DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
7500 Security Boulevard
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Via Electronic Delivery

Randall Gienko,
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Pamela VanArsdale, Appeals Lead
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RE: ***Board Determination on Single Provider CIRP Group***
Mercyhealth CY's 2015 & 2016 Unmatched Medicaid Days CIRP Group
Case No. 20-1732GC (Mercy Health System Corp, Prov. No. 52-0066, as a participant)

Dear Mr. Gienko and Ms. VanArsdale:

The Provider Reimbursement Review Board (the "Board") has reviewed the subject common issue related party ("CIRP") group appeal which was filed by Strategic Reimbursement Group, LLC ("Strategic" or "Representative"). The CIRP group, filed under the Mercyhealth parent organization, includes a single Provider appealing two calendar years ("CY's"). The pertinent facts related to the group case and the Board's determination are set forth below.

Pertinent Facts:

On June 24, 2020, SRG filed the Mercyhealth Unmatched Medicaid Days CIRP Group for CY 2015. On the same date, SRG transferred Mercy Health System Corp (Prov. No. 52-0066) for FYE 06/30/2015 to the group from its individual appeal under Case No. 20-0278.[1]

On July 17, 2020, SRG requested the transfer of the same Provider, from its calendar year ("CY") 6/30/**2016** individual appeal under Case No. 20-0472 ***to*** the CY **2015** group under Case No. 20-1732GC. Because the Transfer Request was for a *different* year than that pending in the group, the Board issued a Request for Information ("RFI") on March 17, 2021advising the Parties of its intent to expand the CY 2015 CIRP group to include CY 2016 in order to allow the transfers, and requesting the Parties' comments.

On March 24, 2021, the Medicare Contractor responded to the Board's RFI indicating that, since there was only one Provider in the group for two CYs, the issue should instead be transferred to

[1] The same provider was used to form three other groups for the SSI Calculation and the SSI & Medicaid Part C issues under Case Nos. 20-1729GC, 20-1730GC and 20-1731GC, respectively. Case No. 20-1731GC was consolidated into the SSI Part C group under Case 20-1730GC on July13, 2021. Ultimately on December 16, 2021, the Board expanded the CY 2017 CIRP groups under Case Nos. 21-1345GC and 21-1443GC to include CYs 2015 and 2016 for the SSI Calculation Error and SSI/Medicaid Part C Days issues in order to consolidate Case No.20-1729GC and 20-1730GC, which were then closed.

an optional group. The Representative did ***not*** submit a response to the Board's RFI, nor did it comment on the Medicare Contractor's response.

On July 13, 2021, even though the Representative had not responded, the Board proceeded with its intended action to expand the CY 2015 CIRP group to include CY 2016, since it is the Board's preference to keep CIRP providers together. However, in its June 13, 2021 determination, the Board requested that SRG provide the status of the group *within 15 days*. The Board counseled that if SRG determined the group was fully formed as it was currently structured, it would fail to meet the minimum number of Providers required pursuant to 42 C.F.R. § 405.1837. In that case, the Board advised that the CIRP group would have to be disbanded and the issue would have to be transferred back to the two individual appeals (Case No. 20-0278 for CY 2015 and Case No. 20-0472 for CY 2016) which would have to be reinstated.

The following day, on July 14, 2021, SRG responded to the Board's request for status, indicating that the CIRP group was complete. SRG's response failed to address the minimum Provider issue raised in the Board's July 13, 2021 determination.[2]

On September 15, 2021, the Board issued another RFI requesting further certifications with regard to various group issues for the Mercyhealth chain. Specifically, with regard to the Unmatched Medicaid Days issue, the Board asked whether SRG would be pursuing a group for CY 2017 (because of Rockford Memorial Hospital's CY 2017 individual appeal of the same issue) or whether the Unmatched Medicaid Days issue in Case No. 20-1732GC should be transferred back to the individual appeals for Mercy Health Corp for CYs 2015 & 2016.[3]

On September 24, 2021, SRG responded to the RFI, indicating it would not be pursuing a group for the Unmatched Medicaid Days for CY 2017 because Rockford Memorial Hospital was working with the Medicare Contractor to administratively resolve the issue thru a reopening, and that it was planning to resolve the issue in a similar manner for Mercy Health Corp.

Therefore, *as a courtesy*, the Board allowed the group case to remain pending with a single Provider to allow progress on the alleged administrative resolution. However, *after more than **seven months** had passed without updates from either Party in this case*, the Board ordered by letter issued on May 13, 2022 that SRG provide the status of the settlement of the issue ***within 15 days*** for both the group case and the related provider appeal under Case No. 21-0220. The Board's notification stated that, if there was no progress on the administrative resolution, the status response was to address whether SRG intended to pursue a CY 2015-2017 CIRP group or whether Case No. 20-1732GC would be disbanded and reinstatement of the individual appeals for CYs 2015 and 2016 (Case Nos. 20-0278 & 20-0472) would be requested for the sole purpose

[2] The Board had previously determined that there were no companion groups for earlier or later years, although the Board did locate a case for a related provider, Rockford Memorial Hospital for CY 6/30/2017 under Case No. 21-0220 – in which it appealed the Unmatched Medicaid Days issue. The Unmatched Medicaid Days issue is the only remaining issue in Case No. 21-0220.

[3] A request to transfer the Unmatched Medicaid Days issue for Rockford Memorial from Case No. 21-0220 would require a further expansion of Case No. 20-1732GC to include CY 2017.

of pursuing the Unmatched Medicaid Days issue. The Board's RFI specified that the deadlines were exempt from the Alert 19 suspension of Board-set deadlines and that failure to respond would result in the Board taking remedial action (*e.g.*, dismissal or ruling without the benefit of that Party's input). To date, the Providers' representative has not replied to the status request for the group case.[4]

Board Determination:

Pursuant to 42 C.F.R. § 405.1837(b), a group appeal is required to have two or more providers. Further, Board Rule 12.6.1 stipulates that **a "CIRP group may be initiated by a single provider under common ownership or control, but at least two different providers must be in the group upon full formation**."[5] (Emphasis added.)

More than three months have passed since the Board's latest status request (now more than 10 months since the last status report was filed in this case). Although the Board attempted to present multiple alternatives and provided SRG multiple opportunities to bring the subject group into conformance with the regulations and Board Rules, Case No. 20-1732GC remains pending as a single Provider group in violation of Board Rules and regulations. Because SRG has failed to provide the necessary information requested in the Board's May 13, 2022 RFI, and the group fails to meet the stator requirements, the Board hereby dismisses Case No. 20-1732GC pursuant to its authority under 42 C.F.R. § 405.1868(a)-(b) and for failing to meet the CIRP requirements in 42 C.F.R. § 405.1837(b)(1).

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

For the Board:

9/2/2022

X Clayton J. Nix

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

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

[4] The Board also requested "comments" from the Medicare Contractor but none were been filed in this case. The Medicare Contractor in the related individual appeal, Case No. 21-0220, did file comments in response to the Board's correspondence, indicating that a notice of reopening was issued on July 1, 2021 for the Provider in that case and that, after multiple information exchanges, it was hopeful a settlement would be reached within 180 days (which would be in November 2022) for that Provider.
[5] Board Rules (effective Aug. 29, 2018, revised Nov. 1, 2021).

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Byron Lamprecht
WPS Gov. Health Adm'rs
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Omaha, NE 68164

RE: ***Jurisdictional Determination***
Franciscan St. Margaret Health – Hammond
FYE 12/31/2014
Case No. 17-2210

Dear Ms. Yang and Mr. Lamprecht,

The Provider Reimbursement Review Board (the "Board") has reviewed jurisdiction in response to the Medicare Contractor's jurisdictional challenge in the above-referenced appeal. The Board's jurisdictional decision is set forth below.

Background

The Board received the Provider's Appeal Request dated September 8, 2017, related to a NPR dated March 13, 2017.[1] The Provider's Appeal Request contained the following issue statement:

> *1. Removal of Charity Care Charges*
>
> *The Provider appeals whether the Medicare Administrative Contractor (MAC) was correct in removing the charity care charges on W/S S-10. During the fiscal 2014 audit, the MAC made the determination to remove the charity care charges based on lack of documentation related to patient income, expenses and assets (Exhibit A).*
>
> *The MAC cited the reference of CMS PUB 15-II Section 4012 which has to deal with the completion of W/S S-10 based on cost report instructions and not a regulation based on charity care determination. The estimated impact is $34,981, based on the attached schedule (Exhibit B).*[2]

On April 9, 2018, the MAC filed a formal Jurisdictional Challenge. The Provider filed ***no*** response.

Medicare Contractor's Jurisdictional Challenge

The MAC argues that EHR/HIT incentive payment computations are not appealable.[3] Section 1886(n) of the Social Security Act provides for incentives for adoption and meaningful use of certified EHR

[1] Providers Request for Appeal (Sept. 8, 2017).
[2] *Id*.
[3] MAC's Jurisdictional Challenge, at 2-3 (Apr. 9, 2018).

technology and bars administrative or judicial review under sections 1869 or 1878.[4] The regulations at 42 C.F.R. § 495.110(b) also precludes administrative and judicial review under sections 1869 or 1878 of the Act, or otherwise, of the methodology and standards for determining the incentive payment amounts made to eligible hospitals, including the estimates or proxies for determining discharges, inpatient-bed-days, hospital charges, charity charges, and Medicare share; and the period used to determine such estimate or proxy.[5]

The MAC goes on to contend:

> Inasmuch as the Provider's claimed charity care is a proxy used in the computations of the provider's EHR/HIT incentive payment, it is clear, the Provider does not have appeal rights before the PRRB, with respect to the MAC's and/or CMS's treatment of charity care charges. The Centers for Medicare & Medicaid Services (CMS) has notified providers (eligible professionals, hospitals, and critical access hospitals) of their limited appeal rights. It is clear, appeal options are not available, with respect to payment adjustments.[6]

Board Decision:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2008), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

The Board finds that it does not have jurisdiction over the Charity Care EHR payment issue in the above-referenced appeal because jurisdiction is precluded by Section 1886(n) of the Social Security Act and 42 C.F.R. § 495.110(b).

Section 1886(n) of the Act provides for incentives for adoption and meaningful use of certified EHR technology. Section 1886(n)(4)(A) states the following:

> **(4)Application.—**
>
> (A)Limitations On Review.— There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, of-
>
> (i) the methodology and standards for determining payment amounts under this subsection and payment adjustments under subsection (b)(3)(B)(ix), including selection of periods under paragraph (2) for

[4] *Id*. at 2.
[5] *Id*. at 3.
[6] *Id*.

> determining, and making estimates or using proxies of, discharges under paragraph (2)(C) and inpatient-bed days, hospital charges, charity charges, and Medicare share under paragraph (2)(D);
>
> (ii) the methodology and standards for determining a meaningful EHR user under paragraph (3), including selection of measures under paragraph (3)(B), specification of the means of demonstrating meaningful EHR use under paragraph (3)(C), and the hardship exception under subsection (b)(3)(B)(ix)(II); and
>
> (iii) the specification of EHR reporting periods under paragraph (6)(B) and the selection of the form of payment under paragraph (2)(F).

The regulations at 42 C.F.R. § 495.110(b) also precludes administrative and judicial review under sections 1869 or 1878 of the Act, or otherwise, of the following:

> (b) *For eligible hospitals*.–The methodology and standards for determining the incentive payment amounts made to eligible hospitals, including –
>
> (i) The estimates or proxies for determining discharges, inpatient-bed-days, hospital charges, charity care charges, and Medicare share; and
>
> (ii) The period used to determine such estimate or proxy.

Based on the above, the Board concludes that it does not have jurisdiction over the Charity Care EHR issue in the above referenced appeal because judicial and administrative review of the calculation is barred by statute and regulation. In making this ruling, the Board notes that the Provider failed to respond to the MAC's April 9, 2018 jurisdictional challenge, requesting dismissal for this very reason. In this regard, the Board further notes that Board Rule 44.4 (July 2015) specifies that "The responding party must file a response within 30 days of the Intermediary's jurisdictional challenge" and that "[f]ailure to respond will result in the Board making a jurisdictional determination with the information contained in the record." Since the Provider failed to respond within 30 days (and, to date, still has not responded),[7] the Board must presume that the Provider does *not* contest the Medicare Contractor's challenge. Therefore, based on the record before it and for the reasons stated above, the Board hereby dismisses the issue.

Finally, as the instant case has no further issues, the Board closes Case No. 17-2210 and removes it from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

[7] The Board notes that the Board Alert 19 suspension of Board set deadlines is not applicable here as it only applied to deadlines occurring on or after Friday, March 13, 2020.

Board Members Participating:

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

FOR THE BOARD:

9/2/2022

X Clayton J. Nix

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RE: ***Jurisdictional Determination***
Queen of the Valley Medical Center (Prov. No. 05-0009)
FYE 06/30/2017
Case No. 22-0915

Dear Ms. Giberti and Ms. Frewert,

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

Background

On March 16, 2021, the Provider's representative, Toyon Associates, Inc. ("Toyon"), submitted a request for reopening to the Medicare Contractor to "request[] a recalculation of [the Provider's] SSI ratio based on its cost reporting period rather than the federal fiscal year" and, in this request, Toyon stated that "[w] e calculate the realigned SSI ratio to be 7.69%."

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

On August 19, 2021, the Medicare Contractor completed this reopening by issuing the Notice of Amount of Corrected Reimbursement ("revised NPR") and the SSI percentage was increased from 7.22 to 7.69 (*consistent with Toyon's expectation stated in the March 16, 2021 Reopening Request*).[3]

[1] Medicare Contractor's Notice of Reopening of Cost Report.
[2] *Id.*
[3] Provider's Request for Individual Appeal, at 2

On February 9, 2022, Toyon filed the instant individual appeal on behalf of the Provider to appeal the revised NPR.[4] The Board assigned this appeal Case No. 22-0915 and it includes the following two (2) issues:

> Issue 1 -- DSH Accuracy of CMS Developed SSI Ratio
> Issue 2 -- DSH Inclusion of Medicare Part C Days in the SSI Ratio[5]

For both issues, the Provider referenced Audit Adjustment #4 from the revised NPR. Adjustment #4 was issued "[t]o proper [*sic*] calculate operating and capital DSH adjustment payment.."[6] As a result, the SSI percentage was increased from 7.22 to 7.69 (*consistent with Toyon's expectation stated in the March 16, 2021 Reopening Request*).

Board Determination

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2019), a provider has a right to a hearing before the Board with respect to specific items claimed on a timely filed cost report if: (1) it is dissatisfied with the final determination of the Medicare contractor; (2) the amount in controversy is $10,000 or more (or $50,000 for a group); and (3) the request for a hearing is filed within 180 days of the date of receipt of the final determination.

