the Board or the intermediary to spend its limited resources to spend time on a Board appeal if the provider has filed a complaint that involves a legal matter that is relevant to a legal issue in the Board appeal**. If the court properly has jurisdiction over the appeal, the decision, that it or a higher court renders, may resolve the issue or issues in the Board case, or otherwise inform the Board in reaching a decision, or affect the parties' decision as to whether they should attempt to settle the Board case. On the other hand, where the basis for the court's jurisdiction is defective (which we believe would most likely be the situation when a provider attempts to file a complaint based on a legal issue related to an appeal still pending before the Board), a contrary rule would not discourage providers from filing improper appeals with the court. We believe our proposal to be in line with the general rule practiced by courts that an appeal to a higher court deprives the lower court of jurisdiction to conduct further proceedings until the appeal is resolved by the higher court.[22]

Based on the above explanation regarding the intent and purpose for 42 C.F.R. § 405.1842(h)(3)(iii), the Board finds that QRS' concurrent filing of the Complaint in the D.C. District Court on June 3, 2022 prohibits the Board from conducting any further proceedings on the consolidated EJR request for the six cases at issue therein as filed, including any proceedings related to the prerequisite jurisdiction and claims filing requirements.

C. QRS' Actions

The Board finds that QRS' decision to withhold notice from the Board and the opposing parties of its filing of the federal district court litigation is tantamount to bad faith and actively created confusion surrounding the status of these cases at the Board because it ignored the 30-day Board review period as provided at 42 U.S.C. § 1395oo(f)(1) ***and*** *implemented at 42 C.F.R. § 405.1842*. Indeed, QRS' preemptive actions, taken without notice to the Board or the opposing parties, demonstrate that QRS had no intent to exhaust its administrative remedies before the Board. Pursuant to Board Rule 1.3 (Nov. 1, 2022),[23] QRS had a duty to communicate early, and in good

[22] 73 Fed. Reg at 30214-15 (bold and underline emphasis added).

[23] The recent changes to the Rules (effective Nov. 1, 2021) were first published in June 16, 2021 and, in advance of their effective date, invited comments from all interested individuals, providers, government contractors and other organization to be submitted by July 30, 2021. Subsequently on September 30, 2021, based on its review of that

faith, with the Board and the opposing parties (in that regard the Secretary is not a party per 42 C.F.R. § 405.1843(b)):

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

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

> **5.2 Responsibilities**
>
> *The case representative is responsible for being familiar with the following rules and procedures* for litigating before the Board:
>
> - The Board's governing statute at 42 U.S.C. § 1395oo;
> - *The Board's governing regulations at 42 C.F.R. Part 405, Subpart R*; and
> - *These Rules*, which include any relevant Orders posted at https://www.cms.gov/Regulations-and-Guidance/ReviewBoards/PRRBReview/PRRB-Instructions (see Rule 1.1).
>
> Further, *the case representative is responsible for*:
>
> - Ensuring his or her contact information is current with the Board, including a current email address and phone number;
> - Meeting the Board's deadlines; and
> - *Responding timely to correspondence or requests from the Board or the opposing party*.
>
> 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

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feedback, the Board then published further revisions to the Rules (effective Nov. 1, 2021). *See* Board Order No. 1 (available at: https://www.cms.gov/files/document/revised-prrb-rules-v-30-cover-order-1-superseded-v-31.pdf); Board Alerts 21 and 22 (available at https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/PRRB-Alerts); Board Order No. 2 (https://www.cms.gov/files/document/current-prrb-rules-v-31-cover-order-2-november-1-2021.pdf).

> appointment of a new case representative will also not be considered good cause for delay of any deadlines or proceedings.[24]

Indeed, the following acts (or inaction) by QRS reinforce the Board's finding that QRS has no basis to claim that proceedings before the Board have been exhausted:

1. QRS did not notify the Board, FSS, or the Medicare Contractors, of its opposition to FSS' motion to extend the Medicare Contractor's time to file jurisdictional challenges in these eight (8) group cases.

2. QRS failed to promptly and timely notify the Board of its objection to the Board's ruling on the extension, and the associated Scheduling Orders for these eight (8) group cases.[25] QRS' failure to file and preserve its objection to the Board's ruling and Scheduling Orders violates QRS' obligations under Board Rules 1.3, 5.2, and 44. QRS' failures further deprived the Board of an opportunity to reconsider its ruling and Scheduling Orders and, if necessary, correct or clarify that ruling and/or the Scheduling Orders.[26]

3. The Board made known to the parties in these cases its position regarding the 30-day period to respond to the EJR request at issue, based on 42 U.S.C. § 1395oo(f), 42 C.F.R. §§ 405.1842(b)(2), 405.1801(d)(2).[27] Specifically, the Board notified the parties that the Board had the authority to stay the start of the 30-day period. The Board's notice was based on 42 C.F.R. § 405.1842(b)(2) which specifies that jurisdiction is a prerequisite to Board consideration of an EJR request ***and*** that the 30-day period to review the EJR request does ***not*** begin until the Board finds jurisdiction. To that end, the Board issued its Scheduling Order for these eight (8) group cases to memorialize, and effectuate, the necessity to conduct the jurisdictional review process and delay the start of the 30-day

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[24] (Italics emphasis added.) *See also, Baptist Mem'l Hosp.-Golden Triangle v. Sebelius*, 566 F.3d 226, 227 (D.C. Cir. 2009) wherein the Circuit Court affirmed the District Court's granting of summary judgment to the Secretary because the Providers failed to follow Board Rules, stating, "The court therefore granted summary judgment to the Board. Because the Board's procedural rules mean what they say and say what they mean, and because the hospitals did not follow them, we affirm."

[25] The Board's dismissal of 2 group cases did not occur until July 22, 2022 (after the initial Scheduling Order). On July 22, 2022, the Board denied the EJR request, dismissed 2 cases, and issued a second Scheduling Order requiring additional information from the parties.

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

[27] The Board's Notice was clear that a Board finding of jurisdiction is a prerequisite to any review of an EJR request citing to 42 C.F.R. §§ 405.1842(b)(2), (e)(2)(ii), (e)(3)(ii).

period to review the EJR request.[28] QRS failed to notify the Board of its objection to the Scheduling Orders. QRS' failure to timely file any objection violates Board Rules 1.3, 5.2 and 44. Indeed, QRS' actions interfered with the speedy, orderly and fair conduct of Board proceedings and prejudiced the Board by depriving it of an opportunity to reconsider its rulings and, if necessary, correct or clarify them,[29] or take other actions, ***prior to*** QRS filing its June 3, 2022 Complaint. Indeed, QRS' preemptive actions did not even allow completion of the 30-day EJR review deadline, ***as alleged by QRS to be established in 42 U.S.C. § 1395oo(f)(1) (and which QRS alleges in its litigation the Board missed)***, to pass, and, under QRS' strained interpretation that ignores the Secretary's regulations, permitted federal litigation to be pursued.[30]

4. QRS' failure to promptly notify the Board that it had filed the lawsuit in the D.C. District Court violates Board Rule 1.3, and prevented the Board and the Medicare Contractors from understanding the nature of QRS' position relative to the 30-day period specified in 42 U.S.C. § 1395oo(f)(1). The following circumstances make it clear that QRS had an affirmative obligation to notify the Board of the Complaint being filed, and that QRS should have been aware of that affirmative obligation:

   a. The Board, in its Scheduling Orders issued for these cases (as well as for other cases prior to June 3, 2022 as set forth in **Appendix B**), made clear the Board's position that the 30-day period for responding to the EJR request would not commence until the Board had completed its jurisdictional review and issued its jurisdictional findings.

   b. The Board and the Medicare Contractors were all acting in reliance on the authority of those Scheduling Orders.

D. Board Actions

These facts demonstrate that QRS had a duty, pursuant to Board Rule 1.3, "to communicate early and act in good faith [with regard] [] to dealings with the opposing party, the Board, and/or any relevant nonparty." Indeed, QRS' failure to comply with Board Rule 1.3, through prompt notification of the lawsuit on, or about, June 3, 2022, prejudiced the Board, FSS and the Medicare Contractors. Specifically, it interfered with the speedy, orderly and fair conduct of the Board proceedings (on these and other cases) and deprived both the Board, and the Medicare Contractors, of the opportunity to decide whether to delay or cease work on these eight (8) group cases and the underlying 34 participants in favor of other time-sensitive work such as ***other*** EJR requests filed by QRS *and* by other representatives. Indeed, QRS' failure to ***timely*** notify the Board, and the opposing parties, of this lawsuit filed in the D.C. District Court, raises very serious concerns about prejudicial sandbagging by QRS to benefit prior, current and subsequent

[28] *See supra* note 27.
[29] For example, the Board could have explained how reliance ***solely*** on 42 U.S.C. § 1395oo(f)(1) would be misplaced, given the Secretary's implementation of that statute at 42 C.F.R. § 405.1842 (including in particular § 405.1842(b)(2)) as promulgated in the May 23, 2008 final rule and the Secretary's explanation of that regulation in the June 25, 2004 proposed rule. *See supra* notes 9-14 and accompanying text.
[30] *See supra* note 26 (discussing how the FRCP supports the Board's position).

EJR requests that QRS filed on behalf of other providers ***or*** by other representatives for EJR requests filed for the same issue.[31] The prejudicial sandbagging is highlighted by the facts that:

1. Across the 6-month period from December 20, 2021 to June 30, 2022, record concentrations of EJR requests were filed covering 642 group cases involving 2000+ participants (with the overlay of challenges caused by the surge in the Omicron variant of the COVID-19 virus at the beginning of that 6-month period); and

2. 80 percent of these requests were filed by either QRS or another representative, Healthcare Reimbursement Services ("HRS") (specifically QRS filed EJR requests covering 359 cases and HRS filed EJR requests covering 148 cases during this 6-month period).[32]

As a point of reference and context for these serious violations by QRS, the Board has included, at **Appendix C**, a copy of the closure letter it issued in 80 QRS cases that were included in a February 14, 2022 Federal Complaint in the California Central District Court. Finally, this is not an isolated event because it is the Board's understanding that: (1) QRS and HRS jointly filed the Complaint in the California Central District Court on April 20, 2022 establishing Case No. 22-cv-02648 covering 178 cases with 969 participants and did so without completing the jurisdictional review process, much less receiving the Board's jurisdictional decision, and without notice to the Board;[33] and (2) QRS filed at least one similar Complaint in the D.C. District Court on May 27, 2022 under Case No. 22-cv-01509.[34]

It is clear the Providers are pursuing the merits of their cases in these eight (8) group cases as part of their lawsuit in the D.C. District Court.[35] Pursuant to 42 C.F.R. § 405.1842(h)(3)(iii), the Board is prohibited from further proceedings in these cases. Therefore, the Board must close these cases.[36]

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

[32] It is the Board's understanding that, on February 14, 2022, QRS established the initial ongoing litigation in the California Central District Court covering 80 group cases with 950+ participants in the aggregate, and that QRS and another representative, HRS *joined* the following additional cases to that lawsuit through the Amended Complaint filed on March 30, 2022 (without any notice to the Board or the opposing party). Similar litigation involving other EJR requests filed by QRS has been filed both in California and the District of Columbia. *See infra* notes 32 and 33 and accompanying text.

[33] Under separate cover, the Board closed the QRS cases by letters dated September 30, 2022 (Grouping A for Case Nos. 13-3842GC, *et al*.; Grouping B for Case Nos. 17-2150GC, *et al*.; and Grouping C for Case Nos. 18-0037GC, *et al*.) , and the HRS cases dated October 19, 2022 (Grouping A for Case Nos. 14-2400GC, *et al*.; and Grouping B for Case Nos. 15-055G, *et al*.). These closure letters included similar findings as in these QRS group cases.

[34] The Board is addressing the cases impacted by this litigation under separate cover.

[35] This is notwithstanding the Board's dismissal of 2 of these group cases.

[36] As noted in 42 C.F.R. § 405.1837(a), a group appeal may only have "a single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group." Similarly, as explained at 42 C.F.R. § 405.1842(d), "[a] provider (or, in the case of a group appeal, a group of providers) may request a determination by the Board that it lacks the authority to decide a legal question relevant to a specific matter at issue in an appeal."

However, the Board cannot permit QRS' reckless and contemptuous disregard for its ***basic*** responsibilities and due diligence as a representative appearing before the Board, its bypassing and abandonment of the jurisdictional review process, and its disregard for the Board's authority, orders and process, to remain unanswered. Accordingly, *if these cases are remanded for further proceedings*, the Board will complete its jurisdictional review and weigh: (a) the severity of QRS' violations of, as well as failure to comply with, Board Rules, regulations and Orders; (b) the prejudice to the Board and the opposing parties; (c) the interference with the speedy, orderly and fair conduct of the Board proceedings (regarding both these cases and others); and (d) the effect on the operations of the Board, when determining what, if any, remedial actions will be taken per 42 C.F.R. § 405.1868.[37] Examples of available remedial actions that the Board may consider taking in these 8 cases[38] to defend its authority resulting from QRS' numerous, egregious regulatory violations and abuses include, but are not limited to:

1. Dismissal of the eight (8) group cases and all underlying participants.

2. Dismissal of any group case in which the Board identifies any jurisdictional or material procedural errors occurred, whether by one participant or more.

3. Dismissal of any participant for which there is an open jurisdictional challenge regardless of the merit of such challenge.

These potential actions are well within the Board's authority pursuant to 42 C.F.R. § 405.1868(a)-(b),[39] as confirmed in the preamble to the May 23, 2008 final rule:

> Most of the comments we received on this subject came from providers, and reflect a perceived disparate treatment by the Board when a provider, rather than an intermediary, fails to follow a procedural rule or timeframe set by the Board. We proposed two

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Accordingly, the Board must assume there are no other issues, particularly since: (1) the existence of other issues would necessarily mean that the Board would not have jurisdiction over the group until that defect was cured; and (2) the Providers did not identify any concurrent issues with the filing of the consolidated EJR request but rather claimed therein that the Board had jurisdiction over the groups.

[37] The Board's planned actions are consistent with those planned for QRS as laid out in **Appendix C**.

[38] As discussed in *supra* note 25, the Board dismissed 2 cases on July 22, 2022. However, then unbeknownst to the Board, QRS had already initiated litigation in the D.C. District Court to pursue the merits on each of these 8 cases (including the 2 that the Board dismissed on July 22, 2022). To the extent the 2 cases that the Board dismissed were remanded back to the Board and reinstated, then the Board would consider remedial actions on these 2 cases.

[39] 42 C.F.R. § 405.1868 states:

> (a) The Board has full power and authority to make rules and establish procedures, not inconsistent with the law, regulations, and CMS Rulings, that are necessary or appropriate to carry out the provisions of section 1878 of the Act and of the regulations in this subpart. The Board's powers include the authority to take *appropriate actions in response to the failure of a party to a Board appeal to comply with Board rules and orders or for inappropriate conduct during proceedings in the appeal*.
> (b) If a provider fails to meet a filing deadline or other requirement established by the Board in a rule or order, the Board may -
> (1) Dismiss the appeal with prejudice;
> (2) Issue an order requiring the provider to show cause why the Board should not dismiss the appeal; or
> (3) Take any other remedial action it considers appropriate.

(Emphasis added.)

> possible actions by the Board, one applicable to a provider and the other applicable to an intermediary. That is, the worst case scenario for a provider would be a dismissal of the appeal by the Board, while the harshest remedy for an intermediary would be the issuance of a decision by the Board based on the written record established at the point of the intermediary's violation. However, we note that, because providers are the proponents of a case, they are responsible for moving the case forward by meeting all deadlines. Additionally, at section 1878(e) of the Act, the Congress has given the Board authority to make rules and establish procedures to carry out its function. Moreover, we note that the Board will have broad discretion to weigh the particular facts at hand in order to decide whether or not an offense merits remedial action.
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> ****
>
> Again, we are clarifying that the proposed rule did not identify a complete listing of all potential Board sanctions. The Board has the authority to take appropriate action against either party for procedural violations, but appropriate action does not necessarily mean a dismissal or the early issuance of a decision by the Board. We believe that these provisions will alert both parties that the Board has a mechanism in place to effectively stop a delaying tactic, or to redress other procedural violations. As a result, the parties should be less inclined to ignore procedural requirements and, accordingly, be more motivated to meet the deadlines set by the Board.[40]

Pursuant to the above, the Board has broad authority to sanction QRS for its repeated, and ongoing, malfeasance.

E. Board Decision and Order

Based on QRS' misconduct, the Board hereby takes the following actions:

1. Closes the six (6) group cases which remain open[41] consistent with 42 C.F.R. § 405.1842(h)(3)(iii); and
2. Suspends the ongoing jurisdictional review process; and
3. Defers consideration of citing QRS for contempt and dismissing these group cases (and/or taking other remedial action to uphold the authority of the Board) based on QRS' numerous, egregious, regulatory violations and abuses until there is an

[40] 73 Fed. Reg. at 30225.
[41] *See supra* note 2 and accompanying text.

Administrator's Remand Order consistent with 42 C.F.R. § 405.1842(h)(3)(iii) and Federal Rule of Civil Procedure ("FRCP") 62.1.[42]

Board Members Participating:

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

For the Board:

9/29/2023

X Clayton J. Nix

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

Accordingly, the Board hereby closes these cases and removes them from the Board's docket. No further proceedings will occur, except upon remand from the Administrator, pursuant to 42 C.F.R. § 405.1877(g)(2).

Enclosures:
Appendix A – Case List
Appendix B – Interim List of Potential Jurisdictional & Procedural Violations Under Review
Appendix C -- June 10, 2022 Board Letter to QRS Deferring Show Cause Order & Closure of Cases

cc: Dana Johnson, Palmetto GBA c/o National Government Services, Inc.
John Bloom, Noridian Healthcare Solutions
Geoff Pike, First Coast Service Options, Inc.
Wilson Leong, FSS
Jacqueline Vaughn, OAA

[42] FRCP 62.1 is entitled "Indicative Ruling on a Motion for Relief That is Barred by a Pending Appeal." While FRCP 62.1 is not directly applicable to the Board, the procedural developments in these cases are similar those addressed in FRCP 62.1 and the Board looked to it for guidance.

