DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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

RE: ***Request for Reconsideration***
The Presbyterian Hospital, Prov. No. 34-0053, FYE 12/31/2007
Case No. 13-0397

Dear Mr. Ravindran,

The Provider Reimbursement Review Board ("Board") has reviewed the Motion for Reinstatement filed on August 30, 2023 by Quality Reimbursement Services ("QRS" or "Representative") on behalf of The Presbyterian Hospital ("Provider") regarding the above-captioned case. The decision of the Board is set forth below.

Pertinent Facts

On January 11, 2013, QRS established this case by filing a request for hearing on behalf of the Provider based on a Notice of Program Reimbursement ("NPR") dated November 14, 2012. The appeal request set forth an appeal of nine (9) issues. Pursuant to 42 C.F.R. § 405.1837(b)(1), five (5) of these 9 issues were transferred to common issue related party ("CIRP") group cases since the Provider is commonly owned. QRS later withdrew (3) other issues.

As a result, the *sole* remaining issue is DSH Payment – Medicaid Eligible Days (Issue 3). The Provider's appeal request describes this issue as follows:

> **Statement of Issue**
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> Whether the MAC properly excluded Medicaid eligible days from the [DSH] calculation.
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> **Statement of Legal Basis**
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> 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.[1]

On August 29, 2013, QRS filed the coversheet for the Provider's preliminary position paper in compliance with the Board Rules then in effect.[2] Similarly, **on December 26, 2013**, the Medicare Contractor filed the coversheet for its preliminary position paper.

On March 30, 2016, QRS filed a complete copy of the Provider's ***first*** final position paper. Similarly, **on April 29, 2016**, the Medicare Contractor filed its ***first*** final position paper.

On June 21, 2016, QRS notified the Board that a Medicaid eligible day listing was being reviewed by the Medicare Contractor potential administrative resolution of Issue 3 and, for the first time in the record of this case identified the Adolescent Psychiatric Days issue by including the following sentence in this notice: "We will be submitting a request for the Adolescent Psych issue pending in case # 13-0397 to be determined by the Board's decision rendered with respect to [Case Nos.] 06-0851 & 06-0852." This filing did ***not*** include a listing of any specific days at issue.

On February 13, 2017, QRS filed a Joint Stipulation Agreement entered into by the Parties. The Joint Stipulation Agreement references Case Nos. 06-0851 and 06-0852 and states that the Parties agree that a decision by the Board on the merits in those cases will be binding on the Parties in this case:

> 6. The same issue of whether the days for inpatient stays in the adolescent psychiatric unit should be included in the DSH calculation was heard by the PRRB in a live hearing involving the same parties on September 25. 2015, In the Matter of: Novant Presbyterian hospital vs. Palmetto Government Benefits Administrators, LLC and Blue Cross Blue Shield, in Case Numbers 06-1851 and 06-1852.

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[11] (Emphasis added.)

[2] Prior to the Board Rule changes on August 29, 2018, parties only filed the first page of their preliminary position paper with the Board, but exchanged the full or complete position with the opposing party. The Board Rules in effect (Mar. 1, 2013) at the time of the preliminary position paper filings specified the preliminary position paper was to be fully developed and include all exhibits. *See, e.g.*, Commentary to Board Rule 23.3 (Mar. 1, 2013) ("the Board expects preliminary position papers to be fully developed and include all available documentation necessary to give the parties a thorough understanding of their opponent's position."); Commentary to Board Rule 25 (Mar. 1, 2013) ("preliminary position papers now are expected to present fully developed positions of the parties and, therefore, require analysis well in advance of the filing deadline."); Board Rule 25.2 (Mar. 1, 2013) ("With preliminary position papers, the parties must exchange all available documentation . . . . 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.").

> 9. Please note that the Parties are stipulating that any decision reached by the Board solely on the merits in PRRB cases 06-1851 and/or 06-1852 will be binding on the parties for PRRB case 08-2581GC [*sic* 13-0397[3]] for Provider no. 34-0053, with the parties reserving their rights to proceed to the CMS Administrator and/or seek judicial review. In 06-1851 and 06-1852, the MAC filed a jurisdictional challenge. ***This stipulation does not apply to any jurisdictional decision rendered by the Board with respect to either case 06-1851 or 06-1852***.[4]

Thus, the Stipulations recognize that the Provider is asserting that Issue 3 contains a sub-issue for Adolescent Psychiatric Unit days. (**NOTE**—On November 17, 2017, the Board issued its determination to dismiss Case Nos. 06-1851 and 06-1852 for lack of jurisdiction and that the Medicare Contractor has included a copy of this November 17, 2017 dismissal determination in the record *for this case* ***both*** at Exhibit C-9 as attached to its final position paper filed on September 13, 2022 ***and*** as Exhibit C-16 as attached to its Jurisdictional Challenge filed on September 9, 2022.)

On March 6, 2017, QRS filed a "Withdraw Issue Due To A Partial Administrative Resolution." In this filing, QRS withdrew the DSH/Medicaid Eligible Days issue (Issue 3) "as per the Partial Administrative Resolution (copy enclosed)." QRS then goes on to state that: (1) "as the Medicaid Eligible Days was the only issue which was to be hear during the live hearing scheduled for March 7, 2017, that hearing is no longer necessary and should be removed from the Board's calendar"; and (2) "pursuant to PRRB Rule 46.2, the Provider . . . reserves its right to reinstate this appeal should a revised NPR not be issued in accordance with the terms of the Administrative Resolution." Pursuant to the enclosed Partial Administrative Resolution executed March 6, 2017, the parties state Issue 3 has two parts, Medicaid eligible days and Adolescent Psychiatric Unit Days. The Medicare Contractor agreed to resolve the Medicaid eligible days issue by including an additional 3,212 Medicaid eligible days in the cost report. However, the Medicare Contractor did "not include any additional Medicaid eligible days that occurred in the Provider's Adolescent Psychiatric Unit based *as these days occurred in an* ***excluded*** *unit* and therefore are not allowable . . . in the DSH calculation."[5]

On December 29, 2021, the Board issued a Notice of Hearing - Rescheduled that required the Provider and the Medicare Contractor to file a *second* final position papers on August 17, 2020 and September 16, 2022 respectively. This Notice included the following instruction on the content of the position paper filing consistent with 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rule 25 as applicable by Board Rule 27.2 (2021):

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[3] This appears to be a typo. Case No. 08-2581GC is another case involving the same issue in which the Provider was a participant but involved other fiscal years. The Medicare Contractor has also entered the Board's January 6, 2021 jurisdictional dismissal determination for that case in the record at Exhibit C-11 (as attached to its final position paper) and that determination references stipulations entered into by the parties at C-0061.

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

[5] (Emphasis added.)

> Provider's Final Position Paper – For each remaining issue, the position paper ***must state the material facts*** *that support the appealed claim,* ***identify*** *the controlling authority* (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments applying the material facts to the controlling authorities*. This filing ***must*** *also* ***include any exhibits*** *the Provider will use* to support its position. See Board Rule 27 for more specific content requirements. If the Provider misses its due date, the Board will dismiss the cases.[6]

On August 17, 2022, QRS timely filed its ***second*** final position paper. However, it generically discussed Medicaid eligible day without any reference or discussion of the Psychiatric Adolescent Unit or days associated with that Unit. It also *generically* promised that "the Medicaid eligible days listing [is] being sent under separate cover." **On September 13, 2022**, the Medicare Contractor timely filed its ***second*** final position paper.

Four days earlier, **on September 9, 2022**, the Medicare Contractor submitted a jurisdictional challenge on the remaining Issue 3 sub-issue contending that the Provider abandoned the sole remaining issue in the appeal, DSH Adolescent Psychiatric Unit Days, when it failed to brief this issue in its final position paper submitted on August 17, 2022. Specifically, the Provider:

- Failed to state the material facts that support its claims that the Medicare Contractor failed to include the disputed adolescent psychiatric days in the DSH calculation;
- Failed to identify or produce any documents explaining or demonstrating that those Medicaid eligible days should have been included; and
- Failed to reference the Partial Administrative Resolution and the fact that the appeal related to DSH Medicaid Eligible Days was partially resolved.

Board Rule 44.4.3 specifies that responses to a jurisdictional challenge be filed within 30 days,[7] making the filing deadline to be Tuesday October 11, 2022.[8] However, QRS *failed to* ***timely*** file its response to the Jurisdictional Challenge by the Tuesday, October 11, 2022 deadline (rather as described below it was filed *4 weeks late*).

On October 20, 2022, QRS filed a request for record hearing and similarly failed to acknowledge the pending jurisdictional challenge or even comply Board Rule 32.4 instructions on the content for a record hearing request (*e.g.*, the request fails to explain why the case is suitable for a record hearing, explain whether material facts are in dispute, confirm the record is substantially complete, and include stipulations of fact). Rather, the request was a perfunctory filing where the request

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[6] (Emphasis added.)
[7] Board Rule 44.4.3 (Nov. 2021) states: "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.").
[8] As the 30th day fell on Sunday, October 9, 2022, the filing deadline gets moved to the next business day. As Monday, October 10, 2022 was a federal holiday, the next business day was Tuesday, October 11, 2022.

was simply: "[QRS] . . . hereby requests that the [Board] hearing . . . currently scheduled for November 15, 2022 be conducted through a record hearing."

On November 8, 2022, QRS filed an ***untimely*** response to the September 9, 2022 Jurisdictional Challenge. It was untimely because it was filed on Tuesday, November 8, 2022, ***four (4) weeks*** after the Tuesday, October 11, 2022 deadline. Further, QRS' filing provided ***no explanation*** to establish good cause for that late filing. QRS' *untimely* response to the jurisdictional challenge made the following arguments:

1. The Issue 3 sub-issue is properly part of this appeal because "[t]he Provider was not required to either make a specific claim on its cost report for the additional Medicaid eligible days or show a practical impediment, in order for the Board to have jurisdiction over its appeals" and because "[e]ven if the Provider were required to make a specific claim on its cost report for the additional Medicaid-eligible days or show a practical impediment, it did demonstrate a practical impediment that prevented it from identifying additional Medicaid-eligible days prior to filing its costs reports."

2. The Provider has not abandoned the Issue 3 sub-issue because: (a) it presented the adolescent psych days in dispute to the Medicare Contractor as demonstrated by "MAC work papers (Exhibit 3, page 6 March 01, 2017 [as attached to the November 8, 2022 filing]) in which it is noted that: the Adolescent Psychiatric days received by the MAC were filtered out prior to the sampling process and the issue will proceed to hearing"; and (b) the MAC acknowledges that it contends that the MAC acknowledged in its final position paper that it was aware the Provider was still pursuing the Issue 3 sub-issue.

On March 9, 2023, the Board issued its determination to dismiss Case No. 13-0397 and the following excerpt summarizes the basis for the dismissal:

> Based on the record before it (on which the Provider has otherwise requested a **record** hearing on October 19, 2022), the Provider **failed to brief** the adolescent psychiatric day issue in compliance with 42 C.F.R. § 405.1853(a)-(b) and Board Rule 25 (via Board Rule 27.2). In particular, **no actual specific adolescent psychiatric days have been identified for the record** and, accordingly, the Board must presume that no adolescent days are in dispute and that the actual amount in controversy for this issue is $0. Regardless, *as a separate and independent basis for dismissal*, based on the Provider's admission that this case has the same facts as FYs 2001 and 2002, the Board would dismiss the issue as unclaimed costs consistent with its dismissal of the issue for FYs 2001 and 2002. Accordingly, the Board hereby dismisses the Issue 3 sub-issue Medicaid Eligible Days for the

> Adolescent Psychiatric Unit from the appeal. Since no issues remain in the appeal, Case No. 13-0397 will be closed and removed from the Board's docket.[9]

Provider's Motion for Reinstatement

On August 30, 2023, the Provider filed a Motion for Reinstatement, stating (in part):

> The Board takes the position that regulation 405.1832(b)(2), as added by the May 23, 2008 final rule (73 Fed. Reg. 30190), justifies dismissal of this appeal, but the Provider respectfully disagrees. As the Board notes, section 405.1832(b)(2) provides that
>
> > Each position paper must set forth the relevant facts and arguments regarding the Board's jurisdiction over each remaining matter at issue in the appeal, and the merits of the provider's Medicare payment claims for each remaining issue.
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> Both the June 25, 2004 proposed rule (69 Fed. Reg. 35716) and the 2008 final rule indicate that an "issue" is encapsulated by a specific cost report adjustment. They do not slice and dice an "issue" into component parts, including the specific reason why Medicaid eligible days were not counted in the numerator of the Medicaid Fraction of the Disproportionate Payment Percentage. The text of 405.1811 and 405.1835, and the discussion of these sections in the proposed and final rules are clear that in order to add an "issue" or claim or self-disallow an issue, it is necessary only to identify the specific adjustment that would result in additional reimbursement.
>
> Nor do the applicable Board Instructions support the dismissal. The Provider's appeal was filed on January 11, 2013 and its Final Position Paper on March 30, 2016. As of the August 29, 2018 version of the Board's Rules, the requirements for a final position paper were considerably less detailed than what the Board asserts was necessary in its dismissal letter. See Board Rule 27.2 of the 2015 version. In its dismissal letter, the Board cites Board Rule 25, governing *preliminary* position papers. However, it is clear from the 2018 version of the Board rules, that the detail required under Rule 25 for preliminary position papers and incorporated into final position papers is applicable only for appeals filed *after* the effective date of the 2018 version. The 2018 version of the Board Rules states that the heightened requirements for preliminary position papers is "a change

[9] (Footnotes omitted, italics emphasis in original, and bold and underline emphasis added.)

in previous Board practice." *See* Commentary to Board Rule 25.3 (2018). The 2018 version of the Board Rules then states, at Rule 27.1

> For new appeals filed on or after the effective date of the rules, the parties will have exchanged, and the Board will have received a copy of, a full preliminary position paper setting forth the arguments and legal authorities for each issue in the appeal. Therefore, for appeals filed after the effective date of the rules, the final position paper is an optional filing, intended to hone the issue if necessary, but is not required. If no paper is submitted, the arguments related to the issues under appeal will be limited to those set forth in the preliminary position paper.
>
> For appeals filed prior to the effective date of the rules, the final position paper remains a required filing, and failure to timely file the final position papers may result in dismissal of the case, or any of the actions under 42 C.F.R. § 405.1868.

The above-quoted language is clear that, because final position papers would now be optional, appeals filed *after* the effective date of the 2018 version of the Board Rules should comply with the *new* requirements for preliminary position papers, but for appeals filed *prior to* the effective date of the 2018 version of the Board Rules, the *existing rules* for final position papers (which state that only failure to timely file the final position paper is grounds for dismissal) remain in effect. Moreover, the 2015 and 2018 versions of the Board Rules state what a provider should do with respect to the content of the final and preliminary position papers, not what they *must* do. In *Harris County Hospital v. Shalala*, 863 F. Supp. 404 (S.D. Tex. 1994), the court found that the Provider Reimbursement Manual's use of "should" was suggestive and not a requirement. The same applies here.

Finally, even if there were legitimate grounds for dismissing the Provider's appeal, it was arbitrary and capricious and an abuse of discretion for the Board to do so. As stated above, the MAC was aware of the controversy surrounding the adolescent psych days, understood what the Provider's position was concerning such days (among other things, it knew that Provider's position was fully explicated in the previous appeals of 08-651 and 08-652 [*sic*]), and there was no prejudice to the MAC if the appeal was not dismissed. Instead, the Board's dismissal was simply borne out of a desire to reduce its pending case backlog.[10]

[10] (Emphasis in original.)

MAC Opposition to Provider's Motion for Reinstatement

On September 13, 2023, the MAC filed an Opposition to Provider's Motion for Reinstatement stating (in part):

> The QRS Motion fails to mention that the MAC's September 9, 2022 jurisdictional challenge contends that the provider abandoned the adolescent psychiatric days sub-issue by failing to brief the issue in the August 17, 2022 Final Position Paper. Specifically, the MAC's jurisdictional challenge asserted that the provider's Final Position Paper failed to meet the applicable regulatory and Board Rules. Of note, the Provider submitted a late jurisdictional responsive brief.
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> ****
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> It is clear that the provider failed to properly brief the issue in the Final Position Paper. Instead, the provider alleges that the MAC was aware of the sub-issue. However, *any argument that the MAC had prior knowledge of the sub-issue totally misses the point and is irrelevant.* ***The provider's obligation*** *to properly brief this sub-issue and provide supporting documentation* ***is an independent obligation under 42 C.F.R. § 405.1853(b)(2), as well as Board Rules 25 and 27***. No amount of knowledge, whether actual or imputed, on the part of the MAC, excuses or waives the providers obligations under the regulations and the Board Rules. In addition, the MAC does not have the authority to excuse or waive the providers' obligations under the regulations and the Board Rules.
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> ****
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> Board Rule 47 addresses reinstatement. While the Rule allows a motion for reinstatement up to three years from the date of Board dismissal, the request must set out the reasons in support of reinstatement. Further, the Rule continues, stating that the "Board will not reinstate an issue(s)/case if the provider was at fault." The QRS Motion attempts to deflect the requirements of Board Rules 25 and 27. Regardless of whether Version 2.0 or Version 3.1 of Board Rules apply, Rule 27 sets out the minimum requirements for the final position paper narrative and are the same as those outlined at Rule 25. The QRS Motion clearly fails to support reinstatement by demonstrating compliance with the applicable regulation and Board Rules. Further, the dismissal was based on the fault of the providers.[11]

[11] (Emphasis added.)

Statutory and Regulatory Background

The regulations governing position papers can be found at 42 C.F.R. § 405.1853(b)(2)-(3):

> (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.[12]

These position paper requirements are consistent with its "burden of production of evidence and burden of proof" that 42 C.F.R. § 405.1871(a)(3) places on providers pursuing appeals before the Board:

> (3) The [Board] decision must include findings of fact and conclusions of law regarding the Board's jurisdiction over each specific matter at issue (see § 405.1840(c)(1)), and *whether the* ***provider*** *carried its* ***burden of production of evidence and burden of proof*** *by establishing, by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue*.[13]

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

> (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.

[12] (All emphasis added except for the title of subsection (b) "*Position papers*").
[13] (Emphasis added.)

> (b) If a provider fails to meet a filing deadline or other requirement established by the Board in a rule or order, the Board may—
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> (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
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> (3) Take any other remedial action it considers appropriate.

When QRS filed the Provider ***first*** final position paper on March 30, 2016, the relevant portions of Board Rules 25 and 27 (2015) set forth the following position paper requirements and notably the instructions for preliminary position papers are applicable to final position papers since final position papers are a "refinement" of the preliminary position paper:

> **Rule 25 – Preliminary Position Papers**
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> **COMMENTARY**: *Under the Regulations effective August 21, 2008, all issues will have been identified well in advance of the due date for preliminary position papers*. Unlike the prior practice, preliminary position papers now are expected to present *fully developed positions of the parties* and, therefore, require analysis well in advance of the filing deadline. To address complaints under the previous Rules that the parties have not had sufficient time to develop meaningful position papers, upon publication of these Rules, 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 Intermediary and fifteen months for the Provider's response. . . .
>
> **25.1 – Content: The text of the Preliminary Position Papers must include the following:**
>
> **A. Provider's Preliminary Position Paper**
>
> 1. For each issue, state the material facts that support your claim.
>
> 2. Identify the controlling authority (e.g., statutes, regulations, policy, or case law) supporting your position.
>
> 3. Provide a conclusion applying the material facts to the controlling authorities.
>
> ****

C. Provider Response to Intermediary Preliminary Position Paper

1. Address rebuttal or Intermediary arguments not previously addressed.

2. Attach documentation not previously furnished with the Provider's preliminary position paper that is responsive to arguments raised by the Intermediary in its responsive preliminary position paper.

25.2 – Preliminary Documents:

A. General: With the preliminary position papers, the parties must exchange *all available* documentation as preliminary exhibits to fully support your position. The Intermediary must also give the Provider all evidence the Intermediary considered in making the determination (see 42 C.F.R. § 405.1853(a)(3)) and identify any documentary evidence that the Intermediary believes is necessary for resolution which has not been submitted by the Provider.

B. Unavailable and Omitted Preliminary 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 opposing party.

C. Preliminary Documentation List: Parties must attach a list of the exhibits exchanged with the preliminary position paper.

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27.1 – General

The final position paper should reflect the *refinement of the issues from the preliminary position paper* or proposed JSO. . . .

27.2 – Content

The final position paper should address each remaining issue including, at a minimum:

a. Identification of each issue and its reimbursement impact.
b. Procedural history of the dispute.
c. A statement of facts that:

i. Indicates which facts are undisputed.
ii. Indicates, for each material disputed fact, the evidence that the party asserts supports those facts with supporting exhibits and page references.

> d. Argument and Authorities – A thorough explanation of the party's position of how the authorities apply to the facts.
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> **27.3 – Revised or Supplemental Final Position Papers**
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> Except on written agreement of the parties, revised or supplemental position papers should not present new positions, arguments or evidence. However, the Board encourages revised or supplemental final position papers which, for administrative efficiency, further **narrow** the parties' positions or provide legal development (such as new case law) that has occurred since the final position paper was filed. Prior to filing such papers, the parties should contact each other to discuss the anticipated substance of such papers and anticipated objections. If a revised or supplemental position paper is filed to further refine or narrow the issues, the opposing party may file a rebuttal or reserve such rebuttal for hearing.
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> **27.4 – Arguments Expanding the Scope of Final Position Papers**
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> If at hearing or through a revised position paper, a party presents an argument or evidence expanding the scope of the position papers, the Board may, upon objection, exclude such arguments or evidence from consideration.[14]

When QRS filed the Provider's ***second*** final position paper on August 17, 2022, the relevant portions of Board Rules 25 and 27 (Nov. 2021) set forth the following final position paper requirements:

> **Rule 25 Preliminary Position Papers**
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> ****
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> **25.1 Content of Position Paper Narrative**
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> The text of the position papers must include the elements addressed in the applicable subsection.
>
> **25.1.1 Provider's Position Paper**
>
> The provider's preliminary position paper must:
>
> A. Identify any issues that were raised in the appeal but are already resolved (whether by administrative resolution, agreement to reopen, transfer, withdrawal, dismissal, etc.) and require no further documentation to be submitted.

[14] Board Rules effective July 1, 2015 (underline and italics emphasis added).

B. For ***each*** issue that has not been fully resolved, provide a ***fully*** developed narrative that:

- States the material facts that support the provider's claim.
- Identifies the controlling authority (e.g., statutes, regulations, policy, or case law) supporting the provider's position.
- Provides a conclusion applying the material facts to the controlling authorities.

C. Comply with Rule 25.2 addressing Exhibits.

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25.2 Position Paper Exhibits

25.2.1 General

With the position papers, the parties must exchange ***all*** available documentation as exhibits to fully support your position. . . .

25.2.2 Unavailable and Omitted Documents

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.

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25.3 – Filing Requirements to Board

The Board requires the parties file a ***complete*** preliminary position paper that includes a fully developed narrative (Rule 25.1), all exhibits (Rule 25.2), a listing of exhibits, and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. If the provider fails to brief an appealed issue in its position paper, the Board will consider the unbriefed issue abandoned and effectively withdrawn**.**

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Rule 27 Final Position Papers

27.1 General

The Board will set due dates for the final position papers in its Notice of Hearing, generally 90 days before the scheduled hearing date for the provider; 60 days for the Medicare contractor; and 30 days for provider response (optional).