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

The Code of Federal Regulations provides for an opportunity for a reopening and RNPR at 42 C.F.R. § 405.1885 (2018), which provides in relevant part:

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

Additionally, 42 C.F.R. § 405.1889 (2018)[7] explains the effect of a cost report revision:

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[4] *Id.,* at 1.
[5] *Id.*, at 3.
[6] Audit Adjustment Report (emphasis added).
[7] *See also St. Mary's of Mich. V. Azar*, No. 18-01790, 2020 WL 4049912 (D.D.C. July 20, 2020); *McLaren Flint v. Azar*, No. 18-2005, 2020 WL 2838566 (D.D.C. May 31, 2020)*, Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F.Supp.3d 348 (D.D.C. 2014); *HCA Health Servs. of OK v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994).

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

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

When a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[8] The reopening in this case was a result of the Provider's request to realign its SSI percentage from the federal fiscal year end to its individual cost reporting fiscal year end. Based on the Notice of Reopening, the RNPR under appeal clearly only revised the SSI percentage in order to realign it from a federal fiscal year to the provider's respective fiscal year. The Board has consistently found that it does not have jurisdiction over revised NPRs that were issued as a result of a provider's request for realignment of its SSI percentage.

As noted in 42 C.F.R. § 412.106(b)(2), CMS gathers data to be used in the SSI fraction on a month-by-month basis:

> (2) *First computation: Federal fiscal year*. **For each month** of the Federal fiscal year in which the hospital's cost reporting period begins, CMS -
>
> (i) Determines the number of patient days that -
>
> (A) Are associated with discharges occurring **during each month**; and

[8] 42 C.F.R. § 405.1889(b)(1).

> (B) Are furnished to patients who **during that month** were entitled to both Medicare Part A (including Medicare Advantage (Part C)) and SSI, excluding those patients who received only State supplementation;
>
> (ii) Adds the results for the whole period; and
>
> (iii) Divides the number determined under paragraph (b)(2)(ii) of this section by the total number of days that -
>
> (A) Are associated with discharges that occur during that period; and
>
> (B) Are furnished to patients entitled to Medicare Part A (including Medicare Advantage (Part C)).[9]

The data matching process by which CMS gathers this *monthly* data is described in the FY 2011 IPPS Final Rule.[10] As described in the Federal Register, under the realignment process, CMS calculates the SSI fraction using the *previously-gathered* data for the months included in the published SSI fractions for 2 Federal fiscal years that encompass the hospital's cost reporting period:

1. *75 Fed. Reg. 50042, 50279 (Aug. 16, 2010)*.—"[W]e publish these [SSI fraction] data for every hospital based on the Federal fiscal year but, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived *from the data match process* ***for the two Federal fiscal years that spanned the hospital's cost reporting period***."[11]

2. *70 Fed. Reg. 47278, 47439 (Aug. 12, 2005)*.—"Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once 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. . . .*

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

> Beginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108–173), we will arrange to furnish, consistent with the Privacy Act, MedPAR LDS data for a hospital's patients eligible for both SSI and Medicare at the hospital's request, regardless of whether there is a properly pending appeal relating to DSH payments. *We will make the information available for either the Federal fiscal year or, if the hospital's fiscal year differs from the Federal fiscal year, for the* ***months included in the 2 Federal fiscal years that encompass the hospital's cost reporting period***. Under this provision, *the hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year*. The data set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year."[12]

Accordingly, the realignment process does not change any of the data underlying the realigned SSI fraction (*e.g*., Part C days or Part A days) because that data had been ***previously*** gathered on a month-by-month basis and *there is no need for CMS to rerun the data matching process* in order to effectuate a realignment (*i.e*., realigning the SSI fraction from the federal fiscal year to the provider's fiscal year). Indeed, as noted in the second Federal Register excerpt, CMS' stated realignment policy is that the provider "must accept" the realigned SSI percentage.

In other words, the determination was only being reopened to include realigned SSI percentages. Since the only matters specifically revised in the revised NPR was the adjustment to realign the SSI percentage from the federal fiscal year to the provider's fiscal year, the Board does not have jurisdiction over either Issue 1 (the DSH Accuracy of CMS Developed SSI Ratio) or Issue 2 (the DSH Inclusion of Medicare Part C Days in the SSI Ratio issue) in the individual appeal.[13] In making this ruling, the Board notes that its application of 42 C.F.R. § 405.1889(b) has been upheld by courts on review.[14]

In conclusion, the Board ***dismisses*** the two issues appealed from the revised NPR in Case No. 22-0915 because, pursuant to 42 C.F.R. § 405.1889(b), the Provider does not have the right to appeal the revised NPR at issue for these issues. As there are no remaining issues in the individual appeal, the Board hereby closes Case No. 22-0915 and removes it from the Board's docket.

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[12] (Emphasis added.)
[13] The Board notes that the Provider could have appealed these issues from its *original* NPR but appears to have forewent that opportunity.
[14] *See St. Mary's of Mich. V. Azar*, No. 18-01790, 2020 WL 4049912 (D.D.C. July 20, 2020); *McLaren Flint v. Azar*, No. 18-2005, 2020 WL 2838566 (D.D.C. May 31, 2020)*, Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F.Supp.3d 348 (D.D.C. 2014); *HCA Health Servs. of OK v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994).

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

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

9/2/2022

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

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RE: ***Dismissal of Duplicate Appeal***

16-2483GC Bon Secours 2014 DSH Medicaid Fraction Part C Days (Pre-10/1/2013) CIRP Group

Dear Mr. Hettich and Ms. Johnson,

The above-referenced group appeal includes a challenge to the inclusion of Medicare Part C days in the Medicare fraction of the disproportionate share ("DSH") percentage and/or the exclusion of Medicare Part C days for patients who are dually eligible for Medicaid from the Medicaid fraction of the DSH percentage, for patient discharges before October 1, 2013. This issue is governed by Centers for Medicare & Medicaid Services ("CMS") Ruling CMS-1739-R and, under the terms of this Ruling, the Provider Reimbursement Review Board (the "Board") must review the jurisdictional documentation to determine if the group issue should be remanded to the Medicare Contractor for calculation of the DSH payment adjustment in accordance with the forthcoming final rule CMS will issue "to govern the treatment of [Medicare Part C] patient days with discharge dates before October 1, 2013." See also 58 Fed. Reg. 47723 (Aug. 6, 2020).

Based on this Ruling, the Board has reviewed the jurisdictional documentation in Case No. 16-2483GC. The background of the case and the Board's determination are set forth below.

Background:

On September 12, 2016, the Board received the Group Representative's Group Appeal Request Form, which originally had two group participants. Additional Providers have since been added to the group appeal; there are currently six participants in the group.

At the same time, the Group Representative also established an SSI Fraction Part C Days group under Case No. 16-2484GC, for the same chain and fiscal year end. That group, the Bon Secours 2014 DSH SSI Fraction Part C Days (Pre – 10/1/2013) CIRP Group, was previously remanded by the Board under CMS Ruling 1739-R on November 25, 2020 (and re-issued with a revised schedule of providers on February 19, 2021). Case No. 16-2484GC included seven participants at the time it was remanded, including the six participants in the instant appeal.

Board Determination:

Having reviewed the pertinent facts in each group, the Board finds that the 1739-R remand for the SSI Fraction Part C Days group issued under Case No. 16-2484C, which the Board granted on November 25, 2020 (and reissued on February 29, 2021), clearly encompassed the complete Part C DSH issue, i.e., both the Medicare and Medicaid fraction for the providers in Case No. 16-2483GC. Per the holdings in *Allina Health Servs. v. Sebelius* (746 F.3d 1102, 1108 (D.C. Cir. 2014)) ("*Allina*"), Part C days must be included in either the SSI fraction or Medicaid fraction. Thus, the disposition of the SSI Fraction Medicare Part C Days issue dictates the disposition of the Medicaid Fraction Medicare Part C Days issue, as *Allina* indicates Part C days must be counted in one fraction or the other.

As such, the Board finds that the Medicaid Fraction Medicare Part C Days CIRP group, currently under appeal in Case No. 16-2483GC, is duplicative of the issue that was previously handled through the remand of the DSH SSI Fraction Part C Days Group under Case No. 16-2484GC. Therefore, the Board hereby dismisses the Bon Secours 2014 DSH Medicaid Fraction Part C Days (Pre-10/1/2013) CIRP Group, Case No. 16-2483GC, and removes it from the docket.

Board Members Participating:

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

For the Board:

9/16/2022

X Kevin D. Smith, CPA

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

cc: Wilson C. Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Jurisdictional Challenge***
Covenant Medical Center (Prov. No. 16-0067)
FYE: 06/30/2015
PRRB Case: 17-2023

Dear Mr. Ravindran,

The Provider Reimbursement Review Board ("Board") has reviewed the documents in the above referenced appeal and dismisses the Disproportionate Share Hospital ("DSH") Payment / Supplemental Security Income ("SSI") Percentage - Provider Specific issue for the reasons set forth below.

Pertinent Facts

On February 13, 2017, the Provider was issued a final Notice of Program Reimbursement ("NPR") for fiscal year end June 30, 2014.

On August 4, 2017, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained seven (7) issues:

1. DSH Payment/SSI Percentage – Provider Specific
2. DSH/SSI Percentage – Systemic Errors[1]
3. DSH Payment - SSI Fraction/Medicare Managed Care Part C Days[2]
4. DSH Payment - SSI Fraction/Dual Eligible Days[3]
5. DSH Payment – Medicaid Eligible Days[4]
6. DSH Payment – Medicaid Fraction/Medicare Managed Care Part C Days[5]
7. DSH Payment – Medicaid Fraction/Dual Eligible Days[6]

[1] On July 20, 2018, this issue was transferred to PRRB Case No. 18-1409G.
[2] On July 20, 2018, this issue was transferred to PRRB Case No. 18-1410G.
[3] On July 20, 2018, this issue was transferred to PRRB Case No. 18-1408G.
[4] Issue withdrawn by the Provider on June 7, 2018.
[5] On July 20, 2018, this issue was transferred to PRRB Case No. 18-1411G.
[6] On July 20, 2018, this issue was transferred to PRRB Case No. 18-1405G.

The only remaining issue is the DSH Payment/SSI Percentage – Provider Specific issue.

In their Individual Appeal Request, Provider summarizes its DSH/SSI – Provider Specific issue as follows:

> The Provider contends that its SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> . . .
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[7]

The Provider described its DSH/SSI – Systemic Errors issue, which has been transferred to a group appeal, as whether the Medicare/SSI Fraction used to calculate their DSH payment accurately and correctly counted the number of patient days to be included therein. More specifically, Provider lists the following reasons for challenging its SSI percentage:

1. Availability of MEDPAR and SSA records,
2. Paid days vs Eligible days,
3. Not in agreement with provider's records,
4. Fundamentals problems in the SSI percentage calculation,
5. Covered days vs Total days, and
6. Failure to adhere to required notice and comment rulemaking procedures.[8]

MAC's Jurisdictional Challenge

The Board received a Jurisdictional Challenge filed on behalf of the Medicare Administrative Contractor ("MAC") on April 10, 2018, which argued that the Board lacks jurisdiction over the DSH/SSI Percentage - Provider Specific issue because it is duplicative of the issue which was transferred to case 18-1409G.[9] The MAC cites prior Board decisions that these issues are considered the same issues.[10]

The MAC also argues that the Board should dismiss the portion of the Provider Specific issue pertaining to realignment because: (1) the decision to realign a hospital's SSI

[7] Issue Statement at 1. (Aug. 4, 2017).
[8] *Id.* at 2.
[9] Jurisdictional Challenge at 2. (Apr. 10, 2018).
[10] *Id*.

percentage with its fiscal year end is a hospital election; and (2) appealing this issue is premature since the Provider did not request an SSI realignment and, as such, there was no final determination to appeal.[11]

Provider's Jurisdictional Response

The Board received a Jurisdictional Response filed on behalf of the Provider on April 30, 2018, which argued that the Board has jurisdiction over the DSH/SSI issues which includes both the "provider specific" and realignment sub-issues.[12] The Provider stated that it is "not only addressing a realignment of the SSI percentage, but also addressing the various errors of omission and commission that do not fit into the 'systemic errors' category."[13] They go on to argue that the two appeal issues "represent different aspects/components of the SSI issue."[14]

Board Decision

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

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

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH SSI Percentage - Systemic Error issue that was transferred to PRRB Case No. 18-1409G.

The DSH/SSI Percentage - Provider Specific issue in the present appeal concerns "whether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation."[15] The Provider's legal basis for its DSH/SSI - Provider Specific issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[16] The Provider argues that "its SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . specifically

[11] *Id* at 3.
[12] Provider's Jurisdictional Response at 1 (Apr. 30, 2018).
[13] *Id*. at 2.
[14] *Id.* at 1.
[15] Issue Statement at 1.
[16] *Id.*

disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[17]

The Provider's DSH SSI Percentage - Systemic Errors issue in group Case No. 18-1409G also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F) and 42 C.F.R. § 412.106. Thus, the Board finds that the DSH SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH SSI Percentage - Systemic Errors issue in Case No. 18-1409G. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.5[18], the Board dismisses this aspect of the DSH/SSI Percentage - Provider Specific issue.

In making this finding, the Board further notes that CMS regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, is pursuing that issue as part of the group under Case 18-1409G. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[19] The Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 18-1409G.

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

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

As this was the only remaining issue in the appeal, the Board closes the case and removes it from the Board's docket.

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

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[17] *Id.*
[18] PRRB Rules v. 1.3 (July 2015).
[19] The types of systemic errors documented in the *Baystate* did not uniformly impact the SSI calculation for all providers but that does not may the errors any less systemic. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). *See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C.

Board Members Participating:

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

For the Board:

9/16/2022

X Kevin D. Smith, CPA

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

James Ravindran
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RE: ***Jurisdictional Decision***
Hospital San Lucas II (40-0044)
FYE 12/31/2011
PRRB Case No. 15-1832

Dear Mr. Ravindran,

The Provider Reimbursement Review Board ("Board") has reviewed the jurisdictional documents in the above referenced appeal and finds that it does not have jurisdiction over the DSH/SSI – Provider Specific issue because it is the same as the DSH/SSI - Systemic Errors issue that was transferred to PRRB Case No. 15-3037G. The jurisdictional decision of the Board is set forth below.

Pertinent Facts:

On March 16, 2015, the Provider appealed an original Notice of Program Reimbursement ("NPR") dated September 17, 2014 for its fiscal year end ("FYE") December 31, 2011 cost reporting period. The initial individual appeal request contained the following seven (7) issues:

1) DSH Payment/SSI Percentage (Provider Specific)
2) DSH/ SSI Percentage (Systemic Errors)
3) DSH – SSI Fraction/Medicare Managed Care Part C Days
4) DSH – SSI Fraction/Dual Eligible Days
5) DSH – Medicaid Eligible Days
6) DSH – Medicaid Fraction/Medicare Managed Care Part C Days
7) DSH – Medicaid Fraction/Dual Eligible Days

After multiple case transfers, only Issues 1 and 5 remained in Case No. 15-1832. In the Provider's Final Position Paper filed on August 30, 2022, Issue 5 was withdrawn. Relevant here, the Medicare Administrative Contractor ("MAC") filed a jurisdictional challenge on June 6, 2018 regarding Issue 1.