APPENDIX A

Grouping A – List of the 8 Group Cases
Covered by the Request for EJR
Filed on June 2, 2022

13-3813GC	Carolinas Healthcare System 2007 DSH Medicaid Fraction Dual Eligible Days CIRP Group
13-3814GC	Carolinas Healthcare System 2007 DSH Medicare Ratio Dual Eligible Days CIRP Group
15-1161GC	QRS University of AZ Health 2012 SSI Fraction Dual Eligible Days CIRP
15-1162GC	QRS University of AZ Health 2012 Medicaid Fraction Dual Eligible Days CIRP
21-1367GC	Baptist Health System CY 2010 DSH Dual Eligible Days (SSI/MCD Fraction) CIRP Group
21-1572GC	Baptist Health System CY 2009 DSH SSI/Medicaid Dual Eligible Days CIRP Group
21-1582GC	Baptist Health System CY 2015 DSH SSI/Medicaid Dual Eligible Days CIRP Group
21-1585GC	Baptist Health System CY 2016 DSH SSI/Medicaid Dual Eligible Days CIRP Group

APPENDIX B

INTERIM LIST OF POTENTIAL JURISDICTIONAL, SUBSTANTIVE CLAIM, AND PROCEDURAL VIOLATIONS UNDER REVIEW[43]

The following summary of jurisdictional, substantive claim and procedural concerns and issues is preliminary and highlights the complexity of the jurisdictional review process.[44] This process is *exponentially* more complex when consolidated EJR requests are concurrently filed involving multiple group cases with 36 participants and when many of those cases are older cases (7+ years old).

The Board, through its ongoing review of jurisdiction, and other procedural issues, in these 8 group cases, has identified multiple, ***material*** jurisdictional issues and concerns that were not raised by FSS or the Medicare Contractors. The Board's review is based on the SoPs filed for these cases because, as explained at Board Rule 20.1.1 (Nov. 2021),[45] the SoPs are supposed to contain all relevant jurisdictional documentation for each participant in the group. The issues and concerns identified by the Board (thus far) include, but are not limited to, the following:

1. *Invalid Appeals Due to Failure to Timely Appeal or Provide the Requisite Documentation*.— QRS failed to include sufficient documentation in the SoPs to establish that many of the participants filed timely appeals. As a result, the Board is reviewing dismissal of a significant number of participants for failure to meet the claims filing requirements. For example, for appeals based on the nonissuance of an NPR, 42 C.F.R. § 405.1835(c)(2) specifies that: "[u]nless the provider qualifies for a good cause extension under § 405.1836, the date of receipt by the Board of the provider's hearing request is no later than 180 days after the expiration of the 12 month period for issuance of the final contractor determination (as determined in accordance with paragraph (c)(1) . . .)." In this instance, the appeal must be filed within 12 months of the Medicare Contractor's receipt of the relevant perfected cost report and, as explained at Board Rule 21.2.2, the SoP must contain the following documents to establish that the cost report was, in fact, filed and when that filing occurred:

    - evidence of the Medicare contractor's receipt of the as-filed or amended cost report under appeal, and
    - evidence of the Medicare contractor's acceptance of the as-filed or amended cost report under appeal. (*See* Board Rule 7.5.)[46]

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[43] This listing is not exhaustive and only reflects preliminary findings and the Board has not yet completed or finalized its jurisdictional findings in these 36 group cases.

[44] The Board notes that 42 C.F.R. § 405.1840 is entitled "Board Jurisdiction" but it also addresses certain claim filing requirements such as timelines or filing deadlines. For example, whether an appeal was timely is not a jurisdictional requirement but rather is a claim filing requirement as the Supreme Court made clear in *Sebelius v. Auburn Reg. Med. Ctr.*, 568 U.S. 145 (2013). *See also* Board Rule 4.1 ("The Board will dismiss appeals that fail *to meet the timely filing requirements* ***and/or*** *jurisdictional requirements*. Similarly, the Board notes that 42 C.F.R. §§ 405.1835(b) and 405.1837(c) address certain claim filing requirements.

[45] *See also* Board Rule 20.1 (Aug. 2018).

[46] Board Rule 7.5 specifies the documentation requirements for appeals based on the nonissuance of a final determination and requires such appeals to include: "evidence of the Medicare contractor's receipt of the as-filed or amended cost report under appeal" and "evidence of the Medicare contractor's acceptance of the as-filed or amended cost report under appeal."

There are a significant number of participants that appealed from the nonissuance of an NPR, and the Board has identified situations where QRS has failed to include the requisite documentation in the SOP to establish that such appeals were timely. *See, e.g.*, Case Nos. 15-1161GC and 15-1162GC (the SoP shows at least both participants as having filed untimely appeals).

2. *Improper Transfer from a Closed Case*.—In Case No. 15-1161GC, the Board is reviewing whether a participant improperly filed a request to transfer from an individual case that had already been closed. If true, the participant would be dismissed as it had no right to transfer from an otherwise closed case.

3. *Unauthorized Representation of Participants*.— The Board reviews the Schedule of Providers to confirm QRS obtained proper ***prior*** authorization from the provider to be a participant in the relevant group.[47,48] This ***prior*** authorization is required to be placed behind Tab H for each participant, as noted by Board Rule 21.9.2, to confirm the participant gave ***prior*** authorization to join the group. The Board is reviewing the SoP to confirm proper authorization.

4. *Participants That Did Not Properly Transfer Into the Group or Only Transferred a Portion of the Issue/Issues Covered By the Group*.— A significant number of the participants in these groups arrived by transfer from an individual appeal. For any participant that transfers into a group from an individual appeal, the Board must review whether the individual appeal properly included the issue the provider seeks to transfer. A provider can only transfer an issue that is properly existing in its individual appeal.[49] The Board expects it would identify multiple participants with these types of jurisdictional transfer issues if it were to complete its jurisdictional review. In this regard, the Board notes that, on March 23, 2023, QRS ***improperly*** requested the Board to reopen Case No. 21-1585GC to permit the transfer a Provider (Baptist Medical Center Jacksonville, FY 2016) from an individual appeal under Case No. 21-0847 to the CIRP group under Case No. 21-1585GC even though, *for over a year*, the CIRP Group had been fully formed and had been pending before the D.C. District Court. Concurrent with this closure letter, the Board issued a

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[47] Per Board Rule 6.4 (Mar.2013, July 2015), "An authorized representative of the Provider must sign the [individual provider] appeal. If the authorized representative is not a Provider employee, attach an Authorization of Representation letter with the Initial Filing on the Provider's letterhead, signed by an owner or officer of the Provider." The Board requires provider-executed letters of representation to be filed *with the appeal* (*i.e.*, to be obtained ***prior to*** taking actions on behalf of the provider) in order to protect providers and health chains from potentially coercive or abusive representation situations, whether in the context of an individual or group appeal.

[48] Per Board Rule 12.4(A) (2015), "The Board will recognize a single Group Representative for all Providers in the group. The Providers filing the initial appeal must appoint the Group Representative by attaching an Authorization of Representation letter on each Provider's letterhead, signed by an owner or officer of the Provider." To this end, the Model Form E (2015) for Direct Add Appeals specifies, "[i]f you are filing as a representative, YOU **MUST** ATTACH A LETTER SIGNED BY THE PROVIDER AUTHORIZING REPRESENTATION UNDER A **TAB LABELED 2**. *See* Rule 5.4." (Emphasis in original.)

[49] The window to add issues to an individual appeal is limited by the regulation at 42 C.F.R. § 405.1835(e) as follows: "After filing a hearing request in accordance with paragraphs (a) and (b), or paragraphs (c) and (d), of this section, a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the Board only if – . . . . (3) The Board receives the provider's request to add issues no later than 60 days after the expiration of the applicable 180-day period prescribed in paragraph (a)(3) or paragraph (c)(2), of this section." *See also* 42 C.F.R. §§ 405.1835(b), 1837(c), & Board Rule 8 for content and specificity requirements for issues being appealed.

ruling, under separate cover, denying the reopening and transfer request and, consistent with 42 C.F.R. § 405.1837(b)(1) and (e)(1), dismissing the issues from the Provider's individual appeal that are the subject of the lawsuit.

5. *Reviewing Scope of the EJR Request and Potential Improper Groups*.—In order for the Board to have jurisdiction over a group appeal, the group appeal must contain only one legal question/issue.[50] Pursuant to 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. § 405.1837(a)(1), a group may only contain one legal issue. In pertinent part, § 405.1837(a)(1) states that "[a] provider . . . has a right to a Board hearing, as part of a group appeal with other providers, with respect to a final contractor or Secretary determination for the provider's cost reporting period, ***only if*** - . . . (2) The matter at issue in the group appeal involves ***a single*** question of fact or ***interpretation*** *of law, regulations, or CMS Rulings* that is common to each provider in the group.[51] The Board is reviewing whether the Providers' consolidated EJR requests are ***improperly*** challenging *multiple* interpretations of law or regulation. In particular, the Board is reviewing whether the EJR request properly includes a challenge to the SSI eligibility codes used to identify the SSI days to be included in the numerator of the Medicare fraction (as embodied in PRRB Dec. No. 2017-D11[52]) in addition to the no-pay Part A days issue (as embodied in the *Empire* litigation decided before the Supreme Court[53]). If true, it raises ***immediate*** jurisdictional problems of whether the additional challenge(s) are *properly* part of the relevant groups[54] and, if true, requires determining: (1) whether each of the participants properly appealed additional issues[55] and, as relevant, whether it requested transfer of those

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[50] *See* 42 C.F.R. §§ 405.1842(a), 405.1842(f); 73 Fed. Reg. 30190, 30212 (May 23, 2008) (in response to comment that "the Board should have the authority to handle more than one question of fact or law in a group appeal" because "sometimes there is more than one disputed fact or question of law pertaining to a single item on the cost report" where "[a] common example of this is the [DSH] adjustment, which is determined by a combination of calculations, each of which may have more than one element in dispute", the Secretary affirmed that [t]he regulations at § 405.1837(a)(2) . . . specify that a group appeal involve a single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group" and that "[w]hat constitutes an appropriate group appeal issue in a given case will be determined by the Board."). The Board further notes that 42 C.F.R. § 405.1839(b) (underline and bold emphasis added) states the following in relevant part:

> (b) *Group appeals*. (1) In order to satisfy the amount in controversy requirement under § 405.1837(a)(3) of this subpart for a Board hearing as a group appeal, the group must demonstrate that if its appeal were successful, the total program reimbursement for the cost reporting periods under appeal would increase, in the aggregate, by at least $50,000.
> (2) *Aggregation of claims*. (i) For purposes of satisfying the amount in controversy requirement, group members are **not allowed to aggregate claims involving different issues**.
> (A) A group appeal must involve a **single** question of fact or **interpretation** of law, regulations, or CMS Ruling that is common to each provider (as described in § 405.1837(a)(2) of this subpart).

[51] (Emphasis added.)

[52] *Hall Render Optional and CIRP DSH Dual/SSI Eligible Group Appeals – Medicare Fraction v. Wisconsin Physicians Servs.*, PRRB Dec. No. 2017-D11 (Mar. 27, 2017).

[53] *Becerra v. Empire Health Found.*, 142 S. Ct. 2354 (2022), *reversing*, 958 F.3d 873 (9th Cir. 2020).

[54] This includes whether the group appeal request includes the additional issue and whether the final SoP filed in the relevant group establishes that the group meets the $50,000 AiC requirement for each of the additional issues. Per 42 C.F.R. § 405.1839(b), participants in a group are ***not*** permitted to aggregate claims involving different issues for purposes of meeting the $50,000 AiC requirement.

[55] Note that a proper appeal on an issue must include an AiC calculation for that issue. If the Providers were to claim that the group had multiple issues, then each participant would have a separate AiC calculation in the SoP *for* ***each*** *issue*. *See* 42 C.F.R. §§ 405.1839(b), 405.1837(c)(2)(iii). However, the Board's initial impressions are that each participant generally only has ***one*** AiC calculation behind Tab E in the relevant SoP.

additional issues to the group; (2) if a preliminary position paper was filed, whether the additional was properly briefed in the preliminary position paper in compliance with 42 C.F.R. § 405.1853(b)(2) and Board Rule 25[56]; and (3) whether the additional issues should be bifurcated from the group per 42 C.F.R. § 405.1837(f)(2).[57] A critical aspect of the jurisdictional inquiry entails confirming that any potential bifurcation would not result in prohibited duplicate appeals by the same providers for the same issue and years. The Board has already flagged this issue in its letter dated July 22, 2022 and it was in the QRS' response to this inquiry that the Board learned of the litigation that QRS filed bypassing completion of the Board's administrative review process.

Notwithstanding the above jurisdictional issues and concerns, QRS made clear, with the June 3, 2022 filing of the Amended Complaint in federal district court, that it was bypassing and abandoning the Board's jurisdictional review process (as discussed above).

[56] 42 C.F.R. § 405.1853(b)(2) and Board Rule 25 require the full briefing of each issue in a position paper filing. Consistent with this regulation and Board Rule 25, Board Rule 25.3 specifies that "[i]f the provider fails to brief an appealed issue in it is position paper, the Board will consider the unbriefed issue abandoned and effectively withdrawn." Cases where the Providers' preliminary position paper was filed prior to the relevant consolidated EJR request being filed include: Case Nos. 21-0237G, 21-0273G and 21-0239G where the position paper was filed in January 2022.

[57] Indeed, the Board is aware that, notwithstanding the fact that it is pursing the merits of its EJR requests in federal district court, it subsequently filed preliminary position papers in the following cases and that these position papers include not just the *Empire* issue but also another separate and distinct issue that the Board refers to in Board Rule 8 as the SSI eligible days issue embodied in PRRB Dec. No. 2017-D12:

- On April 25, 2022 for Case Nos. 19-2534GC, 19-1045GC.
- On May 12, 2022 for Case No. 19-0805GC.
- On June 6, 2022 for Case Nos. 14-2400GC, 14-3295GC, 14-3474GC and 15 2493GCGC.
- On June 13, 2022 for Case Nos. 17-1461GC and 20-1254GC.
- On June 17, 2022 for Case No. 20-1685GC.
- On July 20, 2022 for Case No. 19-1541GC.

The arguments made in these position papers supports the Board's position that the SSI eligibility issue is a separate issue from the *Empire* no pay Part A days issue because each issue involves a different *interpretation* of the relevant statutory provisions, is challenging a different regulatory provision, and seeks different relief since they each involve different types of days (one is seeking removal of no pay Part A days from all of the Medicare fraction while the other is seeking the addition of SSI eligible days to the numerator of the Medicare fraction). *See* 42 C.F.R. § 405.1837(a)(2) (stating providers have a right to participate in a group appeal only if "[t]he matter at issue in the group appeal involves ***a single*** question of fact or ***interpretation*** *of law*, regulations, or CMS Rulings that is common to each provider in the group" (emphasis added)); 42 C.F.R. §§ 405.1835(b), 405.1837(c); Board Rules 7, 8, 12.2, 13, 16, 16.2.

APPENDIX C

June 10, 2022 Board Letter to QRS
Deferring Show Cause Order and Closure of Cases
Pursuant to 42 C.F.R. § 405.1842(h)(3)(iii)
Due to QRS Filing in California Central District Court

(35 pages)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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

Dear Mr. Berends and Ravindran:

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

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

[2] *See supra* note 1.

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

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

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

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

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

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

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

Procedural Background

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

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

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

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

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

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

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

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

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

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

[17] (Emphasis in original.)

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

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

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

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

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

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

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[18] *See supra* note 3.

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

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

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

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

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

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

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

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

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

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

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

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

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

Board Findings and Ruling:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. *Prohibited Duplicate Appeals*

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

2. *Providers With No Appeal Rights*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4. Prohibited Participation of CIRP Providers in Optional Groups

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

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

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

5. *Unauthorized Representation of Participants*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[93] 42 C.F.R. § 405.1868 states:

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

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

(1) Dismiss the appeal with prejudice;

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

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

(Emphasis added.)

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

* * * * *

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

Board Members Participating:

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

For the Board:

6/10/2022

X Clayton J. Nix

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

Enclosures: List of Groups

cc: Bill Tisdale, Novitas Solutions
Judith Cummings, CGS
Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators
Danielle Decker, NGS
Pamela VanArsdale, NGS
Cecile Huggins, Palmetto GBA
Byron Lamprecht, WPS
Wilson Leong, FSS
Jacqueline Vaughn, OAA

[94] 73 Fed. Reg. at 30225.
[95] *See supra* note 92.