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- ***Remains Mandatory For Appeals Filed Prior to August 29, 2018***.—For appeals filed prior to August 29, 2018, the 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).

27.2 Content

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

27.3 Revised or Supplemental Final Position Papers

A party may also file a revised or supplemental position paper; however, this filing should not present new positions, arguments or evidence except on written agreement between the parties. Notwithstanding, the Board encourages revised or supplemental position papers when they promote administrative efficiency and further *narrow* the parties' positions or provide legal development (such as new case law) that has occurred since the final position paper was filed. Prior to filing such papers, the parties should contact each other to discuss the anticipated substance of such papers and anticipated objections. If a revised or supplemental position paper is filed to further refine or narrow the issues, the opposing party may file a rebuttal or reserve such rebuttal for hearing.

27.4 Expanding Scope of Arguments at the Hearing or in Revised or Supplemental Final Position Papers Is Prohibited

If at hearing or through a revised or supplemental position paper, a party presents an argument or evidence expanding the scope of the

> position papers, the Board may, upon objection or its own motion, exclude such arguments or evidence from consideration.[15]

Board Rule 41.2 outlines the circumstances in which the Board may dismiss a case:

> **41.2 Own Motion**
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> 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.[16]

Board's Decision

As set forth below, the Board declines to exercise its authority to reconsider its dismissal and/or reinstate this case. The Board maintains its position outlined in the March 9, 2023 decision that the Provider failed to brief the Adolescent Psychiatric Unit days issue in compliance with 42 C.F.R. § 405.1853(a)-(b) Board Rule 25 (via Board Rule 27.2) in the Provider's Final Position Paper filed on August 17, 2022. The Provider's arguments are meritless and its request failed to include any new arguments or information that would change the Board's decision that the issue was not briefed.

The hollowness of QRS request to reinstate is highlighted by facts that, on October 20, 2022, QRS filed a request that the Board conduct a hearing ***on the record*** for this case (without explaining why a hearing *on the record* was appropriate); and then 19 days later filed an *untimely* response the jurisdictional challenge which seemingly acknowledges that *the record* on which it is asking the Board to conduct a hearing does ***not*** reflect the relevant facts and arguments regarding ***either*** the Board's jurisdiction over ***or*** the merits of the adolescent child psychiatric days issue.

Furthermore, the Board finds that the Provider misconstrues 42 C.F.R. § 405.1853(b)(2)-(3) and the Board Rules for position papers, which *did require* the Provider to specifically brief each open issue, including the Adolescent Psychiatric Unit days issue (including the merits and jurisdiction) *both* in its ***first*** Final Position Paper filed in April 2016 *and* in its ***second*** final position paper filed *over 6 years later* in August 2022. The Provider's final position paper filings did not identify the Adolescent Psychiatric Unit days issue, did not identify the reimbursement impact, did not give a procedural history or statement of the facts, and did not cite to any authorities for the Adolescent

[15] (Underline emphasis added and italics and bold emphasis in original.)
[16] (Italics and underline emphasis added and bold emphasis in original.)

Psychiatric Unit days issue.[17] *Indeed, the August 2022* ***second*** *final position paper filing did* ***not*** *even identify a* ***single*** *Adolescent Psychiatric Unit day being at issue, even though this case had been pending* ***for over 9 years*** *and the fiscal year at issue had been closed* ***for over 14 years***.[18] Moreover, QRS opted not to exercise its right to file an *Optional* Responsive Brief "in response to the arguments and evidence submitted in the Medicare Contractor's final position paper" by the October 16, 2022 deadline as specified in the December 29, 2021 Notice of Hearing[19]; but instead, *4 days later* on October 20, 2022, filed a request that the Board conduct *a hearing* ***on the record***.

As explained at 42 C.F.R. § 405.1871(a)(3), it is the Provider's "burden of production of evidence and burden of proof . . . [to] establish[], by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue."[20] Similarly, 42 C.F.R. § 412.106(b)(4)(iv)

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[17] QRS filed the Providers ***first*** final position paper on ***March 30, 2016*** (before the Board issued its jurisdictional dismissal determination in Case Nos. 06-1851 and 06-1852 as discussed in *infra* note 20) ***and*** the Provider's ***second*** final position paper on ***August 17, 2022*** (well after the Board had issued its November 17, 2017 jurisdictional dismissal determination). However, both position paper filings are perfunctory and virtually identical. Significantly, neither position paper filing discusses or mentions the unique issues associated with the Adolescent Psychiatric Unit days issue both in terms of the jurisdiction and merits as laid out in the Board's November 17, 2017 dismissal determination for Case Nos. 06-1851 and 06-1852 (copy at Exhibit C-9) ***notwithstanding the fact that*** *the parties had filed stipulations in this case asserting that Case Nos. 06-1851 and 06-1852 concerned the* ***same*** *Adolescent Psychiatric Unit days issue.*

[18] The Board recognizes that the ***first*** final position paper filed in 2016 included a Medicaid eligible days listing but that listing did not include any Adolescent Psychiatric Unit days nor does the Provider claim that it does. It was not until QRS filed the reinstatement request that QRS entered, ***at that exceedingly late date***, such a listing of Adolescent Psychiatric Unit days into the record.

[19] QRS opted not to file an Optional Responsive Brief by the October 16, 2022 filing deadline, notwithstanding the fact that the Medicare Contractor's September 9, 2022 jurisdictional challenge and September 13, 2022 final position paper both contains many *material* arguments and evidence relating to the merits and jurisdiction not addressed by QRS in its August 2022 final position paper. *See also infra* note 20.

[20] QRS suggests in its request for reinstatement that: (1) the record from a prior appeal involving the *same* provider but a different fiscal year may be relevant to this case (*see* Request for Reinstatement at 3 citing to Case Nos. 08-1651 and 08-1652); and (2) there is no prejudice to the Medicare Contractor because "the MAC was aware of the controversy surrounding the adolescent psych days" and "understood what the Provider's position was concerning such days" (*id.*). However, notwithstanding its burden of proof, QRS has *failed* to introduce *into the record for* ***this case***: (1) those portions of portions of the record from those prior appeals that it maintains are relevant *for this case*; or (2) any of the evidence and argument *relating to this case* of which it contends the Medicare Contractor was aware. As 42 C.F.R. §§ 405.1853(b)(2)-(3) and 405.1871(a)(3) make clear, it is ***the provider's responsibility*** to present and establish the record in support *of its* ***own*** *case*. In this regard, if the record from another Board appeal involving a *different* fiscal year is relevant to a case pending before the Board, it is ***the provider's responsibility*** to enter the relevant portions of the prior case's record into the record for that pending case. To this end, Board Rule 35.3 states, in pertinent part, that "[t]he Board will ***not*** be responsible for supplementing any record with evidence from a previous hearing. All evidence submitted into the record, ***must*** be done *by the parties*. *See also* Board Rule 35.8 (stating, in pertinent part: "Upon the parties' agreement and subject to the Board's approval, the transcribed testimony from a previous Board hearing may be admitted as evidence. The specific portions must be identified, copied (along with a cover page and certificate to indicate the source and date) and marked as an exhibit. *It is* ***not sufficient*** *to merely reference another case number*." (emphasis added)). Thus, it is not enough that, on February 13, 2017, the parties filed in this case Stipulations that reference the prior cases stating: "[t]he same issue of whether the days for inpatient stays in the adolescent psychiatric unit should be included in the DSH calculation was heard by the PRRB in a live hearing involving the same parties on September 25. 2015, In the Matter of: Novant Presbyterian hospital vs. Palmetto Government Benefits Administrators, LLC and Blue Cross Blue Shield, in Case Numbers 06-1851 and 06-1852. . . . Please note that the Parties are stipulating that any decision reached by the Board solely on the merits in PRRB cases 06-1851 and/or 06-1852 will be binding on the parties for PRRB case 08-2581GC [*sic* 13-0397] for Provider no. 34-0053, with the parties reserving their rights to proceed to the CMS Administrator and/or seek judicial review. In 06-1851 and 06-1852, the MAC filed a jurisdictional

specifies: "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."[21] Accordingly, in the Board's March 9, 2023 dismissal determination, the Board concluded:

> Based on the record before it (***on which the Provider has otherwise requested a record hearing on October 19, 2022***), the Provider failed to brief the adolescent psychiatric day issue in compliance with 42 C.F.R. § 405.1853(a)-(b) and Board Rule 25 (via Board Rule 27.2). In particular, ***no*** *actual specific adolescent psychiatric days have been identified for the record* and, accordingly, the Board must presume that no adolescent days are in dispute and that the actual amount in controversy for this issue is $0.[22]

While QRS' request for reinstatement does include, *at this exceedingly late date* (more than 10 years after this appeal was filed), a listing of Adolescent Psychiatric Unit days in dispute (1435 days in total), it fails to establish good cause for this ***extraordinarily late*** submission and its failure to follow Board regulations and rules governing the briefing and evidentiary/exhibit process and still has not addressed other glaring *material* gaps in its briefing and exhibits discussed above.[23]

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challenge. ***This stipulation does not apply to any jurisdictional decision rendered by the Board with respect to either case 06-1851 or 06-1852.***" (Bold and italics emphasis added and underline in original.) In contrast to the Provider, the Medicare Contractor did:

1. Discuss Case Nos. 06-1851 and 06-1852 both in its Jurisdictional Challenge and its September 13, 2022 final position paper filing;
2. Enter into the record *for this case* the portion of the record from Case Nos. 06-1851 and 06-1852 that it maintains is relevant, namely a copy of the November 17, 2017 jurisdictional dismissal determination issued in those cases (***both*** at Exhibit C-9 as attached to its final position paper filed on September 13, 2022 ***and*** as Exhibit C-7 as attached to its Jurisdictional Challenge filed on September 9, 2022); and
3. Enter into the record *for this case* the portion of the record from Case Nos. 08-2559GC, 08-2570GC, 08-2581GC that it maintains is relevant, namely a copy of the jurisdictional dismissal determination issued in those cases in connection with this same Provider and same issue but for different years (***both*** at Exhibit C-11 attached to its September 13, 2022 final position paper ***and*** at Exhibit C-16 attached to its September 9, 2022 Jurisdictional Challenge).

[21] *See also* HCFA Ruling 97-2 (Feb. 1997) (stating: "The hospitals bear the burden of proof and must verify with the State that a patient was eligible for Medicaid (for some covered services) during each day of the patient's inpatient hospital stay. As the intermediaries may require, hospitals are responsible for and must furnish appropriate documentation to substantiate the number of patient days claimed. Days for patients that cannot be verified by State records to have fallen within a period wherein the patient was eligible for Medicaid cannot be counted.").

[22] (Emphasis added and footnotes omitted.)

[23] Indeed, notwithstanding the fact that it has asked the Board conduct a hearing *on the record* in this case, QRS has ***not*** entered into this record any State Medicaid documentation verifying that *each* of the Adolescent Psychiatric Unit days included on that belated listing pertain to a Medicaid eligible individual in compliance with the Provider's burden of proof in 42 C.F.R. § 412.106(b)(4)(iv), as quoted above. *See also supra* note 21 (quoting HCFA Ruling 97-2 as it relates to the hospital's burden of proof on Medicaid eligible days). Similarly, QRS has not addressed the Adolescent Psychiatric Unit's long history as an excluded unit and whether it continues to be an excluded unit (and therefore not allowable in the DSH calculation) *as discussed in by the Board in its jurisdictional dismissal determination for earlier fiscal years*. *See also* Board's Dismissal Determination at 12-14 (Mar. 9, 2023).

Finally, the Board reaffirms its decision that, *even if the Provider had properly and timely briefed the adolescent psychiatric days issue*, the Board would lack still lack jurisdiction over the issue as explained in its March 9, 2023 determination. In this regard, the Board notes that the Provider *failed* to timely brief its opposition to the Medicare Contractor's jurisdictional challenge but rather filed its response *4 weeks after the deadline*.[24]

*****

In summary, the Board declines to exercise its discretion to reopen Case No. 13-0397 or its decision to dismiss this case pursuant to Board Rule 47.1-47.3 and 42 C.F.R. § 405.1885. Accordingly, the Board denies the Provider's request for reinstatement, the Board's March 9, 2023 dismissal determination remains in effect/unchanged, and Case No. 13-0397 remains closed.

Board Members Participating:

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

For the Board:

10/13/2023

X Clayton J. Nix

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

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

[24] *See supra* notes 7-8 and accompanying text.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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RE: ***Jurisdictional Determination in Part and Dismissal of Duplicate Appeals***

Dignity Health CY 2015 Medicare Part C Days Included in Realigned SSI Ratio CIRP Group
Case Number: 20-1640GC

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") and Original Notices of Program Reimbursement ("ONPRs"). 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 6, 2020, Moss Adams LLP ("Moss Adams") filed the "Dignity Health CY 2015 Medicare Part C Days Included in CMS Realigned SSI Ratio CIRP Group" under Case No. 20-1640GC. The CIRP group is not designated to be fully formed and includes seven participants ("Providers"):

- St. Rose Dominican Hospitals - San Martin Campus (29-0053) **(RNPR)**
- St Joseph's Medical Center (05-0084) **(RNPR)**
- Mercy General Hospital (05-0017) (**RNPR)**
- Sierra Nevada Memorial Hospital (05-0150) **(RNPR)**
- Mercy Gilbert Medical Center (03-0119) **(RNPR)**
- Glendale Memorial Hospital & Health Center (05-0058) **(RNPR)**
- Chandler Regional Medical Center (03-0036) (ONPR)

The group appeal issue filed 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 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 CMS recalculation.
- Provider included in appeal on May 6, 2020.

Pertinent RNPR Facts for St Joseph's Medical Center

- RNPR Date: 12/24/2019
- 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 June 6, 2020

Pertinent RNPR Facts for Mercy General Hospital

- RNPR Date: 2/5/2020
- 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 July 26, 2020

Pertinent RNPR Facts for Sierra Nevada Memorial Hospital

- RNPR Date: 2/24/2020
- Audit Adjustment Nos.:
  #1 Completed cost reporting forms & pages in accordance w/current regulations
  #4 To adjust the SSI Percentage and the Disproportionate Share Amount based on the latest CMS Letter of SSI Percentage Realignment
- Provider added to appeal on August 14, 2020

Pertinent RNPR Facts for Mercy Gilbert Medical Center

- RNPR Date: 3/9/2020
- Audit Adjustment Nos.:
  #1 Completed cost reporting forms & pages in accordance w/current regulations
  #5 To revise the SSI and DSH percentage for proper calculation of the DSH adjustment
- Provider added to appeal on August 31, 2020

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 added to appeal on October 12, 2020

Pertinent ORIGINAL NPR Facts for Chandler Regional Medical Center

- Realignment Request Date: 9/13/2019
- NPR Date: 6/15/2021
- Audit Adjustment Nos.:
  #23 To properly report the current year operating DSH SSI %
- Provider added to appeal on December 9, 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.

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)).
>
> (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 therefore determined that it does not have jurisdiction over the Part C Days issues that were appealed by the Providers from RNPRs. The Board finds that the RNPRs for the six Providers were issued as a result of the Providers' specific 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 the Part C Days issue from these RNPRs 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

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[1] 42 C.F.R. § 405.1889(b).
[2] (Emphasis added).
[3] Based upon the Providers' Requests 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).

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 accomplish that requested realignment 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 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 for 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]

For the remaining Provider appealing from the original NPR (Chandler Regional Medical Center 03-0036), the Board finds its appeal in Case No. 20-1640 is duplicative of the issue which was included in PRRB Case No. 18-0562GC. The Provider is appealing from the same original NPR in each case, for the same issue, to seek the same result: the exclusion of Medicaid Managed Part C Days from the SSI ratio.[8]

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[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 supra* n. 8.

[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] PRRB Case No. 18-1652GC Chandler Regional Medical Center Issue 4 Statement (December 6, 2021)

Board Rule 4.6.1 (as of May 6, 2020, when the appeal was filed) states:

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

Conclusion:

The Board finds that it lacks jurisdiction over the Providers St. Rose Dominican Hospitals - San Martin Campus (29-0053), St Joseph's Medical Center (05-0084), Mercy General Hospital (05-0017), Sierra Nevada Memorial Hospital (05-0150), Mercy Gilbert Medical Center (03-0119), Glendale Memorial Hospital & Health Center (05-0058), which 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. In addition, as duplicative appeals from the same final determination are prohibited by Board Rule 4.6.1, the Board hereby dismisses Chandler Regional Medical Center (03-0036) from Case No. 20-1640GC pursuant to its authority under 42 C.F.R. § 405.1868. The Board hereby dismisses Case No. 20-1640GC in its entirety and removes it from its docket.

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

Board Members:

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

For the Board:

10/18/2023

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)

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Re: Fort Defiance Indian Hospital FFY 2024 Request for hearing: CCN 03-0071 Group
PRRB Case No. 24-0062G

Dear Ms. Haven and Mr. Bloom:

The Provider Reimbursement Review Board ("Board") is in receipt of the above-referenced *group* appeal request. The pertinent facts of the case and the Board's determination are set forth below.

Pertinent Facts:

On October 12, 2023, Fort Defiance Indian Hospital (the "Provider") filed a group appeal with the Board. Upon review of the document uploaded as the issue statement, the appeal is being filed on behalf of a ***single*** Provider that received a "Notice of Quality Reporting Program Noncompliance Decision Upheld" ("Noncompliance Determination") on July 25, 2023.[1] In the appeal request, the Provider indicates it is appealing this Noncompliance Determination "… based on identified quality improvement initiatives identified internally."

The Board notes that, although the appeal included extensive support to document things like "Opportunities for Improvement," a plan of correction, "HCAHPS Process Flow," etc., it did not include:

- a copy of the Provider's final determination (***i.e.,*** the July 25, 2023 Noncompliance Determination) (see 42 C.F.R. § 405.1835(b)(3) and Board Rule 7);
- the reimbursement impact on the facility, including a calculation of the amount in controversy (see Board Rule 6.4); and
- a representation letter (see Board Rule 5.4).[2]

[1] The original determination from the Centers for Medicare & Medicaid Services ("CMS"), dated May 31, 2023, was issued as a result of the facility's "failure to submit HCAHPS."
[2] Board Rules Version 3.1 (Nov. 1, 2021), https://www.cms.gov/medicare/regulations-guidance/provider-reimbursement-review-board/prrb-rules-and-board-orders.

In addition, the Board notes that one of the exhibits previously located at page 12, included protected health information ("PHI"). The Health Insurance Portability and Accountability Act ("HIPAA") Privacy Rule requires a covered entity and its business associates to make reasonable efforts to limit use, disclosure of, and requests for PHI or other personally identifiable information ("PII") to the minimum necessary to accomplish the intended purpose. While the Privacy Rule permits uses and disclosures for litigation, subject to certain conditions, such information is generally not necessary for documentation submitted to the Board. Because the record in Board proceedings may be disclosed to the public, the parties must carefully review their documents to ensure that they do not contain patient names, health insurance or social security numbers, addresses, or other information that identifies individuals. Therefore, in accordance with HIPAA rules, page 12 of the Issue Statement Document titled "2023.10.12 Final Request for hearing.pdf" has been removed from the record and it will not be considered by the Board.

Finally, the Board notes that the appeal, which appears to be for a single Provider (Fort Defiance Indian Hospital) was filed in the group appeal format. Board Rule 12.2 discusses the general requirements for a group and explains that the group appeal format is used when there are at least two providers appealing "… a single question of fact or interpretation of law, regulation, or CMS Rulings that is common to each provider in the group." In addition, the aggregate amount in controversy for a group must be $50,000 or more.

Decision of the Board:

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

42 C.F.R. § 405.1835(b) specifies that, if a Provider's appeal request does not meet the requirements of paragraph (b)(3) of the same section, the Board may dismiss the appeal with prejudice, or take any other remedial action it considers appropriate. Paragraph (b)(3) states in part that the following must be included in the Provider's request:

> A copy of the determination, including any other documentary evidence the provider considers necessary to satisfy the hearing request requirements … .

Including the actual determination being appealed with the appeal request is critical for a myriad of reasons, including to determine whether the Provider met the claim filing requirements specified in 42 C.F.R. § 405.1835.

Further, 42 C.F.R. § 405.1837 specifies that providers may appeal as a ***group*** if each satisfies the individual appeal requirements in 42 C.F.R. § 405.1835 (*except for the $10,000 individual appeal threshold*), the matter at issue involves a single question of fact or interpretation of law, regulation or CMS Ruling; and the aggregate amount in controversy for all providers will meet a $50,000 threshold. Consistent with this regulation, Board Rule 12.6 provides the *minimum*

number of providers in a group (CIRP and optional) and specifies that mandatory and optional group appeals must have a *minimum of **two** different providers*.

Pursuant to 42 C.F.R. § 405.1835(b), "[i]f the provider submits a hearing request that does not meet the requirements of paragraph (b)(1), (2) or (3) …, the Board may dismiss with prejudice the appeal or take other remedial action it considers appropriate.

In this case the Board finds that the Provider failed to submit the required copy of the final determination under appeal, calculation support to document the reimbursement impact of the dispute, or a representation letter. Therefore, the Board finds that the Provider did not meet the regulatory requirements for filing an appeal (***individual or group***) before the Board. Accordingly, the Board finds dismissal is appropriate under § 405.1835(b) and Board Rules, and hereby dismisses Case No. 24-0062G.

Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 105.1877.

Based on the final determination date referenced in the Provider's issue statement, the Provider may still be within its appeal period. Therefore, if the Provider elects, it may refile an individual appeal. Please see 42 C.F.R. § 405.1835 and Board Rules 6 and 7, which discuss individual appeal rights and requirements. Additionally, since the Provider is appealing a Quality Reporting determination, it may be helpful to refer to the Frequently Asked Questions ("FAQs") for Quality Reporting Appeals located at https://www.cms.gov/medicare/regulations-guidance/provider-reimbursement-review-board. Finally, the Representative is advised that it must not include any documents that include PHI/PII. If the Representative believes that it is necessary to include PHI/PII, it must reference Board Rule 1.4 regarding redaction or providing the protected information under seal.

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

For the Board:

10/23/2023

X Ratina Kelly

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Board Decision***
Stormont Vail Hospital (Prov. No. 17-0086)
FYE 09/30/2017
Case No. 22-0182

Dear Mr. Ravindran,

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

Background:

On November 24, 2021, Stormont Vail Hospital filed a request for hearing from a Notice of Program Reimbursement ("NPR") dated June 4, 2021. The hearing request included the following issues:

- Issue 1: Disproportionate Share Hospital (DSH) Supplemental Security Income (SSI) Percentage (Provider Specific)
- Issue 2: DSH-Medicaid Eligible Days
- Issue 3: DSH-SSI Fraction/Medicare Managed Care Part C Days
- Issue 4: DSH-SSI Fraction/Dual Eligible Days
- Issue 5: DSH-Medicaid Fraction/Dual Eligible Days
- Issue 6: IPPS Understated Standardized Payment Amount
- Issue 7: DSH-SSI Percentage

On December 20, 2021, the Provider transferred Issue 6 to an *optional* group appeal on December 20, 2021. On December 23, 2021, Issue 7 was added to the appeal and then immediately transferred to a group appeal on the same day. Also, on December 23, 2021, the Provider transferred Issues 3, 4, and 5 to *optional* group appeals. Last, by letter dated February 22, 2022, the Board dismissed Issue 1. As a result, the *sole* remaining issue in this appeal is Issue 2 relating to DSH Medicaid eligible days.