Medicare Contractor's Contentions:

The MAC first acknowledges that there was an audit adjustment in the original NPR related to the SSI percentage and corresponding DSH calculation. However, based on the Provider's preliminary position paper, the MAC argues it is unclear what the Provider is challenging, and quotes the Provider's argument as follows:

> . . . the Provider has been unable to analyze the Medicare Part A data because it has not yet received the Medicare Part A or Medicare Provider Analysis and Review ('MEDPAR'), HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000, from CMS. *See* 65 Fed. Reg. 50,548 (2000). Upon release of the complete MEDPAR data, the Provider will seek to reconcile its records with that of CMS, and identify patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS based on the Federal Fiscal Year End (September 30) when it determined the Provider's SSI. *See Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) ["*Baystate*"].[1]

The MAC argues that the Provider has not presented valid arguments in contesting the SSI percentage. Further, the MAC contacted CMS and CMS indicated they had not received any requests for MedPAR data from the Provider for the fiscal year in question, and therefore, the Provider has evidently not analyzed the data that is supposedly in question. For this reason, the MAC argues that the Provider has not actually identified the source of its complaint with the SSI percentage and the Board should deny jurisdiction.[2]

The MAC also argues that the Board lacks jurisdiction over the DSH/SSI Percentage - Provider Specific issue because it is duplicative of the SSI percentage issue which was transferred to a group appeal on October 12, 2015 (to Case No. 15-3037G).[3] The MAC explains that in Issue 2, the Provider contends that the Secretary improperly calculated its SSI percentage. The Provider is making the same argument, as the MAC is required to use the SSI ratio provided by CMS. Essentially, the Provider contends that the SSI ratio applied to its cost report was incorrect. In both Issues 1 and 2, the SSI ratio is the underlying dispute and under Board rules, the Provider is barred from filing a duplicate issue. The MAC cites prior Board decisions finding that these issues are considered the same issue.[4]

Provider's Response:

On July 2, 2018, the Board received a Jurisdictional Response filed on behalf of the Provider, which argued that the Board has jurisdiction over the Issue 1, the DSH/SSI issues, which includes both the "provider specific" and realignment sub-issues.[5] The Provider explains that Issues 1 and 2 represent different components of the SSI issue. Specifically, the SSI systemic issue (Issue 2) addresses various errors discussed in *Baystate* in CMS' calculation of the disproportionate payment percentage, which resulted in the MedPAR not reflecting all individuals who are eligible for SSI, and lists those errors, for example, such as not accounting for retroactive SSI eligibility determinations by the Social Security Administration ("SSA"), and omitting days of individuals who were eligible for SSI at the time of their stay due to their records being considered inactive by SSA due to their death following their stay. The Provider asserts that these systemic errors are the result of CMS' improper policies and data matching process, and this issue also covers CMS Ruling 1498-R.

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[1] Jurisdictional Challenge at 3 (June 6, 2018).
[2] *Id.*
[3] *Id.* at 4.
[4] *Id*.
[5] Provider's Jurisdictional Response at 1-2 (July 2, 2018).

With regard to the SSI Provider Specific issue (Issue 1), the Provider asserts that this issue is not addressing the errors which result from CMS' data matching process but instead is addressing the various errors of omission and commission that do not fit into the "systematic errors" category. The Provider argues that it has reason to believe that the SSI percentage determined by CMS is incorrect due to the understated days in the SSI ratio, referring to *Baystate,* where this same issue was considered independent of the systemic errors. The Provider indicates it has analyzed Medicare Part A records and has been able to identify patients believed to be entitled to both Medicare Part A and SSI. The Provider has reason to believe that the SSI percentage determined by CMS is incorrect due to the understated days in the SSI ratio.[6]

Board Analysis and Decision:

The Board finds that it does not have jurisdiction over Issue 1, the DSH/SSI Percentage (Provider Specific) issue.

SSI Provider Specific

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2011), 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.

In Issue 1, the Provider disagrees with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage. In its jurisdictional analysis, the Board has found that the Provider's disagreement with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage is duplicative of the DSH SSI Percentage (Systemic Errors) issue transferred to Group Case No. 15-3037G, "*QRS 2011 DSH SSI Percentage Group 2*."[7]

The DSH SSI Percentage (Provider Specific) issue in the present appeal is as follows:

> …the MAC did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. §1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations.[8]

The Provider contends that its SSI percentage published by the Centers for Medicare and Medicaid Services ("CMS") was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.[9]

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[6] *Id.* at 2.
[7] *See* Request to Transfer Issue, Model Form D (Nov. 4, 2015), PRRB Case No. 15-3037G.
[8] Provider's Request for Hearing, at Issue Statement, Issue 1.
[9] *Id*.

In Issue 2, the Provider asserts that:

> The Provider further contends that the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") and used by the Lead MAC to settle their Cost Report does not address all the deficiencies as described in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37, 44 (D.D.C. 2008) and incorporates a new methodology inconsistent with the Medicare statute.
>
> The Providers challenge their SSI percentages based on the following reasons:
>
> 1. Availability of MEDPAR and SSA Records,
> 2. Paid days vs. eligible days,
> 3. Not in agreement with provider's records,
> 4. Fundamental problems in the SSI percentage calculation,
> 5. Covered days vs. Total days and
> 6. Failure to adhere to required notice and comment rulemaking procedures.[10]

The Board finds that Issue 1 (the DSH/SSI (Provider Specific) issue) in this appeal is duplicative of Issue 2 (the DSH/SSI (Systemic Errors) issue) that was transferred to Case No. 15-3037G. Issue 1 in the present appeal concerns "whether the Medicare Administrative Contractor used the correct [SSI] percentage in the [DSH] Calculation."[11] The Provider's legal basis for this aspect of Issue 1 is simply that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[12] The Provider disagrees specifically "with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[13] Issue 2, transferred to the group under Case No. 15-3037G, similarly alleges that the Medicare Contractor and CMS improperly calculated the DSH/SSI Percentage, the DSH/SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F)(i). Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (Mar. 1, 2013), the Board hereby dismisses the DSH/SSI (Provider Specific) issue (Issue 1).

In making this finding, the Board further notes that CMS regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, the Provider is pursuing that issue as part of the group under Case 15-3037G. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[14] The Provider's reliance upon referring to Issue 1 as

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

"Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any specific examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 15-3037G.

To this end, the Board also reviewed the Provider's Final Position Paper (FPP) to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from Issue 2. Accordingly, the Board finds that the Provider's FPP failed to comply with the Board Rule 25.1 governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions."[15] Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" in its FPP and include *all* exhibits. The Provider stated in its FPP that it was "unable to analyze the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000 from CMS. . . . and [u]pon release of the complete MEDPAR data, the Provider will seek to reconcile its' records with that of CMS, and identify patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS."[16] The Provider filed its FPP on August 30, 2022 in direct violation of Board Rule 25.2.2:

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

Further, while the Provider indicates in its Response to the MAC's Jurisdictional Challenge that Issue 1 includes the realignment sub-issue, namely that the Provider preserves its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period, the Provider's FPP does not mention this sub-issue. Nonetheless, the Board finds that, under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." Without this written request, the Medicare Contractor cannot issue a final determination from which the Provider can be dissatisfied with for appealing purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding DSH SSI Percentage realignment. Therefore, the Board lacks jurisdiction over this aspect of Issue 1 as well.

In sum, the Board finds that Issue 1 and Issue 2, which was transferred to Group Case 15-3037G, are the same issue. Because Issue 1 is duplicative of Issue 2, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (2012), the Board dismisses the DSH/SSI (Provider

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[15] (Emphasis added.) *See also* Rule 27.1

[16] Provider's FPP, at 7-8. We further note that in its Final Position Paper, the MAC indicates that it sought to determine if the Provider had requested MedPAR data for analysis, and CMS indicated that the data was requested and received by the Provider in May 2019. The MAC argues that it is unclear why the Provider states in its Final Position Paper that it is seeking that data that has already been provided.

Specific) issue. To the extent that this appeal also involves the realignment sub-issue, the Board dismisses that aspect of Issue 1 as premature. Accordingly, the Board dismisses Issue 1 in its entirety.

As there are no issues remaining in Case No. 15-1832, the Board hereby closes it and removes this case from the Board's docket.

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

Board Members:

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

For the Board:

9/19/2022

X Kevin D. Smith, CPA

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

cc: Wilson C. Leong, Esq., Federal Specialized Services
Geoff Pike, First Coast Service Options, Inc.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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RE: ***Jurisdictional Decision***
Hospital Episcopal San Lucas II (40-0044)
FYE 12/31/2012
PRRB Case No. 15-2158

Dear Mr. Ravindran,

The Provider Reimbursement Review Board ("Board") has reviewed the jurisdictional documents in the above referenced appeal and finds that it does not have jurisdiction over the DSH/SSI – Provider Specific issue because it is the same as the DSH/SSI - Systemic Errors issue that was transferred to PRRB Case No. 15-1416G. The jurisdictional decision of the Board is set forth below.

Pertinent Facts:

On April 8, 2015, the Provider appealed an original Notice of Program Reimbursement ("NPR") dated October 10, 2014 for its fiscal year end ("FYE") December 31, 2012 cost reporting period. The initial individual appeal request contained the following eight (8) issues:

1) DSH Payment/SSI Percentage (Provider Specific)
2) DSH/ SSI Percentage (Systemic Errors)
3) DSH – SSI Fraction/Medicare Managed Care Part C Days
4) DSH – SSI Fraction/Dual Eligible Days
5) DSH – Medicaid Eligible Days
6) DSH – Medicaid Fraction/Medicare Managed Care Part C Days
7) DSH – Medicaid Fraction/Dual Eligible Days
8) Outlier Payments-Fixed Loss Threshold

After multiple case transfers, only Issues 1 and 5 remained in Case No. 15-2158. In the Provider's Final Position Paper filed on August 30, 2022, Issue 5 was withdrawn. Relevant here, the Medicare Administrative Contractor ("MAC") filed a jurisdictional challenge on June 6, 2018 regarding Issue 1.

Medicare Contractor's Contentions:

The MAC first acknowledges that there was an audit adjustment in the original NPR related to the SSI percentage and corresponding DSH calculation. However, based on the Provider's preliminary position paper, the MAC argues it is unclear what the Provider is challenging, and quotes the Provider's argument as follows:

> . . . the Provider has been unable to analyze the Medicare Part A data because it has not yet received the Medicare Part A or Medicare Provider Analysis and Review ('MEDPAR'), HHS/HCFA/OJS, 09-07-009, which was published in the Federal Register on August 18, 2000, from CMS. *See* 65 Fed. Reg. 50,548 (2000). Upon release of the complete MEDPAR data, the Provider will seek to reconcile its records with that of CMS, and identify patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS based on the Federal Fiscal Year End (September 30) when it determined the Provider's SSI. *See Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) ["*Baystate*"].[1]

The MAC argues that the Provider has not presented valid arguments in contesting the SSI percentage. Further, the MAC contacted CMS and CMS indicated they had not received any requests for MedPAR data from the Provider for the fiscal year in question, and therefore, the Provider has evidently not analyzed the data that is supposedly in question. For this reason, the MAC argues that the Provider has not actually identified the source of its complaint with the SSI percentage and the Board should deny jurisdiction.[2]

The MAC also argues that the Board lacks jurisdiction over the DSH/SSI Percentage - Provider Specific issue because it is duplicative of the SSI percentage issue which was transferred to a group appeal on October 12, 2015 (to Case No. 15-1416G).[3] In Issue 2, the Provider contends that the Secretary improperly calculated its SSI percentage. The Provider is making the same argument, as the MAC is required to use the SSI ratio provided by CMS. Essentially, the Provider contends that the SSI ratio applied to its cost report was incorrect. In both Issues 1 and 2, the SSI ratio is the underlying dispute and under Board rules, the Provider is barred from filing a duplicate issue. The MAC cites prior Board decisions finding that these issues are considered the same issue.[4]

Provider's Response:

On July 2, 2018, the Board received a Jurisdictional Response filed on behalf of the Provider, which argued that the Board has jurisdiction over the issue 1, the DSH/SSI issues, which includes both the "provider specific" and realignment sub-issues.[5] The Provider explains that Issues 1 and 2 represent different components of the SSI issue. Specifically, the SSI systemic issue (Issue 2) addresses various errors discussed in *Baystate* in CMS' calculation of the disproportionate payment percentage, which resulted in the MedPAR not reflecting all individuals who are eligible for SSI, and lists those errors, for example, as not accounting for retroactive SSI eligibility determinations by the Social Security Administration ("SSA"), and omitting days of individuals who were eligible for SSI at the time of their stay due to their records being considered inactive by SSA due to their death following their stay. The

[1] Jurisdictional Challenge at 3 (June 6, 2018).
[2] *Id.*
[3] *Id.* at 4.
[4] *Id*.
[5] Provider's Jurisdictional Response at 1-2 (July 2, 2018).

Provider asserts that these systemic errors are the result of CMS' improper policies and data matching process, and this issue also covers CMS Ruling 1498-R.

With regard to the SSI Provider Specific issue (Issue 1), the Provider asserts that this issue is not addressing the errors which result from CMS' data matching process but instead is addressing the various errors of omission and commission that do not fit into the "systematic errors" category. The Provider argues that it has reason to believe that the SSI percentage determined by CMS is incorrect due to the understated days in the SSI ratio, referring to *Baystate,* where this same issue was considered independent of the systemic errors. "Once these patients are identified, the Provider contends that it will be entitled to a correction of these errors of omission to its SSI percentage."[6]

Board Analysis and Decision:

The Board finds that it does not have jurisdiction over Issue 1, the DSH/SSI Percentage (Provider Specific) issue.

SSI Provider Specific

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2011), 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.

In Issue 1, the Provider disagrees with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage. In its jurisdictional analysis, the Board has found that the Provider's disagreement with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage is duplicative of the DSH SSI Percentage (Systemic Errors) issue transferred to Group Case No. 15-1416G, "*QRS 2012 DSH SSI Percentage Group*."[7]

The DSH SSI Percentage (Provider Specific) issue in the present appeal is as follows:

> …the MAC did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. §1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations.[8]

The Provider contends that its SSI percentage published by the Centers for Medicare and Medicaid Services ("CMS") was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.[9]

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[6] *Id.* at 2.
[7] *See* Request to Transfer Issue, Model Form D (Oct. 12, 2015), PRRB Case No. 15-2158.
[8] Provider's Request for Hearing, at Issue Statement, Issue 1.
[9] *Id*.