LIST OF 80 GROUP CASES

09-1903GC	BHCS 07 DSH Dual Eligible Days
13-1419G	QRS 2006 DSH SSI Fraction Denominator/Dual Eligible Group
13-1440G	QRS 2006 DSH Medicaid Fraction/Dual Eligible Group
13-1720GC	Scott & White 2008 Medicaid Fraction Dual Elig Days CIRP Group
13-1722GC	Scott & White 2008 DSH SSI Fraction Dual Elig Days CIRP Group
13-2678G	QRS 2007 DSH Medicaid Fraction Dual Eligible Days Group (2)
13-2693G	QRS 2008 DSH Medicaid Fraction Dual Eligible Days Group
13-2901GC	QRS BJC 2007 DSH SSI Fraction Dual Eligible Days CIRP Group
13-2903GC	QRS Novant 2007 SSI Fraction Dual Eligible Days CIRP Group
13-2904GC	QRS Novant 2007 Medicaid Fraction Dual Eligible Days CIRP Group
13-3061GC	QRS WFHC 2009 Medicaid Fraction Dual Eligible CIRP Group
13-3191GC	QRS Novant 2006 DSH Dual Eligible Days
13-3942G	QRS 2009 DSH Medicaid Fraction/Dual Eligible Days Group
13-3944G	QRS 2009 DSH SSI Fraction/Dual Eligible Days Group
14-1171G	QRS 2008 DSH SSI Fraction Dual Eligible Days Group
14-1174G	QRS 2007 DSH SSI Fraction Dual Eligible Days Group
14-1816G	QRS 2010 DSH SSI Fraction Dual Eligible Days Group
14-1818G	QRS 2010 DSH Medicaid Fraction Dual Eligible Days Group
14-2217GC	QRS Novant 2009 DSH Medicaid Fraction Dual Eligible Days CIRP Group
14-3306G	QRS 2011 DSH Medicaid Fraction Dual Eligible Days Group
14-3308G	QRS 2011 DSH SSI Fraction Dual Eligible Days Group
15-0018G	QRS 2012 DSH Medicaid Fraction/Dual Eligible Days Group
15-1067G	QRS 2006 DSH Medicaid Fraction Dual Eligible Days Group (2)
15-1147G	QRS 2006 DSH SSI Fraction Dual Eligible Days Group (2)
15-1152GC	QRS Novant 2010 DSH Medicaid Fraction Dual Eligible Days CIRP Group
15-1419G	QRS 2012 DSH SSI Fraction Dual Eligible Days Group
15-2385G	QRS 2010 DSH SSI Fraction Dual Eligible Days Group II
15-2386G	QRS 2010 DSH Medicaid Fraction Dual Eligible Days Group II
15-3031G	QRS 2011 DSH Medicaid Fraction Dual Eligible Days Group 2
15-3039G	QRS 2011 DSH SSI Fraction Dual Eligible Days Group 2
15-3073GC	QRS Progressive Acute Care 2011 DSH Medicaid Fraction/Dual Eligible Days
16-0091GC	HRS DCH 2010 DSH SSI Fraction Dual Eligible Days CIRP Group
16-0092GC	HRS DCH 2010 Medicaid Fraction Dual Eligible Days CIRP Group
16-1142G	QRS 2013 DSH SSI Fraction Dual Eligible Days Group
16-1145G	QRS 2013 DSH Medicaid Fraction Dual Eligible Days Group
16-1750G	QRS 2012 DSH SSI/Medicaid Dual Eligible Days Group II
17-0867G	QRS 2014 DSH SSI/Medicaid Dual Eligible Days Group
17-1405G	QRS 2013 DSH SSI Fraction Dual Eligible Days Group (2)
17-1406G	QRS 2013 DSH Medicaid Fraction Dual Eligible Days Group (2)
17-1409G	QRS 2005 DSH SSI Fraction Dual Eligible Days Group
17-1412G	QRS 2005 DSH Medicaid Fraction Dual Eligible Days Group
17-1426G	QRS 2006 DSH SSI Fraction Dual Eligible Days Group 3

17-1427G	QRS 2006 DSH Medicaid Fraction Dual Eligible Days Group
18-0270G	QRS 2007 DSH SSI Fraction Dual Eligible Days Group (3)
18-0730G	QRS 2011 DSH SSI Fraction Dual Eligible Days Group III
18-1259G	QRS 2014 DSH SSI Fraction Dual Eligible Days Group 2
18-1260G	QRS 2014 DSH Medicaid Fraction Dual Eligible Days Group 2
18-1405G	QRS 2015 DSH Medicaid Fraction Dual Eligible Days Group
18-1408G	QRS 2015 DSH SSI Fraction Dual Eligible Days Group
18-1738GC	AHMC Healthcare CY 2012 DSH Medicaid Fraction Dual Eligible Days CIRP
19-0012GC	AHMC Healthcare CY 2015 DSH SSI Fraction Dual Eligible Days CIRP Group
19-0014GC	AHMC Healthcare CY 2015 DSH Medicaid Fraction Dual Eligible Days CIRP
19-0164GC	AHMC Healthcare CY 2013 DSH Medicaid Fraction Dual Eligible Days CIRP Group
19-0195GC	Houston Methodist CY 2014 DSH SSI Fraction Dual Eligible Days CIRP Group
19-0235GC	Houston Methodist CY 2014 DSH Medicaid Fraction Dual Eligible Days CIRP
19-0270GC	Mercy CY 2016 DSH SSI Fraction Dual Eligible Days CIRP Group
19-0272GC	Mercy CY 2016 DSH Medicaid Fraction Dual Eligible Days CIRP Group
19-0534G	QRS CY 2011 DSH Medicaid Fraction Dual Eligible Days (3) Group
19-0704G	QRS CY 2012 DSH SSI Fraction Dual Eligible Days (3) Group
19-0706G	QRS CY 2012 DSH Medicaid Fraction Dual Eligible Days (3) Group
19-2131GC	Hartford Health CY 2015 DSH SSI Fraction Dual Eligible Days CIRP Group
19-2134GC	Hartford Health CY 2015 DSH Medicaid Fraction Dual Eligible Days CIRP
19-2513G	QRS CY 2016 DSH SSI Fraction Dual Eligible Days Group
19-2515G	QRS CY 2016 DSH Medicaid Fraction Dual Eligible Days Group
19-2594G	QRS CY 2015 DSH SSI Fraction Dual Eligible Days (2) Group
19-2596G	QRS CY 2015 DSH Medicaid Fraction Dual Eligible Days (2) Group
20-0107G	QRS CY 2013 DSH SSI Fraction Dual Eligible Days (3) Group
20-0112G	QRS CY 2013 DSH Medicaid Fraction Dual Eligible (3) Group
20-0209G	QRS CY 2010 DSH SSI Fraction Dual Eligible Days (3) Group
20-0211G	QRS CY 2010 DSH Medicaid Fraction Dual Eligible (3) Group
20-0244G	QRS CY 2007 DSH Medicaid Fraction Dual Eligible Days (4) Group
20-0248G	QRS CY 2006 DSH SSI Fraction Dual Eligible Days (4) Group
20-0250G	QRS CY 2006 DSH Medicaid Fraction Dual Eligible Days (4) Group
20-0367G	QRS CY 2005 DSH SSI Fraction Dual Eligible Days (2) Group
20-0368G	QRS CY 2005 DSH Medicaid Fraction Dual Eligible Days (2) Group
20-0409GC	AHMC Healthcare CY 2016 DSH SSI Fraction Dual Eligible Days CIRP Group
20-0411GC	AHMC Healthcare CY 2016 DSH Medicaid Fraction Dual Eligible Days CIRP
20-1511G	QRS CY 2014 DSH SSI Fraction Dual Eligible Days (2) Group
20-1513G	QRS CY 2014 DSH Medicaid Fraction Dual Eligible Days (2) Group
20-1655G	QRS CY 2007 DSH SSI Fraction Dual Eligible Days (4) Group

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Closure of Group Appeals Pursuant to 42 C.F.R. § 405.1842(h)(3)(iii)***
Case No. 21-0971GC *et al.* (*see* Attached listing marked as Appendix A)

Dear Messrs. Ravindran and Berends:

As the parties are aware, Quality Reimbursement Services, Inc. ("QRS" or "Group Representative"), the Providers' designated representative, filed a *consolidated* request for expedited judicial review ("EJR") on May 13, 2022 involving, in the aggregate, four (4) group cases and fourteen (14) participants. As discussed in further detail *infra*, the Group Representative filed a complaint in the U.S. District Court for the District of Columbia ("D.C. District Court") on either April 20, 2022,[1] (***before*** *the EJR request was filed with the Board*) or on May 13, 2022 (*the* ***same*** *day that the EJR request was filed with the Board*[2]).

Due to the fact that the EJR request was filed concurrently with four cases[3] and Schedules of Providers ("SOPs"), Federal Specialized Services ("FSS"), the Medicare Contractors' representative, requested an extension of time to review those two cases on May 13, 2022. QRS did not file a response or any opposition to FSS' extension request.

The Board issued a Scheduling Order ("Scheduling Order") on June 3, 2022 for all four group cases in the consolidated EJR request granting FSS' extension request.[4] The Scheduling Order set July 12, 2022 as the due date for FSS to file its response to the EJR request and August 11, 2022 as the deadline for QRS to file its response to FSS' filing. The Scheduling Order further notified the parties that the 30-day period for the Board to rule on an EJR request had not begun and that the Board would notify them when it did begin:

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[1] *Cleveland Clinic, et al v. Becerra*, Case No. 2:22-cv-02648 (C.D. Cal. filed April 20, 2022).

[2] As explained *infra*, QRS' September 7, 2022 notification states that: (1) it "commenced an action" in the Central California District Court per the attached Complaint with a filing stamp date of April 20, 2022; (2) it served the CMS Administrator on August 9, 2022; and (3) As a result, "the Board does not at present possess jurisdiction over the . . . cases[] [per] 42 C.F.R. § 405.1842(h)(3)(iii)." However, the Board's review of docket for this case shows that an Amended Complaint was filed on May 13, 2022 listing one or more DCH hospitals. Accordingly, the Board suspects that these 4 appeals were added to the litigation as part of the May 13, 2022 Amended Complaint. However, for purposes of this letter, it does not matter whether it was April 20, 2022 versus May 13, 2022 since either filing date would demonstrate that QRS had *no intention* of allowing the Board to process its EJR requests pursuant to 42 U.S.C. § 1395oo(f)(1) and the regulation at 42 C.F.R. § 405.1842.

[3] PRRB Case Nos. 21-0971GC, 21-0974GC, 21-0979GC and 21-0982GC.

[4] The Board's June 3, 2022 Scheduling Order also addressed additional EJR requests filed by QRS on May 12, 2022 and May 13, 2022 that included a total of 25 cases and 99 providers.

> [A]s jurisdiction is a prerequisite to consideration of an EJR request, this Scheduling Order necessarily affects the 30-day period for the Board's determination of authority required to decide the EJR request. Specifically, this Scheduling Order, "confirm[s] . . . that the 30-day period for the Board to rule on the EJR request has been stayed because the EJR request is incomplete and the Board does not yet have all the information necessary to rule on the EJR request." Further, in issuing this Scheduling Order, the Board is mindful of the Covid-19 pandemic. *Notwithstanding, be advised that the above filing deadlines in this Scheduling Order are **firm** and the Board is **exempting** them from the Alert 19 suspension of Board filing deadlines*. The Board will continue its review of the jurisdiction in these appeals, as well as review the Providers' request for EJR, upon receipt of the requested information, or the August 11, 2022 filing
> deadline, whichever occurs first.
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> ****
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> The Board will notify you when the jurisdiction review process has been completed and the 30-day period begins.

QRS *the Providers filed **no objections** or requests for clarification with regard to the Notice and Extension Ruling*.

On August 10, 2022, the Board issued a Scheduling Order: Additional Briefing for EJR ("Additional Briefing") which noted that the Supreme Court issued a decision in *Becerra v. Empire Health Foundation* ("*Empire*")[5] *after* QRS filed the instant EJR request. Since the *Empire* decision was directly relevant to the issues in the EJR Request, but the request and responses did not discuss the case, the Board exercised its authority under 42 C.F.R. § 405.1842(e)(3) to issue a Scheduling Order requiring QRS to file a response within 21 days (*i.e.*, by September 7, 2022):

1. Giving updates on whether the groups' participants were still pursuing the EJR Request;
2. Requesting withdrawals for each case not being pursued; and
3. Updating, or clarifying as relevant, the EJR request to discuss the impact of *Empire* on the EJR request challenging (whether in whole or in part) the Secretary's policy of including no-pay/exhausted Part A days in the Medicare fraction for each case being pursued.[6]

*Following the Board's Scheduling Order, the Providers filed **no objections** or requests for clarification with regard to the Scheduling Order itself*. As a result, the Board and FSS continued to take actions consistent with that Scheduling Order. The Medicare Contractors were

[5] 142 S.Ct. 2354 (2022).
[6] The Board noted this information was necessary for the Board to determine jurisdiction over the groups and underlying participants and, if the Board found the prerequisite jurisdiction (see 42 C.F.R. § 405.1842(b)(1)-(2)), to then rule on the EJR request. See 42 C.F.R. § 405.1842(f)(2)(iii).

required to file, through FSS, any response to the Group Representative's response no later than 21 days after it was filed.

The Group Representative filed a timely response to the Additional Briefing Order on September 7, 2022. Within its response, QRS notified the Board that they had "commenced an action" in the Central California District Court per the attached Complaint with a filing stamp date of April 20, 2022 under Case No. 2:22-CV-02648 and served the Secretary of Health and Human Services *ninety-eight (98) days later*, on July 27, 2022. It insisted that the Board now lacked jurisdiction to dismiss or take any action in these cases as a result of its federal court filing. It nevertheless argued that the appeals at issue here all included challenges to an alternate issue (whether all patients entitled to SSI, whether or not a payment was received during hospitalization, should be included in the numerator of the DSH Medicare Fraction).

A review of public records for under Case No. 2:22-CV-02648 confirms that an Amended Complaint was later filed on May 13, 2022 listing one or more DCH hospitals. Accordingly, the Board suspects that these 4 appeals were added to the litigation as part of the May 13, 2022 Amended Complaint. However, for purposes of this letter, it does not matter whether it was April 20, 2022 versus May 13, 2022. Specifically, on either April 20, 2022 or May 13, 2022, without notice to the Board or the opposing parties in these cases, QRS bypassed the ongoing jurisdictional review process by filing a complaint (or amended complaint) in the District Court for the Central District of California under Case No. 2:22-CV-02648 seeking judicial review on the merits of its EJR Request in these four group cases.[7] The fact that QRS filed a federal district court complaint ***before*** **(**or on the same day that) it filed its EJR request demonstrates that QRS had *no intention* of allowing the Board to process its EJR requests pursuant to 42 U.S.C. § 1395oo(f)(1) and the regulation at 42 C.F.R. § 405.1842 that implemented the statutory provision. QRS' failure to immediately notify the Board and the opposing parties of this litigation filing demonstrates QRS' lack of good faith and the disingenuous nature of its filings before the Board.

QRS' *egregious* action in these cases is not new to the Board. To provide context for these cases, and the ongoing malfeasance by QRS, the Board attaches and incorporates a copy of the Board's June 10, 2022 closure letter, in response to QRS initiating federal litigation in connection with the consolidated EJR request QRS filed on January 20, 2022 involving 80 group cases for the same issue with 950+ participants in the aggregate, as **Appendix C**.

Procedural Background:

The Scheduling Orders issued in these cases explained that, per 42 C.F.R. §§ 405.1842(b)(2), (e)(2)(ii), and (e)(3)(ii), "jurisdiction is a prerequisite to consideration of an EJR request" and "the 30-day period for [the Board] responding to the EJR request has not yet commenced for these CIRP group appeals and will not commence until the Board completes its jurisdictional review of these CIRP groups." The Board also explained that a Board finding of jurisdiction is a ***prerequisite*** to any review of an EJR request pursuant to 42 C.F.R. § 405.1842.

[7] Case No. 2:22-CV-02648 also includes *numerous* other appeals and hundreds of providers which were be addressed under separate cover.

The Board's conclusion that the 30-day period had not begun is further supported by 42 C.F.R. § 405.1842(b)(2) which states in pertinent part: "the 30-day period for the Board to make a determination under [42 U.S.C. § 1395oo(f)(1)] does not begin to run until the Board finds jurisdiction to conduct a hearing on the specific matter at issue in the EJR request and notifies the provider that the provider's request is complete." Accordingly, 42 C.F.R. § 405.1842(a)(4)(ii) states that a provider may seek EJR review in federal court without an EJR determination by the Board, "*only if* . . . [t]he Board fails to make a determination of its authority to decide the legal question no later than 30 days *after* finding jurisdiction over the matter at issue and notifying the provider that the provider's EJR request is complete." Consistent with these regulatory provisions, Board Rule 42.1 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.

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.[8]

Under Board Rule 44.3, if a party intends to respond to a motion, it must do so within 30 days, unless the Board imposes a different deadline. Significantly, QRS did not file any objection to FSS' extension requests in cases 13-3813GC and 13-3814GC. Nor did QRS file any objection to the Scheduling Orders issued in these cases, and in fact requested *additional* time to comply and participate with the Board's June 28, 2022 Scheduling Order.

QRS made clear by filing the Complaint in federal district court on April 20, 2022 (and the Amended Complaint on May 13, 2022), that it was bypassing and abandoning the Board's prerequisite jurisdictional review process.

If the Providers were successful on the merits of their claims in federal court, then bypassing the Board's jurisdictional review process could result in millions of dollars being improperly paid. To illustrate this very point, the Board has included as **Appendix C**, a non-exhaustive listing of some of the jurisdictional issues that the Board has identified thus far. The Board expects that additional, material, jurisdictional and/or claim filing issues would be identified if it were to complete the jurisdictional review process.

Board Findings:

The Board must consider the significant impact on the proceedings caused by QRS filing a lawsuit in connection with the above-referenced six (6) group cases.

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

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

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

> Providers shall also have the right to obtain judicial review of any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines (on its own motion or at the request of a provider of services as described in the following sentence) that it is without authority to decide the question, by a civil action commenced within sixty days of the date on which notification of such determination is received. ***If a provider of services may obtain a hearing under subsection (a)*** and has filed a request for such a hearing, such provider may file a request for a determination by the Board of its authority to decide the question of law or regulations relevant to the matters in controversy (accompanied by such documents and materials as the Board shall require for purposes of rendering such determination). *The Board shall render such determination in writing within thirty days* ***after the Board receives the request and such accompanying documents and materials***, and the determination shall be considered a final decision and not subject to review by the Secretary.[9]

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).

[9] (Emphasis added.)