On July 22, 2022, the Provider filed its Preliminary Position Paper and promised it was sending a listing of Medicaid eligible days under separate cover. However, no such listing was filed.

Accordingly, on August 16, 2022, the Medicare Contractor filed a Request for DSH Medicaid Days Support requesting that the Provider submit a listing of Medicaid eligible days in dispute with supporting documentation within 45 days. However, the Provider did not file a response to this request.

Accordingly, on October 5, 2022, the Medicare Contractor filed its Jurisdictional Challenge and Request to Dismiss Issue 2 because the Provider has essentially abandoned the issue by never submitting a listing of the Medicaid eligible days in dispute for this issue and failing to file a complete preliminary position paper in accordance with Board rules and regulations. The Provider has not responded as of the date of this letter, notwithstanding Board Rule 44.4.3 which 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."

On October 25, 2022, the MAC filed its Preliminary Position Paper noting its jurisdictional challenge "because the provider has abandoned the [Medicaid eligible days] issue by not submitting a list of additional Medicaid eligible days and has not fully addressed the issue in its preliminary position paper.

MAC's Contentions

On October 5, 2022, the Medicare Contractor filed a Motion to Dismiss the Medicaid Eligible Days issue arguing that the Provider has effectively abandoned the issue by failing to furnish documentation in support of its claim for additional Medicaid Eligible Days or describe why such documentation was and continues to be unavailable. The Motion outlines Board's Rules 25.2.1, and 25.2.2 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. § 413.24(c) and §412.106(b)(4)(iii) which places the burden on the Provider regarding furnishing this documentation. Finally, the Motion notes that the Provider's Preliminary Position Paper affirmative stated that an eligibility listing would be sent under separate cover. The Medicare Contractor claims that no listing has ever been provided in the nearly two years since the appeal was filed. The MAC states it contacted the Provider to request evidentiary support on August 16, 2022. The Provider has not responded with an updated list of additional eligible days.

Provider's Jurisdictional Response

The Provider did not file a response to the Jurisdictional Challenge. 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.

According to its Appeal Request filed on November 24, 2021, the Provider asserts that all Medicaid eligible days were not included in the calculations of the DSH calculations for FY 2013. The Provider states Issue 5 as:

> **Statement of the Issue**
>
> Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.
>
> **Statement of the Legal Basis**
>
> The Provider contends the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.
>
> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.[1]

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) (Nov. 2021) 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.

[1] Provider's Appeal Request (November 3, 2016).

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.[2]

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

Board Rule 25 (Nov. 2021) requires the Provider to file its complete, *fully* developed preliminary position paper with all available documentation and gives the following instruction on the content of position papers:

> **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**
>
> The Provider's preliminary position paper must:
>
> A. Identify any issues that were raised in the appeal but are already resolved (whether by administrative resolution, agreement to reopen, transfer, withdrawal, dismissal, etc.) and require no further documentation to be submitted.
>
> B. For *each* issue that has not been fully resolved, provide a *fully* developed narrative. . .
>
> C. Comply with Rule 25.2 addressing Exhibits.

[2] (Bold emphasis added.)

****

25.2 Position Paper Exhibits

25.2.1 General

With the position papers, the parties must exchange ***all*** available documentation as exhibits to fully support your position. 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

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.

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**
>
> The Board requires the parties file a ***complete*** preliminary position paper with a fully developed narrative (Rule 25.1), all exhibits (Rule 25.2), a listing of exhibits, and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. If the provider fails to brief an appealed issue in its position paper, the Board will consider the unbriefed issue abandoned and effectively withdrawn.

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 July 22, 2022, the Provider filed their preliminary position paper in which it indicated that it would be sending the eligibility listing under separate cover.[3] The position paper did not identify

[3] Provider's Preliminary Position Paper (June 27, 2017).

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, 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*] 2013 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 Jurisdictional Challenge, the Medicare Contractor 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 "Estimated Impact" of $667,504 based on an estimated 1 percent increase in the Medicaid fraction, it is unclear whether this "*Estimated*" amount continues to be in dispute as of the Provider's filing of the position paper as no listing of days in dispute or updated amount was included. Moreover, the Medicare Contractor 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. The Medicare Contractor 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.[4]

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 the provider 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). 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"[5] 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. As the Provider failed to identify even a single Medicaid eligible day as being in dispute as part of the position paper filing notwithstanding its obligations under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25, the Board must find that there are no such days in dispute and that the actual amount in controversy is $0.

****

In summary, based on the record before it,[6] the Board hereby dismisses the 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 Rule 25. Nor has the Provider provided any timely explanation to the MAC as to why the documentation was absent

[4] *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.
[5] (Emphasis added.)
[6] Again the Provider failed to timely respond to the jurisdictional challenge (or even at all as of this decision) and, per Board Rule 44.4.3, the Board will make a determination based on the record before it.

or what is being done to obtain it. Further, the Board takes administrative notice that it has made similar dismissal in other cases in which QRS was the designated representative.[7] and, notwithstanding, QRS failed to provide the Medicaid eligible days listing or respond to the Jurisdictional Challenge.

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

Board Members Participating:

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

For the Board:

10/23/2023

X Clayton J. Nix

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

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

[7] Examples of QRS-represented individual provider cases which the Board dismissed the Medicaid eligible days issue include, but are not limited to: Case No. 14-2674 (Medicaid eligible days issue) dismissed by Board letter dated May 5, 2022 initiated by MAC filing dated Mar. 22, 2022); Case No. 16- 2521 (Medicaid eligible days dismissed by Board letter dated May 5, 2022 initiated by MAC filing dated Mar. 25, 2022); Case No. 16-0054 (Medicaid eligible days dismissed by Board letter dated May 5, 2022 initiated by MAC filing dated Mar. 25, 2022); Case Nos. 13-3022, 13-3211, 14-2506, 14-4313, 16-1712 (Medicaid eligible days dismissed by Board letter dated Sept. 30, 2022 initiated by MAC filing dated Dec. 10, 2020, Dec. 11, 2020, Mar. 12, 2021, Mar. 12, 2021, and Nov. 12, 2021 respectively); Case No. 21-1723 (Medicaid eligible days dismissed by Board letter dated Nov. 21, 2022 initiated by MAC filing dated Sept. 1, 2022); Case No. 16-1016 (Medicaid eligible days dismissed by Board letter dated Nov. 29, 2022 initiated by MAC filings dated May 17, 2018 and Mar. 2, 2022); Case No. 17-1747 (Medicaid eligible days dismissed by Board letter dated Nov. 29, 2022 initiated by MAC filings dated May 24, 2018 and Oct. 17, 2022); Case No. 15-2294 (Medicaid eligible days issue dismissed by Board letter dated Dec. 20, 2022 initiated by MAC filing dated May 23, 2022); Case No. 20-2155 (Medicaid eligible days dismissed by Board letter dated Dec. 30, 2022 initiated by MAC filing dated Oct. 17, 2022).

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

Christopher Kenny, Esq.
King & Spalding, LLP
1700 Pennsylvania Ave, NW, Ste. 200
Washington, DC 20006-4706

RE: ***EJR Determination***

23-1796GC	Hendrick Health FFY 2024 § 1115 Waiver Days Texas CIRP Group
23-1797GC	CHRISTUS Health FFY 2024 § 1115 Waiver Days Texas CIRP Group
23-1798GC	CHS FFY 2024 § 1115 Waiver Days Texas CIRP Group
23-1799GC	Ardent Health FFY 2024 § 1115 Waiver Days Texas CIRP Group
23-1802GC	UHS FFY 2024 § 1115 Waiver Days Texas CIRP Group
23-1803GC	HCA FFY 2024 § 1115 Waiver Days Texas CIRP Group
23-1804G	King & Spalding FFY 2024 § 1115 Waiver Days Texas Group

Dear Mr. Kenny:

The Provider Reimbursement Review Board ("Board") has reviewed the consolidated request for expedited judicial review ("EJR") filed on September 29, 2023 for the seven (7) above referenced cases of which one is an optional group and the remaining 6 are common issue related party ("CIRP") groups. Set forth below is the decision of the Board to deny the EJR request and to dismiss the 7 group appeals.

Background:

On September 29, 2023, the Providers' Representative, King & Spalding, LLP ("King & Spaulding"), filed group appeal requests to establish the six (6) above-referenced CIRP group appeals, and the single *optional* group appeal. Each group appeal involves hospitals located in Texas and is based on an appeal of the FY 2024 IPPS Final Rule as it relates to the inclusion of § 1115 waiver days in the Medicaid fraction of the disproportionate share hospital ("DSH") payment calculation.[1] Specifically, each of the 7 group appeals contains the following issue statement:

> This appeal challenges CMS's final determination set forth in the Inpatient Prospective Payment System Final Rule for fiscal year 2024 to deny hospitals Medicare DSH payments attributable to the inpatient days of individuals whose inpatient hospital services were eligible to be covered in whole or in part by an uncompensated care

[1] 88 Fed. Reg. 58640, 59012-26 (Aug. 28, 2023) (excerpt from the preamble to the final rule addressing "Counting of Certain Days Associated With Section 1115 Demonstration in the Medicaid Fraction").

> pool established under a waiver approved by CMS pursuant to Section 1115 of the Social Security Act. 88 Fed. Reg. 58640, 59016 (Aug. 28, 2023) (adopting 42 C.F.R. § 412.106(b)(4)(iii)). **Beginning on October 1, 2023, newly adopted 42 C.F.R. § 412.106(b)(4)(iii) bars hospitals from claiming in the Medicaid fraction of their Medicare DSH calculations all patient days attributable to such individuals**. This determination is unlawful because CMS is required to include in the Medicaid fraction all patients it has regarded as eligible for Medicaid under a Section 1115 waiver. 42 U.S.C. § 1395ww(d)(5)(F)(vi). Patients whose care is eligible for coverage under an uncompensated care pool that was established under a CMS approved Section 1115 waiver are regarded as eligible for Medicaid. *See Forrest General Hospital v. Azar*, 926 F.3d 221, 229 (5th Cir. 2019); *Bethesda Health, Inc. v. Azar*, 389 F. Supp. 3d 32, 47 (D.D.C. 2019) *aff'd*, 980 F.3d 121 (D.C. Cir. 2020).[2]

On the same day as the filing of the appeal requests, King & Spalding filed a Consolidated Petition for Expedited Judicial Review ("EJR Request") for the 7 group cases.

Statutory and Regulatory Background:

A. Medicare DSH Payment

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the inpatient prospective payment system ("IPPS").[3] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[4]
The IPPS statute contains several provisions that adjust reimbursement based on hospital-specific factors.[5] This case involves the hospital-specific DSH adjustment, which requires the Secretary to provide increased IPPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[6]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[7] 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.[8] The DPP is defined as the sum of two fractions expressed as percentages.[9] Those two

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

fractions are referred to as the "Medicare/SSI fraction" and the "Medicaid fraction." Both of these fractions consider whether a patient was "entitled to benefits under part A."

The statute at 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I) defines the Medicare/SSI fraction as:

> [T]he fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were entitled to benefits under part A of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were entitled to benefits under part A of this subchapter . . . .[10]

The Medicare/SSI fraction is computed annually by the Centers for Medicare and Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[11]

The statute, 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II), defines the Medicaid fraction as:

> The fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX [the Medicaid program], but who were not entitled to benefits under part A of this subchapter, and the denominator of which is the total number of the hospital's patient days for such period.
>
> In determining under [this subclause] the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX, the Secretary may, to the extent and for the period the Secretary determines appropriate, include patient days of patients not so eligible but who are regarded as such because they receive benefits under a demonstration project approved under subchapter XI.

[10] (Emphasis added.)
[11] 42 C.F.R. § 412.106(b)(2)-(3).

The Medicare contractor determines the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A and divides that number by the total number of patient days in the same period.[12]

Until its recent amendment, the implementing regulation at 42 C.F.R. § 412.106(b)(4) (2022) reads, with regard to computing the Medicaid Fraction:

> (4) *Second computation*. The fiscal intermediary determines, for the same cost reporting period used for the first computation, the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period. For purposes of this second computation, the following requirements apply:
>
> (i) For purposes of this computation, a patient is deemed eligible for Medicaid on a given day only if the patient is eligible for inpatient hospital services under an approved State Medicaid plan or under a waiver authorized under section 1115(a)(2) of the Act on that day, regardless of whether particular items or services were covered or paid under the State plan or the authorized waiver.
>
> (ii) Effective with discharges occurring on or after January 20, 2000, for purposes of counting days under paragraph (b)(4)(i) of this section, hospitals may include all days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act.

B. Background on Medicaid State Plans and § 1115 Waivers

Medicaid is a joint Federal and state program, established in Title XIX of the Social Security Act (the "Act").[13] To participate in the Medicaid program and receive federal matching funds (commonly referred to as federal financial participation or "FFP"),[14] a state must enter into an agreement ("State Plan") with the Federal government, describing the individuals covered, services provided, reimbursement methodologies for providers, and other administrative activities.[15]

Federal law provides states flexibility in operating Medicaid programs through multiple waivers of federal law and demonstration programs. To address the medical needs of its residents, a State may choose to apply for, and include in its State Plan, a demonstration program under

[12] 42 C.F.R. § 412.106(b)(4).
[13] 42 U.S.C. § 1396; 42 C.F.R. § 430.0.
[14] 42 U.S.C. § 1396b.
[15] 42 U.S.C. § 1396a.

§ 1115 of the Act (42 U.S.C. § 1315) which allows CMS to waive various Federal Medicaid eligibility and benefits requirements. These projects expand Medicaid eligibility to populations who would ordinarily be disqualified from receiving benefits under the State Plan. The costs of such a demonstration project, including the costs of patient treatment, are regarded as expenditures under the State Plan and thus eligible for Federal matching funds.[16]

Prior to 2000, "hospitals were to include in the Medicare DSH calculation ***only*** those days for populations *under the section 1115 waiver* who were or could have been made eligible under a State plan."[17] As a result, patient days of *expanded* eligibility groups were *not* included in the Medicare DSH calculation.

In 2000, the Secretary published an interim rule to address the DSH adjustment calculation policy in reference to § 1115 waiver days and allow for certain *expanded* eligibility groups to be included in the Medicare DSH calculation.[18] Specifically, the interim rule revised this policy "to allow hospitals to include the patient days of all populations eligible for Title XIX matching payments in a State's section 1115 waiver in calculating the hospital's Medicare DSH adjustment."[19] This change in policy was effective for discharges occurring on or after January 20, 2000 and was codified in the regulations at 42 C.F.R. § 412.106(b)(4)(ii).[20]

In 2003, the Secretary amended the DSH regulation to specify that a patient shall be "deemed eligible for Medicaid on a given day only if the patient is *eligible for inpatient hospital services* under a [State Plan] or under a waiver authorized under section 1115(a)(2)."[21] The rationale was that "certain section 1115 demonstration projects . . . serve expansion populations with benefit packages so limited that the benefits are not similar to the medical assistance available under a Medicaid State plan."[22] The purpose of the refinement was to include in the Medicaid Fraction only days of waiver populations where they were provided inpatient hospital benefits equivalent to the care provided to beneficiaries under a Medicaid State Plan.[23] To achieve this, the DSH regulation at 42 C.F.R. § 412.106(b)(4)(i) was amended to specify that "a patient is deemed eligible for Medicaid on a given day **only if the patient is eligible for inpatient hospital services** under an approved State Medicaid plan or under a waiver authorized under section 1115(a)(2) of the Act on that day . . . ."[24]

In 2006, Congress passed the Deficit Reduction Act of 2005, which amended 42 U.S.C. § 1395ww(d)(5)(F)(vi)[25] by adding the following language below subclause (II):

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[16] 42 U.S.C. § 1315(a)(2)(A).
[17] 65 Fed. Reg. 3136, 3136(Jan. 20, 2000) (emphasis added).
[18] *Id.* The interim rule was followed by a final rule, as well. 65 Fed. Reg. 47054, 47086-87 (Aug. 1, 2000).
[19] 65 Fed. Reg at 3136-3137. *See also* 65 Fed. Reg. at 47086-47087.
[20] 65 Fed. Reg. at 3139.
[21] 68 Fed. Reg. 45346, 45470 (Aug. 1, 2003).
[22] *Id.* at 45420.
[23] *See* 88 Fed. Reg. 58460, 59014 (Aug. 28, 2023).
[24] (2022) (emphasis added).
[25] Pub. L. 109-171, § 5002, 120 Stat. 4, 31 (2006).

> In determining under subclause (II) the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under title XIX, the Secretary may, to the extent and for the period the Secretary determines appropriate, include patient days of patients not so eligible but who are regarded as such because they receive benefits under a demonstration project approved under title XI.

The Secretary has interpreted this amendment as confirming that waiver day groups' days are not automatically "eligible for Medicaid under a State plan," that she has the discretion to determine the extent to which patients are "not so eligible," and to what extent, if any, they may be "regarded as eligible" and thus included in the Medicaid fraction.[26]

On August 28, 2023 as part of the FY 2024 IPPS Final Rule, the Secretary finalized further revisions to the regulations governing the inclusion of § 1115 expansion days in the Medicare DSH calculation.[27] In making these revisions, the Secretary has noted a rise in § 1115 waiver demonstrations which authorize funding a limited and narrowly circumscribed set of payments to hospitals, such as § 1115 demonstrations which include funding for uncompensated/undercompensated care pools. These pools do not extend health insurance to individuals or benefits similar to Medicaid beneficiaries under a State plan. Instead, they provide funds directly to hospitals to offset treatment costs for uninsured and underinsured patients.[28] As such, these days have been typically excluded from the Medicaid fraction of the DSH calculation because the days associated with these § 1115 demonstrations do not create inpatient hospital eligibility.

The Secretary acknowledged that several court decisions have disagreed with this approach and ruled that 42 C.F.R. § 412.106(b)(4) requires the inclusion of days for which hospitals received payment from a uncompensated/undercompensated care pool authorized by a § 1115 waiver.[29] Thus, in the FY 2022 IPPS/LTCH PPS proposed rule,[30] the Secretary proposed to revise the regulation "to more clearly state that in order for an inpatient day to be counted in the DPP Medicaid fraction numerator, the section 1115 demonstration must provide inpatient hospital insurance benefits directly to the individual whose day is being considered for inclusion."[31] After reviewing comments on the proposal, the Secretary proposed different revisions to the regulations in the FY 2023 IPPS/LTCH PPS proposed rule,[32] but opted not to finalize them after reviewing comments on the proposal.[33]

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[26] 88 Fed. Reg. at 59014.
[27] *Id.* at 59012-26.
[28] *Id.* at 59015.
[29] *Id.* (citing *Bethesda Health, Inc.* v. *Azar*, 980 F.3d 121 (D.C. Cir. 2020); *Forrest General Hospital* v. *Azar*, 926 F.3d 221 (5th Cir. 2019); *HealthAlliance Hospitals, Inc.* v. *Azar*, 346 F. Supp. 3d 43 (D.D.C. 2018)).
[30] 86 Fed. Reg. 25070 (May 10, 2021).
[31] *Id.* at 25459.
[32] 87 Fed. Reg. 28108 (May 10, 2022).
[33] 87 Fed. Reg. 48780, 49051 (Aug. 10, 2022).

Finally, in a proposed rule published on February 28, 2023,[34] the Secretary proposed revisions to the regulations "on the counting of days associated with individuals eligible for certain benefits provided by section 1115 demonstrations[.]"[35] Thereafter in the FY 2024 IPPS Final Rule, he announced that "we are modifying our regulations to explicitly state our long-held view that only patients who receive health insurance through a section 1115 demonstration where State expenditures to provide the insurance may be matched with funds from title XIX can be 'regarded as' eligible for Medicaid."[36] He also finalized a proposed amendment "to state specifically that patients whose inpatient hospital costs are paid for with funds from an uncompensated/undercompensated care pool authorized by a section 1115 demonstration are not patients "regarded as" eligible for Medicaid, and the days of such patients may not be included in the DPP Medicaid fraction numerator."[37]

Thus, effective October 1, 2023, 42 C.F.R. § 412.106(b)(4) (2023) now reads:

> (4) *Second computation*. The fiscal intermediary determines, for the same cost reporting period used for the first computation, the number of the hospital's patient days of service for patients who were not entitled to Medicare Part A, and who were either eligible for Medicaid on such days as described in paragraph (b)(4)(i) of this section or who were regarded as eligible for Medicaid on such days and the Secretary has determined to include those days in this computation as described in paragraph (b)(4)(ii)(A) or (B) of this section. The fiscal intermediary then divides that number by the total number of patient days in the same period. For purposes of this second computation, the following requirements apply:
>
> (i) For purposes of this computation, a patient is eligible for Medicaid on a given day if the patient is eligible on that day for inpatient hospital services under a State Medicaid plan approved under title XIX of the Act, regardless of whether particular items or services were covered or paid for on that day under the State plan.
>
> (ii) For purposes of this computation, a patient is regarded as eligible for Medicaid on a given day if the patient receives health insurance authorized by a demonstration approved by the Secretary under section 1115(a)(2) of the Act for that day, where the cost of such health insurance may be counted as expenditures under section 1903 of the Act, or the patient has health insurance for that day purchased using premium assistance received through a

[34] 88 Fed. Reg. 12623 (Feb. 28, 2023).
[35] *Id.* at 12623.
[36] 88 Fed. Reg. at 59016.
[37] *Id.*

> demonstration approved by the Secretary under section 1115(a)(2) of the Act, where the cost of the premium assistance may be counted as expenditures under section 1903 of the Act, and in either case regardless of whether particular items or services were covered or paid for on that day by the health insurance. Of these patients regarded as eligible for Medicaid on a given day, only the days of patients meeting the following criteria on that day may be counted in this second computation:
>
> > (A) Patients who are provided by a demonstration authorized under section 1115(a)(2) of the Act health insurance that covers inpatient hospital services; or
> >
> > (B) Patients who purchase health insurance that covers inpatient hospital services using premium assistance provided by a demonstration authorized under section 1115(a)(2) of the Act and the premium assistance accounts for 100 percent of the premium cost to the patient.
>
> (iii) Patients whose health care costs, including inpatient hospital services costs, for a given day are claimed for payment by a provider from an uncompensated, undercompensated, or other type of funding pool authorized under section 1115(a) of the Act to fund providers' uncompensated care costs are not regarded as eligible for Medicaid for purposes of paragraph (b)(4)(ii) of this section on that day and the days of such patients may not be included in this second computation.[38]

Providers' Request for EJR:

The Providers have appealed from the Federal Register publishing these regulatory amendments. The argue the "determination is unlawful because the Medicare statute does not afford the Secretary the discretion to exclude certain patients once he has conferred a benefit upon them by approving a section 1115 waiver."[39] They claim that the once a section 1115 waiver is approved, all such patient days must be included in the Medicaid fraction without any exceptions or qualifications.[40]

The Providers claim that the justifications set forth by the Secretary to "[c]arve out a sub-population of patients who receive inpatient benefits through an approved section 1115

[38] *Id.* at 59332.
[39] EJR Request at 7 (citing *Forrest General Hospital*, 926 F.3d at 224 ("Once the Secretary authorizes a demonstration project, no take-backs.")).
[40] *Id.* at 8 (citing *Forrest Gen. Hosp.*, 926 F.3d at 228-229).

uncompensated care pool" have been rejected by federal courts.[41] They argue the amended regulations "[flout] prior contrary and binding interpretations of the very statute [the Secretary] believes gives him the discretion to exclude certain categories of section 1115 beneficiaries from calculating the Medicaid fraction."[42] Since the Board is bound by these new regulations, it therefore cannot provide the relief sought by the Providers and, as a result, they are requesting EJR in order to challenge them.