In Issue 2, the Provider asserts that:

> The Provider further contends that the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") and used by the Lead MAC to settle their Cost Report does not address all the deficiencies as described in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37, 44 (D.D.C. 2008) and incorporates a new methodology inconsistent with the Medicare statute.
>
> The Providers challenge their SSI percentages based on the following reasons:
>
> 1. Availability of MEDPAR and SSA Records,
> 2. Paid days vs. eligible days,
> 3. Not in agreement with provider's records,
> 4. Fundamental problems in the SSI percentage calculation,
> 5. Covered days vs. Total days and
> 6. Failure to adhere to required notice and comment rulemaking procedures.[10]

The Board finds that Issue 1 (the DSH/SSI (Provider Specific) issue) in this appeal is duplicative of Issue 2 (the DSH/SSI (Systemic Errors) issue) that was transferred to Case No. 15-1416G. Issue 1 in the present appeal concerns "whether the Medicare Administrative Contractor used the correct [SSI] percentage in the [DSH] Calculation."[11] The Provider's legal basis for this aspect of Issue 1 is simply that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[12] The Provider disagrees specifically "with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[13] Issue 2, transferred to the group under Case No. 15-1416G, similarly alleges that the Medicare Contractor and CMS improperly calculated the DSH/SSI Percentage, the DSH/SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F)(i). Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (Mar. 1, 2013), the Board hereby dismisses the DSH/SSI (Provider Specific) issue (Issue 1).

In making this finding, the Board further notes that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, the Provider is pursuing that issue as part of the group under Case 15-1416G. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[14] The Provider's reliance upon referring to

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

Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any specific examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 15-1416G.

To this end, the Board also reviewed the Provider's Final Position Paper (FPP) to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from Issue 2. Accordingly, the Board finds that the Provider's FPP failed to comply with the Board Rule 25.1 governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions."[15] Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of any alleged "errors" in its FPP and include *all* exhibits. The Provider stated in its FPP that it was "unable to analyze the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000 from CMS. . . . and [u]pon release of the complete MEDPAR data, the Provider will seek to reconcile its' records with that of CMS, and identify patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS."[16] The Provider filed its FPP on August 30, 2022 in direct violation of Board Rule 25.2.2:

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

Further, while the Provider indicates in its Response to the MAC's Jurisdictional Challenge that Issue 1 includes the realignment sub-issue, namely the Provider is preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period, the Provider's FPP does not mention this sub-issue. Nonetheless, the Board finds that, under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." Without this written request, the Medicare Contractor cannot issue a final determination from which the Provider can be dissatisfied with for appealing purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding DSH SSI Percentage realignment. Therefore, the Board lacks jurisdiction over this aspect of Issue 1 as well.

In sum, the Board finds that Issue 1 and Issue 2, which was transferred to Group Case 15-1416G, are the same issue. Because Issue 1 is duplicative of Issue 2, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (2012), the Board dismisses the DSH/SSI (Provider

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[15] (Emphasis added.) *See also* Rule 27.1

[16] Provider's FPP, at 7-8. We further note that in its Final Position Paper, the MAC indicates that it sought to determine if the Provider had requested MedPAR data for analysis, and CMS indicated that the data was requested and received by the Provider in May 2019. The MAC argues that it is unclear why the Provider states in its Final Position Paper that it is seeking that data that has already been provided.

Specific) issue. To the extent that this appeal also involves the realignment sub-issue, the Board dismisses that aspect of Issue 1 as premature. Accordingly, the Board dismisses Issue 1 in its entirety.

As there are no issues remaining in Case No. 15-2158, the Board hereby closes the case and removes it from the Board's docket.

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

Board Members:

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

For the Board:

9/19/2022

X Kevin D. Smith, CPA

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

cc: Wilson C. Leong, Esq., Federal Specialized Services
Geoff Pike, First Coast Service Options, Inc.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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

RE: ***Jurisdictional Decision***
Auxilio Mutuo Hospital (40-0016)
FYE 09/30/2011
PRRB Case No. 15-2461

Dear Mr. Ravindran,

The Provider Reimbursement Review Board ("Board") has reviewed the jurisdictional documents in the above referenced appeal and finds that it does not have jurisdiction over the DSH/SSI – Provider Specific issue because it is the same as the DSH/SSI - Systemic Errors issue that was transferred to PRRB Case No. 15-3037G. The jurisdictional decision of the Board is set forth below.

Pertinent Facts:

On April 27, 2015, the Provider appealed an original Notice of Program Reimbursement ("NPR") dated October 28, 2014 for its fiscal year end ("FYE") September 30, 2011 cost reporting period. The initial individual appeal request contained the following eight (8) issues:

1) DSH Payment/SSI Percentage (Provider Specific)
2) DSH/ SSI Percentage (Systemic Errors)
3) DSH – SSI Fraction/Medicare Managed Care Part C Days
4) DSH – SSI Fraction/Dual Eligible Days
5) DSH – Medicaid Eligible Days
6) DSH – Medicaid Fraction/Medicare Managed Care Part C Days
7) DSH – Medicaid Fraction/Dual Eligible Days
8) Outlier Payments-Fixed Loss Threshold

After multiple case transfers, only Issues 1 and 5 remained in Case No. 15-2461. In the Provider's Final Position Paper filed on August 30, 2022, Issue 5 was withdrawn. Relevant here, the Medicare Administrative Contractor ("MAC") filed a jurisdictional challenge on June 5, 2018 regarding Issue 1.

Medicare Contractor's Contentions:

The MAC first acknowledges that there was an audit adjustment in the original NPR related to the SSI percentage. However, based on the Provider's preliminary position paper, the MAC argues it is unclear what the Provider is challenging, and quotes the Provider's argument as follows:

> The Provider is seeking the Medicare Part A data because it has not yet received the Medicare Part A or Medicare Provider Analysis and Review ('MEDPAR') database, HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000, from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. *See* 65 Fed. Reg. 50,548 (2000). The Provider believes that upon completion of this review it will be entitled to correction of these errors of omission to its SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) ["*Baystate*"] that errors occurred that did not account for all patient days in the Medicare fraction.[1]

The MAC argues that the Provider has not presented valid arguments in contesting the SSI percentage. Further, the MAC contacted CMS and CMS indicated they had not received any requests for MedPAR data from the Provider for the fiscal year in question, and therefore, the Provider has evidently not analyzed the data that is supposedly in question. For this reason, the MAC argues that the Provider has not actually identified the source of its complaint with the SSI percentage and the Board should deny jurisdiction.[2]

The MAC also argues that the Board lacks jurisdiction over the DSH/SSI Percentage - Provider Specific issue because it is duplicative of the SSI percentage issue which was transferred to a group appeal on November 16, 2015 (to Case No. 15-3037G).[3] In issue 2, the Provider contends that the Secretary improperly calculated its SSI percentage. The Provider is making the same argument, as the MAC is required to use the SSI ratio provided by CMS. Essentially, the Provider contends that the SSI ratio applied to its cost report was incorrect. In both issues 1 and 2, the SSI ratio is the underlying dispute and under Board rules, the Provider is barred from filing a duplicate issue. The MAC cites prior Board decisions finding that these issues are considered the same issue.[4]

Provider's Response:

On July 2, 2018, the Board received a Jurisdictional Response filed on behalf of the Provider, which argued that the Board has jurisdiction over the issue 1, the DSH/SSI issues, which includes both the "provider specific" and realignment sub-issues.[5] The Provider explains that issues 1 and 2 represent different components of the SSI issue. Specifically, the SSI systemic issue (issue 2) addresses various errors discussed in *Baystate* in CMS' calculation of the disproportionate payment percentage, which resulted in the MedPAR not reflecting all individuals who are eligible for SSI, and lists those errors, for example, as not accounting for retroactive SSI eligibility determinations by the Social Security Administration ("SSA"), and omitting days of individuals who were eligible for SSI at the time of their stay due to their records being considered inactive by SSA due to their death following their stay. The

[1] Jurisdictional Challenge at 3 (June 5, 2018).
[2] *Id.*
[3] *Id.* at 4.
[4] *Id*.
[5] Provider's Jurisdictional Response at 1-2 (July 2, 2018).

Provider asserts that these systemic errors are the result of CMS' improper policies and data matching process, and this issue also covers CMS Ruling 1498-R.[6]

With regard to the SSI Provider Specific issue (Issue 1), the Provider asserts that this issue is not addressing the errors which result from CMS' data matching process but instead is addressing the various errors of omission and commission that do not fit into the "systematic errors" category. The Provider argues that it has reason to believe that the SSI percentage determined by CMS is incorrect due to the understated days in the SSI ratio, referring to *Baystate,* where this same issue was considered independent of the systemic errors. The Provider indicates that it has analyzed Medicare Part A records and has been able to identify patients believed to be entitled to both Medicare Part A and SSI, and it has reason to believe the SSI percentage determined by CMS is incorrect due to the understated days in the SSI ratio.[7]

Board Analysis and Decision:

The Board finds that it does not have jurisdiction over Issue 1, the DSH/SSI Percentage (Provider Specific) issue.

SSI Provider Specific

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2011), 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.

In Issue 1, the Provider disagrees with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage. In its jurisdictional analysis, the Board has found that the Provider disagreement with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage is duplicative of the DSH SSI Percentage (Systemic Errors) issue transferred to Group Case No. 15-3037G, "*QRS 2011 DSH SSI Percentage Group 2*."[8]

The DSH SSI Percentage (Provider Specific) issue in the present appeal is as follows:

> …the MAC did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. §1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations.[9]

The Provider contends that its SSI percentage published by the Centers for Medicare and Medicaid Services ("CMS") was incorrectly computed because CMS failed to include all

[6] *Id.* at 1-2.
[7] *Id.* at 2.
[8] *See* Request to Transfer Issue, Model Form D (Nov. 4, 2015), PRRB Case No. 15-3037G.
[9] Provider's Request for Hearing, at Issue Statement, Issue 1.

patients that were entitled to SSI benefits in their calculation.[10]

In Issue 2, the Provider asserts that:

> The Provider further contends that the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") and used by the Lead MAC to settle their Cost Report does not address all the deficiencies as described in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37, 44 (D.D.C. 2008) and incorporates a new methodology inconsistent with the Medicare statute.
>
> The Providers challenge their SSI percentages based on the following reasons:
>
> 1. Availability of MEDPAR and SSA Records,
> 2. Paid days vs. eligible days,
> 3. Not in agreement with provider's records,
> 4. Fundamental problems in the SSI percentage calculation,
> 5. Covered days vs. Total days and
> 6. Failure to adhere to required notice and comment rulemaking procedures.[11]

The Board finds that Issue 1 (the DSH/SSI (Provider Specific) issue) in this appeal is duplicative of Issue 2 (the DSH/SSI (Systemic Errors) issue) that was transferred to Case No. 15-3037G. Issue 1 in the present appeal concerns "whether the Medicare Administrative Contractor used the correct [SSI] percentage in the [DSH] Calculation."[12] The Provider's legal basis for this aspect of Issue 1 is simply that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[13] The Provider disagrees specifically "with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[14] Issue 2, transferred to the group under Case No. 15-3037G, similarly alleges that the Medicare Contractor and CMS improperly calculated the DSH/SSI Percentage, the DSH/SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F)(i). Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (Mar. 1, 2013), the Board hereby dismisses the DSH/SSI (Provider Specific) issue (Issue 1).

In making this finding, the Board further notes that CMS regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, the Provider is pursuing that issue as part of the group under Case 15-3037G. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact

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[10] *Id*.
[11] *Id*. Issue 2.
[12] Individual Appeal Request, Issue 1.
[13] *Id.*
[14] *Id.*

the SSI percentage for each provider differently.[15] The Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any specific examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 15-3037G.

To this end, the Board also reviewed the Provider's Final Position Paper (FPP) to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from Issue 2. Accordingly, the Board finds that the Provider's FPP failed to comply with the Board Rule 25.1 governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions."[16] Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" in its FPP and include *all* exhibits. The Provider stated in its FPP that it was "seeking the *Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database*, HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000, from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage."[17] The Provider filed its FPP on August 30, 2022 in direct violation of Board Rule 25.2.2:

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

Further, while the Provider indicates in its Response to the MAC's Jurisdictional Challenge that Issue 1 includes the realignment sub-issue, namely that the Provider preserves its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period, the Provider's FPP does not mention this sub-issue. Nonetheless, the Board finds that, under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." Without this written request, the Medicare Contractor cannot issue a final determination from which the Provider can be dissatisfied with for appealing purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding DSH SSI Percentage realignment. Accordingly, the Board lacks jurisdiction over this aspect of Issue 1 as well.[18]

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[15] The types of systemic errors documented in *Baystate* did not uniformly impact the SSI calculation for all providers but that does not make the errors any less systemic. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). *See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).

[16] (Emphasis added.) *See also* Rule 27.1

[17] FPP, at 8 (emphasis added.) We further note that in its Final Position Paper, the MAC indicates that it sought to determine if the Provider had requested MedPAR data for analysis, and CMS indicated that the data was requested and received by the Provider in May 2019. The MAC argues that it is unclear why the Provider states in its Final Position Paper that it is seeking that data that has already been provided.

[18] Further, the Board notes that since the Provider's cost reporting year end (FYE 9/30) is the same as the federal fiscal year end (9/30), a realignment of the SSI percentage data would have no effect on the SSI, as the same data would be used and the same monthly periods.

In sum, the Board finds that Issue 1 and Issue 2, which was transferred to Group Case 15-3037G, are the same issue. Because Issue 1 is duplicative of Issue 2, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (2012), the Board dismisses the DSH/SSI (Provider Specific) issue. To the extent that this appeal also involves the realignment sub-issue, the Board dismisses that aspect of Issue 1 as premature. Accordingly, the Board dismisses Issue 1 in its entirety.

As there are no issues remaining in Case No. 15-2461, the Board hereby closes the case and removes it from the Board's docket.