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> (4) **The provider has a right to seek EJR** of the legal question under section 1878(f)(1) of the Act ***only if***—
>
> (i) **The final EJR decision of the Board or the Administrator, as applicable, includes a finding of Board jurisdiction over the specific matter at issue** and a determination by the Board that it has no authority to decide the relevant legal question; or
>
> (ii) The Board fails to make a determination of its authority to decide the legal **question no later than 30 days after finding jurisdiction over the matter at issue and notifying the provider that the provider's EJR request is complete**.
>
> (b) *General*—(1) *Prerequisite of Board jurisdiction*. The Board (or the Administrator) **must find that the Board has jurisdiction over the specific matter at issue before the Board may determine its authority to decide the legal question**.
>
> (2) *Initiating EJR procedures*. A provider or group of providers may request the Board to grant EJR of a specific matter or matters under appeal . . . . Under paragraphs (d) and (e) of this section, **a provider may request** a determination of the Board's authority to decide a legal question, but **the 30-day period for the Board to make a determination under section 1878(f)(1) of the Act** [*i.e.*, 42 U.S.C. § 1395oo(f)(1)] **does not begin to run until the Board finds jurisdiction to conduct a hearing on the specific matter at issue in the EJR request and notifies the provider that the provider's request is complete**.[10]

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."[11] Moreover, the Board is bound by this regulation because, as

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[10] (Emphasis added).

[11] 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)).

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.[12]

Thus, it is clear that the 30-day clock does not start until ***after*** the Board determines it has jurisdiction over the relevant providers (*as well as* any associated group(s) in which these providers participate) in the appeals underlying an EJR request. Note that the Board's use of the term "stay" (as used in this and prior similar situations) in relation to the 30-day period for responding to the parties' EJR requests, was an inartful use of that term because the Board's intent was to simply notify the parties that the Board had not yet finished its jurisdictional review of the parties' EJR requests and, as such, the 30-day period for the review of the EJR requests had not yet commenced.

The Board notes that the Secretary had a sound basis for issuing 42 C.F.R. § 405.1842(b)(2). The statute itself states that a provider may be authorized to request EJR "***if*** [it] ***may obtain a hearing under subsection (a). . . .***"[13] Thus, as the Court in *Alexandria Hospital v. Bowen* ("*Alexandria*") noted, "the statute itself suggests that an EJR request need not be considered before the Board determines it has jurisdiction over an appeal. Moreover, the legislative history makes clear that in enacting the EJR provision, Congress sought solely to expedite resolution of the *legal* controversies in Medicare reimbursement appeals."[14] 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

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[12] (Emphasis added.)
[13] 42 U.S.C. § 1395oo(f)(1) (emphasis added).
[14] *See* H.R. Rep. No. 96–1167, *reprinted in* 1980 U.S. Code Cong. & Ad. News at 5757; *Alexandria Hosp. v. Bowen*, 631 F. Supp. 1237, 1244 (W.D. Va. 1986); *San Francisco General Hosp. v. Shalala,* No. C 98-00916, 1999 WL 717830 (N.D. Cal. Sept. 8, 1999); *Total Care, Inc. v. Sullivan,* 754 F. Supp. 1097 (W.D. N.C. 1991); *Abington Mem'l Hosp. v. Bowen,* Civ. A No. 86-7262, 1988 WL 71367 (E.D. Pa. July 1, 1988); *Good Samaritan Hosp. v. Heckler*, No. CV84-L-459, 1986 WL 68497 (D. Neb. June 27, 1986).

> 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***.[15]

The *Alexandria* Court's conclusions are also supported by the practical considerations involved in the EJR process. If EJR requests were permitted to supersede jurisdictional determinations, there would be only two logical outcomes. The first is that jurisdictional determinations need never be made in cases where EJR requests are filed before a jurisdictional determination is reached by the Board. This would result in fraud, waste and abuse concerns if parties, unable to meet the Board's jurisdictional requirements, could still prevail in federal court, merely by filing an EJR request. The second conclusion is that federal trial courts would be forced to resolve jurisdictional disputes.[16] Not only are the federal trial courts ill-suited for making such determinations, it is a task assigned to the Board, *by statute*.

Significantly, in these 4 group cases, the Board has not yet completed its jurisdictional review to confirm whether it has jurisdiction to hear all of the providers' disputes raised in the EJR request. The Board stopped this process after it learned that QRS had bypassed the completion of this process even before the EJR request had been filed or the same day it was filed (i.e., even before the 30 day period for the Board to review an EJR request had begun). Having an opportunity to complete the jurisdictional and substantive claim review[17] process is vital to ensure that the groups, and all of the underlying providers, are properly before the Board both generally and for the issue(s) raised in the EJR request. Further, the jurisdictional and substantive claim review process ensures that the groups, and underlying providers, have complied with the applicable Board regulations and rules (*e.g.*, have not previously withdrawn or been dismissed without being reinstated; are not pursuing a prohibited duplicate appeal of the same issue for the same year; and have complied with the mandatory CIRP group rules). Without a proper jurisdictional review, fraud, waste and abuse concerns arise. Indeed, these concerns are very real and evident in these four (4) group cases as highlighted in **Appendix B**.

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

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[15] *Alexandria Hosp. v. Bowen*, 631 F. Supp. at 1244.

[16] 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.

[17] 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."

begin until the Board completes its jurisdictional review process *and* finds jurisdiction.[18] QRS' filing of the Complaint in federal district court ***23 days before the EJR Request was filed*** (or the Amended Complaint the ***same*** day that the EJR request was filed, as relevant), without notice to the Board or opposing party, is contemptuous of the Board's authority. It also demonstrates that QRS had no intention of allowing the Board to complete its jurisdictional review, much less the 30-day EJR review period to rule on the EJR request.

B. Effect of QRS' Concurrent Filing of the Complaint on the 6 Group Cases

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

> (3) *Provider lawsuits*. (i) If the provider files a lawsuit seeking judicial review (whether on the basis of the EJR provisions of section 1878(f)(1) of the Act or on some other basis) pertaining to a legal question that is allegedly relevant to a specific matter at issue in a Board appeal to which the provider is a party and that is allegedly not within the Board's authority to decide, the Office of the Attorney Advisor must promptly provide the Board with written notice of the lawsuit and a copy of the complaint.
>
> ****
>
> (iii) *If the lawsuit is filed before a final EJR request is issued on the legal question*, ***the Board may not conduct any further proceedings*** on the legal question or the matter at issue until the lawsuit is resolved.[19]

This regulation ***bars any further Board proceedings*** in these 4 group cases, including proceedings on *pre-requisite* jurisdictional issues or other procedural issues. Consistent with FRCP 62.1, the Board issues this ruling on a Motion for Relief that is barred by a pending appeal and, as explained below, is deferring further action in these 4 group cases until, or if, the Administrator remands these cases back to the Board.

To confirm the proper application of § 405.1842(h)(3), the Board reviewed the preambles to the proposed rule, dated June 5, 2004,[20] and the May 23, 2008 final rule[21] that promulgated the regulation at 42 C.F.R. § 405.1842(h)(3)(iii). The preamble to the proposed rule described this regulation as follows:

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[18] "Indeed, the statute and regulation by their terms do not impose *any* time constraints on the Board's determination of jurisdiction. *See* 42 U.S.C. 1395oo(f)(1); 42 CFR § 405.1842. The Hospitals' proffered interpretation of the regulation is so wildly disconnected from the text as to `warrant[] little attention.'" *St. Francis Medical Center, et al v. Xavier Becerra*, Memorandum Opinion, No. 1:22-cv-1960-RCL, at 8 (D.D.C. Sept. 27, 2023) (*citing Cape Cod Hosp. v. Leavitt*, 565 F. Supp. 2d 137, 141 (D.D.C. 2008)).

[19] (Emphasis added.)

[20] 69 Fed. Reg. 35716 (June 25, 2004).

[21] 73 Fed. Reg. 30190 (May 23, 2008).

> Proposed § 405.1842(h)(3) would specify the effect that a provider lawsuit would have on the Board's ability to conduct further proceeding on the legal matter at issue. In general, if a provider files a lawsuit on the same legal issue for the same cost year that is currently pending before the Board - that is, the provider goes into court without waiting for a final administrative decision on EJR, we would seek to have the lawsuit dismissed, and we would prohibit the Board from conducting further proceedings on that issue until the lawsuit is resolved.[22]

The discussion in the final rule includes additional guidance on 42 C.F.R. § 405.1842(h)(3):

> *Comment*: One commenter stated that the proposed rule would provide that, if any allegedly relevant lawsuit was filed before a final EJR decision, the Board would be precluded from conducting any further proceedings on the EJR decision until the lawsuit was resolved, and that it appears that the proposed policy would apply, regardless of the basis for the lawsuit. The commenter suggested that the final rule provide that the Board be required to conduct further proceedings on an EJR decision when the provider subsequently files a lawsuit brought on jurisdictional grounds other than the Social Security Act. If the Board were allowed to grant EJR, the issues jurisdictionally under the Medicare statute could be added to the pending matter in court, thus preserving judicial resources and avoiding multiple lawsuits.
>
> *Response*: The commenter is correct that the proposed policy would apply regardless of the jurisdictional basis for the lawsuit. However, we decline to adopt the commenter's suggestion that we make a distinction based on the jurisdictional basis pleaded in the complaint. **We do not agree that it would be appropriate for the Board or the intermediary to spend its limited resources to spend time on a Board appeal if the provider has filed a complaint that involves a legal matter that is relevant to a legal issue in the Board appeal**. If the court properly has jurisdiction over the appeal, the decision, that it or a higher court renders, may resolve the issue or issues in the Board case, or otherwise inform the Board in reaching a decision, or affect the parties' decision as to whether they should attempt to settle the Board case. On the other hand, where the basis for the court's jurisdiction is defective (which we believe would most likely be the situation when a provider attempts to file a complaint based on a legal issue related to an appeal still pending before the Board), a contrary rule would not discourage providers from filing improper appeals with the court. We believe our proposal to be in line with the general rule practiced by courts that an appeal to a higher court deprives the

[22] 69 Fed. Reg. at 35732.

> lower court of jurisdiction to conduct further proceedings until the appeal is resolved by the higher court.[23]

Based on the above explanation regarding the intent and purpose for 42 C.F.R. § 405.1842(h)(3)(iii), the Board finds that QRS' concurrent filing of the Complaint in the D.C. District Court on April 20, 2022 (or the Amended Complaint on May 13, 2022, as relevant) prohibits the Board from conducting any further proceedings on the consolidated EJR request for the six cases at issue therein as filed, including any proceedings related to the prerequisite jurisdiction and claims filing requirements.

C. QRS' Actions

The Board finds that QRS' decision to withhold notice from the Board and the opposing parties of its filing of the federal district court litigation is tantamount to bad faith and actively created confusion surrounding the status of these cases at the Board because it ignored the 30-day Board review period as provided at 42 U.S.C. § 1395oo(f)(1) ***and*** *implemented at 42 C.F.R. § 405.1842*. Indeed, QRS' *preemptive* actions, taken without notice to the Board or the opposing parties, demonstrate that QRS had no intent to exhaust its administrative remedies before the Board. Pursuant to Board Rule 1.3 (Nov. 1, 2022),[24] QRS had a duty to communicate early, and in good faith, with the Board and the opposing parties (in that regard the Secretary is not a party per 42 C.F.R. § 405.1843(b)):

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

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

> **5.2 Responsibilities**
>
> *The case representative is responsible for being familiar with the following rules and procedures* for litigating before the Board:

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[23] 73 Fed. Reg at 30214-15 (bold and underline emphasis added).

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

- The Board's governing statute at 42 U.S.C. § 1395oo;
- *The Board's governing regulations at 42 C.F.R. Part 405, Subpart R*; and
- *These Rules*, which include any relevant Orders posted at https://www.cms.gov/Regulations-and-Guidance/ReviewBoards/PRRBReview/PRRB-Instructions (see Rule 1.1).

Further, *the case representative is responsible for*:

- Ensuring his or her contact information is current with the Board, including a current email address and phone number;
- Meeting the Board's deadlines; and
- *Responding timely to correspondence or requests from the Board or the opposing party*.

Failure of a case representative to carry out his or her responsibilities is not considered by the Board to be good cause for failing to meet any deadlines. Withdrawal of a case representative or the recent appointment of a new case representative will also not be considered good cause for delay of any deadlines or proceedings.[25]

Indeed, the following acts (or inaction) by QRS reinforce the Board's finding that QRS has no basis to claim that proceedings before the Board have been exhausted:

1. QRS can make no claims that it was harmed by any delay caused by the Board's extension of time to complete a jurisdictional review when it filed a federal district court case either ***before filing*** *its EJR request* ***or on the same day as the filing*** *of the EJR request.*

2. QRS did not notify the Board, FSS, or the Medicare Contractors, of its opposition to FSS' motion to extend the Medicare Contractor's time to file jurisdictional challenges in these four (4) group cases.

3. QRS failed to promptly and timely notify the Board of its objection to the Board's ruling on the extension, and the associated Scheduling Orders for these four (4) group cases. QRS' failure to file and preserve its objection to the Board's ruling and Scheduling Orders violates QRS' obligations under Board Rules 1.3, 5.2, and 44. QRS' failures further deprived the Board of an opportunity to reconsider its ruling and Scheduling Orders and, if necessary, correct or clarify that ruling and/or the Scheduling Orders.[26]

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[25] (Italics emphasis added.) *See also, Baptist Mem'l Hosp.-Golden Triangle v. Sebelius*, 566 F.3d 226, 227 (D.C. Cir. 2009) wherein the Circuit Court affirmed the District Court's granting of summary judgment to the Secretary because the Providers failed to follow Board Rules, stating, "The court therefore granted summary judgment to the Board. Because the Board's procedural rules mean what they say and say what they mean, and because the hospitals did not follow them, we affirm."

[26] While the Board is not bound by the FRCP, the Board refers to them for guidance and notes that the principles of FRCP 46 are similar. FRCP 46 applies to trial-like proceedings and "requires that a party seeking to preserve an objection to the

4. The Board made known to the parties in these cases its position regarding the 30-day period to respond to the EJR request at issue, based on 42 U.S.C. § 1395oo(f), 42 C.F.R. §§ 405.1842(b)(2), 405.1801(d)(2).[27] Specifically, the Board notified the parties that the Board had the authority to stay the start of the 30-day period. The Board's notice was based on 42 C.F.R. § 405.1842(b)(2) which specifies that jurisdiction is a prerequisite to Board consideration of an EJR request ***and*** that the 30-day period to review the EJR request does ***not*** begin until the Board finds jurisdiction. To that end, the Board issued its Scheduling Order for these four (4) group cases to memorialize, and effectuate, the necessity to conduct the jurisdictional review process and delay the start of the 30-day period to review the EJR request.[28] QRS failed to notify the Board of its objection to the Scheduling Orders. QRS' failure to timely file any objection violates Board Rules 1.3, 5.2 and 44. Indeed, QRS' actions interfered with the speedy, orderly and fair conduct of Board proceedings and prejudiced the Board by depriving it of an opportunity to reconsider its rulings and, if necessary, correct or clarify them,[29] or take other actions, ***prior to*** QRS filing its April 20, 2022 Complaint (or May 13, 2022 Amended Complaint, as relevant). Indeed, QRS' preemptive actions did not even allow initiation of the 30-day EJR review deadline, ***as alleged by QRS to be established in 42 U.S.C. § 1395oo(f)(1) (and which QRS alleges in its litigation the Board missed)***, to pass, and, under QRS' strained interpretation that ignores the Secretary's regulations, permitted federal litigation to be pursued.[30]

5. QRS' failure to promptly notify the Board that it had filed the lawsuit in the Central California District Court violates Board Rule 1.3, and caused both the Board and the Medicare Contractors to waste time and administrative resources when the Board was prohibited from taking any further action on these four (4) appeals pursuant to 42 U.S.C. § 405.1842(h)(3).

D. Board Actions

These facts demonstrate that QRS had a duty, pursuant to Board Rule 1.3, "to communicate early and act in good faith [with regard] [] to dealings with the opposing party, the Board, and/or any

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

[27] The Board's Notice was clear that a Board finding of jurisdiction is a prerequisite to any review of an EJR request citing to 42 C.F.R. §§ 405.1842(b)(2), (e)(2)(ii), (e)(3)(ii).

[28] *See supra* note 27.

[29] For example, the Board could have explained how reliance ***solely*** on 42 U.S.C. § 1395oo(f)(1) would be misplaced, given the Secretary's implementation of that statute at 42 C.F.R. § 405.1842 (including in particular § 405.1842(b)(2)) as promulgated in the May 23, 2008 final rule and the Secretary's explanation of that regulation in the June 25, 2004 proposed rule. *See supra* notes 11-16 and accompanying text.

[30] *See supra* note 26 (discussing how the FRCP supports the Board's position).

relevant nonparty." Indeed, QRS' failure to comply with Board Rule 1.3, through prompt notification of the lawsuit on, or about, April 20, 2022 (or May 13, 2022 as relevant), prejudiced the Board, FSS and the Medicare Contractors. Specifically, it hijacked the speedy, orderly and fair conduct of the Board proceedings (on these and other cases) and deprived both the Board, and the Medicare Contractors, of the opportunity to cease work on these four (4) group cases in favor of other time-sensitive work such as ***other*** EJR requests filed by QRS *and* by other representatives. Indeed, QRS' failure to ***timely*** notify the Board, and the opposing parties, of this lawsuit filed in the Central District of California District Court, raises very serious concerns about prejudicial sandbagging by QRS to benefit prior, current and subsequent EJR requests that QRS filed on behalf of other providers ***or*** by other representatives for EJR requests filed for the same issue.[31] The prejudicial sandbagging is highlighted by the facts that:

1. Across the 6-month period from December 20, 2021 to June 30, 2022, record concentrations of EJR requests were filed covering 642 group cases involving 2000+ participants (with the overlay of challenges caused by the surge in the Omicron variant of the COVID-19 virus at the beginning of that 6-month period); and

2. 80 percent of these requests were filed by either QRS or another representative, Healthcare Reimbursement Services ("HRS") (specifically QRS filed EJR requests covering 359 cases and HRS filed EJR requests covering 148 cases during this 6-month period).[32]

As a point of reference and context for these serious violations by QRS, the Board has included, at **Appendix C**, a copy of the closure letter it issued in 80 QRS cases that were included in a separate February 14, 2022 Federal Complaint similarly filed in the California Central District Court. Finally, this is not an isolated event because it is the Board's understanding that: (1) the April 20, 2022 Complaint was jointly filed QRS and HRS jointly to establish Case No. 22-cv-02648 and includes 178 other cases with 969 participants and the pursuit of these other cases was done so without completing the jurisdictional review process, much less receiving the Board's jurisdictional decision, and without notice to the Board;[33] and (2) QRS filed at least one similar Complaint in the D.C. District Court on May 27, 2022 under Case No. 22-cv-01509.[34]

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

[32] It is the Board's understanding that, on February 14, 2022, QRS established the initial ongoing litigation in the California Central District Court covering 80 group cases with 950+ participants in the aggregate, and that QRS and another representative, HRS *joined* the following additional cases to that lawsuit through the Amended Complaint filed on March 30, 2022 (without any notice to the Board or the opposing party). Similar litigation involving other EJR requests filed by QRS has been filed both in California and the District of Columbia. *See infra* notes 33 and 34 and accompanying text.