Medicare Contractor's Response to Request for EJR:

The Medicare Contractor filed a Response to Providers' EJR Request on October 6, 2023. It argues the appeal is premature because the rule being challenged is effective for discharges on or after October 1, 2023 and, therefore, the affected cost reporting periods have not yet ended. The Medicare Contractor believes this situation is analogous to the Board's recent denial of EJR over a challenge to the retroactive Part C regulations:

> Though providers are challenging the legality of the final rule, because their DSH payment has not yet been computed – and won't be computed until final settlement of the cost reports that are not yet due – Providers cannot point to a final determination by either the MACs or the Secretary as to the amounts due. Likewise, they cannot demonstrate that they are dissatisfied with a final determination by the fiscal intermediary or the Secretary as required by 42 U.S.C. § 1395oo.
>
> ****
>
> Like the post-Alina appeal, these providers are appealing an interpretative rule for one component of a multi-component calculation without noting how that calculation actually impacts them. Until they can demonstrate an actual, as opposed to purely hypothetical, impact, the appeal will be premature.

Decision of the Board:

Pursuant to 42 C.F.R. § 405.1837(a)(1), a group of providers generally have the right to a hearing before the Board "with respect to a final contractor or Secretary determination ***for the provider's cost reporting period***"[43] if each provider satisfies individuals the requirements for a Board hearing under § 405.1835(a) and the group's amount in controversy is $50,000 or more. Pursuant to 42 C.F.R. § 405.1835(a)(1), an individual provider generally has a right to a hearing before the Board "with respect to a final contractor or Secretary determination ***for the provider's cost reporting period***"[44] if:

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[41] *Id.* (citing *Bethesda Health*, 389 F. Supp. 3d at 46-47; *Forrest Gen. Hosp.*, 926 F.3d at 229).
[42] *Id.* at 9.
[43] (Emphasis added).
[44] 42 C.F.R. § 405.1835(a) (emphasis added).

- It "is dissatisfied *with the contractor's final determination of the total amount of reimbursement* ***due the provider***, as set forth in the contractor's written notice specified under § 405.1803"[45] In other words, providers must appeal from a "final determination" that impacts payment for the period under appeal.[46]

- The request for a hearing is filed within 180 days of the date of receipt of the final determination.[47]

42 C.F.R. § 405.1837(c)(1) specifically notes that the hearing request must include "[a] demonstration that the request satisfies the requirements for a Board hearing as a group appeal, as specified in paragraph (a) [which includes the requirements of 42 C.F.R .§ 405.1835(a)]." Section 405.1835(a) states, in pertinent part, that a provider has a right to a Board hearing:

> [W]ith respect to a final … determination ***for the provider's cost reporting period***, if – (1) The provider is dissatisfied with the contractor's final *determination* of total amount *of reimbursement* ***due the provider***, as set forth in the contractor's written notice specified under § 405.1803.[48]

42 C.F.R. § 405.1801(a) defines the term "contractor determination" as including:

> (2) With respect to a hospital that receives payments for inpatient hospital services under the prospective payment system (part 412 of this chapter), the term means a final determination of the total amount of payment due the hospital, pursuant to § 405.1803 following the close of the hospital's cost reporting period, under that system for the period covered by the final determination.
>
> (3) For purposes of appeal to the Provider Reimbursement Review Board, the term is synonymous with the phrases "intermediary's final determination," "final determination of the organization serving as its fiscal intermediary," "Secretary's final determination" and "final determination of the Secretary," as those

[45] 42 C.F.R. § 405.1835(a)(1) (emphasis added).
[46] *See also* 42 U.S.C. § 1395oo(a)(1)(A); *Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 144-146 (D.C. Cir. 1986) (stating: "Viewing the amendments as a whole, we are inescapably drawn to the same conclusion as the District Court: § 1395oo (a) 'clearly contemplates two different kinds of appeal. One begins when the intermediary issues an NPR; the other, when the intermediary issues a notice of ***what will be paid*** *under the PPS system*.' . . . . Under PPS, in contrast, ***payment amounts*** are independent of current costs and *can be determined with finality* prior to the beginning of the cost year. Id. § 412.71(d). Thus a year-end cost report is not a report which is necessary ***in order for the Secretary to make PPS payments***, and the appeals provision applicable to PPS recipients cannot be read to require hospitals to file cost reports and await NPRs prior to filing a PRRB appeal." (emphasis added and citations omitted)).
[47] 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835 – 1840.
[48] (Emphasis added.)

> phrases are used in section 1878(a) of the Act, and with the phrases "final contractor determination" and "final Secretary determination" as those phrases are used in this subpart.

Similarly, Paragraph (c)(2) of 42 C.F.R. § 405.1837 requires certain information relative to each specific item under appeal with respect to the final determination under appeal:

> (2) An explanation (for each specific item at issue) of each provider's dissatisfaction with the final contractor or Secretary determination under appeal, including an account of:
>
> (i) *Why the provider believes Medicare* ***payment*** *is incorrect for each disputed item*;
>
> (ii) How and why the provider believes Medicare payment must be determined differently for each disputed item; and
>
> (iii) If the provider self-disallows a specific item (as specified in § 413.24(j) of this chapter), an explanation of the nature and amount of each self-disallowed item, the reimbursement sought for the item, and why the provider self-disallowed the item instead of claiming reimbursement for the item.

42 C.F.R. § 405.1837(a)(3) also states that a group must demonstrate that the amount in controversy is $50,000 or more. Satisfying the criteria set out in 42 C.F.R. §§ 405.1835(a) and 1837(a) is required before the Board can exercise jurisdiction over an appeal.[49]

Pursuant to 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R.§ 405.1842(f)(1), the Board will grant an EJR request if it determines that: (i) it has jurisdiction to conduct a hearing on the specific matter at issue; and (ii) it 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. This regulation makes clear that a finding of jurisdiction is a prerequisite to consideration of an EJR request.

The Providers are appealing the Final Rule published on August 28, 2023 pursuant to 42 U.S.C. § 1395oo(a)(1)(A)(i),[50] which allows for a hearing before the Board if a provider:

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[49] 42 C.F.R. § 405.1840(a), (b). The Board notes that 42 C.F.R. § 405.1840 is entitled "Board Jurisdiction" but it also addresses certain claim filing requirements such as timelines or filing deadlines. However, whether an appeal was timely is not a jurisdictional requirement but rather is a claim filing requirement as the Supreme Court made clear in *Sebelius v. Auburn Reg. Med. Ctr.*, 568 U.S. 145 (2013). *See also* Board Rule 4.1 ("The Board will dismiss appeals that fail *to meet the timely filing requirements* ***and/or*** *jurisdictional requirements*. Similarly, the Board notes that 42 C.F.R. § 405.1835(b) addresses claim filing requirements.

[50] EJR Request at 11.

> [I]s dissatisfied **with a final determination *of the organization serving as its fiscal intermediary*** pursuant to section 1395h of this title as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under this subchapter for the period covered by such report.[51]

The Board notes that the "final determination" being appealed in this case is a final rule published in the federal register, which is not a final determination of the Providers' fiscal intermediary.

42 U.S.C. § 1395oo(a)(1)(A)(ii) does, however, allow for an appeal from a Secretary determination. But this was the same provision relied upon for the providers appealing the publication of SSI ratios in *Memorial Hospital v. Becerra*.[52] The statute allows an appeal if a Provider:

> (ii) is dissatisfied with a final determination of the Secretary **as to the amount of the payment** under subsection (b) or (d) of section 1395ww of this title[53]

In *Memorial Hospital*, certain providers appealed the publication of SSI ratios. The D.C. District Court ultimately agreed with the Board that this was not an appealable final determination. In its discussion, the court noted that the SSI ratios, even if final, could not be a final determination "as to the amount of payment" because they are just one component of the DSH adjustment.[54] It explained that challenging the SSI ratios was a challenge to one element that eventually flows into the amount of payment for a final determination. Appealing such an element prior to payment is only appropriate if it was the only variable element as to the amount of payment due.[55]

The providers in *Memorial Hospital* also argued that there are certain instances where a provider can appeal prior to receiving an NPR. The Court distinguished these cases because "the secretarial determination at issue was either the only determination on which payment depended or clearly promulgated as a final rule."[56] It reiterated that SSI ratios are just one of the variables that determine whether hospitals receive a DSH payment and, if so, for how much.

While the August 28, 2023 Final Rule being appealed in the instant case was clearly promulgated as a final rule, it is ***not*** the only determination or variable on which the Provider's DSH payment depends. Just like the publication of SSI ratios, the policy at issue impacts one of many variables in calculating the Provider's DSH payment and is thus not an appealable final determination.

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[51] (Emphasis added.)
[52] 2022 WL 888190 (D.D.C. 2022).
[53] (Emphasis added).
[54] 2022 WL 888190 at *7.
[55] *Id.* at *8.
[56] *Id.*

More specifically, here, each of the Providers are asserting that certain § 1115 waiver days must be included in the Medicaid fraction for their DSH adjustment calculation for their 2024 fiscal year. However, the following factual gaps or flaws demonstrate that the final rule was not an appealable reimbursement "determination":

1. The final rule does not apply its policy to specific State Medicaid programs which have § 1115 waiver programs that are otherwise covered by the "bar" described in the group issue statements. Indeed, to this end, the Providers do not provide nor assert which § 1115 waiver program is relevant to their appeal in either the issue statement included with the appeal request or the text of the EJR Request. One can only *presume* it is Texas and *only* Texas[57] because the Providers are located in Texas and the title for each group includes "Texas" in the title. Even if the appeal relates *only* to Texas § 1115 waiver days, it is unclear that Texas has a § 1115 waiver day program, much less one that has "an uncompensated care pool" covering inpatient hospital services because neither the final rule nor the appeal request nor the EJR request addresses this fact.

2. It is unclear whether any of the Providers in these groups will qualify for a DSH payment during their fiscal year 2024 as that is not determined in the FY 2024 Final Rule. Rather, that is a case-by-case determination made by the Medicare Contactor after the cost report is filed. Moreover, no information is provided in the appeal request to suggest that each of the Providers are expected to qualify for a DSH payment for their respective 2024 fiscal year based on receipt of DSH payments in prior years. As a result, it is not clear whether the groups will meet the minimum amount in controversy of $50,000 to establish a group appeal.

3. Even if the Providers were to qualify for a 2024 fiscal year DSH payment, it is not clear that *any* of the Providers would have patients during the 2024 fiscal year that are, in fact, covered under a § 1115 waiver program, much less "an uncompensated care pool." The Providers have included amounts in controversy but it is unclear what those estimates are based on since these are prospective estimates of anticipated § 1115 uncompensated care pool days. Indeed, § 1115 waiver days are one type of Medicaid eligible day and 42 C.F.R. § 412.106(b)(4)(iv) specifies that "[t]he hospital has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day." None of the Providers has met this burden of proof relative to the fiscal years at issue because ***none*** of the days that could or would be at issue were known/provided when the alleged determination (i.e., the FY 2024 IPPS Final Rule) was issued. As such is not even clear whether each of the groups would meet the $50,000 threshold amount in controversy requirement.

[57] That said, the Providers could potentially claim § 1115 days associated with out-of-state Medicaid programs. While unlikely, it is not clear from the Providers' filings and one cannot determine this from the 4 corners of the alleged "determination" (i.e., the FY 2024 IPPS Final Rule).

4. To the extent any § 1115 waiver days are included in the numerator of the Medicaid fraction for a hospital that is eligible for a DSH payment, the § 1115 waiver days would be just one category of Medicaid eligible days that would be included in the numerator and the Medicare Contractor must review/audit any days claimed on the as-filed cost report to confirm Medicaid eligibility for each day claimed because, per 42 C.F.R. § 412.106(b)(4), the hospital has the burden of proof to establish Medicaid eligibility for each day claimed.

As discussed above, the Board finds that the August 28, 2023 Final Rule appealed in the instant cases is not an appealable "final determination" within the context of 42 U.S.C. § 1395oo(a)(1)(A)(ii) and 42 C.F.R. § 405.1835. Since satisfying the criteria set out in 42 C.F.R. § 405.1835 is required before the Board can exercise jurisdiction over an appeal,[58] and since the Providers have failed to demonstrate in their hearing requests that those criteria have been met for the year under appeal (*i.e*., FY 2024), the Board is permitted under § 405.1835(b) to "dismiss with prejudice the appeal or take any other remedial action it considers appropriate."[59] In this instance, the Board finds it is appropriate to deny the EJR request and dismiss the appeals ***with prejudice*** and remove them from the Board's docket. The Board finds this is an appropriate remedial action based on its findings that the August 28, 2023 Final Rule is not an appealable final determination.[60]

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:

10/25/2023

X Clayton J. Nix

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

cc: Michael Redmond, Novitas Solutions, Inc. (J-H), (J-L)
Byron Lamprecht, WPS Government Health Administrators (J-5)
Wilson Leong, FSS
Jacqueline Vaughn, OAA

[58] 42 C.F.R. § 405.1840(a), (b).
[59] 42 C.F.R. § 405.1835(b).
[60] The Board's position is supported also by *Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 147 (D.C. Cir. 1986) ("*Washington Hospital*") because in that case the final rule contained "the only variable factor . . . as to the amount of payment under § 1395ww(d) . . . [,] the hospital's target amount, which the Secretary refers to as the hospital-specific rate." Unlike *Washington Hospital*, the policy on § 1115 waiver days is just one factor involved in determining the amount of a DSH payment for a particular year which is only calculated (i.e., relevant) if a hospital qualifies for DSH for that year. *See Memorial Hospital v. Becerra*, 2022 WL 888190 at *7-8 (D.D.C. 2022).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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RE: ***EJR Determination***
Univ. of Washington 2007 SSI Covered vs. Total Days CIRP Group
Case No. 10-1325GC

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the request for expedited judicial review ("EJR") filed on September 29, 2023 in the above-referenced common issue related part ("CIRP") group appeal. Set forth below is the decision of the Board to **deny** Provider's EJR request *and* **dismiss** the appeal because it is a prohibited duplicative of the following lawsuit being pursued by the Providers in the U.S. District Court for the District of Columbia in connection with the appeal of Case No. 15-0560GC[1]: *Tarzana Providence Health System, et al. v Becerra*, No. 22-cv-01509-TNM (D.D.C. May 27, 2022). The Board has included, as **Attachment A**, a copy of the Complaint filed to establish that lawsuit which QRS filed with the Board on September 6, 2022 in connection with Case No. 15-0560GC; ***and***, as **Attachment B**, a copy of the Board's letter dated September 29, 2023 closing Case No. 15-0560GC due to that lawsuit.

PROCEDURAL HISTORY:

A. Formation of Case 10-1325GC

On February 26, 2010, Harborview Medical Center (Prov. No. 50-0064) filed an individual appeal request from its Notice of Program Reimbursement ("NPR") dated August 31, 2009 for fiscal year ending ("FYE") June 30, 2007. The Board assigned this individual provider appeal to Case No. 10-0767. Issue No. 8 in this individual appeal was titled: SSI Percentage – Covered Versus Total Medicare Part A Days: DSH Payment and IRF LIP Adjustment ("Covered vs. Total Days Issue"). The issue statement reads as follows:

> Whether the SSI percentages used in the Medicare DSH payment calculation under 42. C.F.R. § 412.l06(b)(2)(i), and the IRF LIP payment calculation under 42 C.F.R. § 412.624(e)(2), include all of the Provider's SSI entitled Medicare Part A patients and violates the applicable statutes and regulations because the denominator

[1] Case No. 15-0560 is entitled "QRS Univ. of Washington 10/1/2004 – 2007 Dual Eligible Days CIRP."

includes inpatient days Medicare classifies as not covered and/or not paid while the numerator is restricted to only paid days.

Legal Basis for Appeal:

In calculating the published SSI percentage used by the Intermediary in finalizing the Provider's cost report for FYE 6/30/07, the Provider believes that CMS used a denominator that included both covered (paid for) and non-covered (not paid for) Medicare Part A inpatient days. By failing to limit the denominator to covered or paid for days, as it had in calculating the published SSI percentage for federal fiscal year 2004, CMS violated the Medicare statute, its own regulation, and its own policy articulated in the Federal Register.

Pursuant to Section 1886(d)(5)(f) of the Social Security Act (42 U.S.C. § l395w(d)(5)(F)), hospitals subject to the prospective payment system serving a disproportionate share of low income patients are eligible to receive an additional payment. Whether a hospital qualifies for this payment and how much the payment will be depends on a hospital's percentage of low income patients, also known as the hospital's disproportionate share patient percentage. 42 U.S.C. § l395w(d)(5)(F). Pursuant to the statutory language, the measure for determining the disproportionate patient percentage is the sum of two fractions expressed as percentages, one based on entitlement to SSI and the other based on Medicaid eligibility. The statute at 42 U.S.C. § 1395ww (d)(5)(F)(vi)(1) defines the SSI fraction, also known as the Medicare fraction, as follows:

> the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were entitled to benefits under part A of this subchapter and were entitled to supplementary security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were entitled to benefits under part A of this subchapter.

Similarly, the CMS DSH regulation, 42 C.F.R. § 412.106(b)(2), applicable to the cost reporting periods at issue herein, defines the Medicare fraction's numerator as patient days furnished to patients who "were entitled to both Medicare Part A and SSI, excluding

those patients who received only State supplementation," and defines the denominator as the total number of patient days "furnished to patients entitled to Medicare Part A."

The IRF LIP adjustment under 42 C.F.R. § 412.624(e)(2), also uses an SSI percentage for rehabilitation facility patients that mirrors the SSI percentage described above for use in the Medicare DSH adjustment calculation.

Covered (and/or Paid) Days vs. Non-Covered (and/or Non-Paid Days)

It has long been CMS' policy that the Medicare fraction only includes covered Medicare days. For example, on August 11, 2004, at 69 Fed. Reg. 48916, 49098, CMS expressly stated "[o]ur Policy has been that only covered patient days are included in the Medicare fraction." In fact, CMS pointed out further that it had posted a notice to this effect on the CMS web site on July 9, 2004. *Id.* This CMS policy dates back to its implementation of the DSH payment adjustment in 1986, where HCFA stated that the SSI percentage (Medicare fraction) would only include days paid for by Medicare. 51 Fed. Reg. 31454, 31460 (Sep. 3, 1986). Moreover, the Secretary agreed before the Ninth Circuit that the Medicare fraction only includes days actually paid for by Medicare. *Legacy Emanuel Hospital & Health. Center v. Shalala*, 97 F.3d 1261, 1265 (9th Cir., 1996) ("both parties agree that the Medicare proxy only counts patient days paid by Medicare"). Testimony in *Baystate Medical Center v. Mutual of Omaha*, PRRB Case Nos. 96-1882, 97-1579, 98-1827, and 99-2061, before the Board by Patricia Cribbs, a team leader for the database analysis section at the Social Security Administration ("SSA"), confirms that "entitled" means actual payment. *Baystate* Evidentiary Hearing (Apr. 29, 2003), p. 319, in. 10-13. Ms. Cribbs testified that the Social Security Administration ("SSA") did not include anyone as SSI entitled on the file sent to CMS unless that person had received an SSI payment in the month in question. *Id.* at 326, In. 14-18; p. 356, in. 16-21.

As noted above, the Provider believes that the SSI percentages in question resulted from a denominator that included all Medicare days, both covered and non-covered, paid for and not paid for, in violation of CMS' long held policy. Additionally, while the denominator of the SSI fractions has been expanded by CMS, the Provider is not aware of anything that indicates that the numerator no longer excludes SSI-entitled patients that did not receive a payment in a particular month as testified by Ms. Cribbs at the Board's

> *Baystate* evidentiary bearing. This unlawful action by CMS reduced both the DSH and IRF LIP payments, and the Board should require a recalculation of the SSI percentage using a denominator based solely on covered and paid for Medicare days, or alternatively, an expansion of the numerator to include paid as well as unpaid and covered as well as non-covered days.

On March 19, 2010, the University of Washington Medical Center (Prov. No. 50-0008) filed an individual appeal from its NPR dated September 21, 2009 for FYE June 30, 2007. The Board assigned this individual provider appeal to Case No. 10-0381. Issue number 8 in this individual appeal was entitled "SSI Percentage – Covered Versus Total Medicare Part A Days: DSH Payment and IRF LIP Adjustment." The issue statement for the "Covered vs. Total Days" Issue was identical to the one presented in Case No. 10-0767.

On September 13, 2010, the instant CIRP group was formed and both Providers noted above transferred their "Covered vs. Total Days" Issue to this CIRP group on the same day. The Board assigned this CIRP group to Case No. 10-1325GC. The group issue statement is identical to the statement presented in the "Covered vs. Total Days" Issue statements in the individual appeals.

On January 23, 2015, QRS designated the group to be fully formed.

B. First EJR Request

On May 9, 2016, QRS filed the Providers' *first* request for EJR, in which they asked the Board to either:

> require a recalculation of the SSI percentage using a denominator based solely on covered and paid for Medicare days, ***or alternatively***, an expansion of the numerator to include paid as well as unpaid and covered as well as non -covered days. The Board should require a recalculation of the SSI percentage using a denominator based solely on covered and paid for Medicare days, or alternatively, an expansion of the numerator to include paid as well as unpaid and covered as well as non-covered days.[2]

On June 1, 2016, the Board issued a Request for Additional Information ("RFI") in response to this EJR Request. The Board notified the Providers that the LIP portion of their group issue statement was a distinct issue; and, *since **only** one issue can be present in a CIRP group appeal*, instructed the Providers to bifurcate the LIP issue by creating a separate group appeal. ***The Board also noted that the issue raised in the EJR Request was not the same issue initially raised in the group appeal***. Based on the inconsistency between issue statements, the Board notified the Providers that it considered the EJR Request to be seeking EJR over the group issue statement ***as filed on September 7, 2010***, namely:

[2] *See* Board's Request for Additional Information (June 1, 2016) (citing EJR Request at 1).