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

Board Members:

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

For the Board:

9/19/2022

X Kevin D. Smith, CPA

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

cc: Wilson C. Leong, Esq., Federal Specialized Services
Geoff Pike, First Coast Service Options, Inc.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Corinna Goron
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RE: ***Closure of Group Appeals Pursuant to 42 C.F.R. § 405.1842(h)(3)(iii)***
Case Nos. 13-3115GC, *et. al* (*see* attached listing marked as Appendix A)
Case Nos. 14-0416G, *et. al* (*see* attached listing marked as Appendix B)
Case Nos. 15-0007GC, *et. al* (*see* attached listing marked as Appendix C)

Dear Mr. Berends and Ms. Goron:

As the parties are aware, Healthcare Reimbursement Services ("HRS"), the Providers' designated representative, filed the following 3 separate consolidated requests for expedited judicial review ("EJR") identified as "Groupings" A, B, and C and involving, in the aggregate, 120 group cases and 569 participants:

Date of EJR Request	Lead Case	Groups	Participants in Aggregate	*Hereinafter Referred To As*
Dec. 29, 2021	Case No. 13-3115GC	63 (*see* Appendix A)	255	"Grouping A"
Jan. 17, 2022	Case No. 14-0416G	40 (*see* Appendix B)	200	"Grouping B"
Feb. 27, 2022	Case No. 15-0007GC	17 (*see* Appendix C)	114	"Grouping C"

The Medicare Contractors' representative, Federal Specialized Services ("FSS"), requested an extension of time to review the cases covered by Groupings A, B and C on January 6, 2022, January 27, 2022 and March 4, 2022 respectively due to the sheer size of each grouping, the number of Medicare contractors involved with each grouping, and already pending[1] or planned[2]

[1] FSS' Response to the consolidated request for EJR for Grouping A identified the jurisdictional challenges ("JCs") as being pending and unresolved in the following group cases:
- Case No. 15-3345G (JC filed May 14, 2018 challenging Provider No. 12-0001 on the grounds that the individual appeal request was untimely; and
- Case No. 15-3346G (JC filed May 14, 2018 challenging Provider No. 12-0001 on the grounds that the individual appeal request was untimely.

[2] For Grouping B, FSS' response to the consolidated request asserted that JCs or substantive claim challenges were going to be filed in the following group cases:
- A JC in Case No. 14-1522GC as two providers (Prov. Nos. 05-0739 and 41-0011) are appealing from revised NPRs that do not pertain to the appeal issue in this case;
- A JC in Case No. 14-1523GC as there was no adjustment to the Medicaid fraction in the revised NPRs and several providers (Prov Nos 31-0006 and 31-0096) are not proper participants in the group;
- A JC in Case No. 14-2930GC as there was no adjustment to the Medicaid fraction for Provider No. 39-0016;

jurisdictional challenges in certain cases. In Grouping A, HRS filed its opposition to FSS' extension request alleging that the Medicare Contractors have had enough time to review the relevant jurisdictional documents for Grouping A because "the MAC has had most of these documents for months and in some cases years." HRS did not oppose the FSS extension requests made in Groupings B and C.

On January 18, 2022, January 28, 2022 and March 16, 2022 for Groupings A, B, and C respectively, the Board issued a Notice of Stay and Scheduling Order ("Scheduling Order") taking the following actions for each group:

1. Granting FSS' extension in light of the number of cases involved in the EJR request, the number of participants within those cases, and the number of MACs involved in those cases and the fact that the final SOP for the majority (if not virtually all) of these cases was filed *within 60 days* of HRS' EJR request[3];

2. Issuing a Scheduling Order to manage the jurisdictional review process for the cases within the relevant grouping and assigning ongoing tasks to *both* parties; and

3. Issuing notice to the parties of 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*. As a result, the Board and the Medicare Contractors continued to take actions consistent with that Scheduling Order.

On May 6, 2022, the Board received a request from OAA that asked for a copy of the administrative record as HRS had filed suit in federal district court on these 120 group cases. A review of public records confirmed that, on March 30, 2022, without notice to the Board or the opposing parties in these cases, HRS bypassed the ongoing jurisdictional review process by joining an already-pending lawsuit in the U.S. District Court for the Central District of California ("California Central District Court") under Case No. 22-cv-00989 seeking judicial review on the merits of its consolidated EJR request in these 120 group cases encompassed by Groupings A, B, and C. Significantly, this

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- A substantive claim challenge (*see infra* note 4) in Case No. 20-1801GC and 20-1803GC as Prov. No. 12-0028 did not include the group issue in its protested items on the as filed cost report at issue.

Similarly, for Grouping C, FSS' response to the consolidated request asserted that JCs or substantive claim challenges were going to be filed in the following group cases:

- A JC in Case No. 15-2680GC as Prov. No. 05-0518 appealed an issue beyond the adjustments in the revised NPR at issue and Prov. Nos. 05-0588 and 05-0709 are duplicates since these Providers appealed from a failure to issue a timely determination and then appealed from the NPR; and
- A JC in Case No. 15-2681GC as Prov. Nos. 05-0588 and 05-0709 are duplicates since these Providers appealed from a failure to issue a timely determination and then appealed from the NPR.

[3] For Grouping A, the Board noted that HRS generally filed SOPs with supporting documentation several days prior to or concurrent with the EJR request. It is not readily apparent to what extent those SOP documents differ from the earlier versions previously filed with the Board. Indeed, in some cases there had been subsequent withdrawals and transfers. Given that there are 63 cases in Grouping A and the fact that an SoP can be quite lengthy (*e.g.*, the SoP for Case No. 14-1059 for just 3 participants is 175 pages long), it would have been an intolerable burden to resolve those issues across the 63 cases in the Grouping while also conducting a thoughtful review of those SoP documents in the Grouping.

litigation was established by another representative, Quality Reimbursement Services ("QRS") on February 14, 2022 under similar circumstances relating to an EJR request for the same issue for 80 group cases covering 950+ participants. As the Board took actions similar to those being taken here and the litigation is intertwined, the Board has attached as **Appendix D** a copy of the closure letter issued in the 80 QRS group cases.

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

1. Closes these 120 cases (to the extent they are not already closed[4]) consistent with 42 C.F.R. § 405.1842(h)(3)(iii); and
2. Suspends completion of:

   - The ongoing jurisdictional review process;

   - The ongoing substantive claim review process under 42 C.F.R. § 405.1873(b) which was triggered by "Substantive Claim Challenges"[5] filed in Case Nos. 20-1801GC and 20-1803GC and, as a result, must issue findings pursuant to § 405.1873(d)(2) on these particular participants' compliance with the "appropriate cost report claim" requirements in § 413.24(j), if the Board were to find jurisdiction and issue an EJR decision;[6] and

   - Defers action on the 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.[7]

Procedural Background

The Scheduling Order issued in Groupings A, B, and C 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.[8] 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

[4] There are a number of cases that were closed either prior to the relevant consolidated EJR request being filed or afterwards. The Board has noted in Appendices A, B and C which cases are already closed as well as when and why that closure occurred.

[5] As explained in Board Rule 44.5, "the Board adoption of the term 'Substantive Claim Challenge' simply refers to any question raised by a party concerning whether the cost report at issue included an appropriate claim for one or more of the specific items being appealed in order to receive or potentially qualify for reimbursement for those specific items" ***as required*** *by 42 C.F.R. § 413.24(j)*.

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

[7] 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,

[8] 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.

status.[9] 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 decision. 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. The notice for Grouping B[10] was as follows:

> 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)**. Based on the foregoing, 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.[11]

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, for Groupings A and B, 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.[12] 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:

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[9] *See also infra* note 62.

[10] The Scheduling Order for all three Groupings was virtually identical to this example.

[11] Grouping B Board Ruling on FSS' Extension Request Relating to HRS' Request for EJR Request in 40 Groups at 1-2 (Jan. 28, 2022) (footnote omitted and bold and underline emphasis added.)

[12] Specifically, for Groupings A and B, 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***." Grouping A Board letter (Jan. 18, 2022) (emphasis added); Grouping B Board letter (Jan. 28, 2022).

> 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).[13]

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, while HRS timely filed an objection to FSS' request for extension in Grouping A, HRS did not file any objection to FSS' extension requests in Groupings B and C, even though it had the benefit of the Board's rationale to grant FSS' request in Grouping A. Nor did HRS file any objection to the Scheduling Order issued for Groupings A, B, and C. HRS was simply silent.

On March 14, 2022, FSS complied with the Board's Scheduling Order and filed jurisdictional challenges in distinct group cases. These challenges were different from, and in addition to, pending, unresolved, jurisdictional challenges that FSS noted in its response (as well as others not noted).[14]

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 120 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

[13] (Emphasis in original.)
[14] *See supra* notes 1-3.

> 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.[15]

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

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

[15] (Emphasis added).

> (b) *General*—(1) *Prerequisite of Board jurisdiction*. The Board (or the Administrator) **must find that the Board has jurisdiction over the specific matter at issue before the Board may determine its authority to decide the legal question**.
>
> (2) *Initiating EJR procedures*. A provider or group of providers may request the Board to grant EJR of a specific matter or matters under appeal . . . . Under paragraphs (d) and (e) of this section, **a provider may request** a determination of the Board's authority to decide a legal question, but **the 30-day period for the Board to make a determination under section 1878(f)(1) of the Act** [*i.e.*, 42 U.S.C. § 1395oo(f)(1)] **does not begin to run until the Board finds jurisdiction to conduct a hearing on the specific matter at issue in the EJR request and notifies the provider that the provider's request is complete**.[16]

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."[17] 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.[18]

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

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[16] (Emphasis added).

[17] 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)).

[18] (Emphasis added.)

participate) 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). . . .***"[19] 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."[20] The Court in *Alexandria* continued, stating:

> Nor will the hospitals be heard to argue that the filing of an EJR request requires the PRRB to determine its jurisdiction over an appeal *and* respond to the EJR request within 30 days. Such an argument confuses what are in reality two separate analyses: jurisdiction and EJR. *The jurisdictional analysis determines whether the PRRB may consider a provider's appeal*. The EJR inquiry, on the other hand, determines whether a party properly before the PRRB raises issues which must be resolved before a court rather than the Board. *The language of the statute supports this distinction*. EJR requests relate to the authority of the PRRB to decide questions of law, not whether an appeal is properly before them. While Congress has clearly imposed a 30-day limit on the PRRB's evaluation of EJR requests, no such limits have been placed on the PRRB's evaluation of its jurisdiction. . . .
>
> The court is also unconvinced that Congress meant to require evaluation of EJR requests within a 30-day time frame when the PRRB has not made a jurisdictional determination. It makes no sense to require the PRRB to evaluate an EJR request they might never reach if the appeal is not properly before the Board. *Thus, the hospitals' argument that the PRRB absolutely must make an EJR determination within 30 days of document receipt is* ***without merit***.[21]

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,

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[19] 42 U.S.C. § 1395oo(f)(1) (emphasis added).
[20] *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).
[21] *Alexandria Hosp. v. Bowen*, 631 F. Supp. at 1244.

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.[22] 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 120 group cases, with over 569 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[23] 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 120 group cases.

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

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

In compliance with the Board's Scheduling Order in Groupings A, B, and C, the Medicare Contractors began submitting Jurisdictional Challenges in their respective cases. These challenges, as well as separate challenges or jurisdictional issues 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. 14-1522GC, 14-1523GC, 14-0366G, 14-0416G, 14-1768GC, and 19-2067.

- Jurisdictional challenges claiming that Case Nos. 16-1317GC and 16-1318GC are not valid because each group failed to meet the minimum $50,000 amount in controversy as documented in the SoP and supporting documents filed for these groups.

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[22] It is hard to see federal courts deciding jurisdictional issues, including determining whether a case or provider: (a) has been previously withdrawn or dismissed without being reinstated; (b) is pursuing a prohibited duplicate appeal of the same issue for the same year; or (c) has complied with the mandatory CIRP group rules.

[23] 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."

- Jurisdictional issues noted in Case Nos. 15-3345G, 15-3346G, and 19-2067G regarding certain participants that failed to *timely* file their individual appeal request or direct add to the group within the 180-day period required under 42 C.F.R. § 405.1835(a)(3).[24]

- Jurisdictional challenges filed in Case Nos. 14-2930, 15-2656G and 15-2657G 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 jurisdictional challenge filed in Case No. 15-2189GC alleges that HRS failed to provide records in the final SoP to establish that one participant was timely, and properly added to the group and, thus, that provider should be dismissed.

- A substantive claim challenge[25] was filed on June 1, 2022 for Case Nos. 20-1801GC and 20-1803GC 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). On July 5, 2022, HRS responded by filing a withdrawal of North Hawaii Community Hospital and requesting that, since the withdrawal leaves a single provider in each of these groups, the Board combine these groups with the Queens Health System CIRP groups for the same issue for 2018, namely Case Nos. 21-1165GC and 21-1167GC. Significantly, HRS acknowledges that neither Case No. 21-1165GC nor Case No. 21-1167GC are fully formed. This would suggest that HRS would be withdrawing its EJR request in Case Nos. 20-1801GC and 20-1803GC. However, HRS failed to acknowledge that it was pursuing the merits of the EJR request in federal district court based on the complaint it filed on March 30, 2022. Indeed, given the facts that the withdrawal is not reflected in the relevant SoPs attached to the EJR requests and that the withdrawal was filed with the Board subsequent to the March 30, 2022 Amended Complaint filed the California Central District Court, it is unclear to what extent this withdrawal of this participant from 20-1801GC and 20-1803GC impacts or is reflected in the litigation it is pursing in the California Central District Court.[26]

The Board, through its ongoing review of jurisdiction, and other procedural issues, in these 120 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. *Providers With No Appeal Rights*.—In the following cases, there are providers that, pursuant to 42 C.F.R. §405.1889(b), had no right to appeal a revised NPR for the group issue: Case Nos. 13-3612GC, 16-0371GC, 15 0802GC, 14-0366G, 14-0542GC, 15-0543GC, 14-1522GC, 14-1523GC, 14-2018GC, 14-2025GC, 14-2107GC, 14-2108GC,

[24] Through the application of 42 C.F.R. § 405.1837(a)(1), 42 C.F.R. § 405.1835(a)(3) applies to appeal request to directly add to a group.
[25] *See supra* note 5 (discussing what the Board's use of the term "substantive claim challenge" means).
[26] If Case Nos. 20-1801GC and 20-1803GC were to be remanded back to the Board, the Board would consider North Hawaii Community Hospital to have been effectively withdrawn, unless otherwise directed on remand, since participant withdrawals are self-effectuating under Board Rules. *See infra* note 28.

14-2930GC, 14-2931GC, 14-1768GC, 14-0416G, 14-3522G, 14-0416GC, 15-0800GC, 15-2680GC, and 13-3443GC.

2. *Invalid Appeals Due to Failure to Timely Appeal*.—Pursuant to 42 C.F.R. § 405.1835(a)(3), "[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 must be *no later than 180 days* after the date of receipt by the provider of the final contractor or Secretary determination." As the date of receipt is presumed to be 5 days after the date the final determination is issued,[27] an appeal request effectively must be filed with the Board within 185 days of the determination in order to be considered timely. The Board's preliminary review of jurisdiction has identified the following examples of participants that failed to timely appeal the group issue.

   a. In Case Nos. 15-3345G and 15-3346G, the Board is reviewing whether the appeal for Participant #2 Sonoma Valley, based on the non-issuance of an NPR, was timely filed.

   b. In Case Nos. 14-1522GC and 14-1523GC, the Board is reviewing the timeliness of Participant #11 Dallas Medical Center's appeal request because the proof of delivery included in the SoP is the Board Acknowledgement dated Friday, February 28, 2014 while the deadline for filing was Monday February 24, 2014.

   c. In both Case Nos. 19-2521G and 19-2524G, the Board is reviewing the timeliness of the appeal of Baton Rouge General Medical Center ("Baton Rouge"). Baton Rouge filed its appeal on August 27, 2019, based on the MAC's failure to timely issue an NPR under 42 C.F.R. § 405.1835(c) (2014). However, prior to filing that appeal, Baton Rouge had filed and the MAC accepted an amended cost report on April 16, 2019 suggesting that the August 27, 2018 appeal was premature.