[33] Under separate cover, the Board closed the QRS cases by letters dated September 30, 2022 (Grouping A for Case Nos. 13-3842GC, *et al.*; Grouping B for Case Nos. 17-2150GC, *et al.*; and Grouping C for Case Nos. 18-0037GC, *et al.*) , and the HRS cases dated October 19, 2022 (Grouping A for Case Nos. 14-2400GC, *et al.*; and Grouping B for Case Nos. 15-055G, *et al.*). These closure letters included similar findings as in these QRS group cases.

[34] The Board addressed the cases impacted by this litigation under separate cover.

It is clear the Providers are pursuing the merits of their cases in these four (4) group cases as part of their lawsuit in the California Central District Court.[35] Pursuant to 42 C.F.R. § 405.1842(h)(3)(iii), the Board is prohibited from further proceedings in these cases. Therefore, the Board must close these cases.[36]

However, the Board cannot permit QRS' reckless and contemptuous disregard for its ***basic*** responsibilities and due diligence as a representative appearing before the Board, its bypassing and abandonment of the jurisdictional review process, and its disregard for the Board's authority, orders and process, to remain unanswered. Accordingly, *if these cases are remanded for further proceedings*, the Board will complete its jurisdictional review and weigh: (a) the severity of QRS' violations of, as well as failure to comply with, Board Rules, regulations and Orders; (b) the prejudice to the Board and the opposing parties; (c) the interference with the speedy, orderly and fair conduct of the Board proceedings (regarding both these cases and others); and (d) the effect on the operations of the Board, when determining what, if any, remedial actions will be taken per 42 C.F.R. § 405.1868.[37] Examples of available remedial actions that the Board may consider taking in these 8 cases to defend its authority resulting from QRS' numerous, egregious regulatory violations and abuses include, but are not limited to:

1. Dismissal of the four (4) group cases and all underlying participants.

2. Dismissal of any group case in which the Board identifies any jurisdictional or material procedural errors occurred, whether by one participant or more.

3. Dismissal of any participant for which there is an open jurisdictional challenge regardless of the merit of such challenge.

These potential actions are well within the Board's authority pursuant to 42 C.F.R. § 405.1868(a)-(b),[38] as confirmed in the preamble to the May 23, 2008 final rule:

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[35] This is notwithstanding the Board's dismissal of 2 of these group cases.

[36] As noted in 42 C.F.R. § 405.1837(a), a group appeal may only have "a single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group." Similarly, as explained at 42 C.F.R. § 405.1842(d), "[a] provider (or, in the case of a group appeal, a group of providers) may request a determination by the Board that it lacks the authority to decide a legal question relevant to a specific matter at issue in an appeal." Accordingly, the Board must assume there are no other issues, particularly since: (1) the existence of other issues would necessarily mean that the Board would not have jurisdiction over the group until that defect was cured; and (2) the Providers did not identify any concurrent issues with the filing of the consolidated EJR request but rather claimed therein that the Board had jurisdiction over the groups.

[37] The Board's planned actions are consistent with those planned for QRS as laid out in **Appendix C**.

[38] 42 C.F.R. § 405.1868 states:

> (a) The Board has full power and authority to make rules and establish procedures, not inconsistent with the law, regulations, and CMS Rulings, that are necessary or appropriate to carry out the provisions of section 1878 of the Act and of the regulations in this subpart. The Board's powers include the authority to take *appropriate actions in response to the failure of a party to a Board appeal to comply with Board rules and orders or for inappropriate conduct during proceedings in the appeal*.
> (b) If a provider fails to meet a filing deadline or other requirement established by the Board in a rule or order, the Board may -
> (1) Dismiss the appeal with prejudice;
> (2) Issue an order requiring the provider to show cause why the Board should not dismiss the appeal; or

> Most of the comments we received on this subject came from providers, and reflect a perceived disparate treatment by the Board when a provider, rather than an intermediary, fails to follow a procedural rule or timeframe set by the Board. We proposed two possible actions by the Board, one applicable to a provider and the other applicable to an intermediary. That is, the worst case scenario for a provider would be a dismissal of the appeal by the Board, while the harshest remedy for an intermediary would be the issuance of a decision by the Board based on the written record established at the point of the intermediary's violation. However, we note that, because providers are the proponents of a case, they are responsible for moving the case forward by meeting all deadlines. Additionally, at section 1878(e) of the Act, the Congress has given the Board authority to make rules and establish procedures to carry out its function. Moreover, we note that the Board will have broad discretion to weigh the particular facts at hand in order to decide whether or not an offense merits remedial action.
>
> ****
>
> Again, we are clarifying that the proposed rule did not identify a complete listing of all potential Board sanctions. The Board has the authority to take appropriate action against either party for procedural violations, but appropriate action does not necessarily mean a dismissal or the early issuance of a decision by the Board. We believe that these provisions will alert both parties that the Board has a mechanism in place to effectively stop a delaying tactic, or to redress other procedural violations. As a result, the parties should be less inclined to ignore procedural requirements and, accordingly, be more motivated to meet the deadlines set by the Board.[39]

Pursuant to the above, the Board has broad authority to sanction QRS for its repeated, and ongoing, malfeasance.

E. Board Decision and Order

Based on QRS' misconduct, the Board hereby takes the following actions:

1. Closes the four (4) group cases which remain open consistent with 42 C.F.R. § 405.1842(h)(3)(iii); and
2. Suspends the ongoing jurisdictional review process; and

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

[39] 73 Fed. Reg. at 30225.

3. Defers consideration of citing QRS for contempt and dismissing these group cases (and/or taking other remedial action to uphold the authority of the Board) based on QRS' numerous, egregious, regulatory violations and abuses until there is an Administrator's Remand Order consistent with 42 C.F.R. § 405.1842(h)(3)(iii) and Federal Rule of Civil Procedure ("FRCP") 62.1.[40]

Accordingly, the Board hereby closes these cases and removes them from the Board's docket. No further proceedings will occur, except upon remand from the Administrator, pursuant to 42 C.F.R. § 405.1877(g)(2).

Board Members Participating:

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

For the Board:

9/29/2023

X Clayton J. Nix

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

Enclosures:
Appendix A – Case List
Appendix B – Interim List of Potential Jurisdictional & Procedural Violations Under Review
Appendix C -- June 10, 2022 Board Letter to QRS Deferring Show Cause Order & Closure of Cases

cc: Cecile Huggins, Palmetto GBA
Wilson Leong, FSS
Jacqueline Vaughn, OAA

[40] FRCP 62.1 is entitled "Indicative Ruling on a Motion for Relief That is Barred by a Pending Appeal." While FRCP 62.1 is not directly applicable to the Board, the procedural developments in these cases are similar those addressed in FRCP 62.1 and the Board looked to it for guidance.

APPENDIX A

Grouping A – List of the 8 Group Cases
Covered by the Request for EJR
Filed on May 13, 2022

21-0971GC DCH Health CYs 2011 & 2014 – 2015 DSH SSI Fraction Dual Elig. Days CIRP Grp.
21-0974GC DCH CYs 2011 & 2014 – 2015 DSH Medicaid Fraction Dual Elig. Days CIRP Grp.
21-0979GC DCH Health CY 2016 SSI Fraction Dual Eligible Days CIRP Group
21-0982GC DCH Health CY 2016 DSH Medicaid Fraction Dual Eligible Days CIRP Group

APPENDIX B

INTERIM LIST OF POTENTIAL JURISDICTIONAL, SUBSTANTIVE CLAIM, AND PROCEDURAL VIOLATIONS UNDER REVIEW[41]

The following summary of jurisdictional, substantive claim and procedural concerns and issues is preliminary and highlights the complexity of the jurisdictional review process.[42] The complexity of the process is heightened when consolidated EJR requests are concurrently filed involving multiple group cases with 14 participants.

The Board, through its ongoing review of jurisdiction, and other procedural issues, in these group cases, has identified multiple, ***material*** jurisdictional issues and concerns that were not raised by FSS or the Medicare Contractors. The Board's review is based on the SoPs filed for these cases because, as explained at Board Rule 20.1.1 (Nov. 2021),[43] the SoPs are supposed to contain all relevant jurisdictional documentation for each participant in the group. The issues and concerns identified by the Board (thus far) include, but are not limited to, the following:

1. *Reviewing Scope of the EJR Request and Potential Improper Groups*.—In order for the Board to have jurisdiction over a group appeal, the group appeal must contain only one legal question/issue.[44] Pursuant to 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. § 405.1837(a)(1), a group may only contain one legal issue. In pertinent part, § 405.1837(a)(1) states that "[a] provider . . . has a right to a Board hearing, as part of a group appeal with other providers, with respect to a final contractor or Secretary determination for the provider's cost reporting period, ***only if*** - . . . (2) The matter at issue in the group appeal involves ***a single*** question of fact or

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[41] This listing is not exhaustive and only reflects preliminary findings and the Board has not yet completed or finalized its jurisdictional findings in these 4 group cases.

[42] The Board notes that 42 C.F.R. § 405.1840 is entitled "Board Jurisdiction" but it also addresses certain claim filing requirements such as timelines or filing deadlines. For example, whether an appeal was timely is not a jurisdictional requirement but rather is a claim filing requirement as the Supreme Court made clear in *Sebelius v. Auburn Reg. Med. Ctr.*, 568 U.S. 145 (2013). *See also* Board Rule 4.1 ("The Board will dismiss appeals that fail *to meet the timely filing requirements* ***and/or*** *jurisdictional requirements*. Similarly, the Board notes that 42 C.F.R. §§ 405.1835(b) and 405.1837(c) address certain claim filing requirements.

[43] *See also* Board Rule 20.1 (Aug. 2018).

[44] *See* 42 C.F.R. §§ 405.1842(a), 405.1842(f); 73 Fed. Reg. 30190, 30212 (May 23, 2008) (in response to comment that "the Board should have the authority to handle more than one question of fact or law in a group appeal" because "sometimes there is more than one disputed fact or question of law pertaining to a single item on the cost report" where "[a] common example of this is the [DSH] adjustment, which is determined by a combination of calculations, each of which may have more than one element in dispute", the Secretary affirmed that [t]he regulations at § 405.1837(a)(2) . . . specify that a group appeal involve a single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group" and that "[w]hat constitutes an appropriate group appeal issue in a given case will be determined by the Board."). The Board further notes that 42 C.F.R. § 405.1839(b) (underline and bold emphasis added) states the following in relevant part:

> (b) *Group appeals*. (1) In order to satisfy the amount in controversy requirement under § 405.1837(a)(3) of this subpart for a Board hearing as a group appeal, the group must demonstrate that if its appeal were successful, the total program reimbursement for the cost reporting periods under appeal would increase, in the aggregate, by at least $50,000.
> (2) *Aggregation of claims*. (i) For purposes of satisfying the amount in controversy requirement, group members are **not allowed to aggregate claims involving different issues**.
> (A) A group appeal must involve a **single** question of fact or **interpretation** of law, regulations, or CMS Ruling that is common to each provider (as described in § 405.1837(a)(2) of this subpart).

interpretation *of law, regulations, or CMS Rulings* that is common to each provider in the group.[45] The Board is reviewing whether the Providers' consolidated EJR requests are ***improperly*** challenging *multiple* interpretations of law or regulation. In particular, the Board is reviewing whether the EJR request properly includes a challenge to the SSI eligibility codes used to identify the SSI days to be included in the numerator of the Medicare fraction (as embodied in PRRB Dec. No. 2017-D11[46]) in addition to the no-pay Part A days issue (as embodied in the *Empire* litigation decided before the Supreme Court[47]). If true, it raises ***immediate*** jurisdictional problems of whether the additional challenge(s) are *properly* part of the relevant groups[48] and, if true, requires determining: (1) whether each of the participants properly appealed additional issues[49] and, as relevant, whether it requested transfer of those additional issues to the group; (2) if a preliminary position paper was filed, whether the additional was properly briefed in the preliminary position paper in compliance with 42 C.F.R. § 405.1853(b)(2) and Board Rule 25[50]; and (3) whether the additional issues should be bifurcated from the group per 42 C.F.R. § 405.1837(f)(2).[51] A critical aspect of the jurisdictional inquiry entails confirming that any potential bifurcation would not result in prohibited duplicate appeals by the same providers for the same issue and years.

2. *Unauthorized Representation of Participants*.— The Board reviews the Schedule of Providers to confirm QRS obtained proper ***prior*** authorization from the provider to be a participant in the relevant group.[52,53] This ***prior*** authorization is required to be placed behind Tab H for each

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[45] (Emphasis added.)
[46] *Hall Render Optional and CIRP DSH Dual/SSI Eligible Group Appeals – Medicare Fraction v. Wisconsin Physicians Servs.*, PRRB Dec. No. 2017-D11 (Mar. 27, 2017).
[47] *Becerra v. Empire Health Found.*, 142 S. Ct. 2354 (2022), *reversing*, 958 F.3d 873 (9th Cir. 2020).
[48] This includes whether the group appeal request includes the additional issue and whether the final SoP filed in the relevant group establishes that the group meets the $50,000 AiC requirement for each of the additional issues. Per 42 C.F.R. § 405.1839(b), participants in a group are ***not*** permitted to aggregate claims involving different issues for purposes of meeting the $50,000 AiC requirement.
[49] Note that a proper appeal on an issue must include an AiC calculation for that issue. If the Providers were to claim that the group had multiple issues, then each participant would have a separate AiC calculation in the SoP *for* ***each*** *issue*. *See* 42 C.F.R. §§ 405.1839(b), 405.1837(c)(2)(iii). However, the Board's initial impressions are that each participant generally only has ***one*** AiC calculation behind Tab E in the relevant SoP.
[50] 42 C.F.R. § 405.1853(b)(2) and Board Rule 25 require the full briefing of each issue in a position paper filing. Consistent with this regulation and Board Rule 25, Board Rule 25.3 specifies that "[i]f the provider fails to brief an appealed issue in it is position paper, the Board will consider the unbriefed issue abandoned and effectively withdrawn." Cases where the Providers' preliminary position paper was filed prior to the relevant consolidated EJR request being filed include: Case Nos. 21-0237G, 21-0273G and 21-0239G where the position paper was filed in January 2022.
[51] *See* 42 C.F.R. § 405.1837(a)(2) (stating providers have a right to participate in a group appeal only if "[t]he matter at issue in the group appeal involves ***a single*** question of fact or ***interpretation*** *of law*, regulations, or CMS Rulings that is common to each provider in the group" (emphasis added)); 42 C.F.R. §§ 405.1835(b), 405.1837(c); Board Rules 7, 8, 12.2, 13, 16, 16.2.
[52] Per Board Rule 6.4 (Mar.2013, July 2015), "An authorized representative of the Provider must sign the [individual provider] appeal. If the authorized representative is not a Provider employee, attach an Authorization of Representation letter with the Initial Filing on the Provider's letterhead, signed by an owner or officer of the Provider." The Board requires provider-executed letters of representation to be filed *with the appeal* (*i.e.*, to be obtained ***prior to*** taking actions on behalf of the provider) in order to protect providers and health chains from potentially coercive or abusive representation situations, whether in the context of an individual or group appeal.
[53] Per Board Rule 12.4(A) (2015), "The Board will recognize a single Group Representative for all Providers in the group. The Providers filing the initial appeal must appoint the Group Representative by attaching an Authorization of Representation letter on each Provider's letterhead, signed by an owner or officer of the Provider." To this end, the Model Form E (2015) for Direct Add Appeals specifies, "[i]f you are filing as a representative, YOU **MUST**

participant, as noted by Board Rule 21.9.2, to confirm the participant gave ***prior*** authorization to join the group. The Board is reviewing the SoP to confirm proper authorization.

3. *Participants That Did Not Properly Transfer Into the Group or Only Transferred a Portion of the Issue/Issues Covered By the Group*.— A significant number of the participants in these groups arrived by transfer from an individual appeal. For any participant that transfers into a group from an individual appeal, the Board must review whether the individual appeal properly included the issue the provider seeks to transfer. A provider can only transfer an issue that is properly existing in its individual appeal.[54] The Board expects it may identify multiple participants with these types of jurisdictional transfer issues if it were to complete its jurisdictional review.

Notwithstanding the above jurisdictional issues and concerns, QRS made clear, with the May 13, 2022 filing of the Amended Complaint in federal district court, that it was bypassing and abandoning the Board's jurisdictional review process (as discussed above).

ATTACH A LETTER SIGNED BY THE PROVIDER AUTHORIZING REPRESENTATION UNDER A **TAB LABELED 2**. *See* Rule 5.4." (Emphasis in original.)

[54] The window to add issues to an individual appeal is limited by the regulation at 42 C.F.R. § 405.1835(e) as follows: "After filing a hearing request in accordance with paragraphs (a) and (b), or paragraphs (c) and (d), of this section, a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the Board only if – . . . . (3) The Board receives the provider's request to add issues no later than 60 days after the expiration of the applicable 180-day period prescribed in paragraph (a)(3) or paragraph (c)(2), of this section." *See also* 42 C.F.R. §§ 405.1835(b), 1837(c), & Board Rule 8 for content and specificity requirements for issues being appealed.