> Whether the SSI percentages used in the Medicare DSH payment calculation under 42 C.F.R. § 412.106(b)(2)(i), and the IRF LIP payment calculation under 42 C.F.R. § 412.624(e)(2), include all of the Provider's [*sic*] SSI entitled Medicare Part A patients and violates the applicable statues and regulations *because the denominator includes inpatient days Medicare classifies as not covered and/or not paid while the numerator is restricted to only paid days*.[3]

It concluded that it would consider EJR once the LIP issue had been bifurcated.[4]

On June 14, 2016, the Providers withdrew the LIP issue from Case No. 10-1325GC.[5]

Following the withdrawal, **on July 8, 2016**, the Board issued a second RFI, noting that: (1) the underlying individual appeals were filed just *prior to* the issuance of CMS Ruling 1498-R (*i.e.*, February and March, 2010), which became effective on April 28, 2010; and (2) "In that ruling, CMS stated properly pending [DSH] appeals of the [SSI] fraction data matching process issue would be resolved by apply[ing] a revised data match process that would be adopted in the final [IPPS] rule published in the Federal Register for 2011."[6] The Board asked the parties to respond to the following questions:

1. Have the Providers in this group appeal received revised NPRs?
2. If the Providers have received revised NPRs, what are the dates of the revised NPRs? . . .
3. If the Providers received revised NPRs, was the SSI percentage changed? . . .
4. If the Providers received revised NPRs, did the Providers appeal the SSI percentage issue?
5. If revised NPRs were issued with a new SSI percentages, was the new SSI percentage calculated by CMS using the methodology described in the August 16, 2010 Federal Register (75 Fed. Reg. 50,042)?
6. If the Providers received revised NPRs with the new SSI percentage based on the new methodology in the August 16th Federal Register, does this make the current case moot? Explain your position.[7]

On July 25, 2016, the Providers filed their response to this RFI, claiming that: (1) the instant "appeal challenges an entirely different aspect of the SSI percentage that is ***not*** *addressed by Ruling 1498-R*, namely, CMS's inconsistent policy of treating eligible but unpaid Part A days as days

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[3] *Id.* at 3 (emphasis added).
[4] *Id.* at 1-2 (emphasis added).
[5] *See* Board's Request for Additional Information (July 8, 2016).
[6] (Footnotes omitted.)
[7] *Id.*

"entitled to [SSI] benefits'";[8] and (2) *a different CIRP group appeal* for the same providers under Case No. 09-1763GC concerned the 1498-R data matching issue and the Board remanded Case No. 09-1763GC pursuant to CMS Ruling 1498-R on March 23, 2016.[9] The response also advised that the group participants had received revised NPRs which changed their SSI percentages, and also furnished copies of the revised NPRs to the Board.[10]

On August 22, 2016, the Board issued a decision granting EJR for Case No. 10-1325GC finding that "it is without authority to decide the legal question of whether 42 C.F.R. § 412.106(b)(2)(i), is valid."[11] In granting EJR, the Board noted that: (1) "[t]he Providers contend that the term 'entitled' has been interpreted broadly [by the Secretary] as it relates to anyone who is eligible to enroll in Medicare Part A, regardless of whether Medicare makes payment" but that "the definition [of the term 'entitled'] is more narrowly interpreted in the SSI context"; and (2) as a result, the Providers contend that "applying different interpretations to the same provision of the statute is arbitrary and capricious."[12]

C. District Court Proceedings and Administrator Remand

Consistent with the Board's August 22, 2016 decision to grant EJR, the Providers filed for Judicial Review in the U.S. District Court for the Western District of Washington. **On April 3, 2017**, in response to the parties' Joint Motion for Voluntary Remand, the Court dismissed the case without prejudice "so the plaintiff hospitals may seek clarification and/or reconsideration from the [Board] of the terms of its grant of [EJR]."

On June 29, 2017, the Administrator issued an ordering the following:

> THAT the [Board's] decision in University of Washington Medical Center and Harborview Medical Center, PRRB Case. No. 10-1325CC, dated October 10, 2016 [*sic*], is hereby remanded to the [Board]; and
>
> THAT the [Board] shall take actions necessary to reinstate the appeal and notify the Providers of the actions taken by the Court; and
>
> THAT pursuant to the Court's order, the [Board] will permit the Providers to seek clarification and/or reconsideration from the [Board] of the terms of its grant of expedited judicial review; and
>
> THAT the decision of the Board is subject to the provisions of 42 CFR 405.1875.[13]

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[8] Response to Board RFI, 1-2 (July 25, 2016) (footnote omitted and emphasis added).
[9] *Id.*
[10] *Id.*
[11] EJR Request at 4 (Aug. 22, 2016).
[12] *Id.* at 3.
[13] The Administrator's Order was received by the Board on July 5, 2017.

Accordingly, **on August 1, 2017**, the Board reopened Case No. 10-1325GC and ordered the parties to file comments and make requests regarding the EJR previously granted on August 22, 2016.

On August 31, 2017, the Providers filed a request for clarification of the Board's decision. They claimed that the issue they sought EJR for was the interpretation of the term "entitled," but that the Board's decision granting EJR was worded to imply the Providers were simply challenging 42 C.F.R. § 412.106(b)(2)(i), and that regulation had been vacated at the time of judicial review.[14] The Providers concluded that they were:

> seeking clarification in the form of a revised EJR determination to address the implications of the D.C. Circuit Court's vacatur of the regulation on the Board's EJR determination as well as an explicit discussion of whether the Board believes it is bound by CMS's explicit policy statements contained in preamble [of the FY 2005 IPPS Final Rule], including those statements addressing CMS ' s interpretation of what it means to be entitled to SSI benefits.[15]

If the Board found itself bound by the preamble statements, the Providers believed EJR was appropriate.

On January 16, 2018, QRS filed a request that the Board "advise . . . whether the Board will be forthcoming with a fresh grant of EJR clarifying the issue being pursued, or should we submit a new request for EJR."

On April 5, 2018, the Providers filed an affirmative document titled "Request for Whether EJR is Appropriate" that was 10 pages long and included over 200 pages of exhibits. QRS filed "this new EJR request for the Board to determine the two specific issues previously raised on remand, namely, 1) whether the Board is bound by CMS's policy to treat Part C days as days entitled to benefits as Part A for purposes of Medicare [DSH] payments *despite the D.C. Circuit Court's vacatur of the associated regulation* and 2) whether the Board has the authority to invalidate CMS's separate but related policy of including only three SSI status codes that represent actual receipt of SSI payments as days entitled to SSI benefits."[16]

On April 27, 2018, the Board denied EJR and scheduled the case for a hearing "because [it] has determined that it has jurisdiction over the issue under appeal and has the authority to hear the issue in dispute."[17]

On June 25, 2018, QRS filed a request that the Board reconsider or clarify its April 27, 2018 EJR denial. QRS characterized its April 5, 2018 EJR request as a challenge to 3 separate policies:

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[14] Clarification of EJR Request/Decision, 2-2 (Aug. 31, 2017).
[15] *Id.* at 3.
[16] EJR Request at 1-2 (Apr. 5, 2018).
[17] Board EJR Denial Letter (Apr. 27. 2018).

> [O]n April 5, 2018, the Providers filed a new request for EJR. Specifically, the Providers asked the Board to determine whether it has authority to set aside the following policies of the Secretary, which the Providers contend are based upon inconsistent interpretations of the statutory term "entitled."
>
> a. The treatment of Part C days as entitled to benefits under Part A for purposes of the DSH calculation, *see* 69 Fed. Reg. 48916, 49099 (Aug. 11, 2004); 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007);
>
> b. The treatment of other days for which the beneficiary did not receive Part A payments, such as days for which the beneficiary's Part A benefits were exhausted and days for which Medicare Part A was a secondary payor, as days entitled to benefits under Part A for purposes of the DSH calculation, *see id*.; and
>
> c. The treatment of days for individuals that have not received SSI payments as not entitled to SSI benefits for purposes of calculating the Medicare fraction of the DSH calculation, *see* 75 Fed. Reg. 50042, 50280 (Aug. 16, 2010).
>
> Specifically, the Providers sought an order from the Board setting aside (a) and (b) above, or in the alternative, setting aside (c). . . . In the alternative, if the Board declines to reconsider its decision denying EJR, the Providers ask that the Board issue a statement clarifying which of policies (a), (b) or (c) the Board has determined that it has authority to overturn so the Providers know which of those policies they are expected to litigate before the Board. (The Providers note that remand is not necessary pursuant to CMS Ruling 1498-R to correct the SSI matching errors litigated in Baystate because that issue has been separately appealed and the Board has previously remanded that appeal to the MAC.)[18]

On July 11, 2018, the Board clarified that the Providers' August, 2017 comments identified three sub-issues in the appeal for which the Providers were seeking EJR:

1. The treatment of Part C days as entitled to benefits under Part A for purposes of the DSH calculation (which the Board dismissed from the appeal as duplicative of the issue in case 09-1506GC);

[18] QRS Request for Reconsideration/Clarification at 1-2 (June 25, 2018) (emphasis in original and footnote omitted).

2. The treatment of other days for which the beneficiary did not receive Part A payments, such as exhausted benefit days and days for which Medicare was a secondary payer, as days entitled to benefits under Part A for purposes of the DSH calculation (which the Board dismissed from the appeal as duplicative of case 15-0560GC); and

3. The treatment of days for individuals that have not received SSI payments as not entitled to SSI benefits for purposes of calculating the Medicare fraction of the DSH calculation (which was to be heard at the scheduled hearing).

Accordingly, the Board found that the sole remaining issue in Case No. 10-1325GC was #3 above. However, in connection with this issue, the Board noted that the EJR request cited to 75 Fed. Reg. 50042, 50280 (Aug. 16, 2010) as the authority being challenge and that, notwithstanding, the NPRs in Case No. 10-1325GC were issued in 2009 ***prior to*** that final rule being published. Accordingly, the Board found it was not bound by the language in that 2010 final rule, since it was not applicable to the NPRs appealed, and thereby denied the EJR Request.[19]

On June 27, 2018, QRS filed the Providers' final position paper. Similarly, **on August 30, 2018**, the Medicare Contractor filed its final position paper.

On December 12, 2018, Board staff notified the parties that the hearing was being cancelled because the record needed further development and that the parties should expect a development request for at least two areas: jurisdiction and reconsideration of the EJR on remand.

On September 29, 2023, QRS filed a new EJR Request on behalf of the Providers that is very short at 3 pages long without any exhibits or attachments.

D. Current EJR Request

On September 29, 2023, QRS filed *a very short* EJR request (3-page long *without* any exhibits) on behalf of the Providers. The Providers recount how Board noted that the Providers' prior EJR request cited to 75 Fed. Reg. 50042, 50280 (Aug. 16, 2010) ("FY 2011 IPPS Final Rule"), but that the NPRs in Case No. 10-1325GC were issued prior to that Final Rule. In the instant EJR Request, they claim that there are 2 policies being challenged (*i.e.,* only including days where SSI benefits were actually paid, and the use of only 3 SSI codes as evidencing payment for SSI) and that these policies predated that Federal Register.[20] They contend that CMS has stated that the data match process described in the FY 2011 *proposed* Rule had existed since the inception of the DSH program. They also argue that the FY 2011 IPPS Final Rule made clear that it had already been CMS policy to use only 3 SSI codes to evidence SSI payment. Notwithstanding, the EJR request does ***not*** include any citations or references on where that policy *was published* ***prior to*** the FY 2011 IPPS Final Rule and, as such, it is unclear what the prior authority of that policy was (*e.g.*, unwritten policy vs. manual provision or memorandum vs. uncodified regulation published in the preamble to a final rule).

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[19] Board Letter re: Request to Reconsider or Clarify Denial of EJR (July 11, 2018).
[20] Request for Expedited Judicial Review, 2 (Sept. 29, 2023).

In summary, the Providers claim they are challenging "***both*** the policy that only paid days can be included in the numerator of the Medicare Fraction as contrary to the statute ***as well as*** the policy that paid days can be demonstrated only by SSI codes of C01, M01, and M02."[21]

BOARD ANALYSIS AND DECISION:

On July 11, 2018, the Board confirmed that the ***sole*** issue remaining in this CIRP group is the treatment of days for individuals that have not received SSI payments as not entitled to SSI benefits for purposes of calculating the Medicare fraction of the DSH calculation. However, QRS states in the September 29, 2023 EJR Request that the Providers are requesting EJR over (2) two different *distinct* issues/policies:

Challenge #1 "The Providers challenge . . . the policy that *only* ***paid*** [SSI] days can be included in the numerator of the Medicare Fraction as contrary to the statute . . . ."[22]

Challenge #2 "The Providers challenge . . . the policy that ***paid*** [SSI] days can be demonstrated only by SSI codes of C01, M01, and M02."[23]

The Board notes the EJR request is *very short/brief* as it is only 3 pages long (*without* any exhibits), notwithstanding the fact that there are 2 different challenges and that Board Rule 42.3 specifying that an EJR request must contain:

> a ***fully developed*** narrative that:
>
> - Identifies the issue for which EJR is requested;
> - Demonstrates that there are no factual issues in dispute;
> - Demonstrates that the Board has jurisdiction;
> - Identifies the controlling law, regulation, Federal Register notice, or CMS ruling that is being challenged; and
> - Explains why the Board does not have authority to decide the legal question posted by the appeal.[24]

While the Providers attempt to treat each challenge as part of a bigger, singular *challenge*, they have acknowledged within this appeal that the policies are distinct[25] and, as such, the Board will address them individually, *as the Board understands them based on the 4 corners of the very short 3-page EJR request* (*see infra* discussion on failure to meet the content requirements for an EJR request under Board Rule 42.3).

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[21] *Id.* at 3 (emphasis added).
[22] Providers' EJR Request at 3 (Sept. 29, 2023) (emphasis added).
[23] *Id.* (emphasis added).
[24] (Emphasis added.)
[25] *Id.* (challenging "***both*** the policy that only paid days can *be* included in the numerator of the Medicare Fraction as contrary to the statute ***as well as*** the policy that paid days can be demonstrated only by SSI codes of C01, M01, and M02." (emphasis added)).

A. Challenge #1 to the Policy that Only "Paid" SSI Days can be Included in the Numerator of the Medicare Fraction as Contrary to the Statute

The EJR request that QRS filed on behalf of the Providers states that the Providers are challenging the "the policy that *only* ***paid*** [SSI] days can be included in the numerator of the Medicare Fraction *as contrary to the statute*."[26] The Board has identified this challenge as Challenge #1. However, the EJR Request gives scant detail regarding Challenge #1 and, in particular, fails to identify which specific "statute" it is referencing.[27]

Similarly, QRS' EJR request contends that the "*longstanding policy* of CMS was to include only paid [SSI] days in the numerator of the Medicare Fraction"[28] and that "the policy of including only days of beneficiaries who were paid SSI benefits for the month of their hospital stay . . . predated the FY 2011 final rule by many years."[29] However, the EJR request fails to identify where that the Secretary adopted that "longstanding" policy and *precisely* what the controlling ***authority*** is for that policy statement that is being challenged in this EJR request. Identification of the specific controlling ***authority*** being challenged (*e.g*, is the controlling authority a specific unwritten policy vs. a manual provision or memorandum vs. an uncodified regulation issued in the preamble to a final rule) is ***critical*** for the Board to determine whether it is "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)."[30] It is not for the Board to try to guess but rather, as set forth in Board Rule 42.3 (and consistent with 42 C.F.R. § 405.1842(d)), the EJR Request must "[i]dentif[y] the controlling law, regulation, Federal Register notice, or CMS ruling that is being challenged."[31]

Finally, QRS' EJR Request fails to tie its challenge of this policy to the Providers' appeal requests based on FY 2007 original NPRs issued in August/September 2009 (*i.e*., appeals of SSI fractions issued during or prior to August/September 2009). In particular, this relates to demonstrating that there are no factual issues in dispute and demonstrating the Board has jurisdiction over the challenge being made *as it relates to the specific controlling authority being challenged*.

Based on the above, it is clear that that the EJR request as it relates to Challenge #1 fails to meet the *content* requirements for an EJR request as set forth in Board Rule 42.3. Accordingly, the Board hereby **denies** the Providers' EJR request for Challenge #1.

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[26] (Emphasis added.)
[27] Indeed, the September 29, 2023 EJR Request similarly does not include discussion of any relevant court cases that may impact the EJR request, notwithstanding significant and potentially material case law developments in both the Ninth and D.C. Circuits (the only circuits in which the Providers may file their appeal pursuant to 42 U.S.C. § 1395oo(f)(1) since the Providers are all located in the State of Washington). *See, e.g., Advocate Christ Med. Ctr. v. Becerra*, 80 F.4th 346 (D.C. Cir. 2023); *Pomona Valley Hosp. Med. Ctr. v. Becerra*, No. 20-5350, 2023 WL 5654315 (D.D.C. Sept. 1, 2023); *Becerra v. Empire Health Found.*, 142 S. Ct. 2354 (2022); *Empire Health Found. v. Azar*, 958 F.3d 873 (9th Cir. 2020).
[28] Providers' EJR Request at 1 (Sept. 29, 2023).
[29] *Id.* at 2.
[30] 42 C.F.R. § 405.1842(a)(1).
[31] *See supra* note 27.

The Board further **dismisses** this issue (*i.e.*, Challenge #1) because the Board is aware that, ***more than 1 year ago***, *on May 27, 2022*, the participants in Case No. 15-0560GC filed a Complaint in the U.S. District Court for the District of Columbia that encompasses the Challenge #1 that is being made in Case No. 10-1325GC.[32] Specifically, in a filing made on September 6, 2022 in Case No. 15-0560GC for the University of Washington for the periods October 1, 2004 through 2007, QRS notified the Board of this lawsuit and included a copy of the Complaint which the Board includes as **Attachment A**. Significantly, the Complaint contains the following two challenges, and it is the second challenge that is duplicative of Challenge #1 that is being made in Case No. 10-1325GC:

> The Hospitals challenge the policy of [the Secretary] of treating patient days for which no payment was received under Medicare Part A as nonetheless "entitled to benefits under part A" for purposes of calculating both fractions of the [DSH] payment adjustment. *If the Secretary's treatment of unpaid Part A days as "days entitled to benefits under part A" is upheld*, ***the Hospitals contend that the Secretary must*** at least apply that interpretation of the word "entitled" consistently by ***also treating days for which no supplemental security income payments were received as days "entitled to supplemental security income benefits" under 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I)***.

Thus, the Complaint clearly encompasses the following Challenge #1 that is being made in the EJR request for Case No. 10-1325GC: "The Providers challenge . . . the policy that *only* ***paid*** [SSI] days can be included in the numerator of the Medicare Fraction as contrary to the statute . . . ."[33] As the Providers are already pursuing this issue for the same year, 2007, in federal court via its appeal of Case No. 15-0560GC, the Providers may not continue to pursue it in this case because it would be a prohibited duplicate in violation of the mandatory CIRP group rules at 42 C.F.R. §§ 405.1837(b)(1) and (e)(1) and Board Rules 4.6, and 19.2 which specify that any commonly owned providers pursuing a common issue for a particular year can only pursue that issue for that year in a single CIRP group.[34] As it is clear that the Providers are pursuing the Challenge #1 in the federal lawsuit relating to Case No. 15-0560GC for the same year (*i.e.*, 2007), the Board hereby **dismisses** this issue (*i.e.*, Challenge #1) from Case No. 10-1325GC. Note this dismissal also serves as an independent basis for denying the EJR request.

Indeed, *the Board* ***admonishes*** *QRS because, as described below, the Board already notified QRS previously the duplication of Case No.15-0560GC with this case (i.e., Case No. 10-1325GC) before it closed Case No. 15-0560GC and at no point in the EJR Request does QRS discuss or recognize this duplication issue*. To this end, the Board has included as **Attachment B**, a copy of its closure letter issued on September 29, 2023 detailing that, on June 17, 2022, the Board issued a Scheduling Order requiring QRS to "address the Board's jurisdiction over Case No. 15-0560GC

[32] 1:22-cv-01509-TNM (May 27, 2022).
[33] Providers' EJR Request at 3 (Sept. 29, 2023) (emphasis added).
[34] *See also* 42 C.F.R. § 405.1842(h)(3)(iii).

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 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."[35] However, notwithstanding the Scheduling Order, QRS failed to timely file its response to the potential duplication identified by the Board between Case Nos. 15-0560GC and 10-1325GC.[36] Instead, QRS filed the notice at **Attachment A** to inform the Board that it had *already* filed a lawsuit ***3 months earlier*** in federal court to pursue the merits of Case No. 15-0560GC, effectively bypassing the completion of the Board's administrative proceedings in Case No. 15-0560GC. As thoroughly explained in **Attachment B**, the Board closed Case No. 15-0560GC because 42 C.F.R. § 405.1842(h)(3)(iii) prohibits the Board from conducting further proceedings in Case No. 15-0560GC. Accordingly, due to QRS failure to meet the deadline in the June 17, 2022 Scheduling Order, the Board has an alternate independent basis to dismiss Case No. 10-1325GC as a prohibited duplicate of Case No. 15-0560GC for which the Providers are pursuing in federal court.

B. Challenge #2 to the Policy that Paid Days can be Demonstrated Only by SSI Codes C01, M01, and M02

The Providers' EJR request also "challenge[s] . . . the policy that ***paid*** [SSI] days can be demonstrated only by SSI codes of C01, M01, and M02."[37] This policy relates to CMS' process for data matching to identify the days that must be included in the numerator of the Medicare fraction of the DSH adjustment calculation as specified at 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). As set forth below, the Board hereby **denies** the EJR request as it relates to Challenge #2 because the EJR Request fails to meet the content requirements specified in Board Rule 42.3 for an EJR request. Further, the Board hereby **dismisses** this issue (*i.e.*, Challenge #2) because: (1) it is otherwise a sub-issue of Challenge #1 that is thereby covered by the dismissal of Challenge #1; and (2) if not, it would be covered by CMS Ruling 1498-R and, on July 25, 2016, the Providers ***expressly*** confirmed Case No. 10-1325GC was not subject to CMS Ruling 1498-R and, to this end, recognized that the Providers had already appealed the data matching process issue in Case No. 09-1763GC which the Board remanded pursuant to 1498-R on March 23, 2016.[38]

1. Background of "SSI Codes" or "Data Matching" Issue

As discussed above, the Medicare DSH adjustment is calculated using two fractions known as the Medicare fraction (also referred to as the SSI fraction or SSI ratio) and the Medicaid fraction. Pursuant to 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I), the Medicare fraction is calculated by using: (a) in the numerator, the "number of such hospital's patient days…which were made up of patients who (for such days) were ***entitled*** to benefits under part A of the subchapter and were

[35] **Attachment B** at 1-2, 20-21.
[36] *See* **Attachment B** at 21.
[37] Providers' EJR Request at 3 (Sept. 29, 2023) (emphasis added).
[38] *See also supra* note 18 and accompanying text ("The Providers note that remand is not necessary pursuant to CMS Ruling 1498-R to correct the SSI matching errors litigated in Baystate because that issue has been separately appealed and the Board has previously remanded that appeal to the MAC.").

entitled to supplementary security income benefits…under subchapter XVI of this chapter…";[39] and (b) in the denominator, the number of days of care that are furnished to patients who were entitled to Medicare Part A. The Secretary incorporated this statutory provision into the regulations at 42 C.F.R. § 412.106(b)(2)(i)(B) which states:

> (2) *First computation: Federal fiscal year.* For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS –
>
> (i) Determines the number of patient days that –
>
> (A) Are associated with discharges occurring during each month; and
>
> (B) Are furnished to patients who during that month were **entitled to** both Medicare Part A (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)).[40]

This particular issue involves CMS' determination of which patients are "entitled to" both Medicare Part A and SSI benefits for purposes of the Medicare fraction of the DSH calculation.