3. *Improper Pursuit of Previously Withdrawn/Dismissed Participants* ***in Excess of $500,000***.— There are a significant number of participants in these 120 groups for whom HRS is ***improperly*** pursuing reimbursement by including them on the Schedule of Providers even though either ***HRS*** had ***previously withdrawn*** them from the relevant group case,[28] ***or*** the Board dismissed them and/or denied their transfer to the group appeal. Although the Board has not yet completed its review, the following examples from only 11 of the 120 cases alone demonstrate that HRS is ***improperly*** pursuing reimbursement ***in excess of $500,000.*** Such action on the part of HRS raises significant fraud and abuse concerns,[29] and the Board takes administrative notice that this is not an

[27] 42 C.F.R. § 405.1801(a) includes the definition for "date of receipt" and paragraph (1)(iii) of that definition explains that "[t]his [5-day] presumption, which is otherwise conclusive, may be overcome if it is established by a preponderance of the evidence that such materials were actually received on a later date."

[28] *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 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.").

[29] Based on its preliminary review of just some of these cases, the Board fully expects to identify other situations where HRS failed to remove withdrawn/dismissed providers from the SoPs, particularly in light of the age of some of the SoPs that HRS refiled and is relying on for its consolidated EJR requests.

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[30] 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*. The following are recent examples of cases in which the Board has identified that HRS has improperly included previously dismissed or withdrawn providers on final SoPs without identifying those prior dismissals/withdrawals; ***or*** has improperly pursued appeals that were prohibited duplicates of prior cases: Case Nos. 14-0369GC,[31] 14-3521,[32] 15-049G, 15-0554G,[33] 15-0605GC, 15-0606GC,[34] 14-3518G,[35] 15-1966GC,[36] 16-1224GC,[37] 19-0052,

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

[31] As part of an EJR determination dated March 29, 2019, the Board notified HRS that it had *improperly* included St. Vincent Charity Medical Center on the final SoPs for Case Nos. 14-0369G because the Board had previously issued a determination (addressed to HRS) denying the request to transfer the Provider to that case more than 3 years earlier on dated May 25, 2015.

[32] As part of an EJR determination dated March 29, 2019, the Board notified HRS that it had *improperly* included Central Maine Medical Center on the final SoPs for Case Nos. 14-3521G because the Board had previously issued a determination (addressed to HRS) denying the request to transfer the Provider from Case No. 14-1712 to that group case more than 4 years earlier on April 10, 2014. Indeed, the April 10, 2014 determination shows that, even though HRS was not the designated representative in Case No. 14-1712, HRS had *improperly* attempted to add issues to that individual appeal and then transfer them to various optional groups, one of which was Case No. 14-3521G. As a result, the Board denied the transfer request to Case No. 14-3521G and dismissed the issue underlying that request.

[33] As part of an EJR determination dated March 29, 2019, the Board notified HRS that it had *improperly* included in the final SoPs for Case Nos. 15-0549G and 15-0554G Wooster Community Hospital for which the Board previously had issued a determination on November 25, 2015 dismissing the individual appeal as untimely and denying the request to transfer that Provider to the respective group appeals.

[34] As part of an EJR determination dated May 6, 2019, the Board notified HRS that:

1. It had *improperly* included Participant #20A because the Board previously had issued a determination on March 10, 2015 dismissing that Provider from its individual appeal under Case No. 15-0871 due to the failure to include a copy of the relevant cost report with its appeal as required under 42 C.F.R. § 405.1835(b) and Board Rules.
2. It had improperly included Participant #21 (Pampa Regional Medical Center) because "[o]n April 15, 2015, the HRS withdrew Pampa Regional Medical Center from both Case Nos. 15-0605GC and 15-0606GC and stated that the Group Representative '***will remove*** Pampa Regional Medical Center from the Schedule of Providers when submitted [to the Board].'" (Emphasis in original and quoting HRS withdrawal notice.)

[35] As part of an EJR determination dated April 1, 2019, the Board notified HRS that it had *improperly* included Central Maine Medical Center on the final SoP because "the Board previously ruled ***multiple*** times that [the Provider] did not properly add the Part C Days issue to its individual appeal and, thus, the Board has denied *multiple* times the Provider's request to transfer the issue to Case No. 14-3518G." (Emphasis in original and footnotes omitted.) In one of the footnotes appended to this statement, the Board noted that it had issued *three* ***separate*** denials dated April 10, 2014, July 10, 2014, and December 17, 2014.

[36] As part of an EJR determination dated April 1, 2019, the Board notified HRS that it had *improperly* included Providence Hospital on the final SoP for Case No. 15-1966GC because, on July 15, 2015, the Board had previously issued to HRS a dismissal of the Provider's individual appeal under Case No. 15-0481 for lack of jurisdiction and denied the Provider's request to transfer to Case No. 15-1966GC.

[37] In a jurisdiction determination, the Board dismissed Akron General Medical Center from the 2013 Cleveland Clinic CIRP group because the Provider was not owned or controlled by the Cleveland Clinic Foundation during that year and the Board had ***already*** granted EJR in a duplicate appeal (for the same issue and year) in the *optional* group under Case No. 17-0223G. As part of this dismissal, the Board noted that: (1) HRS had included the Provider as a direct add to the optional group (as a founding participant) approximately 3 weeks after HRS had already added the Provider to the CIRP group; and (2) notwithstanding, HRS had ***certified*** in the Provider's direct add to the optional

19-2149G, 19-2148G, 19-2147G, 19-2145G, 19-2144G, [38] 20-0154,[39] and 21-1780GC.[40] These examples highlight, *at a minimum*, HRS' reckless disregard for its ***basic*** responsibilities and due diligence as a representative appearing before the Board. As a representative with more than 650 open cases (of which the overwhelming majority are groups), HRS should be intimately familiar with the need to track and account for withdrawals and dismissals in its filings of SoPs with the Board[41] as well as Board Rule 47 addressing how a dismissed or withdrawn provider may be reinstated to an appeal.[42]

Especially egregious examples of HRS's failure to competently fulfill its responsibilities as a Provider Representative *in 11 of the instant 120 group cases* include:

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group that ***no appeal with the same group issue for the same year and same provider is pending with the Board***.

[38] On July 29, 2020, the Board notified HRS that it was denying the transfer of Adventist – Lodi from the individual case under Case No. 19-0052 to the 5 HRS optional groups under Case Nos. 19-2149G, 19-2148G, 19-2147G, 19-2145G, and 19-2144G because the Provider was commonly owned by Adventist and was required to be transferred to Adventist CIRP groups for the same issue and year. To this end, "[t]he Board remind[ed HRS] that, as a provider's representative, it is your responsibility, among other things confirm whether your client is subject to the CIRP group requirements in 42 C.F.R. § 405.1837(b)(1)(i); and if so, ensure that your client complies with those requirements (e.g., joining the relevant existing open CIRP group or establishing a new CIRP group if one had not been previously established)." Accordingly, "*the Board admonishe[d] HRS for its failure to identify the 5 CIRP group issues and further* ***instruct[ed] HRS to remove*** *Adventist – Lodi from the respective Schedules of Providers and supporting documentation for all five (5)* ***optional*** *group cases (i.e., 19-2149G, 19-2148G, 19-2147G, 19-2145G, and 19-2144G)*." (Emphasis in original.)

[39] By letter dated January 10, 2020, the Board issued notice to HRS that "*due to both [HRS's] mismanagement of [Case No. 20-01540 for the University Medical Center New Orleans] (as well as two related [2011 LSU] CIRP groups) and [HRS's] failure to provide complete and accurate information to the Board in response to the RFI, the Board [was] dismiss[ing] this case if,* ***within ten (10) days,*** *[HRS did] not properly transfer this case to the related CIRP groups and confirm whether these CIRP groups are complete*." By way of background, on March 19, 2018, HRS had filed an ***improper EJR request*** for those two related 2011 LSU CIRP groups because the CIRP groups were yet not fully formed and were waiting on the University Medical Center New Orleans for FY 2011. Accordingly, it was clear that HRS should have been aware that subsequently filing an EJR request for the University Medical Center New Orleans for FY 2011 on October 24, 2019 was improper. "These facts demonstrate that, ***if [HRS] had maintained an accurate inventory of your appeals and/or properly reviewed your records in response to the Board's RFI****, [HRS]u would have known to either directly add or transfer the Provider to the CIRP group, Case No. 14-2994GC, and known that immediately requesting EJR in the above captioned* ***individual*** *case9 was improper*." (Emphasis in original.)

[40] In Case No. 21-1780GC, HRS had filed a request for EJR and, on September 9, 2021, the Board notified HRS that more than 3 years earlier on June 13, 2018, the Board had already granted Prime Healthcare EJR for this same issue for the same year in the CIRP group under Case No. 18-0497GC *for which HRS was also the representative*. As such, the Board denied EJR and dismissed Case No. 21-1780GC because the group violated the CIRP regulation and was a prohibited duplicate under Board Rule 4.6. Finally, "***the Board remind[ed HRS]*** *that they have the responsibility to consult with their client and track and manage their cases and ensure they exercise due diligence prior to making filings*" and that "[***i***]***n particular, this responsibility includes consultation with the client prior to making the following certification*** *required for CIRP group appeals per Board Rule 12.10*." (Emphasis in original.)

[41] The Board has identified two SoPs where HRS noted withdrawals of a provider, namely the SoPs for the companion cases under Case Nos. 17-1236G and 17-1240G reflect the withdrawal of participant #3, Sonoma Valley Hospital for FY 2014. These SoPs were attached to the Grouping B consolidated EJR request dated January 17, 2022 and show an example of 2 SoPs where HRS *correctly* noted a provider that was previously withdrawn.

[42] *See 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.)

a. In Case Nos. 14-0366G and 14-3519G, HRS *improperly* lists Participant #10 (Akron General Medical Center) in the final SoP as a participant because, on September 17, 2015, the Board issued a letter to HRS (as the representative in Case No. 13-0413) denying transfer of this Provider from its individual appeal under Case No. 13-0413 to the optional group under Case Nos. 14-0366G and 14-3519G. The 3-year period under 42 C.F.R. § 405.1885(b), and Board Rule 47, to reverse the Board's dismissal from Case No. 13-0412 has lapsed.[43] The Amount in Controversy ("AiC") for Participant #10 is $21,706 in *both* Case Nos. 14-0366 and 14-3519G.

b. In Case No. 14-2993GC, even though HRS withdrew Participant #2 (Medical Center of Louisiana at New Orleans) and Participant #4 (EA Conway Medical Center) on December 21, 2021, HRS *improperly* lists those providers as participants in the final SoP attached to the EJR request (filed just 8 days later on December 30, 2021). The AiC for Participant ##2 and 4 are $34,174 and $12,296 respectively.

c. In Case No. 15-0595GC, HRS *improperly* lists Pampa Regional Medical Center as Participant ## 19, 20A and 20B on the final SoP even though, on April 17, 2015, HRS had requested that Provider be "withdrawn from the Group" and represented that "HRS will remove Pampa Medical Center from the Schedule of Providers when submitted." The AiC for Participant ## 19, 20A, and 20B are $1,285, unlisted, and $1,505.

d. In Case No. 14-1768GC, HRS *improperly* lists Participant #1 (UH Richmond Medical Center) in the final SoP filed on January 11, 2022 because, earlier by letter dated May 16, 2018 (addressed to HRS), the Board dismissed this issue from the Provider's individual appeal under Case No. 13-2247 and denied transfer to Case No. 14-1768GC. The AiC for Participant #1 is $3,060. This also results in a prohibited single participant CIRP group under Case No. 14-1768GC.

e. In Case Nos. 19-2065G and 19-2067G, on January 7, 2021, HRS withdrew Arrowhead Regional Medical Center shortly after the MAC filed a Jurisdictional Challenge on December 23, 2020 requesting the Board to dismiss Arrowhead from the Group.[44] On January 11, 2021, the Board sent notice that the jurisdictional challenge regarding Arrowhead was moot given HRS' withdrawal of Arrowhead. Notwithstanding the withdrawal one year earlier (or the Board's notice), the SoP attached to the EJR request filed on January 17, 2022 continues to *improperly* list Arrowhead Regional Medical Center as a participant in Case Nos. 19-2065GC and

[43] The Board closed Case No. 13-0413 following its dismissal of the Medicaid fraction dual eligible days issue on September 17, 2015. As such, HRS filed the final SoP with Akron listed as a participant and EJR request in Case No. 14-0366G with that SoP attached thereto ***more than 6 years following*** the Board's dismissal and denial of Akron's transfer to Case No. 14-0366G.

[44] Also, earlier, by letters dated October 5 and 6, 2020, the MAC filed a jurisdictional challenges over Arrowhead in Case Nos. 19-2065G and 19-2067G based on its contention that Arrowhead had no appeal rights under 42 C.F.R. § 405.1835(a) since Arrowhead's appeal request was not timely (the appeal was submitted in 186 days) and under 42 C.F.R. § 405.1889 since the appeal was based on an revised NPR that did not adjust the dual eligible days at issue but rather only adjusted for a Worksheet S-10 review.