APPENDIX C

June 10, 2022 Board Letter to QRS
Deferring Show Cause Order and Closure of Cases
Pursuant to 42 C.F.R. § 405.1842(h)(3)(iii)
Due to QRS Filing in California Central District Court

(35 pages)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

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

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

Dear Mr. Berends and Ravindran:

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

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

[2] *See supra* note 1.

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

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

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

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

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

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

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

Procedural Background

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

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

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

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

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

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

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

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

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

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

[17] (Emphasis in original.)

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

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

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

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

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

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

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[18] *See supra* note 3.

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

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

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

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

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

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

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

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

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

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

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

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

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

Board Findings and Ruling:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. *Prohibited Duplicate Appeals*

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

2. *Providers With No Appeal Rights*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4. Prohibited Participation of CIRP Providers in Optional Groups

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

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

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

5. *Unauthorized Representation of Participants*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

> Most of the comments we received on this subject came from providers, and reflect a perceived disparate treatment by the Board when a provider, rather than an intermediary, fails to follow a procedural rule or timeframe set by the Board. We proposed two possible actions by the Board, one applicable to a provider and the other applicable to an intermediary. That is, the worst case scenario for a provider would be a dismissal of the appeal by the Board, while the harshest remedy for an intermediary would be the issuance of a decision by the Board based on the written record established at the point of the intermediary's violation. However, we note that, because providers are the proponents of a case, they are responsible for moving the case forward by meeting all deadlines. Additionally, at section 1878(e) of the Act, the Congress has given the Board authority to make rules and establish procedures to carry out its function. Moreover, we note that the Board will have broad discretion to weigh the particular facts at hand in order to decide whether or not an offense merits remedial action.
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> ****
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> Again, we are clarifying that the proposed rule did not identify a complete listing of all potential Board sanctions. The Board has the

[93] 42 C.F.R. § 405.1868 states:

(a) The Board has full power and authority to make rules and establish procedures, not inconsistent with the law, regulations, and CMS Rulings, that are necessary or appropriate to carry out the provisions of section 1878 of the Act and of the regulations in this subpart. The Board's powers include the authority to take *appropriate actions in response to the failure of a party to a Board appeal to comply with Board rules and orders or for inappropriate conduct during proceedings in the appeal*.

(b) If a provider fails to meet a filing deadline or other requirement established by the Board in a rule or order, the Board may -

(1) Dismiss the appeal with prejudice;

(2) Issue an order requiring the provider to show cause why the Board should not dismiss the appeal; or

(3) Take any other remedial action it considers appropriate.

(Emphasis added.)

> authority to take appropriate action against either party for procedural violations, but appropriate action does not necessarily mean a dismissal or the early issuance of a decision by the Board. We believe that these provisions will alert both parties that the Board has a mechanism in place to effectively stop a delaying tactic, or to redress other procedural violations. As a result, the parties should be less inclined to ignore procedural requirements and, accordingly, be more motivated to meet the deadlines set by the Board.[94]

* * * * *

In summary, 42 C.F.R. § 405.1842(h)(iii) bars the Board from conducting any further proceedings, because the Providers are pursuing the merits of their appealed issue in the California Central District Court, and there are no remaining issues beyond the EJR request.[95] Accordingly, the Board hereby closes these cases and removes them from the Board's docket. No further proceedings will occur, except upon remand from the Administrator, pursuant to 42 C.F.R. 405.1877(g)(2).

Board Members Participating:

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For the Board:

6/10/2022

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: PIV

Enclosures: List of Groups

cc: Bill Tisdale, Novitas Solutions
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[94] 73 Fed. Reg. at 30225.
[95] *See supra* note 92.

LIST OF 80 GROUP CASES

09-1903GC	BHCS 07 DSH Dual Eligible Days
13-1419G	QRS 2006 DSH SSI Fraction Denominator/Dual Eligible Group
13-1440G	QRS 2006 DSH Medicaid Fraction/Dual Eligible Group
13-1720GC	Scott & White 2008 Medicaid Fraction Dual Elig Days CIRP Group
13-1722GC	Scott & White 2008 DSH SSI Fraction Dual Elig Days CIRP Group
13-2678G	QRS 2007 DSH Medicaid Fraction Dual Eligible Days Group (2)
13-2693G	QRS 2008 DSH Medicaid Fraction Dual Eligible Days Group
13-2901GC	QRS BJC 2007 DSH SSI Fraction Dual Eligible Days CIRP Group
13-2903GC	QRS Novant 2007 SSI Fraction Dual Eligible Days CIRP Group
13-2904GC	QRS Novant 2007 Medicaid Fraction Dual Eligible Days CIRP Group
13-3061GC	QRS WFHC 2009 Medicaid Fraction Dual Eligible CIRP Group
13-3191GC	QRS Novant 2006 DSH Dual Eligible Days
13-3942G	QRS 2009 DSH Medicaid Fraction/Dual Eligible Days Group
13-3944G	QRS 2009 DSH SSI Fraction/Dual Eligible Days Group
14-1171G	QRS 2008 DSH SSI Fraction Dual Eligible Days Group
14-1174G	QRS 2007 DSH SSI Fraction Dual Eligible Days Group
14-1816G	QRS 2010 DSH SSI Fraction Dual Eligible Days Group
14-1818G	QRS 2010 DSH Medicaid Fraction Dual Eligible Days Group
14-2217GC	QRS Novant 2009 DSH Medicaid Fraction Dual Eligible Days CIRP Group
14-3306G	QRS 2011 DSH Medicaid Fraction Dual Eligible Days Group
14-3308G	QRS 2011 DSH SSI Fraction Dual Eligible Days Group
15-0018G	QRS 2012 DSH Medicaid Fraction/Dual Eligible Days Group
15-1067G	QRS 2006 DSH Medicaid Fraction Dual Eligible Days Group (2)
15-1147G	QRS 2006 DSH SSI Fraction Dual Eligible Days Group (2)
15-1152GC	QRS Novant 2010 DSH Medicaid Fraction Dual Eligible Days CIRP Group
15-1419G	QRS 2012 DSH SSI Fraction Dual Eligible Days Group
15-2385G	QRS 2010 DSH SSI Fraction Dual Eligible Days Group II
15-2386G	QRS 2010 DSH Medicaid Fraction Dual Eligible Days Group II
15-3031G	QRS 2011 DSH Medicaid Fraction Dual Eligible Days Group 2
15-3039G	QRS 2011 DSH SSI Fraction Dual Eligible Days Group 2
15-3073GC	QRS Progressive Acute Care 2011 DSH Medicaid Fraction/Dual Eligible Days
16-0091GC	HRS DCH 2010 DSH SSI Fraction Dual Eligible Days CIRP Group
16-0092GC	HRS DCH 2010 Medicaid Fraction Dual Eligible Days CIRP Group
16-1142G	QRS 2013 DSH SSI Fraction Dual Eligible Days Group
16-1145G	QRS 2013 DSH Medicaid Fraction Dual Eligible Days Group
16-1750G	QRS 2012 DSH SSI/Medicaid Dual Eligible Days Group II
17-0867G	QRS 2014 DSH SSI/Medicaid Dual Eligible Days Group
17-1405G	QRS 2013 DSH SSI Fraction Dual Eligible Days Group (2)
17-1406G	QRS 2013 DSH Medicaid Fraction Dual Eligible Days Group (2)
17-1409G	QRS 2005 DSH SSI Fraction Dual Eligible Days Group
17-1412G	QRS 2005 DSH Medicaid Fraction Dual Eligible Days Group
17-1426G	QRS 2006 DSH SSI Fraction Dual Eligible Days Group 3

17-1427G	QRS 2006 DSH Medicaid Fraction Dual Eligible Days Group
18-0270G	QRS 2007 DSH SSI Fraction Dual Eligible Days Group (3)
18-0730G	QRS 2011 DSH SSI Fraction Dual Eligible Days Group III
18-1259G	QRS 2014 DSH SSI Fraction Dual Eligible Days Group 2
18-1260G	QRS 2014 DSH Medicaid Fraction Dual Eligible Days Group 2
18-1405G	QRS 2015 DSH Medicaid Fraction Dual Eligible Days Group
18-1408G	QRS 2015 DSH SSI Fraction Dual Eligible Days Group
18-1738GC	AHMC Healthcare CY 2012 DSH Medicaid Fraction Dual Eligible Days CIRP
19-0012GC	AHMC Healthcare CY 2015 DSH SSI Fraction Dual Eligible Days CIRP Group
19-0014GC	AHMC Healthcare CY 2015 DSH Medicaid Fraction Dual Eligible Days CIRP
19-0164GC	AHMC Healthcare CY 2013 DSH Medicaid Fraction Dual Eligible Days CIRP Group
19-0195GC	Houston Methodist CY 2014 DSH SSI Fraction Dual Eligible Days CIRP Group
19-0235GC	Houston Methodist CY 2014 DSH Medicaid Fraction Dual Eligible Days CIRP
19-0270GC	Mercy CY 2016 DSH SSI Fraction Dual Eligible Days CIRP Group
19-0272GC	Mercy CY 2016 DSH Medicaid Fraction Dual Eligible Days CIRP Group
19-0534G	QRS CY 2011 DSH Medicaid Fraction Dual Eligible Days (3) Group
19-0704G	QRS CY 2012 DSH SSI Fraction Dual Eligible Days (3) Group
19-0706G	QRS CY 2012 DSH Medicaid Fraction Dual Eligible Days (3) Group
19-2131GC	Hartford Health CY 2015 DSH SSI Fraction Dual Eligible Days CIRP Group
19-2134GC	Hartford Health CY 2015 DSH Medicaid Fraction Dual Eligible Days CIRP
19-2513G	QRS CY 2016 DSH SSI Fraction Dual Eligible Days Group
19-2515G	QRS CY 2016 DSH Medicaid Fraction Dual Eligible Days Group
19-2594G	QRS CY 2015 DSH SSI Fraction Dual Eligible Days (2) Group
19-2596G	QRS CY 2015 DSH Medicaid Fraction Dual Eligible Days (2) Group
20-0107G	QRS CY 2013 DSH SSI Fraction Dual Eligible Days (3) Group
20-0112G	QRS CY 2013 DSH Medicaid Fraction Dual Eligible (3) Group
20-0209G	QRS CY 2010 DSH SSI Fraction Dual Eligible Days (3) Group
20-0211G	QRS CY 2010 DSH Medicaid Fraction Dual Eligible (3) Group
20-0244G	QRS CY 2007 DSH Medicaid Fraction Dual Eligible Days (4) Group
20-0248G	QRS CY 2006 DSH SSI Fraction Dual Eligible Days (4) Group
20-0250G	QRS CY 2006 DSH Medicaid Fraction Dual Eligible Days (4) Group
20-0367G	QRS CY 2005 DSH SSI Fraction Dual Eligible Days (2) Group
20-0368G	QRS CY 2005 DSH Medicaid Fraction Dual Eligible Days (2) Group
20-0409GC	AHMC Healthcare CY 2016 DSH SSI Fraction Dual Eligible Days CIRP Group
20-0411GC	AHMC Healthcare CY 2016 DSH Medicaid Fraction Dual Eligible Days CIRP
20-1511G	QRS CY 2014 DSH SSI Fraction Dual Eligible Days (2) Group
20-1513G	QRS CY 2014 DSH Medicaid Fraction Dual Eligible Days (2) Group
20-1655G	QRS CY 2007 DSH SSI Fraction Dual Eligible Days (4) Group

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Murry McGowan
Tenet Healthcare Corporation
14201 Dallas Parkway
Dallas, TX 75254

RE: ***Dismissal for Untimely Filing Pursuant to Board Rules 20 and 20.1***
13-1438GC Tenet FY 2009 DSH Eligible Days CIRP Group

Dear Mr. McGowan:

The Provider Reimbursement Review Board (the "Board") has reviewed the subject common issue related party ("CIRP") group appeal, which was filed prior to the implementation of the Office of Hearing Case & Document Management System ("OH CDMS").[1] The electronic record for the group, which is considered a "Legacy" case, has not yet been populated. A brief history of the facts and the Board's determination are set forth below.

Pertinent Facts:

On March 30, 2023, Tenet Healthcare Corporation ("Tenet"/"Group Representative") designated the CIRP group fully formed. Pursuant to Board Rule 20, within 60 days of the group's full formation, the Group Representative is required to file a certification indicating whether the participants in the group are fully populated (*i.e.*, listed) behind the Participants tab in OH CDMS and, if not as it is here, submit an electronic copy of the full Schedule of Providers per Board Rule 20.1.1. That Rule 20.1.1 submission would have been due on May 29, 2023.

On June 5, 2023, Tenet Healthcare Corporation ("Tenet") filed its preliminary position paper, and as one of the exhibits, included a listing of providers in the group ("Schedule of Providers"/ "SoP") but without any supporting documentation. On July 12, 2023, the Medicare Contractor filed its Rule 22 review of the fully formed group and pointed out that the group's Rule 20 Certification letter had not yet been filed.[2]

As set forth below Tenet's preliminary position paper exhibit does not meet the requirements of Rules 20 and 20.1. Below is a discussion regarding Rule 20 and Rule 20.1 requirements and the information that was required in this case.

[1] The group was filed on April 8, 2013.
[2] The Medicare Contractor's correspondence also indicated that the group included only a single provider, however, based on the Listing of Providers included with the Group's preliminary position paper, that was not accurate.

Rule 20/20.1 Background:

Rule 20 addresses the population of Issues/Providers in OH CDMS. Pursuant to Board Rule 20:

> If ***all*** the participants in a fully-formed group are ***populated*** under the Issues/Providers Tab in OH CDMS with supporting jurisdictional documentation (*see* Rule 21), then the representative is exempt from filing a ***hard copy*** of the schedule of providers with supporting jurisdictional documentation. In this instance, the Board uses the schedule of providers and supporting jurisdictional documentation that is created in OH CDMS using the information and documents included in each participating provider's request for transfer or direct add to the group.
>
> ***Prior to*** certifying that the group is fully formed or the date on which a group is fully formed, the group representative should review each participating provider's supporting jurisdictional documentation to ensure it is complete and, if not, file any additional documentation in OH CDMS.[3] 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).[4]

Board Rule 20.1 applies to **"Group Cases that Are Not Fully Populated in OH CDMS."** Pursuant to Board Rule 20.1:

> If any participants in a fully-formed group are ***not*** populated under the Issues/Providers Tab in OH CDMS with supporting jurisdictional documentation (*see* Rule 21), then the Representative must prepare a traditional schedule of providers (*i.e.* Model Form G at Appendix G), for *all* participants in the group **following the instructions in this Rule and Rule 21, unless the Board instructs otherwise.** Specifically, *within sixty (60) days of the full formation of the group* (see Rule 19), the group representative

[3] If all participants are populated but jurisdictional support is not complete, the Rule 20 Certification must certify that all participants are populated, but should include an identification of the documents that are missing and then ***only*** file in OH CDMS those additional missing documents. See, https://www.cms.gov/files/document/oh-cdms-prrb-user-manual-supplement-supplemental-document-uploads-individual-appeals.pdf.
[4] (Underline emphasis added.)

> must prepare and file a schedule of providers with the supporting jurisdictional documentation for all providers in the group that demonstrates that the Board has jurisdiction over each participant named in the group appeal (*see* Rule 21) . . . .

Based on the fact that ***none*** of the providers in this CIRP group were listed or populated behind the Participants tab in Case No. 13-1438GC, it is clear that Board Rule 20.1 applies and, as such, the Representative was required to separately file a PDF copy of the ***full*** SoP with ***all*** **relevant supporting jurisdictional documentation** within the 60-day period allotted under Board Rule 20.1.[5] However, Tenet failed to do so even after the MAC alerted Tenet of its error. Moreover, the Board notes that the Rule 20.1.1 filing must be made a separate filing and *not* embedded in another filing such as a position paper.[6]

Board Determination:

Pursuant to 42 C.F.R. § 405.1868:

> (a) The Board has full power and authority to make rules and establish procedures, not inconsistent with the law, regulations, and CMS Rulings, that are necessary or appropriate to carry out the provisions of section 1878 of the Act and of the regulations in this subpart. *The Board's powers include the authority to take appropriate actions in response to the* ***failure of a party*** *to a Board appeal* ***to comply with Board*** rules and ***orders*** or for inappropriate conduct during proceedings in the appeal.
>
> (b) *If a provider fails to meet a filing deadline or other requirement established by the Board in a rule or order, the Board may—*
>
> *(1) Dismiss the appeal with prejudice***;**
>
> (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]

Because the full SoP with supporting documentation was not timely filed and the SoP is necessary to establish the Board's jurisdiction over the participants in this CIRP group, the Board hereby dismisses the subject group appeal pursuant to its authority under 42 C.F.R. § 405.1868.

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[5] Rule 20/20.1 Certifications must be stand-alone filings and never part of another filing *(e.g., never embedded within a preliminary position paper filing, group status response, etc.).*
[6] *See supra* note 5.

Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members:
Clayton J. Nix, Esq.
Robert A. Evarts, Esq.
Kevin D. Smith, CPA
Ratina Kelly, CPA

For the Board:

9/29/2023

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: PIV

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services
Michael Redmond, Novitas Solutions Inc. (J-H)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Own-Motion EJR Determination***
Memorial Hermann Bad Debt Not Returned from Collection Agency CIRP Groups
FYEs 2007-2012
Case Nos. 13-0583GC, 13-1710GC, 14-0584GC, 14-3382GC, 14-3963GC, 15-1816GC

Dear Ms. Webster and Mr. Lau:

The Provider Reimbursement Review Board ("Board") has reviewed the records in the above-referenced group appeals and, on August 17, 2021, as required by 42 C.F.R. § 405.1842(c), notified the Providers that it was considering, on its own motion, whether Expedited Judicial Review ("EJR") was appropriate. Specifically, the Board requested comments as to whether the it is without the authority to determine the validity of the retroactive bad debt regulations found at 42 C.F.R. § 413.89(e)(2)(i)(B) which were promulgated in the FY 2021 Final Rule. The Board requested comments on how the two prongs of the Bad Debt Moratorium operate in relation to the new regulation, particularly as it relates to the second prong which states:

> *The Secretary may not require a hospital to change its bad debt collection policy* ***if*** a fiscal intermediary, in accordance with the rules in effect as of August 1, 1987, with respect to criteria for indigency determination procedures, record keeping, and determining whether to refer a claim to an external collection agency, has accepted such policy before that date, and the Secretary may not collect from the hospital on the basis of an expectation of a change in the hospital's collection policy.[1]

Procedural History:

These six group appeals were consolidated by the Board on November 21, 2019. The group issue statement for these appeals concerns the Medicare Contractor's treatment of the Providers' reimbursable bad debts. The Provider disputes the Medicare Contractor's disallowance of bad

[1] Reprinted at 42 U.S.C. § 1395f note entitled "Continuation of Bad Debt Recognition for Hospital Services" (emphasis added). The Bad Debt Moratorium (both the first and second prongs) was enacted as a non-codified statutory provision pursuant to the Omnibus Budget Reconciliation Act of 1987, Pub. L. No. 100-203, § 4008(c)101 Stat. 1330, 1330-55 (1987) and later modified by: (1) the Technical and Miscellaneous Revenue Act of 1989, Pub. L. No. 100-647, § 8402, 102 Stat. 3342, 3798 (1988); (2) the Omnibus Budget Reconciliation Act of 1989 Pub. L. No. 101-239, § 6023, 103 Stat. 2106, 2167 (1989); and (3) the Middle Class Tax Relief and Job Creation Act of 2012, Pub. L. No. 112-96, § 3201, 126 Stat. 156, 192-193 (2012).

debt accounts that had not been returned from an outside collection agency. According to the Providers, the bad debt regulations permit reimbursement of bad debts attributable to deductibles and coinsurance amounts if certain criteria are met. Whether certain bad debts met these criteria is at issue; specifically, whether the Providers have "established[ed] that reasonable collection efforts were made" on the bad debts at issue pursuant to 42 C.F.R. § 413.89(e)(2) (2013). The Providers note that the Provider Reimbursement Manual, Part 1, ("PRM 15-1") describes what constitutes a "reasonable collection effort" at § 310. They contend that their bad debts not returned from an outside collection agency still met the criteria for Medicare-reimbursable bad debts in the applicable regulation and PRM provisions. The Providers further allege that the Medicare Contractor's disallowance violates both prongs of the Bad Debt Moratorium.[2]

A live hearing was held on February 27, 2020. Subsequently, on September 18, 2020, the Centers for Medicare & Medicaid Services ("CMS") issued the FY 2021 Final Rule,[3] promulgating certain *retroactive* bad debt regulations. These new regulations specifically address bad debts still at a collection agency at 42 C.F.R. § 413.89(e)(2)(i)(B), which states:

> (B) A provider that uses a collection agency to perform its collection effort ***must*** do all of the following:
>
> (1) Reduce the beneficiary's account receivable by the gross amount collected.
>
> (2) Include any fee charged by the collection agency as an administrative cost.
>
> (3) ***Before claiming*** *the unpaid amounts as a Medicare bad debt,* ***cease all collection efforts****, including the collection agency efforts, and ensure that the collection accounts have been returned to the provider from the agency.*[4]

The Final Rule confirms that the above provision is *retroactive*:

> The amendments at § 413.89**(e)(2)**(i)(A)(1), (4) through (6), **(i)(B)**, (iii), and (f) are applicable to cost reporting periods ***before***, on, and after ***October 1, 2020***.[5]

Significantly, the parties filed their Post-Hearing Briefs after these retroactive changes became final. While the Medicare Contractor did not address the relevance of this new regulation in its Post-Hearing Brief, the Providers' representative did. Specifically, the Providers' representative recognized *in its Post-Hearing Brief* that the above new regulation directly impacts this case and that the regulation applies retroactively to the fiscal years at issue in these appeals:

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[2] *E.g.*, PRRB Case 13-0583GC, Group Issue Statement (Jan. 30, 2013).
[3] 85 Fed. Reg. 58432, 58989 (Sept. 18, 2020).
[4] (Emphasis added.)
[5] 85 Fed. Reg. 58432 (emphasis added).

> The agency has attempted to bolster its position in this and other ongoing bad debt appeals by codifying its position through retroactive rulemaking after the hearing before the Board.
>
> ****
>
> [T]he agency's new regulation ignores the plain language of Congress and brazenly attempts to make just such a change retroactively, for any "cost reporting beginning before . . . the effective date of this rule," including for cost years like those at issue here that are subject to the bad debt moratorium. 85 Fed. Reg. at 58,990.
>
> ****
>
> CMS cannot have it both ways by issuing a rulemaking with retroactive effect on the ground that it has positive effects on providers, while also asserting that it "does not affect prior transactions," 85 Fed. Reg. at 58,990-91, only ignoring the material impact on hospitals like Memorial Hermann here.[6]

On May 3, 2021 (over 7 months after the retroactive regulatory changes were made), the parties filed their Post-Hearing Briefs. *In their Post-Hearing Brief*, the Providers devoted over 14 pages to arguments challenging the validity of the new *retroactive* bad debt regulation and its application to the Providers for the years at issue. The two main arguments are:

1. The new *retroactive* bad debt regulation "conflicts with the plain language of Congress's Bad Debt Moratorium."[7] Contrary to the prohibition in the Bad Debt Moratorium that the agency "'shall not make any change in the [bad debt] policy in effect on August 1, 1987 . . . . [t]he agency's new regulation ignores the plain language of Congress and brazenly attempts to make just such a change retroactively . . . ."[8]

2. "[B]y purporting to apply retroactively to cost years before the date of its promulgation, the new regulation violates the general prohibition on retroactive rulemaking under well-established precedent and the Medicare Act, qualifying for neither of two limited exceptions."[9]

In sum, the Providers argue that "the agency's new, retroactive rule is contrary to law, arbitrary and capricious, and unsupported by substantial evidence to the extent that it would be applied retroactively" and that "the agency's rationale for applying its amended regulation retroactively to the beginning of the Medicare program, despite the Bad Debt Moratorium, lacks any foundation."[10] On August 17, 2021, the Board issued a Notice of Potential Board Own Motion EJR and Scheduling Order. It noted that, pursuant to 42 C.F.R. § 405.1867, it is bound by the bad debt regulations

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[6] Provider's Post-Hearing Brief at 28, 29-30, 35. *See also id.* at 2, 13-14, 28-42.
[7] *Id.* at 28.
[8] *Id.* at 29 (quoting the Bad Debt Moratorium).
[9] *Id. See also id.* at 14 (citations omitted).
[10] *Id.* at 41.

promulgated in the FY 2021 Final Rule. It also noted that, *based on the Providers' post-hearing brief*, it is clear the Providers intend to challenge the validity of 42 C.F.R. § 413.89(e)(2)(i)(B). As a result, the Board reopened the record to request supplemental briefing on the impact of the new retroactive regulations, as well as how both prongs of the Bad Debt Moratorium operate in relation to the new regulation, particularly as it relates to the second prong, as noted above.

The Parties' Comments on the Board's Notice of Own-Motion EJR:

Both parties argue that the Board cannot or should not grant EJR over the validity of the retroactive regulation in this case. Set forth below is a summary of each party's position.

A. The Providers' Comments

The Providers argue that the Board's letter requesting comments on EJR is *procedurally* deficient because it contends that the Board did not comply with the regulations governing own motion EJR. They argue that the Board must first make a *jurisdictional* finding over particular issues **before** issuing any notice and request for comments. They continue, stating that these jurisdictional findings must be included in the notice to the parties of the Board's intent to consider EJR, emphasizing the following from 42 C.F.R. § 405.1842:

> (c) ***Board's own motion consideration.***
>
> (1) If the Board makes a finding that it has jurisdiction to conduct a hearing on a specific matter at issue in accordance with § 405.1840(a) of this part, it may then consider on its own motion whether it lacks the authority to decide a legal question relevant to the matter at issue.
>
> (2) The Board must initiate its own motion consideration by issuing a written notice to each of the parties to the appeal (as described in § 405.1843 of this subpart). The notice must –
>
> (i) Identify each specific matter at issue for which the Board has made a finding that it has jurisdiction under § 405.1840(a) of this part, and for each specific matter, identify each relevant statutory provision, regulation, or CMS Ruling;
>
> (ii) Specify a reasonable period of time for the parties to respond in writing.[11]

Accordingly, the Providers contend that, since the Board's notice of own motion EJR was insufficient, the Board's consideration of EJR is premature and inappropriate.[12]

[11] Providers' Supplemental Brief, 7-8 (Oct. 4, 2021) (quoting portions of 42 C.F.R. § 405.1837(c) and adding emphasis as denoted by the underline emphasis).
[12] *Id.* at 8.

Next, the Providers argue that the Board lacks jurisdiction *over the propriety of the retroactive bad debt regulations in this case* because the Medicare Contractor's determination did not apply them. The Providers claim the issue is not ripe in this appeal and thus the Board lacks jurisdiction, which is a prerequisite to granting EJR over an issue.[13] The Providers' argument is summarized as follows:

> Because the new regulation was ***not*** *applied*, *relied upon*, ***or*** *even mentioned in the MAC's original findings* (or the MAC's Post-Hearing Brief, suggesting agreement that neither the MAC nor the Board can apply the new regulation), *the Board has no subject matter jurisdiction over the new rule*, which is not ripe for review by the Board.[14]

The Providers note that the Board's jurisdiction over a provider's appeal requires dissatisfaction with a final determination,[15] but that "the Providers were not and could not have been dissatisfied with the new rule when they appealed the MAC's final determinations, as the rule did not exist at the time and could not have been applied to them."[16] This segues to the Providers' next argument, noting that if the new regulations were not used in creating the final determination being appealed, neither the Board nor the Medicare Contractor are able to *reopen* it to apply the new regulation.[17] They further contend that "[CMS] indicated that the provision of the new rule concerning unreturned bad debt is not intended to apply to pending appeals, as the agency also explained that retroactive application 'does not affect prior transactions or impose additional duties or adverse consequences upon providers or beneficiaries, nor does it diminish rights of providers or beneficiaries.'"[18]

The Providers conclude by requesting the Board *not* grant EJR, even if the Board determines that it may do so. Rather than invalidate the new regulation, the Providers request the Board simply *apply* the regulation and issue a decision because this decision would determine whether the new regulations may be applied to the cost report years at issue, especially in light of the Bad Debt Moratorium. Even if it can be applied, the Providers seek an actual decision *on the merits* to avoid a remand on appeal because no injury will have been identified to pursue in federal court.[19] They conclude that, regardless, any Board decision *on the merits* should be in favor of the Providers based on their contention that the application of the retroactive regulations to these cases would violate the Bad Debt Moratorium.[20]

B. The Medicare Contractor's Comments

The Medicare Contractor acknowledges that the Providers' Post-Hearing Brief appears to challenge the validity of 42 C.F.R. § 413.89(e)(2)(i)(B), but argues that EJR is not appropriate or

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[13] *Id.* at 8-9.
[14] *Id.* at 9 (emphasis added).
[15] 42 U.S.C. § 1395oo(a)(1).
[16] Providers' Supplemental Brief at 10.
[17] *Id.* at 11-12. The Providers' also argue that the reopening regulations would not permit a reopening based on a "change of legal interpretation or policy." *Id.* at 12-13 (citing 42 C.F.R. § 405.1885(c)(1)-(2)).
[18] *Id.* at 12 (quoting 85 Fed. Reg. at 58991).
[19] *Id.* at 14-16.
[20] *Id.* at 16-18.

warranted.[21] It contends that the validity of this regulation is not a *legitimate* issue in these appeals because: (1) the FY 2021 final rule could not have been an appealed issue since it did not exist when the appeals were formed; and (2) CIRP groups are limited to one issue and this would be a second issue, which the Board cannot add *sua sponte*.[22] Finally, the Medicare Contractor asserts that, since the Providers' comments indicated they did not want to pursue EJR of this regulation, they have "essentially withdrawn or waived their challenges to the FY 2021 Final Rule."[23]

With regard to the first prong of the Bad Debt Moratorium, the Medicare Contractor claims that "in accordance with the regulation/policy in effect prior to August 1, 1987, moratorium, until a provider's reasonable collection efforts have been completed, including both in-house efforts and the use of a collection agency, unpaid deductible and coinsurance amounts cannot be recognized as a Medicare bad debt."[24] The Medicare Contractor continues to note that CMS' position on its policy has always been that "[i]n no case is an unpaid Medicare account which is in collection, including at a collection agency, an allowable bad debt under the regulations[,]"and that any Medicare Contractor interpreting CMS policy differently was incorrect.[25] The Medicare Contractor does explicitly note that "the FY 2021 Final Rule is a codification of *long-standing* CMS policy[,]" and that this has always been CMS' policy.[26]

The Medicare Contractor acknowledges that the Bad Debt Moratorium prohibits the Secretary from requiring a hospital change its bad debt collection policy "if a fiscal intermediary *in accordance with the rules in effect as of August 1, 1987* . . . has accepted such policy before that date." However, it concludes that the second prong of the Bad Debt Moratorium is not implicated in these cases because, even as of August 1, 1987, CMS policy "required that bad debts be returned from a collection agency prior to being written off."[27] In further support, the Medicare Contractor notes that "the majority of the Providers in this CIRP group of appeals did ***not*** receive their Medicare certification number until after August 1, 1987, and the Bad Debt Moratorium would not apply to these Providers."[28] The Medicare Contractor concludes that the Board should apply the retroactive regulations as written and issue a decision on the merits.

C. The Providers' Reply

Though not explicitly requested or authorized by the Board, the Providers filed a reply to the Medicare Contractor's comments. First, they dispute whether all of the providers had their certification numbers prior to August 1, 1987 (or whether it matters).[29] They dispute the Medicare Contractor's description of CMS' pre-Moratorium policies, noting that regulation and PRM provisions "simply do not contain a requirement that bad debts be returned from a collection

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[21] MAC Supplemental Brief, unnumbered page 2 (Nov. 5, 2021).
[22] *Id.*
[23] *Id.* at 3.
[24] *Id.* at 6.
[25] *Id.* at 7.
[26] *Id.* (emphasis added).
[27] *Id* at 8.
[28] *Id.* at 10 (citing MAC Post Hearing Brief at 7-9).
[29] Providers' Response to MAC's Supplemental Brief, n. 4 (Dec. 3, 2021) (citing Providers' Post-Hearing Brief at 7, 10, nn.4-5).

agency to be reimbursable."[30] The Providers note that federal courts have found that PRM § 310.2 does not require the return of bad debts as a necessary precondition for reimbursement.[31] Such a precondition would run contrary to the presumption of noncollectibility set forth in § 310.2.[32] The Providers dispute the remainder of the Medicare Contractor's points, largely citing to previous briefs where the issues were discussed in greater detail.

Statutory Background:

Prior to the FY 2021 IPPS Final Rule, the regulations at 42 C.F.R. § 413.89(e)(2) read as follows:

> (e) *Criteria for allowable bad debt*. A bad debt must meet the following criteria to be allowable:
>
> (1) The debt must be related to covered services and derived from deductible and coinsurance amounts.
> (2) The provider must be able to establish that reasonable collection efforts were made.
>
> (3) The debt was actually uncollectible when claimed as worthless.
>
> (4) Sound business judgment established that there was no likelihood of recovery at any time in the future.

As part of the FY 2021 IPPS Final Rule, CMS amended the regulations to add language related the "reasonable collection efforts" criteria set forth at 42 C.F.R. § 413.89(e)(2) and specifically made it "effective for cost reporting periods beginning ***before***, on, *and* after the effective date of this rule [*i.e.*, October 1, 2021]."[33] Hence, it is to be applied *retroactively* to cost reporting periods *before*, on, ***or*** after October 1, 2021 (*i.e.*, the effective date of the must-bill codification). The amendment impacts bad debts still at a collection agency since 42 C.F.R. § 413.89(e)(2)(i)(B) states, for non-indigent beneficiaries:

> (B) A provider that uses a collection agency to perform its collection effort ***must*** do all of the following:
>
> (1) Reduce the beneficiary's account receivable by the gross amount collected.
>
> (2) Include any fee charged by the collection agency as an administrative cost.
>
> (3) ***Before claiming*** *the unpaid amounts as a Medicare bad debt,* ***cease all collection efforts****, including the collection agency efforts,*

[30] *Id.* at 4-5.
[31] *Id.* at 5.
[32] *Id.* at 6.
[33] 85 Fed. Reg. at 58994, 58989-58900.

> *and ensure that the collection accounts have been returned to the provider from the agency.*[34]

The Final Rule specifically confirms that the above provision is retroactive:

> The amendments at § 413.89**(e)(2)**(i)(A)(1), (4) through (6), **(i)(B)**, (iii), and (f) are applicable to cost reporting periods ***before***, on, and after ***October 1, 2020***.[35]

The Secretary has insisted that CMS has the statutory authority to *retroactively* codify these policies for non-indigent beneficiaries because it is merely clarifying *longstanding* requirements that existed prior to the Bad Debt Moratorium.[36] Indeed, it is precisely because of this finding that the Secretary determined to apply them *retroactively*.[37]

Significantly, the Board's governing statute at 42 U.S.C. § 1395oo(d) gives broad authority to the Board on the matters it may address in a hearing decision:

> (d) *Decisions of Board*. A decision by the Board shall be based upon the record made at such hearing, which shall include the evidence considered by the intermediary and such other evidence as may be obtained or received by the Board, and shall be supported by substantial evidence when the record is viewed as a whole. The Board shall have the power to affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report ***and*** *to make any other revisions on matters covered by such cost report* (including revisions adverse to the provider of services) ***even though such matters were <u>not</u> considered by the intermediary in making such final determination***.[38]

In implementing this statutory provision, the Secretary provides the following guidance in 42 C.F.R. § 405.1869(a) addresses the scope of the Board's authority in hearing decisions and specifies:

> (a) If the Board has jurisdiction to conduct a hearing on a specific matter at issue under section 1878(a) or (b) of the Act and §405.1840 of this subpart, and the legal authority to fully resolve the matter in a hearing decision (as described in §§405.1842(f), 405.1867, and 405.1871 of this subpart), *section 1878 of the Act, and paragraph (a) of this section give the Board the power to affirm, modify, or reverse the contractor's findings on each specific matter at issue in the contractor determination for the cost*

[34] (Emphasis added.)
[35] 85 Fed. Reg. at 58432 (emphasis added).
[36] *Id*. at 58902.
[37] *Id.* at 58990-91.
[38] (Bold emphasis added.)