The SSI program is a federal cash assistance program for low-income individuals who are aged, blind, or disabled,[41] administered by the Social Security Administration ("SSA"). The statutory provisions governing SSI, generally, do not use the term "entitled" to SSI benefits. Rather, the SSI statutory provisions typically refer to whether an individual is "eligible for benefits."[42] In order to be "eligible" for SSI benefits, a person must be: (1) 65 years of age or older, blind or disabled; (2) a lawful resident of the United States; (3) have limited income and resources; (4) not be fleeing to

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[39] (Emphasis added.)
[40] (Bold emphasis added and italics emphasis in original.) *See also* 42 U.S.C. § 1395w2(d)(5)(F)(vi)(I).
[41] 42 U.S.C. § 1382.
[42] 42 U.S.C. §§ 1381a, 1382(a) (emphasis added).

avoid prosecution for a crime or violating a condition of parole; and (5) file an application for benefits.[43]

In contrast, the Medicare program is an insurance program where an individual is automatically "entitled" to Medicare Part A when the person reaches age 65 and is entitled to Social Security benefits or becomes disabled and had been entitled to disability benefits for 24 calendar months.[44] In addition, the Medicare program provides that certain qualifying individuals with end stage renal disease are entitled to Medicare Part A.[45]

Unlike entitlement for Medicare Part A benefits, an individual who is currently eligible for SSI benefits may later become *in*eligible for SSI benefits. In this regard, SSA conducts periodic redeterminations to ensure continued eligibility[46] and may terminate,[47] suspend[48] or stop payments to individuals who are either temporarily or permanently ineligible for payment of SSI benefits.[49] In particular, SSI eligibility may be lost if a person no longer meets the basic requirements. For example, an individual may lose SSI eligibility if the individual is no longer disabled or the individual meets one of the following reasons set forth in §§ 416.207-416.216:

1. The individual fails to give the SSA permission to contact financial institutions;[50]
2. The individual fails to apply for other benefits to which the individual may be entitled;[51]
3. The individual fails to participate in drug or alcohol addiction treatment;[52]
4. The individuals is absent from the United States for more than 30 days;[53] or
5. The individual becomes a resident of a public institutions or prison.[54]

In addition, under certain circumstances, SSA may not pay benefits for administrative reasons, such as removal of a representative payee, an unknown address for the beneficiary, or because of income from a previous month.[55]

After the Medicare DSH statutory provisions were enacted in 1984, CMS (then known as the Health Care Financing Administration ("HCFA")) announced that the Secretary of Health and Human Services, rather than hospitals, would be solely responsible for computation of the

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[43] 20 C.F.R. § 416.202.
[44] 42 U.S.C. § 426.
[45] 42 U.S.C. § 426-1.
[46] 20 C.F.R. § 416.204.
[47] 20 C.F.R. §§ 416.1331-1335.
[48] 20 C.F.R. §§ 416.1320-1330.
[49] 20 C.F.R. § 1320.
[50] 20 C.F.R. § 416.207.
[51] 20 C.F.R. § 416.210.
[52] 20 C.F.R. § 416.214.
[53] 20 C.F.R. § 416.215.
[54] 20 C.F.R. § 416.211.
[55] *See* SSA Program Operations Manual ("POMS") § SI 02301.201 (describing certain SSI post-eligibility events on the internet at https://secure.ssa.gov/apps10/poms.nsf/lnx/0502301201).

Medicare fraction because the data necessary to calculate the Medicare fraction is voluminous and much of this data needed to be obtained from another agency, SSA.[56] CMS noted that, as of 1986, the data sources for the computation of the Medicare fraction included approximately 11 million billing records from the Medicare inpatient discharge file and over 5 million records from the SSI file compiled by SSA.[57] To compute the Medicare fraction, CMS had to match individual Medicare billing records to individual SSI records.[58] Considering the administrative burdens and complexity of the data matching process, CMS concluded that the Secretary would be responsible for the data matching process, which she would conduct retrospectively for every eligible Medicare hospital on a "federal fiscal year" basis—that is, based on discharges occurring in the federal fiscal year.[59] CMS notifies Medicare contractors of the SSI ratios after they are calculated. CMS currently makes this notification by posting the resulting SSI percentages on its website. Medicare contractors then use the posted SSI ratios to calculate the Medicare DSH percentage to determine each qualifying hospital's Medicare DSH payment adjustment.[60]

The Medicare DSH payment adjustment has been the subject of much litigation and, from that litigation, the following case is of particular relevance to this appeal: *Baystate v. Leavitt*, 545 F. Supp. 2d 20 *as amended* 587 F. Supp. 2d 37, 44 (D.D.C. 2008) ("*Baystate*"). In *Baystate*, the plaintiff alleged that the Secretary's process to identify and gather the data necessary to calculate each hospital's SSI ratio was deficient and the Court remanded the case to the Administrator for further action. The Board notes that this case discusses the Secretary's historical practice of basing "entitled to . . . SSI" under 42 C.F.R. § 412.106(b)(2) on actual payment of SSI cash benefits.[61]

On April 28, 2010, the Secretary through CMS acted on the *Baystate* remand order and published CMS Ruling CMS-1498-R ("Ruling 1498-R"). Specifically, the Ruling stated that CMS had implemented the *Baystate* remand order by recalculating the plaintiff's SSI fractions and Medicare DSH payment adjustments using a revised data matching process that used "updated and refined

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[56] 51 Fed. Reg. 31454, 31459 (Sept. 3, 1986).
[57] *Id.*
[58] *Id.*
[59] *Id.* at 31459–31460; 42 C.F.R. § 412.106(b).
[60] 42 C.F.R. § 412.106(b)(5); 42 C.F.R. § 405.1803.
[61] *Baystate* began with a hearing before the Board. *See Baystate Med. Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006), *modified by*, CMS Adm'r Dec. (May 11, 2006). The Board heard extensive testimony on the Secretary's then-existing data match process. This included testimony from several SSA employees on the data tapes historically sent from SSA to CMS that included "42 monthly indicators (ones and zeros) denoting the payment or non-payment of Federal SSI cash benefits during the period covered by the SSA tape." *Id.* at 11 (citations omitted). Further, this testimony established that SSA's program would "assign a '1' to a month if the CMPH field shows one of two payment codes, C01 (current pay status) or M01 (manual or forced pay), and the FAM field reflects an amount due for the month" and that "[o]therwise, the program assigns a '0' to that month." *Id.* The provider in *Baystate* contested among other things: (1) "the omission of SSI records relating to individuals who received a forced payment from an SSA filed office; (2) "the omission of SSI days associated with individuals whose SSI benefits were temporarily on hold or in suspense when SSA ran each year's SSI tape;" (3) "the omission of SSI days associated with individuals whose benefits were restored or retroactively after SSA ran each year's tape;" and (4) "the omission of individuals who were entitled to non-cash Federal SSI benefits." *Id.* at 23. The Board's discussion of these contentions confirms SSI days were counted when there was actual SSI cash benefits. *See id*. at 26-30. The CMS Administrator's decision and the ensuing decision of the D.C. District Court also contain references to the Secretary's policy. *See, e.g.,* Adm'r Dec. at 5, 16, 39, 41, 48-49; 545 F. Supp. 2d at 28-29 n.13 & n.17, 36-39.

SSI eligibility data and Medicare records, and by matching individuals' records with reference to Social Security numbers (SSNs) as well as HICANs and Title II numbers."[62] The Ruling also stated that "in the FY 2011 proposed rule, CMS is proposing to adopt the same revised data matching process" for use with all hospitals and that "[i]n the forthcoming FY 2011 IPPS final rule, CMS expects to respond to public comments filed on the proposed new data matching process, make any changes to such matching process that seem appropriate, and adopt finally a new data matching process."[63] Finally, CMS stated that it would "use that new data matching process in calculating SSI fractions and DSH payments for specific claims that are found to qualify for relief under this Ruling."[64]

Consistent with Ruling 1498-R, the Secretary published the new data matching process in the FY 2011 IPPS proposed rule published on May 4, 2010.[65] The proposed rule includes references to the Secretary's historical practice of basing "entitled to . . . SSI" under 42 C.F.R. § 412.106(b)(2) on actual payment of SSI cash benefits.[66]

The Secretary finalized that data matching process in the FY 2011 IPPS final rule published on August 16, 2010 ("FY 2011 IPPS Final Rule").[67] Significantly, in the preamble to the FY 2011 IPPS Final Rule, CMS acknowledged a public comment that: (1) requested that "CMS include both paid and unpaid days for both SSI entitlement and Medicare entitlement such that there would be consistency between the numerator and denominator of the SSI fraction"; and (2) provided examples of "several SSI codes that represent individuals who were eligible for SSI but not eligible for SSI payments, that should be included as SSI-entitled for purposes of the data match process."[68] CMS responded in detail to this comment and explained that CMS interprets SSI entitlement to correspond with any month for which an individual *receives* payment of SSI benefits. In this regard, CMS stated that the three SSI codes denoted as C01, M01, and M02 "accurately captures all SSI-entitled individuals during the month(s) they are entitled to receive SSI benefits."[69] CMS explicitly rejected the inclusion of other SSA codes because "SSI entitlement can change from time to time" and none of these codes "would be used to describe an individual who was entitled to receive SSI benefits during the month that one of these codes was used."[70] Finally, in the preamble,

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[62] CMS-1498-R at 5.
[63] *Id.*
[64] *Id.* at 5-6.
[65] 85 Fed. Reg. 23852, 24002-24007 (May 4, 2010).
[66] *See, e.g.,* 75 Fed. Reg. at 24003 (discussing SSI cash payment issues discussed in the *Baystate* decision), 24003-24004 (discussing the proposed matching process where "[t]he SSI eligibility file serves as the system of record for whether or not SSA made a payment of SSI benefits to an individual who applied for SSI"), 24004-06 (discussing the time of the matching process including how "it is important to find an appropriate balance between administrative finality (that is, the final settlement of a hospital's cost report) and the inclusion of retroactive SSI eligibility determinations and the lifting of SSI payment suspensions by using the best and latest available SSI eligibility data at the time of cost report settlement benefits").
[67] 75 Fed. Reg. 50041, 50280-50281. (Aug. 16, 2010).
[68] *Id.* at 50280.
[69] *Id.* at 50280-50281.
[70] *Id.* This include all codes with the "S" prefix indicating a suspension of payment; codes beginning with "N" for nonpayment; code "E01" indicating that the individual had countable income which eliminated the SSI payment; and code "E02" indicating that the patient was not entitled to SSI benefits during that month but became entitled during a subsequent month.

CMS confirms that "[t]he same data matching process [used for FY 2011 and beyond] will be used to calculate SSI fractions for cost reporting periods covered under the Ruling [1498-R]."[71]

While the new data matching process established in the preamble to the FY 2011 IPPS Final Rule was effective October 1, 2010 (*i.e.*, for FY 2011 and forward), Ruling 1498-R directed that the Medicare contractors apply "the same, unitary relief" consisting of SSI fractions that the Secretary had calculated using the new "suitably revised" data matching process to: (1) any Medicare cost report that had not been settled; and (2) all properly pending Medicare DSH appeals of the SSI fraction data matching process issue.[72] The Ruling noted that hospitals dissatisfied with the initial or revised NPR issued using the new SSI ratios in the Medicare DSH adjustment calculation could seek administrative and judicial review provided they met the jurisdictional and procedural requirements of 42 U.S.C. § 1395oo, the Medicare regulations, and other agency rules and guidelines.[73] In the FY 2011 IPPS Final Rule, the Secretary explicitly recognized that "[t]he data matching process provisions of the Ruling would apply to . . . open cost reports for cost reporting periods beginning prior to October 1, 2010 (that is those preceding the effective date of the FY 2011 IPPS final rule)."[74]

On April 22, 2015, CMS published Ruling 1498-R2 modifying and amending Ruling 1498-R by allowing hospitals to elect whether to use new Medicare SSI fractions calculated on the basis of "total days" or "covered days" for cost reports involving patient discharges *prior* to October 1, 2004.[75] However, neither Ruling 1498-R nor Ruling 1498-R2 are applicable to this appeal. The Providers confirmed that the instant "appeal challenges an entirely different aspect of the SSI percentage that is not addressed by Ruling 1498-R, namely, CMS's inconsistent policy of treating eligible but unpaid Part A days as days "entitled to [SSI] benefits.'"[76]

Finally, ***on September 1, 2023*** *(4 weeks prior to QRS filing its EJR Request)*, the D.C. Circuit issued a decision in *Advocate Christ Med. Ctr. v. Becerra* ("*Advocate Christ*")[77] on September 1, 2023 addressing the Secretary's interpretation of the statutory phrase "entitled to [SSI] benefits" located at 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). Specifically, the D.C. Circuit found that:

(1) This statutory phrase "cover[s] only to Medicare beneficiaries who are entitled to SSI cash payments at the time of their hospitalization";[78]

(2) The Secretary's process to match a patient's enrollment in Medicare and entitlement to SSI cash payments was not arbitrary and capricious;[79] and

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[71] *Id.* at 50285.
[72] CMS-1498-R at 6-7, 31.
[73] *Id.* at 28, 31.
[74] 75 Fed. Reg. at 24006.
[75] CMS-1498-R2 at 2, 6.
[76] Response to Board RFI, 1-2 (July 25, 2016). *See also supra* notes 8 and 37 and accompanying text.
[77] 80 F.4th 346 (D.C. 2023).
[78] *Id.* at 352-53.
[79] *Id.* at 354.

(3) MMA § 951 does not require the Secretary to furnish hospitals with data on all specific codes used by SSA to track why patients did or did not qualify for SSI cash payment.[80]

Significantly, the Providers' EJR Request does *not* discuss the D.C. Circuit's decision in *Advocate Christ*.

2. Board Decision re: Challenge #2

The EJR request that QRS filed on behalf of the Providers "challenge[s] . . . the policy that ***paid*** [SSI] days can be demonstrated only by SSI codes of C01, M01, and M02."[81] The EJR Request confirms that the policy was published as part of the FY 2011 IPPS Final Rule but then asserts that "the use of ***only*** the three SSI codes of C01, M01 and M02 as evidencing payment for SSI ***predated*** *the FY 2011 final rule by many years*."[82] However, the EJR request fails to identify where that the Secretary adopted ***previously*** the policy of "us[ing] of ***only*** the three SSI codes of C01, M01 and M02 as evidencing payment for SSI,"[83] and *precisely* what the controlling ***authority*** is for that prior/predating policy statement that is being challenged in this EJR request as it relates to Challenge #2. Identification of the specific controlling ***authority*** being challenged (*e.g*, is the controlling authority a specific unwritten policy vs. a manual provision or memorandum vs. an uncodified regulation issued in the preamble to a final rule) is ***critical*** for the Board to determine whether it is "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)."[84] It is not for the Board to try to guess but rather, as set forth in Board Rule 42.3 (and consistent with 42 C.F.R. § 405.1842(d)), the EJR Request must "[i]dentif[y] the controlling law, regulation, Federal Register notice, or CMS ruling that is being challenged."

Similarly, QRS' EJR Request as it relates to Challenge #2 fails to tie its challenge of this policy to the Providers' appeal requests based on FY 2007 original NPRs issued in August/September 2009 (*i.e*., appeals of SSI fractions issued during or prior to August/September 2009). In particular, this relates to demonstrating that there are no factual issues in dispute and demonstrating the Board has jurisdiction over the challenge being made *as it relates to the specific controlling authority being challenged*.

Based on the above, it is clear that that the EJR request as it relates to Challenge #2 fails to meet the *content* requirements for an EJR request as set forth in Board Rule 42.3. This is highlighted by the fact that the EJR request does not discuss any recent Court decisions such as the D.C. Circuit's recent decision in *Advocate Christ*.[85] Accordingly, the Board hereby **denies** the Providers' EJR request as it relates to Challenge #2.

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[80] *Id.* at 354-55.
[81] Providers' EJR Request at 3 (Sept. 29, 2023) (emphasis added).
[82] Provider's EJR Request at 2 (Sept. 29, 2023) (emphasis added).
[83] *Id.* (emphasis added).
[84] 42 C.F.R. § 405.1842(a)(1).
[85] *See also supra* note 27.

The Board further **dismisses** Challenge #2 because: (1) it is otherwise a sub-issue of Challenge #1 that is thereby covered by the dismissal of Challenge #1; or (2) if not, it would be covered by CMS Ruling 1498-R and, on July 25, 2016, the Providers ***expressly*** confirmed Case No. 10-1325GC was not subject to CMS Ruling 1498-R and, to this end, recognized that the Providers had already appealed the data matching process issue in Case No. 09-1763GC which the Board remanded pursuant to 1498-R on March 23, 2016. Note this dismissal also serves as an independent basis for denying the EJR request.

First, Challenge #2 appears to be a sub-issue of Challenge #1 because it appears as if the Providers are asserting that SSI "paid" days as evidenced by Codes C01, M01, and M02 should be expanded to include other SSI codes that demonstrate an individual was *eligible* for SSI even though *no payment* of SSI benefits was made. This is simply Challenge #1 expressed using SSI codes. As such, it is duplicative of Challenge #1 and the Board hereby dismisses Challenge #2 based on the same reasons it dismissed Challenge #1.

To the extent, the Providers are asserting that the Secretary failed to capture all SSI "paid" days because there are other SSI codes that capture SSI "paid" days (*i.e*., codes outside of C01, M01 and M02),[86] then it would be an issue covered by CMS Ruling 1498-R and would be subject to immediate remand pursuant to that Ruling. CMS Ruling 1498-R states the following:

> CMS' action eliminates any actual case or controversy regarding the hospital's previously calculated SSI fraction and DSH payment adjustment and thereby renders moot each properly pending claim in a DSH appeal involving the hospital's previously calculated SSI fraction and the process by which CMS matches Medicare and SSI eligibility data, provided that such claim otherwise satisfies the applicable jurisdictional and procedural requirements of section 1878 of the Act, the Medicare regulations, and other agency rules and guidelines. Accordingly, it is hereby held that the PRRB and the other administrative tribunals lack jurisdiction *over* ***each*** *properly pending claim on the SSI fraction* ***data matching process*** *issue*, provided that such claim otherwise satisfies the applicable jurisdictional and procedural requirements for appeal.[87]

Similarly, QRS recognize that CMS policy to use SSI codes C01, M01, and M02 ***predates*** CMS Ruling 1498-R and that the *Baystate* case discusses CMS' use of those codes.[88] If the Providers

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[86] Again, the EJR Request is very short at 3 pages long and fails to fully explain what it is challenging in Challenge #2.

[87] CMS Ruling 1498-R at 6 (Apr. 28, 2010) (emphasis added).

[88] EJR Request at 3 (Sept. 29 2023) (stating: "In the *Baystate Medical Center* case, the court discussed the limited SSI codes (specifically C01 and MO1) that were obtained by CMS from SSA for use in computing the Medicare Fractions for FYs 1993-1996. *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20, 28 (D.D.C. 2008). The FY 2011 IPPS proposed rule described its current matching process, which it stated existed since the inception of the DSH program as matching CMS's Medicare records and SSA's SSI eligibility records for each hospital's patients. *See* 74 *Fed. Reg*. at 24002. *See also* 51 *Fed. Reg*. at 16777 (May 6, 1986) ('The number of patient days of those

are asserting in Challenge #2 that the Secretary failed to capture all SSI "paid" days because there are other SSI codes that capture SSI "paid" days (*i.e.*, codes outside of C01, M01 and M02), then it would be a data matching issue where the Providers would be asserting that the Secretary's data matching process was flawed because it failed to capture all SSI "paid" days. As the Providers' March 2010 appeals ***predated*** both the April 2010 CMS Ruling 1498-R and the FY 2011 IPPS Final Rule, their appeals would be subject to that Ruling if the Providers appealed a data matching issue and then effectively and properly transferred that issue to this group appeal.[89] In this regard, the Board notes that 42 C.F.R. § 405.1837(f)(1) makes clear that issues may ***not*** be added to a group appeal after it is established:

> *After the date of receipt by the Board of a* ***group appeal*** *hearing request* under paragraph (c) of this section, *a provider may* ***not*** *add other questions* of fact or law to the appeal, regardless of whether the question is common to other members of the appeal (as described in § 405.1837(a)(2) and (g) of this subpart).[90]

Indeed, on July 25, 2016, QRS ***expressly*** confirmed Case No. 10-1325GC was not subject to CMS Ruling 1498-R and recognized that the Providers had already appealed the data matching process issue in Case No. 09-1763GC which the Board remanded pursuant to CMS Ruling 1498-R on March 23, 2016. Similarly, on June 25, 2018, QRS reaffirmed that this case did not involve issues subject to remand under 1498-R and that such issues had already been separately appealed and remanded.[91] As a result, to the extent Challenge #2 is asserting that the Secretary failed to capture all SSI "paid" days because there are other SSI codes that capture SSI "paid" days (*i.e.*, codes outside of C01, M01 and M02), then it would be a data matching issue and would improperly duplicate Case No. 09-1763GC which encompassed the Provider's data matching process issue and which, pursuant to CMS Ruling 1498-R, the Board remanded and closed on March 23, 2016. Accordingly, the Board would **dismiss** Challenge #2 and **deny** the EJR Request for Challenge #2.

Regardless of whether Challenge #2 is distinct from Challenge #1 or is covered by CMS Ruling 1498-R, it is clear that the Complaint encompasses both Challenge #1 and Challenge #2. Specifically, in addition to pursuing Challenge #1 challenging the policy "of treating patient days

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patients entitled to both Medicare Part A and SSI will be determined by matching data from the Medicare Part A Tape Bill (PATBILL) file with the Social Security Administration's (SSA's) SSI file'). The FY 2011 IPPS likewise made clear that CMS's policy had always been to include only paid days in the numerator of the Medicare Fraction and that codes CO1, MO1 and MO2 are the sole codes that evidence payment. *See* 75 *Fed. Reg*. at 50280 n.19 ('our policy has always been to include only Medicare beneficiaries who are entitled to receive SSI benefits in the numerator of the SSI fraction'); *id.* at 50281 ('none of the SSI status codes that the commenter mentioned would be used to describe an individual who was entitled to receive SSI benefits during the month that one of those status codes was used,' and 'we believe that including SSI codes of C01, M01, and M02 accurately captures all SSI-entitled individuals during the month(s) that they are entitled to receive SSI benefits').").

[89] In so stating, the Board is ***not*** finding that this *potential* interpretation of Challenge #2 is properly part of Case No. 10-1325GC since it need not do so based on the reasons for dismissal and since it is not clear the Providers are, in fact, pursuing this *potential* interpretation of Challenge #2.

[90] (Emphasis added.)

[91] *See supra* notes 18 and 38 and accompanying text.

for which no payment was received under Medicare Part A as nonetheless 'entitled to benefits under part A' for purposes of calculating both fractions of the [DSH] payment adjustment" (*i.e.*, Challenge #1),[92] the Complaint ***also*** makes clear its argument for Challenge #2 that there while "the Secretary only uses C01, M01, and M02, to identify SSI entitled individuals . . . [t]he Secretary is aware of other payment codes . . . which could be used to determine the numerator of the SSI fraction . . . ."[93]

Based on the foregoing, the Board finds that the present case is a duplicate appeal and denies EJR on that basis as well as the fact that the EJR Request failed to meet the minimum content requirements. Additionally, since the Board's rules and regulations prohibit duplicate appeals, the Board hereby and **dismisses** the instant case since both participants are seeking the same relief in federal court for the same issue and fiscal years.