19-2067G and HRS did not file an updated final SoP in OH CDMS reflecting the withdrawal of Arrowhead. The AiC in Case Nos. 19-2065G and 19-2067G are $96,328 and $229,030, respectively.

f. In Case Nos. 15-0007GC and 15-0008GC, even though HRS withdrew Participant #14 (Pampa Regional Medical Center) on April 17, 2015, HRS continues to *improperly* list Pampa as a participant both on the final SoPs filed in these cases on February 17, 2022 as well as on the SoPs attached to the EJR request filed on February 27, 2022. The AiC listed on the SoP for Pampa in ***both*** cases is $4,931.

g. In Case No. 15-2680GC pertaining to the SSI fraction, HRS withdrew the original NPR appeal of Participant #1, Harlingen Medical Center ("Harlingen"), on December 21, 2018 and HRS used OH CDMS to make this filing which means that the withdrawal is readily confirmed. Notwithstanding this withdrawal, HRS continues to *improperly* list Harlingen's original appeal as Participant No. 24 with an AiC of $47,320. It also is unclear why Harlingen also remains listed as Participant #25 based on its revised NPR and an AiC of $2,989.[45] Moreover, HRS has failed to address whether it is appropriate for Harlingen to continue to participate in the companion case under Case No. 15-2681GC pertaining to the Medicaid fraction as Participant ## 24 and 25 with AiCs of $47,320 and $2,989, respectively; and, in particular, it raises issues about whether, following the withdrawal of Harlingen from Case No. 15-2680GC, the Provider continues to have the same factual or legal question common to each of the other participants in Case No. 15-2680GC and, in turn, whether the ***full*** legal framework and questions posed in the EJR request could continue be applicable to Harlingen.

h. HRS *improperly* submitted an EJR request for the ***closed*** case under Case No. 13-3496GC. Roughly 5 years earlier, by letter dated January 17, 2017, the Board dismissed Case No. 13-3496GC for failure to timely file a preliminary position paper. This 2007 LSU CIRP group pertained to the Medicaid fraction portion of the dual eligible days issue and there is a separate 2007 LSU CIRP relating to the SSI fraction portion of the dual eligible days issue under Case No. 15-0802GC.[46] Notwithstanding the CIRP group having been dismissed almost 5 years prior, and OH CDMS showing the "status" of Case No. 13-3496GC as being "closed," HRS filed ***in OH CMDS*** a request for EJR for Case No. 13-3496GC claiming an aggregate amount in controversy of $22,706 *without acknowledging the closed status or requesting reopening or reinstatement*. By letter dated January 4, 2022, the Board notified HRS that the EJR request as it related to Case No. 13-3496GC was "***void*** in the first instance"[47] because the Board had "dismissed the subject CIRP group almost 5 years ago on January 17,

[45] Regardless, the Board is also reviewing whether Harlingen had a right under 42 C.F.R. § 405.1889(b) to appeal the group issue in Case No. 15-2680GC.

[46] By letter dated October 30, 2014, HRS requested that the Board grant bifurcation of the "SSI Fraction/dual Eligible Days sub-issue[]" from Case No. 13-3495GC. In making that request, HRS specifically recognized "[f]or . . . the Medicaid Fraction/Dual Eligible Days sub-issues, HRS already established groups. *See* . . . HRS LSU 2007 DSH Payment Dual Eligible Days CIRP Group, PRRB Case Number 13-3496GC." The Board granted that bifurcation to establish Case No. 15-0802GC for the SSI fraction portion of the dual eligible days issue.

[47] (Emphasis added.)

2017 for failure to timely file a preliminary position paper (which incidentally is more than two years beyond the 3-year period in which a case can potentially be reinstated under Board Rule 47)." Notwithstanding, it is the Board's understanding that HRS is pursuing the merits of this case (which relates to the Medicaid fraction portion of the issues stated in the EJR request) in federal district court.[48] If HRS is in fact pursuing the Medicaid fraction portion of the EJR request as captured in Case No. 13-3496GC, then that pursuit would have ***no creditable*** basis or merit since, as previously noted, the 3-year period to request the Board to reinstate or reopen has lapsed per 42 C.F.R. § 405.1885(b) and Board Rule 47.

4. *Unauthorized Representation of Participants*.— The Board has also identified situations where HRS ***failed*** to obtain proper authorization from the provider to be a participant in the relevant group. For example, in both Case Nos. 15-0595GC and 15-0604GC, HRS failed to have a proper letter of representation on file authorizing it to file direct-add appeal requests for the following 2 participants to Case Nos. 14-0494GC and 15-0604GC: Participant #15, Garden City Hospital ("Garden City"), whose direct add request was filed on or about December 30, 2016; and Participant #17, St. Mary's Hospital, Passaic ("St. Mary's Passaic") whose direct add request was filed on or about May 16, 2016. Each of the final SoPs with supporting jurisdictional documentation filed for these cases lists participants through Participant 25B, and the letter of representation included behind Tab H for all the ***other*** participants consisted of a cover letter dated June 13, 2014 from Michael Bogert, the Vice President of Corporate Finance at Prime Healthcare where the "RE:" line stated:

> RE: APPOINTMENT OF DESIGNATED REPRESENTATIVE
> System Name: Prime Healthcare Management, Inc.
> Provider Numbers: Various – See Attached Listing
> Fiscal Years: Various (Fiscal Years 2001 through 2015)
> Lead MAC: Noridian Heathcare Solutions, LLC

The referenced listing was a single page attachment entitled "List of Prime Healthcare Management, Inc. Providers" and consisted of 24 providers where the relevant fiscal years varies from provider to provider (*e.g.*, Desert Valley is authorized for all 15 years, FYs 2001 through 2015, while Sherman Oaks Hospital is only authorized ***only*** for 10 years, FYs 2006 through 2015, and Harlingen Medical Center is authorized ***only*** for 6 years, FYs 2010 through 2015). Significantly, neither Garden City nor St. Mary's Passaic are listed on the attached list of 24 Prime Healthcare providers. In contrast, the letter of representation included in the SoPs of these two CIRP groups for Garden City and St. Mary's Passaic consists of the *exact* ***same*** cover letter (*e.g.*, same date, same re: line, same text, same signature and signatory, and same cc's) but the attached list of providers is *strikingly* ***different*** in that it consists of 39 providers (as opposed to 24) and does not specify which fiscal years from 2001 to 2015 that the authorization applies (*e.g.*, the authorization for Harlingen Medical Center is somehow no longer restricted to FYs 2010 through 2015 and would be authorized for FYs 2001 through 2015 under this

[48] Exhibit A attached to the March 30, 2022 Amended Complaint includes Case No. 13-3496GC and, as such, it appears that HRS is pursuing the merits of the EJR request as it relates to this case in federal district court.

attachment). Indeed, the Board suspects that most if not all of the additional 15 providers listed on this new attachment were neither owned nor controlled by Prime Healthcare during the 2001 to 2015 timeframe (in whole or in part)[49] and that, upon review of its files, this new attachment was originally appended to a cover letter from Prime dated July 11, 2016 as shown in the direct add request for St Mary's Regional Medical Center filed by HRS in Case No. 15-0604GC on November 28, 2016. Accordingly, the Board would reject the authenticity of the letter of representation included for Garden City and St. Mary's Passaic and dismiss them from Case Nos. 15-0595GC and 15-0604GC.

5. *Failure to meet minimum $50,000 AiC requirement for a group appeal*. —As explained in 42 C.F.R. § 405.1839(b), "[i]n order to satisfy the amount in controversy [or AiC] requirement . . . 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." Further, it explains that, "[f]or purposes of satisfying the amount in controversy requirement, group members are ***not*** allowed to aggregate claims involving different issues" because "[a] group appeal must involve a single question of fact or interpretation of law, regulations, or CMS Ruling that is common to each provider . . . ." The following cases are examples of cases where the Board is reviewing whether the AiC requirement is met.

   a. Both Case Nos. 15-0542GC and 15-0543GC have only 2 participants and each case fails to meet the minimum $50,000 amount in controversy required for a group in that the SoP for each case lists a total AiC of $9,092 (2,878 for one provider and 6,214 for the other provider). Significantly, both participants were direct adds and neither provider would meet the minimum $10,000 AiC required for an individual appeal.

   b. Case Nos. 16-1317GC and 16-1318GC are companion 2013 CIRP group cases involving UHHS where one appeal addresses the SSI fraction and the other the Medicaid fraction. The final SoP filed on February 17, 2022 in each case only listed 3 participants and a total AiC list on the final SoP of $21,531 in each case. Thus, each UHHS 2013 CIRP group, though fully formed, failed to meet the minimum $50,000 AiC required for a group. By letter dated March 18, 2022, the Board noted this "impediment with regard to jurisdiction" and proposed expansion of the UHHS 2014 CIRP groups under Case Nos. 17-1095GC and 17-1096GC to include 2013 and then consolidate Case Nos. 16-1317GC and 16-1318GC into them, respectively. To this end, the Board required HRS to respond *within 15 days on the proposed actions*, and noted that, "as jurisdiction is a prerequisite to consideration of an EJR request, this [RFI] necessarily affects the 30-day period for responding to the EJR requests in these cases." On March 29, 2022, HRS responded and requested that the Board instead expand the UHHS 2012 CIRP groups under Case Nos. 15-2629GC and 15-2630GC and consolidate them with Case Nos. 16-1317GC and 16-1318GC respectively because these 2 cases were also part of the same consolidated EJR request filed on February 27, 2022. Significantly, HRS did ***not*** dispute the Board's characterization of

[49] For example, it is the Board's understanding that Prime Healthcare did not own or otherwise control Suburban Community Hospital until 2016 and Lake Huron Medical Center, Saint Clare's Hospital, and Riverview Medical Center until 2015. If true, all of these acquisitions would have occurred after the September 10, 2014 execution date.

> failure to meet the $50,000 AiC as an "impediment with regard to jurisdiction" or the Board's position that jurisdiction is a prerequisite to the beginning of the 30-day EJR determination period. The Board, by letter dated April 4, 2022: (1) granted HRS' request, expanded Case Nos. 15-2629GC and 15-2630GC to include CY 2012, consolidated them with Case Nos. 16-1317GC and 16-1318GC, respectively, and issued a consolidation of these cases with another case; (2) required HRS to file an updated SoP with supporting jurisdictional documentation for Case Nos. 15-2629GC and 15-2630GC to reflect the consolidation; and (3) confirmed that it "will take no further action on the EJR in the surviving cases 15-2629GC and 15-2630GC, until the record is complete and the updated SoPs have been submitted." On April 7, 2022, HRS filed the updated SoPs in Case Nos. 15-2629GC and 15-2630GC.[50]

6. *Apparent Abandonment of Providers*.—It appears that HRS has abandoned 3 participants in Case No. 15-0595GC, namely Participants 8A and 8B (San Dimas Community Hospital, FYE 12/31/2012 based on an appeal for failure to issue an NPR and an appeal of the original NPR) and Participant #19 (Lower Bucks Hospital FYE 12/31/2012 based on an appeal for failure to issue an NPR). Specifically, the final SoP for Case No. 15-0595GC, filed on March 1, 2021, included participants starting at Participant 1A and ending with Participant 25B and included San Dimas as Participants ##8A and 8B and Lower Bucks as Participant #19. In contrast, the SoP attached to the EJR request filed in Case No. 15-0595GC on December 29, 2021 only included participants through 23B and did ***not*** include either San Dimas or Lower Bucks. Without additional information, the Board would have to assume those providers have been withdrawn or otherwise abandoned.

7. *The Compliance of Commonly Owned/Controlled Providers with the CIRP group requirements*.—Pursuant to 42 C.F.R. § 405.1837(b)(1):

> Two or more providers *under common ownership or control* that wish to appeal to the Board a specific matter at issue that involves a question of fact or interpretation of law, regulations, or CMS Rulings *that is common to the providers*, and that arises in cost reporting periods that end in the same calendar year, and for which

[50] The SoP attached to the EJR for both Case No. 15-2629GC and Case No. 15-2630GC only lists 2 participants (UH Regional Hospitals and UH Case Medical Center) and each case only concerned one fiscal year, namely FY 2012. However, by letter dated March 18, 2022, the Board requested comments on whether to expand CIRP groups for FY 2014 under Case Nos. 17-1095GC and 17-1096GC to include FY 2013 for UHHS as the 2013 CIRP groups under Case Nos. 16-1317GC and 16-1318GC were fully formed but only failed to meet the minimum $50,000 amount in controversy required for a group. On March 29, 2018, HRS responded and requested that the Board instead combine the 2013 CIRP group under 16-1317GC and 16-1318GC with those for FY 2012 under Case Nos. 15-2629GC and 15-2630GC because HRS had requested EJR for both sets of cases in the same EJR request dated February 27, 2022 and it would "allow the continuation of the EJR request." However, HRS failed to disclose in its March 29, 2018 response to the Board that it was filing suit in the U.S. District Court for the Central District of California the next day on March 30, 2022. Due to HRS' failure to disclose this information, the Board continued its work on these cases and, by letter dated April 4, 2022, consolidated the 2012 and 2013 CIRP groups and characterized the EJR request as "pending" and noted that the March 16, 2022 Alert 19 letter previously extended the deadlines." The Board required the representative to file a new SoP within 30 days to reflect the consolidation. HRS filed this updated SoP on April 7, 2022 and, again, failed to inform the Board of its litigation filed earlier on March 30, 2022.

> the amount in controversy is $50,000 or more in the aggregate, ***must*** ***bring the appeal as a group appeal***.[51]

In these situations, the commonly owned/controlled providers must establish a common issue related party ("CIRP") group. The following are examples of participants in optional groups that the Board has, to date, identified as being potentially subject to the mandatory CIRP group requirements.

a. Case Nos. 15-3345G and 15-3346G contain participants that appear to be commonly owned or controlled and potentially subject to the mandatory CIRP group requirements for the fiscal year at issue (*see, e.g.*, #5 Queens, #3 Prime East, #9 EMH, #11 Landmark Prime, and #12 Warsaw Ascension).

b. In the 2016 optional groups under Case Nos. 19-2065G and 19-2067G, the Board issued a "Show Cause Order for Dismissal of Optional Group Participant" on April 28, 2022 because one of the participants, Akron General Medical Center ("Akron"), may be subject to dismissal for failure to comply with the mandatory CIRP group regulations.[52] In issuing the Show Cause Order, the Board noted that the Cleveland Clinic already had two 2016 CIRP groups of the same issues pending before the Board in the ***fully formed*** CIRP groups under Case Nos. 20-1711GC and 20-1713GC and that Akron is a participant in the Cleveland Clinic CIRP groups that HRS formed ***one year earlier*** for 2015 under Case No. 18-1593GC ***and*** for 2016 under Case No. 19-0426GC. Consequently, pursuant to its authority under 42 C.F.R. § 405.1868(b)(2), the Board required that HRS "confirm whether, or not, [Akron] is *owned* ***or controlled*** by the Cleveland Clinic Foundation." On May 4, 2022, HRS responded by alleging that "[Akron] was not *owned or operating* under Cleveland Clinic Foundation but was reporting under Akron General Health System up through and including the 2017 cost year" and that "[i]t wasn't until 2018 that Akron began *reporting* under Cleveland Clinic Foundation as it's parent company." Significantly, HRS' response failed to address: (1) whether the Cleveland Clinic Foundation ***controlled*** Akron General Health System prior to 2018 as suggested by the fact that HRS has included Akron in Cleveland Clinic CIRP groups for both the prior fiscal year (2015) and the current fiscal year (2016);[53] and (2) the fact that HRS had filed an amended complaint in federal district court earlier on March 30, 2022 regarding the merits of its EJR request in Case Nos. 19-2065G and 19-2067G in order to join ongoing litigation under Case No. 22-cv-00989 established by QRS.

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[51] (Emphasis added.)

[52] Significantly, the representative authorization letter was generic to Cleveland Clinic Health System stating that "Cleveland Clinic Health System hereby formally appoints [HRS] as its' designated representative for fiscal years 2010 to 2019 for the Cleveland Clinic Foundation with respect to the attached list of Provider Numbers. The attached list was entitled "Cleveland Clinic Health System List of Providers and listed 11 providers which included Akron General Medical Center. The year at issue 2016 is in the middle of the fiscal years 2010 to 2019 authorized in the letter as pertaining to the Cleveland Clinic Health System Providers.