> *reporting period under appeal, and to make additional revisions on specific matters* ***regardless of whether the contractor considered the matters in issuing the contractor determination***. The Board's power to make additional revisions in a hearing decision does not authorize the Board to consider or decide a specific matter at issue for which it lacks jurisdiction (as described in § 405.1840(b) of this subpart) or which was not timely raised in the provider's hearing request. The Board's power under section 1878(d) of the Act [*i.e.*, 42 U.S.C. § 1395oo(d)] and paragraph (a) of this section to make additional revisions is limited to those revisions necessary to resolve fully a specific matter at issue if—
>
> (1) The Board has jurisdiction to grant a hearing on the specific matter at issue under section 1878(a) or (b) of the Act and §405.1840 of this subpart; and
>
> (2) The specific matter at issue was timely raised in an initial request for a Board hearing filed in accordance with §405.1835 or §405.1837 of this subpart, as applicable, or in a timely request to add issues to a single provider appeal submitted in accordance with §405.1835(c) of this subpart.

42 C.F.R. § 405.1840(a) addresses the Board's jurisdiction over an appeal as follows, in pertinent part:

> (a) *General Rules*. (1) After a request for a Board hearing is filed under §405.1835 or §405.1837 of this part, the Board must determine in accordance with paragraph (b) of this section, whether or not it has jurisdiction to grant a hearing on each of the specific matters at issue in the hearing request.
>
> (2) The Board must make a **preliminary** determination of the scope of its jurisdiction (that is, whether the request for hearing was timely, and whether the amount in controversy requirement has been met), if any, over the matters at issue in the appeal before conducting any of the following proceedings:
>
> (i) Determining its authority to decide a legal question relevant to a matter at issue (as described in §405.1842 of this subpart).
>
> ****
>
> (iv) Conducting a hearing (as described in §405.1845 of this subpart).
>
> (3) The Board may revise a preliminary determination of jurisdiction at any subsequent stage of the proceedings in a Board appeal, and must promptly notify the parties of any revised determination. Under

> paragraph (c)(1) of this section, each expedited judicial review (EJR) decision (as described in §405.1842 of this subpart) and hearing decision (as described in §405.1871 of this subpart) by the Board must include a jurisdictional finding for each specific matter at issue in the appeal.
>
> ****
>
> (5) Final jurisdictional findings and dismissal decisions by the Board under paragraphs (c)(1) and (c)(2) of this section are subject to Administrator and judicial review in accordance with paragraph (d) of this section.
>
> (b) *Criteria*. Except with respect to the amount in controversy requirement, the jurisdiction of the Board to grant a hearing must be determined separately **for <u>each</u> specific matter at issue** in each contractor or Secretary determination for each cost reporting period under appeal. The Board has jurisdiction to grant a hearing over **a <u>specific</u> matter at issue** in an appeal only if the provider has a right to a Board hearing as a single provider appeal under §405.1835 of this subpart or as part of a group appeal under §405.1837 of this subpart, as applicable. Certain matters at issue are removed from jurisdiction of the Board. . . .

Consistent with the above provisions, 42 C.F.R. § 405.1842(b)(1) specifies that, in considering EJR, the Board is required to "find that the Board has jurisdiction over the specific matter at issue before [it] may determine its authority to decide the legal question."[39]

Finally, 42 C.F.R. § 405.1867 addresses the "[s]cope of the Board's legal authority" and specifies, in pertinent part, that "[i]n exercising its authority to conduct proceedings under this subpart, the Board ***must*** *comply with* ***<u>all</u>*** 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."[40]

<u>Own Motion EJR & Request for Comments:</u>

The Medicare statute at 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R. § 405.1842(f)(1), require the Board to grant expedited judicial review 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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[39] *See also* 42 C.F.R. § 405.1842(e); Board Rule 42 (v. 3.1).
[40] (Emphasis added.)

Additionally, the regulation at 42 C.F.R. § 405.1842(c) permits the Board to consider granting EJR, on its own motion, once it has: (1) made a finding that it has jurisdiction to conduct a hearing under the provisions of 42 C.F.R. §§ 405.1840(a) and 405.1837(a); and then (2) solicited comments from the parties on whether it lacks the authority to decide a legal question relevant to the matter at issue.

A. The Board has jurisdiction over application of the retroactive bad debt regulation to the "specific matter" appealed consistent with 42 U.S.C. §§ 1395oo(a)(1) and (d) and 42 C.F.R. §§ 405.1840(a)-(b), 1867, and 405.1869(a)

The "specific matter" appealed in these cases (as that term is used in 42 C.F.R. §§ 405.1835 and 1837) is whether the Medicare bad debts written off while still at a collection agency can be allowable Medicare bad debts. With regard to the Board's jurisdiction over the retroactive bad debt regulations in these cases, the Providers argue that the new, retroactive regulations are not part of the appealed issue, nor were they actually applied by the Medicare Contractor in these cases. They conclude that this precludes the Board's jurisdiction, which only extends over issues that were appealed. As set forth below, the Board rejects the Provider's assertion that its Own Motion EJR request was defective and that the Board lacks jurisdiction over the retroactive bad debt regulations at issue.

First, the Providers have argued that the Board's August 17, 2021 Notice of Own Motion EJR and request for comments was procedurally deficient because 42 C.F.R. § 405.1842(c)(1) requires the Board to make a finding of jurisdiction ***prior to*** issuing any such notice. The Board notes that a live hearing was held on February 27, 2020 and this necessarily illustrates that the Board conducted a review of these cases and made a *preliminary* finding of jurisdiction as to the "specific matter" appealed in these cases – whether the Medicare bad debts at issue that were written off while still at a collection agency were improperly determined to not be Medicare allowable.[41] Further, the Board notes that the Provider's Post-Hearing brief readily admits that regulation is applicable but argues that it conflicts with the Bad Debt Moratorium:

> The agency has attempted to bolster its position in this and other ongoing bad debt appeals by codifying its position through retroactive rulemaking after the hearing before the Board. This attempt fails. First, the agency's retroactive regulation conflicts with the plain language of Congress's Bad Debt Moratorium. The agency may not override the will of Congress, especially where the Congressional action at issue is specifically designed to restrict the agency from acting. Second, by purporting to apply retroactively to cost years before the date of its promulgation, the new regulation violates the general prohibition on retroactive

[41] *See* 42 C.F.R. § 405.1840(a)(3) ("The Board may revise a preliminary determination of jurisdiction at any subsequent stage of the proceedings in a Board appeal . . . ."). *See also* Board Rule 4.1 (Nov. 2021) (specifying that the Board may review jurisdiction on its own motion at any time).

> rulemaking under well-established precedent and the Medicare Act, qualifying for neither of two limited exceptions.[42]

At no point in its final position paper, in its argument at hearing, or in its post-hearing brief does the Provider raise any arguments that the Board lacks jurisdiction to consider the retroactive bad debt regulation at issue in these consolidated cases *as it relates to the "specific matter" appealed in these cases*.[43]

Specifically, pursuant to 42 C.F.R. § 405.1840(a)(2), the Board must make a preliminary determination of the scope of its jurisdiction before conducting a hearing on the "specific matter" appealed in these cases. Furthermore, even assuming there was some procedural defect in issuing a notice of own motion EJR prior to issuing specific, separate *preliminary*[44] jurisdictional findings, the Providers would not have suffered any prejudice. The Providers were given ample opportunity to brief the issues of jurisdiction and the Board's authority to grant EJR as evidenced by their lengthy Supplemental Brief (and Reply to the Medicare Contractor's Brief, which was not requested in the Board's initial scheduling order).

The Board notes that the Providers' appeals, from the outset, have asserted that their collection efforts are reasonable within CMS' stated policies and therefore the related bad debts should not be disallowed. CMS has argued, as has the Medicare Contractor, that the newly amended regulations – part of which specifically expound on what collection efforts are deemed reasonable – are merely codifying existing and long standing policy. A newly promulgated regulation would typically have no impact or relevance on pending appeal because regulations are generally effective on a *prospective* basis. However, the retroactive nature of these regulations and the fact that they address the *specific* criteria at issue in these appeals make them directly relevant. Moreover, pursuant to 42 C.F.R. § 405.1867, the Board "must comply" with

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[42] Provider's Post-Hearing Brief at 28. *See also id.* at 34 ("Moreover, applying the regulation retroactively also threatens to hurt the Providers by forcing them—in light of the requirement to treat Medicare and non-Medicare accounts similarly—to pull back their non-Medicare accounts for the cost years at issue from collection agencies. It is not, and cannot be, in providers' or the public interest to deprive safety-net hospitals of an important source of revenue, especially now, in the wake of the COVID-19 pandemic and resulting declines in patient revenue.")

[43] The Provider does include the following argument in its post hearing brief, but it was not raised as a jurisdictional issue but rather in support of its argument that the Secretary's basis and/or rationale to apply the bad debt regulation at issue retroactively was flawed:

> Although the agency's notice of proposed rulemaking includes a statement that notwithstanding the retroactive effective date of the rule it "does not affect prior transactions or impose additional duties or adverse consequences upon providers or beneficiaries, nor does it diminish rights of providers," this non sequitur is irreconcilable with the fact that the rule is "effective for cost reporting periods beginning *before*, on, and after the effective date of this rule." 85 Fed. Reg. at 58,990 (emphasis added). The proposal would necessarily change the legal consequences of furnishing care to patients and is, therefore, retroactive. . . . CMS cannot have it both ways by issuing a rulemaking with retroactive effect on the ground that it has positive effects on providers, while also asserting that it "does not affect prior transactions," 85 Fed. Reg. at 58,990-91, only ignoring the material impact on hospitals like Memorial Hermann here.

(Emphasis in original.)

[44] If jurisdictional findings do not result in the dismissal and closure of a case under 42 C.F.R. § 405.1840(c)(2), such findings are *preliminary* and remain so during the pendency of a case until the Board issues a final appealable determination (*e.g.*, a final decision on the merits pursuant to 42 C.F.R. § 405.1871(a) or a decision granting EJR pursuant to 42 C.F.R. § 405.1842(f)).

these retroactive regulations. And while it would have been impossible to appeal a regulation that was not yet promulgated, the "specific matter" that the Providers' appealed clearly encompasses the retroactive bad debt regulations. The parties dispute whether the Medicare program had policies that prevented providers from claiming Medicare bad debts still at a collection agency and whether those policies existed prior to the Bad Debt Moratorium. The bad debt retroactive regulation squarely falls within that dispute and the Board is otherwise bound by the retroactive regulation. The Board sees this as no different from a decision by the Supreme Court or a U.S. Court of Appeals being issued during the pendency of an appeal that addresses a law or regulation governing the "specific matter" appealed.

The fact that the regulations were not considered in the determinations at issue, in and of itself, has no bearing on the Board's jurisdiction over the "specific matter" appealed. First, the reopening regulations at 42 C.F.R. § 405.1885 have no bearing on the scope of the Board's authority in a hearing decision and the Board's review of the determinations at issue is not a "reopening" in and of itself. Indeed, none of the determinations at issue involve "revised" determinations issued pursuant to 42 C.F.R. §§ 405.1885 to 405.1889. 42 U.S.C. § 1395oo(d) permits the Board to assert jurisdiction over matters covered by a cost repot "even though such matters were not considered by the intermediary in making such final determination." Similarly, 42 C.F.R. § 405.1869(a) confirms that the Board has the authority to modify a Medicare Contractor determination and 42 C.F.R. § 405.1867 confirms the Board is bound by the retroactive regulation. Indeed, how would a retractive regulation be applied if it was not applicable to pending appeals before the Board and yet the Board was otherwise bound by it? In this regard, the final rule adopting the retroactive regulations does not specifically preclude the application of the retroactive regulation to pending appeals because it is apparent that the Secretary clarified and codified "longstanding" policies which pre-date the Bad Debt Moratorium and of which providers should have been aware.[45] The codification of those policies into binding regulations does not change their applicability in this appeal. Rather, it merely affects the nature of the Board's authority to consider those policies and changes the nature of the Providers' challenge to those policies. As those policies are now codified and it is the Secretary's position that the codification complies with the first prong of the Bad Debt Moratorium, the Board is otherwise bound by them. It does not mean that the Providers cannot contest those policies and/or their application on appeal and, in particular, their contention that the codified policies violate the Bad Debt Moratorium.

Since the retroactive regulation applies to the cost reporting periods at issue, and since each of the Providers have met the other jurisdictional and claims filing requirements for a hearing before the Board, the Board affirms that it does have jurisdiction over the Providers in Case Nos. 13-0583GC, 13-1710GC, 14-0583GC, 14-3382GC, 14-3963GC, and 15-1816GC including, but not limited to, the application and/or impact of the retroactive bad debt regulations promulgated in the FY 2021 Final Rule.

Pursuant to 42 U.S.C. § 1395oo(a), 42 C.F.R. § 405.1837 and 42 C.F.R. § 405.1835(a), a provider has a right to a Board hearing for specific items claimed for a cost reporting period covered by a final determination if it has preserved its right to claim dissatisfaction with the

[45] *See, e.g.,* 85 Fed. Reg. at 59002, 58994.

amount of Medicare payment for the specific item(s) at issue, 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. In each of these cases, each Provider requested a hearing within 180 days of receipt of its final determination, and the $50,000 amount in controversy requirement for a group appeal has been met. Additionally, the Providers have preserved their right to claim dissatisfaction with the amount of Medicare payment for the specific issue under appeal by including the coinsurance and deductible amounts in question as protested items on the cost reports under appeal.

B. Board's Decision Regarding the EJR Request

Upon review, the Board finds that these cases (*i.e.*, Case Nos. 13-0583GC, 13-1710GC, 14-0583GC, 14-3382GC, 14-3963GC, and 15-1816GC) are net yet ripe for expedited judicial review because there remain factual disputes that the Board must resolve before the Board can consider EJR. More specifically, while the retroactive regulations would appear to confirm that the bad debts at issue must be disallowed and that this disallowance does comply with the Bad Debt Moratorium,[46] there remains a factual and legal dispute regarding the applicability of the second prong of the Bad Debt Moratorium as demonstrated by the following excerpt from the Providers' Response to MAC's Supplemental Brief:

> [T]he Providers would be protected under prong two even if their pre-Moratorium bad debt policy conflicted with CMS' pre-Moratorium policy (which it does not). The interpretation offered by the MAC would eviscerate the Moratorium's protection. For example, case law construing the second prong has explained that, as here, "the Secretary wants [the 1989 amendment] to say that she cannot force a hospital to change the policy only if the policy is in accord with the rules. If the policy is not, then she can. That would leave nothing to the moratorium." *Harris Cty. Hosp. Dist. v. Shalala,* 863 F. Supp. 404, 408–09 (S.D. Tex. 1994), *aff'd* 64 F.3d 220 (5th Cir. 1995); *see Foothill*, 558 F.Supp.2d at 4 (discussing text and "historical context" of prong two and concluding that it "clearly prevents the Secretary from changing a provider's established bad debt policy"). Instead, "[t]he phrase 'in accordance with the rules in effect on August 1, 1987' modifies 'accepted,' not 'policy,'" such that the process used by the intermediary in accepting a provider's policy must be "in accordance" with CMS' existing rules, rather than the substance of the accepted policy itself. *See Harris Cty.*, 863 F. Supp. at 408–09. And even if the "in accordance" clause pertains to the substance of CMS' bad debt policy, it is quite plain that the Providers' bad debt policy triggers protection under prong two because it is at least consistent with (i.e., "in accordance with" or compliant with) CMS' pre-Moratorium rules. *See Hennepin Cty.*

[46] This statement is preliminary and made for purposes of the Board's ruling on its notice of own motion EJR. The Board is issuing its decision on the merits in this case and that will contain the Board's final findings on the merits of this case.

> *Med. Ctr. v. Shalala*, 81 F.3d 743, 751 n.6 (8th Cir. 1996) (concluding that prong two "[p]revent[s] disallowance . . . when an intermediary has accepted a provider's policy based on a *reasonable* interpretation of the rules in existence on August 1, 1987" (emphasis added); *Foothill*, 558 F. Supp. 2d at 3-6.
>
> The MAC commits another logical blunder by claiming that a MAC must explicitly endorse the Providers' policy at issue through some special means in order to trigger protection under prong two. The MAC begins by mischaracterizing the Providers' brief as asserting that "the fiscal intermediary *had to* 'explicitly approve[] a provider's bad debt collection practices before August 1, 1987 . . . ." MAC's Suppl. Br. at 8 (quoting Providers' Suppl. Br. at 4) (emphasis added). But the Providers simply noted that explicit approval would surely suffice. Providers' Suppl. Br. at 4. The MAC thus confuses a sufficient condition with a necessary condition.[47]

Accordingly, this case remains open and a decision on the merits will be issued under separate cover.

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Clayton J. Nix, Esq.
Robert A. Everts, Esq.
Kevin D. Smith, CPA

FOR THE BOARD:

9/29/2023

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: PIV

Enclosures: Schedules of Providers

cc: Bill Tisdale, Novitas Solutions, Inc. (J-H)
Wilson Leong, FSS

[47] Provider's Response to MAC's Supplemental Brief at 9-10 (Dec. 3, 2021) (footnotes omitted).