* * * * *

In summary, the September 29, 2023 EJR Request filed by QRS in Case No. 10-1325GC states that the Providers are seeking EJR over two distinct DSH policies in this CIRP Group:

Challenge #1 "The Providers challenge . . . the policy that *only* ***paid*** [SSI] days can be included in the numerator of the Medicare Fraction as contrary to the statute . . . ."[94]

Challenge #2 "The Providers challenge . . . the policy that ***paid*** [SSI] days can be demonstrated only by SSI codes of C01, M01, and M02."[95]

The Board **denies** the EJR Request for both Challenge ##1 and 2 because the EJR Request fails to include sufficient detail as required under Board Rule 42.3 as highlighted by the fact that the EJR Request is extremely short at 3 pages long, notwithstanding the history of Case No. 10-1325GC and the related 2011 University of Washington CIRP groups under Case Nos. 15-0560GC and 09-1763GC. Further, the Board dismisses Case No. 15-0560 in its entirety because the Providers are pursuing the merits of Challenge ##1 and 2 through litigation it filed on May 27, 2022 in relation to Case No. 15-0560GC and, as such, Case No. 10-1325GC is a prohibited duplicate appeal of 15-0560GC.[96] The dismissal is a separate and independent basis to deny the EJR Request.

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[92] *Id.* at ¶ 1.
[93] *Id.* at ¶ 29-30.
[94] Providers' EJR Request at 3 (Sept. 29, 2023) (emphasis added).
[95] *Id.* (emphasis added).
[96] Further, to the extent Challenge #2 is asserting that there are other SSI Codes outside of C01, M01, and M02 that capture SSI "paid" days, then it is an issue that would be covered by CMS Ruling 1498-R. However, QRS previously confirmed more than 7 years earlier on July 25, 2016 that this case did ***not*** involve issues subject to CMS Ruling 1498-R and, to that end, the Providers had already appealed the data matching process issue for 2007 as part of Case No. 09-1763GC which the Board remanded on March 23, 2016 pursuant to CMS Ruling 1498-R. Further QRS reaffirmed this fact in its filing made on June 25, 2018. Finally, the Board notes that, 42 C.F.R. § 405.1837(f)(1) specifies that ***no*** issues may be added to a group appeal once following the group appeal request (which in this case occurred *more than 13 years ago* on September 13, 2010).

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:

10/25/2023

X Clayton J. Nix

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

Enclosures: Attachment A – Sept. 6, 2022 QRS letter filed in Case No. 15-0560GC (34 pages)
Attachment B – Sept. 29, 2023 Board closure letter for Case No. 15-0560GC (60 pages)

cc: John Bloom, Noridian Healthcare Solutions (J-F)
Wilson Leong, FSS
Jacqueline Vaughn, OAA

ATTACHMENT A

QRS Letter Dated Sept. 6, 2022 Filed In
Case No. 15-0560GC (34 pages with Exhibits 1 & 2)

QUALITY REIMBURSEMENT SERVICES, INC.
Healthcare Consultants

VIA OH CDMS

September 6, 2022

Clayton J. Nix, Esq.
Chairman
Provider Reimbursement Review Board
7500 Security Boulevard
Mail Stop: B1-01-31
Baltimore, MD 21244

Re: **Providers' Response To Scheduling Order: Additional Briefing for EJR**
14-1309GC QRS DCH 2007 DSH SSI Fraction Dual Eligible Days CIRP
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
14-2384GC QRS DCH 2008 DSH Medicaid Fraction Dual Eligible Days CIRP
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 2009 DSH Medicaid Fraction Dual Eligible Days CIRP Group
14-4404GC QRS John C. Lincoln Health Netwk. 2009 Medicaid Fract./Dual Eligible Days CIRP
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

Dear Mr. Chair Nix:

The undersigned is the authorized representative for, and this letter is written on behalf of the Providers in the captioned case(s). This letter responds to the Board's letter dated August 09, 2022, regarding the Board's Scheduling Order: Additional Briefing for EJR. The Providers respond as follows:

1. 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).[1] In another recent set of cases the Board has recognized and complied with this regulation:

> 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. 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).

Case Nos. 09-1903GC et al., letter of Board dated June 10, 2022 at 33 (footnote omitted).

2. The Board has directed the Providers to file supplemental briefings regarding their EJR request in light of the decision of the United States Supreme Court in *Becerra v. Empire Health Foundation*, 142 S. Ct. 2354 (2022) (Slip Opinion Case No. 20-1312 (June 24, 2022)). Although, as noted, the Board does not possess jurisdiction over these cases because they have been filed in federal court, nonetheless in good faith and in compliance with the Board's directive the Providers explain how their EJR request has been affected by the *Empire Health Foundation* decision of the Supreme Court as follows:

    a. In *Empire Health Foundation*, the Plaintiff appealed the computation of the DSH Medicare Fraction in two respects. First, the Plaintiff challenged the inclusion of all Part A days in the denominator, whether Medicare Part A payment was made for a patient's hospital stay.

    b. In the alternative, *i.e.*, if the Court upheld the Part A days policy (which the Supreme Court ultimately upheld), the Plaintiff challenged the failure of CMS to include all patient days for such patients who were entitled to SSI in the numerator of the SSI fraction, without regard to whether the patient received SSI during the hospital stay. Thus, the Plaintiff in *Empire Health Foundation* challenged the failure of CMS to include all but three SSI codes in computing the numerator of the DSH Medicare Fraction.

    c. In its "2005 Rule" construing the Medicare fraction, CMS interpreted the phrase "entitled to benefits under part A" to encompass any patient who satisfies part A's statutory eligibility criteria, whether or not Medicare actually pays for her care. In *Empire Health Foundation* the Supreme Court held in favor of CMS regarding the meaning of the word "entitled" for purposes of the DSH Medicare Fraction. At the same time however, CMS interprets the phrase

[1] As the Board lacked jurisdiction over these cases, the Board lacked, and continues to lack, authority to dismiss or to take any other action regarding the cases.

"entitled to [SSI] benefits" to cover only patients who actually receive SSI payments. *See* 75 Fed. Reg. 50,042, 50,280-81 (Aug. 16, 2010).

d. Thus in *Empire Health Foundation* the Plaintiff contends that the Court should now consider the alternative argument that HHS impermissibly interprets "entitled to [SSI] benefits" to *exclude* patients who do not receive benefit payments.

e. The Supreme Court "express[ed] no view" on the Hospital's alternative argument that CMS has impermissibly "interpreted the phrase 'entitled to [SSI] benefits.'" *Id.*, slip op. at 7 n.2. Thus, that question remained for the United States Court of Appeals for the Ninth Circuit to address in "further proceedings" on "remand." *See*, slip op. at 19. In fact, the Supreme Court has remanded *Empire Health Foundation* to the Ninth Circuit. On July 19, 2022 (*i.e.*, on or about the date of the Board's Denial of EJR Request & Scheduling Order), the Plaintiff in *Empire Health Foundation* filed a motion for the Ninth Circuit to conduct proceedings regarding the alternative issue. CMS has opposed the motion. Enclosed as Exhibit 2 is the relevant excerpt of the docket sheet for *Empire Health Foundation* evidencing that upon remand from the Supreme Court further proceedings are occurring regarding the alternate issue.

f. The alternate issue is also presented to the United States Court of Appeals for the District of Columbia in the pending case of *Advocate Christ Medical Center v. Becerra*, No. 22-5214. Thus, in addition to the final decision in *Empire Health Foundation*, the Providers' case, which is filed within the jurisdiction of the DC Circuit, will be directly impacted by the final decision in *Advocate Christ Medical Center*.

g. At present it is impossible to predict with any accuracy the final decisions in either *Empire Health Foundation* or *Advocate Christ Medical Center*. Moreover, it is impossible to predict whether an appeal will be filed with the United States Supreme Court regarding the final decisions in either or both of these cases.

3. Thus, with the proceedings in *Empire Health Foundation and Advocate Christ Medical Center* in mind, and to respond directly to the Board's inquiry, the Providers in the captioned cases likewise appeal the alternate issue, *i.e.*, of whether all patients entitled to SSI, whether or not a payment was received during hospitalization, should be included in the numerator of the DSH Medicare Fraction. The Providers' complaint filed in the United States District Court for the District of Columbia includes allegations, and request for relief, regarding the alternate issue.

4. The Providers respectfully submit that the decision of the Ninth Circuit in *Empire Health Foundation* on remand from the Supreme Court and the decision of the DC Circuit in *Advocate Christ Medical Center* likely will decide the dispositive jurisdictional and substantive issues relating to the alternative issue. As noted, the

Providers in the captioned cases have commenced an action in the United States District Court for the District of Columbia and thus their case will be directly impacted by *Advocate Christ Medical Center*. Thus, in the interest of conserving the resources of the Board, the MAC and the Providers, it is the suggestion of the Providers that the Board (which as noted in any event at present lacks jurisdiction over these cases) refrain from conducting further proceedings in the captioned cases until the final decisions are issued in *Empire Health Foundation, Advocate Christ Medical Center*, and the Providers' case, *TARZANA PROVIDENCE HEALTH SYSTEM et al v. BECERRA, Case No. 22-01509.* The Providers propose to submit a status report to the Board upon the completion of proceedings the in *Empire Health Foundation* on remand from the Supreme Court and in *Advocate Christ Medical Center*.

Please contact me if the Board requires any further information or documentation regarding this request.

Respectfully submitted,

Russell Kramer
Director

cc: Cecile Huggins, Palmetto GBA (VIA OH CDMS).
John Bloom, Noridian Healthcare Solutions (VIA OH CDMS).
Geoff Pike, FCSO, Inc. (VIA OH CDMS).
Wilson Leong, FSS(VIA OH CDMS).

Exhibit 1

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UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

TARZANA PROVIDENCE HEALTH SYSTEM 18321 Clark Street Tarzana, CA 91356 FAYETTE MEDICAL CENTER 1653 Temple Avenue Fayette, AL 35555 DCH REGIONAL MEDICAL CNTER 809 University Boulevard East Tuscaloosa, AL 35401 NORTHPORT MEDICAL CENTER 2700 Hospital Drive Northport, AL 35476 PROVIDENCE ALASKA MEDICAL CENTER 3200 Providence Drive Anchorage, AK 99508 JOHN C. LINCOLN NORTH MOUNTAIN HOSPITAL 250 East Dunlop Avenue Phoenix, AZ 85020	Case No. **PLAINTIFFS' COMPLAINT FOR DECLARATORY, RESTITUTIONARY, AND INJUNCTIVE RELIEF AND FOR SUMS DUE UNDER THE MEDICARE ACT FROM FINAL PRRB DECISION IN CASES 14-1309GC**

JOHN C. LINCOLN DEER VALLEY HOSPITAL
19829 North 27th Avenue
Phoenix, AZ 85027

LITTLE COMPANY OF MARY HOSPITAL – SAN PEDRO
1300 West 7th Street
San Pedro, CA 90732

PROVIDENCE ST. JOSEPH MEDICAL CENTER
501 South Buena Vista Street
Burbank, CA 91505

PROVIDENCE HOLY CROSS MEDICAL CENTER
15031 Rinaldi Street
Mission Hills, CA 91345

LITTLE COMPANY OF MARY HOSPITAL – TORRANCE
4101 Torrance Boulevard
Torrance, CA 90503

JAMES E. HOLMES REGIONAL MEDICAL CENTER
1350 South Hickory Street
Melbourne, FL 32901

CAPE CANAVERAL HOSPITAL
701 West Cocoa Beach Causeway
Cocoa Beach, FL 32931

SAINT PATRICK HOSPITAL
500 West Broadway
Missoula, MT 59802

PROVIDENCE SAINT VINCENT MEDICAL CENTER
9205 Southwest Barnes Road
Portland, OR 97225

PROVIDENCE NEWBERG MEDICAL CENTER
1001 Providence Drive
Newberg, OR 97132

WILLAMETTE FALLS HOSPITAL
1500 Division Street
Oregon City, OR 97045

PROVIDENCE PORTLAND MEDICAL CENTER
4805 North Northeast Glisan Street
Portland, OR 97213

PROVIDENCE MEDFORD MEDICAL CENTER
1111 Crater Lake Avenue
Medford, OR 97504

PROVIDENCE MILWAUKIE HOSPITAL
10150 Southeast 32nd Avenue
Milwaukie, OR 97222

SAINT MARY MEDICAL CENTER
401 West Poplar Street
Walla Walla, WA 99362

UNIVERSITY OF WASHINGTON MEDICAL CENTER
1959 Northeast Pacific
Seattle, WA 98195

PROVIDENCE REGIONAL MEDICAL CENTER
1700 13th Street
Everett, WA 98201

PROVIDENCE SAINT PETER HOSPITAL
413 Lilly Road Northeast
Olympia, WA 98506

SWEDISH MEDICAL CENTER – CHERRY HILL
500 17th Avenue
Seattle, WA 98122

STEVENS HEALTHCARE
21601 76th Avenue West
Edmonds, WA 98026

SWEDISH MEDICAL CENTER
747 Broadway
Seattle, WA 98122

SACRED HEART MEDICAL CENTER
101 West Eighth Avenue
Spokane, WA 99204

KADLEC MEDICAL CENTER
888 Swift Boulevard
Richland, WA 99352

HARBORVIEW MEDICAL CENTER
325 Ninth Avenue
Seattle, WA 98104

HOLY FAMILY HOSPITAL
5633 North Lidgerwood Street
Spokane, WA 99208 +

VALLEY MEDICAL CENTER
400 South 43rd Street
Renton, WA 98055

PROVIDENCE HEALTH & SERVICES – ISSAQUAH
751 Northeast Blakely Drive
Issaquah, WA 98029

Plaintiffs,

v.

XAVIER BECERRA, SECRETARY OF HEALTH AND HUMAN SERVICES,

Defendant.

I. INTRODUCTION

1. Plaintiffs (also referred to hereinafter as the "Hospitals") were, at all relevant times, hospitals that participated in the Medicare and Medicaid programs. The Hospitals challenge the policy of Defendant Xavier Becerra, Secretary of Health and Human Services (the "Secretary") of treating patient days for which no payment was received under Medicare Part A as nonetheless "entitled to benefits under part A" for purposes of calculating both fractions of the Disproportionate Share Hospital ("DSH") payment adjustment. See 42 U.S.C. §1395ww(d)(5)(F)(vi) (the "Medicare DSH Statute"). If the Secretary's treatment of unpaid Part A days as "days entitled to benefits under part A" is upheld, the Hospitals contend that the Secretary must at least apply that interpretation of the word "entitled" consistently by also treating days for which no supplemental security income payments were received as days "entitled to supplemental security income benefits" under 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I).

As explained below, the Secretary's policy of applying different interpretations to the same term, "entitled," used in the same sentence of the statute is the epitome of arbitrary and capricious agency action and must be reversed. *See Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1, 20 n.1 (D.C. Cir. 2011) (Kavanagh, J., concurring) ("HHS thus interprets the word "entitled" differently within the same sentence of the statute. The only thing that unifies the Government's inconsistent

definitions of this term is its apparent policy of paying out as little money as possible. ("I appreciate the desire for frugality, but not in derogation of law."); *see also Walter O. Boswell Mem'l Hosp. v. Heckler*, 749 F.2d 788, 799 (D.C. Cir. 1984) ("It would be arbitrary and capricious for [the Secretary] to bring varying interpretations of the statute to bear, depending upon whether the result helps or hurts Medicare's balance sheets …. ").

In *Empire Health Found. v. Price*, 334 F.Supp. 3d 1134 (E.D. Wash. 2018), the court found that the Secretary's notice failed to satisfy the procedural rulemaking requirements of the APA and that the regulation is procedurally invalid. The decision in *Empire Health Found*. was appealed to the United States Court of Appeals for the Ninth Circuit, which held that the regulation was substantively invalid. *Empire Health Found. v. Price*, 958 F3d. 873; 2020 WL 2123363; 20 Cal. Daily Op. Serv.4283. The United States Supreme Court has granted the Secretary's petition for certiorari, *Xavier Becerra, Secretary of Health and Human Services v. Empire Health Foundation*, Case No. 20-1312, and conducted oral argument on November 29, 2021. The decision of the United States Supreme Court may narrow the issues or be dispositive of the instant case. and *Torrance Memorial Medical Center*.

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II. JURISDICTION AND VENUE

2. This action arises under Title XVIII of the Social Security Act, as amended ("Medicare Act") (42 U.S.C. §§1395 et. seq.), and the Administrative Procedure Act ("APA"), 5 U.S.C. §§551 et seq.

3. This Court has jurisdiction under 42 U.S.C. §1395oo(f)(1) to review a final decision of the Provider Reimbursement Review Board ("PRRB"). Plaintiffs timely commenced their appeals before the PRRB. Plaintiffs challenged the Secretary's regulation regarding the DSH adjustment. The PRRB lacks authority to decide the validity of the Secretary's DSH adjustment regulation. *See, supra*, *Empire Health Found. v. Price*, 334 F.Supp. 3d 1134 (E.D. Wash. 2018). When as here a regulation is in dispute, the appropriate procedure is for the PRRB to order expedited judicial review("EJR") as provided by 42 U.S.C. §1395oo(f)(1), which enables the Plaintiffs to proceed before this Court. Accordingly, the Plaintiffs requested that the PRRB grant orders for EJR. See exhibits, A, B, and C. The statute 42 U.S.C. §1395oo(f)(1) requires the PRRB to decide an EJR request within thirty days. To the best of Plaintiffs' knowledge, no requests for EJR have thus far been granted, nor has the PRRB rendered its decision(s) on any such request. In response to several of the Plaintiffs' requests for EJR, the Medicare contractor has opposed such requests. To date, however, the PRRB has not issued its ruling on any of the contractor's opposition to any such request. The statute allows a hospital to initiate an action in

this Court if the PRRB determines that expedited judicial review is appropriate or fails to make a determination as to its authority within 30 days after receipt of a request for such a determination. *See* 42 U.S.C. § 1395oo(f)(1); *Clarian Health W., LLC v. Hargan*, 878 F.3d 346, 354 (D.C. Cir. 2017) ("The expedited judicial review provision makes it clear that 'if the Board fails to render [a] determination' on its authority within 30 days, 'the provider may bring a civil action . . . with respect to the matter in controversy contained in such request for a hearing.'").

4. Based upon the information and belief of the Plaintiffs, the PRRB has in virtually every instance wherein the specific issues set forth below (and each based upon the *Empire* case, infra.) are pled, granted expedited judicial review upon the basis that the Board, "… is without the authority to decide the legal question of whether 42 C.F.R. §412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule) is valid, and if successful, what policy should then apply which necessarily would determine the appropriate relief, namely whether to simply exclude such non-covered Part A days from both the SSI and Medicaid fraction (as was done prior to the FY 2005 IPPS Final Rule) or to count only those non-covered Part A days involving patients who are also eligible Medicaid in the Medicaid fraction." (As quoted from the Board's letter dated March 17, 2022, in the appeals matters of Case No's. 13-1376GC and 14-4030GC, such appeals consisting of the **identical** issues and arguments set forth in the instant case.) There is no logical basis to believe that

the Board shall not in this matter rule thusly, thereby granting EJR (or alternatively, not respond to the request within the statutory time to so respond).

5. Pursuant to 42 U.S.C. §1395oo(f)(1), venue is proper in this judicial district because the greatest number of Hospitals are located in *this* judicial district.

III. PARTIES

6. The Hospitals in this action and Hospital fiscal years at issue are identified in the caption and the Lists of Cases included with the requests for EJR submitted by Plaintiffs attached as Exhibits A, B, and C.

7. Defendant, XAVIER BECERRA is the Secretary of the Department of Health and Human Services, 200 Independence Avenue, S.W., Washington D.C. 20201, the federal agency responsible for the administration of the Medicare and Medicaid Programs. Defendant BECERRA is sued in his official capacity. References to the Secretary herein are meant to refer to him, to his subordinates, and to his official predecessors or successors as the context requires.

8. The Center for Medicare and Medicaid Services ("CMS") is a component of the Department of Health and Human Services ("HHS") with responsibility for day-to-day operations and administration of the Medicare program. References to CMS herein are meant to refer to the agency and its predecessors.

IV. THE MEDICARE PROGRAM

9. Congress enacted the Medicare Program (Title XVIII of the Social Security Act) in 1965. As originally enacted, Medicare was a public health insurance program that furnished health benefits to the aged, blind and disabled. Over the years, the scope of benefits and covered individuals has been expanded.

10. Among the benefits covered by Medicare are inpatient hospital services. For cost reporting years beginning prior to October 1, 1983, the Medicare Program reimbursed inpatient hospital services on a "reasonable cost" basis. 42 U.S.C. §1395f(b). Effective with cost reporting years beginning on or after October 1, 1983, Congress adopted a prospective payment system ("PPS") to reimburse most acute care hospitals, including Plaintiffs, for inpatient operating costs. 42 U.S.C. §1395ww(d). Under PPS, hospitals are paid a fixed amount for services rendered based upon diagnosis-related groups ("DRGs"), subject to certain payment adjustments, such as the DSH payment at issue here.

11. The Secretary has delegated much of the responsibility for administering the Medicare Program to CMS, which was formerly known as the Health Care Financing Administration. The Secretary, through CMS, contracted out many of the audit and payment functions for inpatient hospital care furnished to Medicare program beneficiaries to organizations known as fiscal intermediaries or Medicare administrative contractors ("Medicare contractor"). 42 U.S.C. §1395h.

12. At the close of the fiscal year, a hospital provider of services must submit to its Medicare contractor a cost report showing the allowable costs incurred and amounts due from Medicare for the fiscal year and the payments received from Medicare. The Medicare contractor is required to audit the cost report and inform the hospital provider of a final determination of the amount of Medicare reimbursement through a Notice of Program Reimbursement ("NPR"). 42 CFR §405.1803.

13. A hospital provider dissatisfied with its Medicare contractor's determination may file an appeal to the Provider Reimbursement Review Board ("PRRB") as long as the amount in controversy is $10,000 or more and the request for hearing is within 180 days of the date the hospital provider receives the NPR. 42 U.S.C. §1395oo(a). The PRRB was established by the Social Security Amendments of 1972 (Pub. L. 92-603) as a national, independent forum for hearing and deciding payment disputes between hospital providers and their Medicare contractors.

14. Upon filing a timely hearing request, a hospital provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the PRRB within no later than 60 days after the expiration of the applicable 180-day period to file the initial hearing request. 42 C.F.R. §405.1835(e).

15. Pursuant to PRRB Rule 16 a hospital provider may transfer a specific issue from an individual appeal to an existing group appeal when there is a single

common issue to be resolved. The PRRB Rules set out the documentation requirements for such a transfer.

16. The decision of the PRRB is a final administrative decision, unless the Secretary, through the Administrator of CMS, reviews the PRRB's decision; the Administrator may reverse, affirm or modify the PRRB's decision. 42 U.S.C. §1395oo(f).

17. The Medicare statute authorizes the PRRB to determine that it is without authority to decide a question of law or regulations relevant to a matter in controversy in an appeal before the PRRB and to grant the right to expedited judicial review. 42 U.S.C. § 1395oo(f)(1). Pursuant to the Secretary's regulations, the PRRB is bound by agency rules and rulings, like the 2004 rule at issue. 42 C.F.R. § 405.1867. Accordingly, the statute allows a hospital to request a PRRB determination as to its authority to decide a question of law or regulations and to initiate an action in this Court if the PRRB determines that expedited judicial review is appropriate or fails to make a determination as to its authority within 30 days after receipt of a request for such a determination. *See* 42 U.S.C. § 1395oo(f)(1); *Los Angeles Haven Hospice, Inc. v. Sebelius,* 638 F.3d 644 at 652 (Ninth Cir.2011) (PRRB lacks authority to decide purely legal issue); *Empire Health Found. v. Price*, 334 F.Supp. 3d 1134 (E.D. Wash. 2018) (EJR granted over plaintiffs' challenge to DSH adjustment regulation): *Clarian Health W., LLC v. Hargan*, 878 F.3d 346, 354

(D.C. Cir. 2017) ("The expedited judicial review provision makes it clear that 'if the Board fails to render [a] determination' on its authority within 30 days, 'the provider may bring a civil action . . . with respect to the matter in controversy contained in such request for a hearing.'"); *Allina Health Services v. Price,* 863 F.3d 937 at 941 ("A provider may bring suit in the district court even when the Board fails to make a timely determination of its authority to decide a case."). *Accord Methodist Hosp. of Memphis v. Sullivan*, 799 F. Supp. 1210, 1216 (D.D.C. 1992) *rev'd on other grounds, Adm'rs of Tulane Educ. Fund v. Shalala*, 987 F.2d 790 (D.C. Cir. 1993).

18. The regulation implementing the expedited judicial review ("EJR") statute, 42 C.F.R. § 405.1842(f), sets forth an additional requirement for granting EJR, not found in the statute, that the Board have "jurisdiction to conduct a hearing on the specific matter at issue." When presented with a request for EJR, the regulations require that the Board "must make a preliminary determination of the scope of its jurisdiction (that is, whether the hearing request was timely, and whether the amount in controversy has been met)." *Id.* § 405.1840(a)(2). The regulation does not create any further conditions beyond those in the statute to establish jurisdiction for a Board appeal. *See* 42 C.F.R. §§ 405.1835, 405.1837. Under the EJR regulations, only after finding that the statutory requirements for jurisdiction have been met, as set forth in 42 C.F.R. § 405.1840(a)(2), does the Board then proceed to

determine if it has the authority to decide a legal question relevant to a matter at issue. *Id.* § 405.1842(e)(1).

19. When the PRRB grants a hospital provider's request for EJR because it has jurisdiction over an appeal but lacks the authority to grant the relief requested, the Administrator of CMS may only review the jurisdictional component of the PRRB's EJR decision. The Administrator of CMS may not review the PRRB's determination of its authority to decide the legal question. 42 C.F.R. §405.1842(g)(1)(i) and (ii).

20. A hospital provider has the right to obtain judicial review of any final decision of the PRRB, or of the Secretary, by filing a civil action within 60 days of the date on which notice of any final decision by the PRRB, or of any reversal, affirmance, or modification by the Secretary, is received. 42 U.S.C. §1395oo(f). Pursuant to 42 C.F.R. §405.1801 the date of receipt for a decision of the PRRB is presumed to be 5 days after the date of issuance of such decision. If the PRRB grants EJR, the hospital provider may file a complaint in Federal district court in order to obtain review of the legal question. 42 C.F.R. §405.1842(g)(2).

V. THE MEDICARE DISPROPORTIONATE SHARE PAYMENT ADJUSTMENT

21. In 1986, Congress amended Title XVIII of the Social Security Act to require the Secretary to make additional payments to hospitals that serve "a significantly disproportionate number of low-income patients ...." 42 U.S.C.

§1395ww(d)(5)(F)(i)(1). Eligibility for these "disproportionate share" (DS1-1) payments, and the level of these payments, is based on the calculation or a "disproportionate share percentage" that considers the number of low-income patients a hospital serves. See 42 U.S.C. §§1395ww(d)(5)(F)(v) and (vi).

22. As the Ninth Circuit observed in *Portland Adventist Medical Ctr. v. Thompson*, 399 F.3d 1091, 1095 (9th Cir. 2005) (quoting *Legacy Emanuel Hosp. & Health Ctr. v. Shalala*, 97 F.3d 1261, 1265 (9th Cir. 1996)):

> Congress "overarching intent" in passing the [Medicare] disproportionate share provision was to supplement the prospective payment system payments of hospitals serving "low income" persons . . . Congress intended the Medicare and Medicaid fractions to serve as a proxy for all low-income patients.

23. To be eligible for the DSH payment, a hospital must meet certain systemic criteria, including a disproportionate patient percentage that exceeds the threshold. The amount of the DSH payment then depends upon the extent to which the disproportionate patient percentage exceeds the threshold.

24. The disproportionate patient percentage is statutorily defined as the sum of two fractions expressed as a percentage for a hospital's cost reporting period. These fractions are commonly known as the "SSI fraction" and the "Medicaid fraction," respectively, and are defined as follows:

> (I) The fraction (expressed as a percentage) the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such

> dates) were *entitled* to benefits under part A of this title and were *entitled* to supplemental security income benefits (excluding any State supplementation) under title XVI of this Act, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were *entitled* to benefits under part A of this title,
>
> (II) The fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consists of patients who (for such days) were *eligible* for medical assistance under a State plan approved under title XIX of this chapter, but who were not *entitled* to benefits under part A of this title, and the denominator of which is the total number of the hospital's patient days for such period.

42 U.S.C. §1395ww(d)(5)(F)(vi) (emphasis added).

25. As set forth in the statutory language above, the numerator of the Medicaid fraction consists of days of patients who were both *eligible* for medical assistance under Title XIX, or Medicaid, and not entitled to benefits under Part A of Title XVII, or Medicare. The denominator for the Medicaid fraction is the hospital's total patient days for the period. The statutory language defines the SSI fraction as consisting solely of days for patients who were "*entitled* to benefits under part A" of Medicare. The denominator of the SSI fraction includes all Part A days, and the numerator includes only those Part A days for patients who are also *entitled* to social security income ("SSI") benefits.

26. The Secretary implemented the Medicare DSH provisions through 42 C.F.R. § 412.106. The portion of the regulation which applies to the SSI fraction, prior to the change in language in 2008, states:

(b) *Determination of a hospital's disproportionate patient percentage*-
(1) *General Rule*. A hospital's disproportionate patient percentage is determined by adding the results of two computations and expressing that sum as a percentage.
(2) *First computation*: *Federal fiscal year*. For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS-
(i) Determines the number of **covered** patient days that-
(A) Are associated with discharges occurring during each month; and
(B) Are furnished to patients who during that month were entitled to both Medicare Part A and SSI, excluding those patients who received only State supplementation;
(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 patient days that-
(A) Are associate with discharges that occur during that period; and
(B) Are furnished to patients entitled to Medicare Part A.

(Emphasis added to the word "covered"). The change to the regulation which first appeared in the 2008 regulations, but allegedly effective October 1, 2004, omits the word "covered":

(b) *Determination of a hospital's disproportionate patient percentage*-
(1) *General Rule*. A hospital's disproportionate patient percentage is determined by adding the results of two computations and expressing that sum as a percentage.
(2) *First computation: Federal fiscal year*. For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS-
(i) Determines the number of patient days that-
(A) Are associated with discharges occurring during each month; and
(B) Are furnished to patients who during that month were entitled to both Medicare Part A and SSI, excluding those patients who received only State supplementation;
(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 patient days that-

(A) Are associate with discharges that occur during that period; and
(B) Are furnished to patients entitled to Medicare Part A.

27. While the Secretary attempted to enshrine her policy in regulation by amending 42 C.F.R. § 412.106(b)(2) through rulemaking as described above, she has now acquiesced to the D.C. Circuit's decision in *Allina Health Servs. v. Sebelius*, 746 F.3d 1102, 1111 (D.C. Cir. 2014) ("*Allina*") that her rulemaking process violated the APA. Since all hospitals have recourse to the D.C. Circuit for their Medicare reimbursement appeals, the Secretary conceded that "the 2004 Final Rule has ceased to exist." See Def's Response to the Court's Sept. 29, 2014, Minute Order at 2, *Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75 (D.D.C. 2012), *aff'd in part*, *rev'd in part*, 746 F.3d at 1111 (No. 1:14-cv-01415-RMC), ECF No. 13 ("Because the D.C. Circuit upheld [the vacat[ur] of the 2004 Final Rule] . . ., the 2004 Final Rule has ceased to exist"); see also 42 U.S.C. §1395hh(a)(4) (stating that when a final Medicare rule is not the logical outgrowth of a proposed rule that it "shall be treated as a proposed regulation and shall not take effect until there is the further opportunity for public comment and a publication of the provision again as a final regulation").

That recently invalidated regulation, however, was clearly relied upon in establishing the Hospitals' DSH percentage for the relevant cost reporting periods.

While the Hospitals believe that the reliance on the invalidated regulation was error, it is nonetheless true that the Secretary continues to consider an individual to be "entitled to benefits under Part A," regardless of whether the days were "covered" or not "covered" by Medicare Part A, even in the absence of the invalidated regulation.

In other words, it is the Secretary's policy that non-covered categories of Medicare Part A days — for example, days for which Part A benefits have been exhausted, days for which payment was made under Part C and not Part A, and days for which Medicare Part A was a secondary payor and therefore made no payments, are included in the SSI fraction and, even if Medicaid eligible, excluded from the Medicaid fraction.

28. Despite the Secretary's policy of treating unpaid Part A days as days entitled to benefits under Part A, CMS has at all times required that a beneficiary be paid SSI benefits (or "covered" by SSI) during the period of his or her hospital stay in order for such days to be included in the numerator of the SSI fraction as a day "entitled to supplemental security income benefits." The Secretary, therefore, does not include days in the numerator of the SSI fraction when individuals were eligible for SSI but did not receive SSI payment during their hospitalization for such reasons as failure of the beneficiary to have a valid address, representative payee problems, Medicaid paying for more than 50% of the cost of care in a medical facility, or the

period of hospitalization is during the first month of eligibility before a cash payment is made. This policy ultimately reduces the Secretary's DSH payment obligation, as does the Secretary's wholly inconsistent policy of treating unpaid Part A days as days entitled to benefits under Part A.

29. Of more than one hundred (100+) Social Security Administration payment status codes, the Secretary only uses C01, M01, and M02, to identify SSI entitled individuals. 75 Fed. Reg. 50280-50281 (August 16, 2010).

30. The Secretary is aware of other payment codes, as identified in the August 16, 2010, Federal Register, which could be used to determine the numerator of the 551 fraction but has adopted a policy of including only codes reflecting actual SSI cash payments. *Id*.

31. In sum, the Secretary contends that "the phrase 'entitled to benefits under part A' applies to all individuals who meet the statutory criteria in 42 U.S.C. § 426(a) and (b) for receiving 'hospital insurance benefits under Part A,'" *Northeast Hosp. Corp.*, 657 F.3d at 20 n.1, but does not interpret the analogous phrase "entitled to supplemental security income benefits" as encompassing all individuals who meet the statutory criteria in 42 U.S.C. § 1382(a) for receiving supplemental security income benefits. Because these contradictory interpretations reduce the Secretary's DSH payment obligation, they can only be reconciled with the Secretary's interest in "paying out as little money as possible." *Id*. The Secretary has, therefore,

arbitrarily and capriciously adopted two conflicting interpretations of the same word in the same sentence.

VI. THE HOSPITALS' ADMINISTRATIVE APPEAL

32. Pursuant to the procedures set forth at 42 U.S.C. § 1395oo, the Hospitals have challenged and are dissatisfied with the Secretary's failure to make a the appropriate DSH payment as a result of the Secretary's policy to treat days for which no Part A payments were made as nonetheless "entitled to benefits under part A." The Hospitals timely filed appeals with the PRRB. The Hospitals' appeals satisfied all jurisdictional requirements for an appeal set forth at 42 U.S.C. § 1395oo(a)-(b). The Hospitals' request for appeal before the PRRB specifically challenged the Part A days issue with respect to the DSH Medicare and Medicaid Fractions. Because the Hospitals challenged the DSH adjustment regulation, and as did the plaintiff in *Empire Health Found. v. Price*, 334 F.Supp. 3d 1134 (E.D. Wash. 2018), they filed requests for EJR.

33. Insofar as the regulation in 42 C.F.R. § 405.1801(d)(2) provides that the PRRB need not make a determination as to its authority to decide a question of law or regulations in a request for expedited judicial review within the 30-day statutory time period where the PRRB "is unable to conduct business in the usual manner due to extraordinary circumstances beyond its control," the regulation is inconsistent with the plain language and intent of the statute, which provides no

mechanism for the Board to delay or otherwise decide not to make a determination on whether it has authority to decide a question within the 30-day period for rendering an EJR decision. *See* 42 U.S.C. § 1395oo(f)(1); H.R. Rep. No. 1167, 96th Cong., 2d Sess. 394 (1980), U.S.C.C.A.N. 1980, 5526, 5757 (EJR provision was intended to grant "[M]edicare providers the right to obtain immediate judicial review.").

34. The Hospitals now file this civil action in lieu of the PRRB's rulings on the five (5) requests for EJR (exhibits A, B, C, D and E) with the firm belief that the PRRB had no intention of deciding, and in fact will not decide, the Plaintiffs' EJR requests within thirty days as prescribed by statute, or alternatively, should they so decide, they will as in past cases with identical issues grant EJR.

VII. ASSIGNMENT OF ERRORS

35. The applicable provisions of the APA provide that the "reviewing court shall ... hold unlawful and set aside agency action ... found to be... (A) arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law; ... (C) in excess of statutory jurisdiction, authority, or limitations, or short of statutory right; (D) without observance of procedure required by law; [or] (E) unsupported by substantial evidence[.]" 5 U.S.C. §706(2).

36. The Secretary's determination to treat days for which no Part A payments were made as nonetheless "entitled to benefits under part A" is arbitrary and capricious and otherwise contrary to law because it is:

a) inconsistent with the plain language of the Medicare statute and conflates the statutory term "entitled" with the statutory term "eligible;"

b) inconsistent with the plain language of the controlling pre-2004 regulation, which explicitly included only "covered," i.e., "paid," Part A days and that pre-2004 is controlling since CMS admitted that its attempt to amend that 2004 regulation was procedurally invalid and "ceased to exist";

c) inconsistent with the Secretary's longstanding interpretation of "entitled to benefits under Part A" to mean "entitled to payment under Part A," see 55 Fed. Reg. 35990, 35996 ("entitle[ment] to benefits under part A" ceases when "[e]ntitlement to payment under part A ceases"); and

d) inconsistent with the Secretary's longstanding interpretation of "entitled to supplemental security income benefits" as including only SSI days for which payment was actually made, see, e.g., 75 Fed. Reg. 50042, 50280 (Aug. 16, 2010) (stating that "[e]ntitlement to" receive SSI benefits [requires that an individual] 'be paid benefits by the Commissioner of the Social Security'…)

37. The Secretary's interpretation of "entitled to supplemental security income benefits" under 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I) as including only days for which actual SSI payments were made is arbitrarily and capriciously inconsistent with her policy described above of treating unpaid Part A days as "entitled to benefits under part A" and arbitrarily assigns two different meanings to the same term "entitled."

In addition, because the purpose of the DSH adjustment is to provide additional payment to hospitals that incur higher costs in treating low-income patients, an agency interpretation that does not take into account SSI payment status codes associated with eligible SSI individuals is also unreasonably and impermissibly inconsistent with the legislative history and purpose of the Medicare DSH Statute.

38. For the reasons set forth above, the Secretary's amendment of the regulation, and policy in its application, conflicts with the Medicare DSH Statute and is otherwise arbitrary and capricious, as well as an abuse of discretion.

WHEREFORE the Hospitals request an order:

a) Declaring invalid and enjoining the Secretary from applying her policy that unpaid Medicare Part A days are "days entitled to benefits under part A" for purposes of the DSH SSI and Medicaid fractions or, in the alternative, directing the Secretary to include unpaid SSI eligible patient days

in the numerator of the SSI percentage utilizing SSI payment status codes that reflect the individuals' eligibility for SSI — even if the individuals did not receive SSI payments:

b) Directing the Secretary to calculate the Plaintiff Hospitals' DSH payment consistent with that Order and to make prompt payment of any additional amounts due to the Plaintiff Hospitals plus interest calculated in accordance with 42 U.S.C. § 1395oo(f)(2): and

c) For Plaintiff's costs and reasonable attorney's fees, and for such other and further relief as the Court deems appropriate.

Dated: May 27, 2022

Respectfully submitted,

ALAN J. SEDLEY LAW CORPORATION

By: /s/ Alan J. Sedley

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Exhibit 2

General Docket
United States Court of Appeals for the Ninth Circuit

Court of Appeals Docket #: 18-35845 **Docketed:** 10/12/2018
Nature of Suit: 2899 Other Statutes - APA Review/Appeal
Empire Health Foundation v. Alex Azar, II
Appeal From: U.S. District Court for Eastern Washington, Spokane
Fee Status: USA - No Fee Req

Case Type Information:
1) civil
2) united states
3) null

Originating Court Information:
District: 0980-2 : 2:16-cv-00209-RMP
Court Reporter: Allison Anderson
Court Reporter: Ronelle Faye Corbey
Trial Judge: Rosanna Malouf Peterson, Senior District Judge
Date Filed: 06/09/2016

Date Order/Judgment:	Date Order/Judgment EOD:	Date NOA Filed:	Date Rec'd COA:
08/13/2018	08/13/2018	10/11/2018	10/11/2018

04/28/2021 61 **Supreme Court Case Info**
Case number: 20-1486
Filed on: 04/19/2021
Cert Petition Action 1: Pending
[12089287] [18-35845, 18-35872] (RR) [Entered: 04/28/2021 08:20 AM]

07/02/2021 62 **Supreme Court Case Info**
Case number: 20-1312
Filed on: 03/19/2021
Cert Petition Action 1: Granted, 07/02/2021
[12161813] [18-35845, 18-35872] (RL) [Entered: 07/02/2021 01:24 PM]

07/02/2021 63 **Supreme Court Case Info**
Case number: 20-1486
Filed on: 04/19/2021
Cert Petition Action 1: Denied, 07/02/2021
[12161817] [18-35845, 18-35872] (RL) [Entered: 07/02/2021 01:25 PM]

06/24/2022 64 **Supreme Court Case Info**
Case number: 20-1312
Filed on: 03/19/2021
Cert Petition Action 1: Granted, 07/02/2021
Ruling: Reversed/Remanded, 06/24/2022
[12479318] [18-35845, 18-35872] (RL) [Entered: 06/24/2022 12:18 PM]

07/19/2022 65 Filed (ECF) Appellee Empire Health Foundation in 18-35845, Appellant Empire Health Foundation in 18-35872 Motion for miscellaneous relief [for consideration of argument in the alternative], Motion to file supplemental brief. Date of service: 07/19/2022. [12497826] [18-35845, 18-35872] (Hettich, Daniel) [Entered: 07/19/2022 07:11 PM]

07/26/2022 66 **Supreme Court Case Info**
Case number: 20-1312
Filed on: 03/19/2021
Cert Petition Action 1: Granted, 07/02/2021
Ruling: Reversed/Remanded, 06/24/2022
to remand case to 9th Circuit [12502261] [18-35845, 18-35872] (RL) [Entered: 07/26/2022 10:14 AM]

07/29/2022 67 Filed (ECF) Appellant Alex M. Azar, II in 18-35845, Appellee Alex M. Azar, II in 18-35872 Motion for miscellaneous relief [motion to affirm district court's dismissal of plaintiff's alternative claim following Supreme Court judgment and remand] and Response to motion ([65] Motion (ECF Filing), [65] Motion (ECF Filing), [65] Motion (ECF Filing)). Date of service: 07/29/2022. [12505107] [18-35845, 18-35872] (Marcus, Stephanie) [Entered: 07/29/2022 12:18 PM]

08/05/2022 68 Filed (ECF) Appellant Alex M. Azar, II and Appellee Empire Health Foundation in 18-35845, Appellee Alex M. Azar, II and Appellant Empire Health Foundation in 18-35872 reply to response (). Date of service: 08/05/2022. [12510765] [18-35845, 18-35872] (Hettich, Daniel) [Entered: 08/05/2022 03:13 PM]

08/08/2022 69 Filed (ECF) Appellee Empire Health Foundation in 18-35845, Appellant Empire Health Foundation in 18-35872 response to motion ([67] Motion and Response to Motion (ECF Filing), [67] Motion and Response to Motion (ECF Filing) motion for miscellaneous relief (to be used only if no other relief applies)). Date of service: 08/08/2022. [12512591] [18-35845, 18-35872] (Hettich, Daniel) [Entered: 08/08/2022 07:30 PM]

08/15/2022 70 Filed (ECF) Appellant Alex M. Azar, II in 18-35845, Appellee Alex M. Azar, II in 18-35872 reply to response (). Date of service: 08/15/2022. [12516888] [18-35845, 18-35872] (Marcus, Stephanie) [Entered: 08/15/2022 11:38 AM]

ATTACHMENT B

Board Closure Letter Dated Sept. 29, 2023 Closing Case No. 15-0560GC (60 pages with Appendices A to C)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

Scott Berends, Esq.
Federal Specialized Services
1701 South Racine Ave.
Chicago, IL 60608

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.
>
> ****
>
> (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.
>
> ****
>
> 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
7500 Security Blvd.
Mail Stop: B1-01-31
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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:

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

For the Board:

6/10/2022

X Clayton J. Nix

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

Enclosures: List of Groups

cc: Bill Tisdale, Novitas Solutions
Judith Cummings, CGS
Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators
Danielle Decker, NGS
Pamela VanArsdale, NGS
Cecile Huggins, Palmetto GBA
Byron Lamprecht, WPS
Wilson Leong, FSS
Jacqueline Vaughn, OAA

[94] 73 Fed. Reg. at 30225.
[95] *See supra* note 92.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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410-786-2671

Via Electronic Delivery

Ednaida Engle
Advantage Health Systems-Riverside
4100 Latham St. Suite E
Riverside, CA 92501

RE: ***Notice of Dismissal***
Advantage Health Systems-Riverside (Provider Number A0-1600)
FFY: 2021
Case Number: 21-0667

Dear Ms. Engle:

The Provider Reimbursement Review Board ("Board" or "PRRB") received Advantage Health Systems-Riverside's ("Provider") Individual Appeal Request in Case No. 21-0667 on February 2, 2021. On February 7, 2023, the Board issued a Notice of Hearing to the parties scheduling the hearing in Case No. 21-0667 for October 19, 2023.

The Provider failed to appear at its October 19, 2023 hearing for this case.

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

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

(1) Dismiss the appeal with prejudice;

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

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

The Provider failed to appear at the hearing and the Provider has not shown good cause beyond its control as to why this case should not be dismissed. Accordingly, the Board hereby dismisses Case No. 21-0667 with prejudice.

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.

For the Board:

10/27/2023

X Kevin D. Smith, CPA

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

Board Members:

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

cc: Edward Lau, Federal Specialized Services
Wilson C. Leong, Esq. Federal Specialized Services
Pamela VanArsdale, National Government Services, Inc.