[53] Moreover, publicly available information suggests that the Cleveland Clinic Foundation acquired a controlling interest in the Akron General Health System in 2015. *See, e.g., https://www.justice.gov/opa/pr/northern-ohio-health-system-agrees-pay-over-21-million-resolve-false-claims-act-allegations*.

8. *Participants That Did Not Properly Transfer Into the Group or Only Transferred a Portion of the Issue/Issues Covered By the Group*.— A significant portion of the participants in these 120 groups arrived by transfer from an individual appeal. For any participant that transfers into a group from an individual appeal, the Board must review whether the individual appeal properly included the issue the provider seeks to transfer. A provider can only transfer an issue that is properly existing in its individual appeal.[54] The Board expects it would identify additional issues if it were to complete its jurisdictional review. For example, in Case Nos. 14-0366G and 14-3519G, the Board is reviewing to dismiss Participant #12, Robinson Memorial, as this participant transferred into this group from its individual appeal but its individual appeal did not include the issue that is the subject of these groups and EJR request.

9. *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; 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. Examples include:

    a. In Case No. 15-0802GC for LSU, the Board is reviewing whether the EJR request should be denied because it is beyond the scope of the group issue statement.

    b. In Case No. 15-0800GC for FMOLHS, the Board is reviewing whether the EJR request should be denied, in whole or in part, because the EJR request addresses both fractions in the DSH computation, the group issue statement only encompasses one fraction in the DSH computation, and there is a FMOLHS companion case pending for the other fraction under Case No. 13-3443GC that was ***not*** included in the instant EJR request.

    c. In Case No. 20-0259GC for Lafayette General, the Board is reviewing whether the EJR request should be denied, in whole or in part, because the EJR request addresses both fractions in the DSH computation, the group issue statement only encompasses one fraction in the DSH computation, and there is a Lafayette General companion case pending for the other fraction under Case No. 20-0261GC that was ***not*** included in the instant EJR request. (Lafayette).

[54] 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.

10. *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.[55] Pursuant to 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. § 405.1837(a)(1), a group may only contain one legal issue. In pertinent part, § 405.1837(a)(1) states that "[a] provider . . . has a right to a Board hearing, as part of a group appeal with other providers, with respect to a final contractor or Secretary determination for the provider's cost reporting period, ***only if*** - . . . (2) The matter at issue in the group appeal involves ***a single*** question of fact or ***interpretation*** *of law, regulations, or CMS Rulings* that is common to each provider in the group.[56] The Board is reviewing whether the Providers' consolidated EJR requests filed for Groupings A, B and C are 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[57]) in addition to the no-pay Part A days issue (as embodied in the *Empire* litigation decided before the Supreme Court[58]). If true, it raises immediate jurisdictional problems of whether the additional challenges are *properly* part of the relevant groups[59] and, if true, resolving: (1) whether each of the participants properly appealed additional issues and, as relevant, whether it requested transfer of those additional issues to the group; and (2) whether the additional issues should be bifurcated from the group per 42 C.F.R. § 405.1837(f)(2).[60] A critical aspect of

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[55] *See* 42 C.F.R. §§ 405.1842(a), 405.1842(f); 73 Fed. Reg. 30190, 30212 (May 23, 2008) (in response to comment that "the Board should have the authority to handle more than one question of fact or law in a group appeal" because "sometimes there is more than one disputed fact or question of law pertaining to a single item on the cost report" where "[a] common example of this is the [DSH] adjustment, which is determined by a combination of calculations, each of which may have more than one element in dispute", the Secretary affirmed that [t]he regulations at § 405.1837(a)(2) . . . specify that a group appeal involve a single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group" and that "[w]hat constitutes an appropriate group appeal issue in a given case will be determined by the Board."). The Board further notes that 42 C.F.R. § 405.1839(b) (underline and bole 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).

[56] (Emphasis added.)

[57] *Hall Render Optional and CIRP DSH Dual/SSI Eligible Group Appeals – Medicare Fraction v. Wisconsin Physicians Services*, PRRB Dec. No. 2017-D11 (Mar. 27, 2017).

[58] *Becerra v. Empire Health Foundation*, 142 S. Ct. 2354 (2022), *reversing*, 958 F.3d 873 (9th Cir. 2020).

[59] 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.

[60] Indeed, the Board is aware that, notwithstanding the fact that it is pursing the merits of its EJR requests in federal district court, it subsequently filed preliminary position papers in the following case and that this position papers include not just the *Empire* issue but also the SSI eligibility code issue embodied in PRRB Dec. No. 2017-D11:

- On April 11, 2022 for Case Nos. 15-1890GC, 15-1968GC, 14-1526GC, 14-2992GC, and 14-3281GC.
- On April 13, for Case No. 14-1668GC.

> 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.

Notwithstanding the above jurisdictional issues and concerns, HRS made clear with the March 30, 2022 filing of the Amended Complaint in federal district court that it has abandoned the Board's jurisdictional review process (as discussed above). However, to date, HRS still has not notified the Board that it filed the amended complaint in federal court to pursue the merits of its EJR requests in Groupings A, B, and C.

The delay in learning of HRS' abandonment of the Board's jurisdictional process by virtue of the OAA request for records has caused significant waste of the Board's limited resources, as well as those of FSS and the Medicare contractors servicing the 569 participants in the 120 group cases.[61] More concerning is HRS' 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. HRS essentially self-declared that the 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.[62]

C. Effect of HRS' Filing of the Amended Complaint on the 120 Group Cases

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 <u>not</u> conduct any further***

- On May 13, 2022, for Case Nos. 15-0008GC, 15-2402GC, 15-2629GC, and 17-0438GC.

[61] The Board takes administrative notice that it has a very large docket of pending cases (9485 as of April 1, 2022) and was then processing many EJR requests involving multiple thousands of participants. As of April 1, 2022, ***in addition to*** *the 120 cases covered in this notice*, the Board had 178 cases with EJR requests pending. On or after April 1, 2022, EJR requests were filed for an additional 218 cases in April, 54 in May and 72 in June. As these cases were primarily group cases, they involved thousands of participants in the aggregate.

[62] As explained *supra*, a partial review of just 11 of the 120 group cases being pursued as part of the ongoing lawsuit reveals previously withdrawn/dismissed participants accounting for approximately $500,000 in controversy on the related SoPs.

> ***proceedings*** on the legal question or the matter at issue until the lawsuit is resolved.[63]

This regulation ***bars any further Board proceedings*** in these 120 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 120 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,[64] and the May 23, 2008 final rule[65] 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.[66]

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,

[63] (Emphasis added.)
[64] 69 Fed. Reg. 35716 (June 25, 2004).
[65] 73 Fed. Reg. 30190 (May 23, 2008).
[66] 69 Fed. Reg. at 3572

> 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.[67]

Based on the above explanation regarding the intent and purpose for 42 C.F.R. § 405.1842(h)(3)(iii), the Board finds that HRS' March 30, 2022 filing of the Amended Complaint in the California Central District Court prohibits the Board from conducting any further proceedings on the consolidated EJR requests for Groupings A, B, and C as filed, including any proceedings related to the prerequisite jurisdiction.

In so ruling, the Board notes that HRS created the confusion surrounding the status of these cases at the Board. HRS' filing of the Amended Complaint was not made in good faith as it ignores both the Board's ruling in its Scheduling Order ***and*** the Providers' obligations under Board Rules. Pursuant to Board Rule 1.3 (Nov. 1, 2022),[68] HRS 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)):

> **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.

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[67] 73 Fed. Reg at 30214-15.

[68] 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 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), HRS, 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.[69]

Indeed, the following inaction on HRS' part belies any claim that proceedings before the Board have been exhausted:

1. For Groupings B and C, HRS 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

[69] (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."

jurisdictional challenges. Moreover, HRS' objection to FSS' extension request for Grouping A did not discuss or mention the 30-day period, after a Board finding of proper jurisdiction, in which the Board has to process a complete and proper EJR request.

2. HRS failed to notify the Board of its objection to the Board's ruling on the extension, and the associated Scheduling Order. HRS' failure to file and preserve its objection to the Board's ruling and Scheduling Order violates HRS' 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.[70]

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)[71] and Board Alert 19. 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. The Board was not able to operate 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 Orders for Groupings A, B, and C 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. HRS failed to notify the Board of its objection to the Board Scheduling Orders. HRS' failure to timely file any objection violates Board Rules 1.3, 5.2 and 44. Indeed, HRS' 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 ruling and, if necessary, correct or clarify it,[72] or take other actions, ***prior to*** the HRS filing its March 30, 2022 Amended Complaint. HRS' failure to provide proper notice allowed the 30-day EJR review deadline, as alleged by HRS to be established in 42 U.S.C. § 1395oo(f)(1) (that HRS alleges in its litigation the Board missed), to pass, and, under

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[70] 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).

[71] 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).

[72] 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 66, 67 and accompanying text.

HRS' strained interpretation that ignores the Secretary's regulations, permitted federal litigation to be pursued.[73]

4. In its Scheduling Orders, the Board set forth its process for conducting jurisdictional review. For Groupings A and B, 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***"[74]:

> 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*.

HRS blatantly disregarded the Board's directive to supplement the record relative to jurisdiction.

5. HRS' failure to promptly notify the Board that it had joined 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 HRS' position relative to the 30-day period specified in 42 U.S.C. § 1395oo(f)(1). The following circumstances make it clear that HRS had an affirmative obligation to notify the Board of the Complaint being filed, and that HRS should have been aware of that affirmative obligation:

   a. The Board, in its Scheduling Orders, made clear its position that the 30-day period for responding to the EJR request had not yet commenced. Further, the Scheduling Orders directed both parties to submit certain jurisdictional related information, over a 90-day time frame.

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

   c. Notwithstanding its March 30, 2022 joinder of the litigation in the California Central District Court, HRS subsequently filed preliminary position papers ("PPPs) in the following cases and included *disingenuous* "Good Faith"

[73] *See supra* note 70 (discussing how the FRCP supports the Board's position).
[74] (Emphasis added.)

statements that "[d]ue to the [insert name of issue[75]], I assume we cannot seek a joint settlement or an agreement and will need to proceed to the PRRB":

- On April 11, 2022 for Case Nos. 15-1890GC, 15-1891GC, 15-1968GC, 15-1969GC, 14-1526GC, 14-1593GC, 14-2992GC, 14-2993GC, 14-3281GC, and 14-3276GC.[76]

- On April 13, 2022, for in Case Nos. 14-1668GC and 14-1669GC.[77]

- On May 13, 2022 for Case Nos. 15-0007GC, 15-0008GC, 15-2402GC, 15-2403GC, 15-2629GC, 15-2630GC, 17-0438GC, and 17-0439GC.[78]

In this regard, Board Rule 25.3 specifies "[t]he Board requires the parties file a complete preliminary position paper that includes . . . a statement indicating ***how a good faith effort to confer was made*** in accordance with 42 C.F.R. § 405.1853." Notwithstanding, HRS failed to disclose that, on March 30, 2022, it had joined the litigation in the California Central District Court.

These circumstances make clear that HRS 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, HRS' failure to comply with Board Rule 1.3, by promptly notifying the Board, FSS and the Medicare Contractors of the lawsuit on, or about, March 30, 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 120 group cases and the underlying 569 participants in favor of other time-sensitive work such as ***other*** EJR requests filed by HRS and other representatives. Indeed, HRS' failure to notify the Board, and the opposing parties, of the lawsuit filed in the California Central District Court raises concerns about potential prejudicial sandbagging by HRS to benefit current and subsequent EJR requests that HRS filed on behalf of other providers ***or*** EJR requests for the same issue filed by QRS.[79] In this regard, it is the Board's understanding that QRS had, on February 14, 2022, established the ongoing litigation in the California Central District Court covering 80 group cases with 950+ participants in the aggregate, and that HRS *joined* QRS in that lawsuit when an Amended Complaint was filed on March 30, 2022 incorporating the instant EJR requests for Groupings A, B, and C into that lawsuit. For a point of reference and context for these serious violations by HRS and QRS, the Board has

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[75] The Good Faith statements referenced the group issue in the case as either the "DSH Payment Dual Eligible Days issue," "DSH Medicaid Fraction Dual Eligible Days issue" or "DSH SSI Fraction Dual Eligible Days issue."
[76] Attached to each PPP was a Good Faith Statement dated April 1, 2022.
[77] Attached to each PPP was a Good Faith Statement dated April 1, 2022.
[78] Attached to each PPP was a Good Faith Statement dated May 1, 2022.
[79] *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.").

included as **Appendix D** a copy of the closure letter it issued in those 80 QRS group cases. Finally, it is the Board's understanding that HRS filed another Complaint in the California Central District Court on April 20, 2022 establishing Case No. 22-cv-02648 covering other EJR requests but without completing the jurisdictional review process and without notice to the Board.[80]

It is clear the Providers are pursuing the merits of their cases in Groupings A, B, and C 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.[81] However, the Board cannot permit HRS' 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 to it for further proceedings*, the Board will complete its jurisdictional review and weigh the severity of HRS' 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 effect on the operations of the Board, when determining what, if any, remedial actions will be taken per 42 C.F.R. § 405.1868.[82]

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.[83] Accordingly, the Board hereby closes these cases and removes them from the Board's docket.[84] 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:

9/23/2022

X Clayton J. Nix

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

[80] The Board will be addressing the status of these other cases under separate cover shortly.
[81] 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.
[82] The Board's planed actions are consistent with those planned for QRS as laid out in Appendix.
[83] In order for the Board to have jurisdiction over a group, it can only have one issue as noted in *supra* note 55, 81 and accompanying text.
[84] *See supra* note 5.

Enclosures:

Appendix A – Case List for Grouping A
Appendix B – Case List for Grouping B
Appendix C – Case List for Grouping C
Appendix D – June 10, 2022 Board Letter to QRS Deferring Show Cause Order & Closure of Cases

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

APPENDIX A

Grouping A – List of the 63 Group Cases Covered by the Consolidated Request for EJR Filed on December 29, 2021

13-3115GC	HRS FMOLHS 2008 DSH Medicaid Fraction Dual Eligible Days CIRP Group
15-0604GC	HRS Prime Healthcare 2012 DSH SSI Fraction Dual Eligible Days CIRP Group
15-0804GC	HRS LSU 2008 SSI Fraction Dual Eligible Days CIRP
15-1890GC	HRS Willis-Knighton Health Systems 2012 DSH SSI Fraction Dual Eligible Days CIRP
15-1891GC	HRS Willis-Knighton Health Systems 2012 DSH Medicaid Fraction Dual Elig. Days CIRP
15-1968GC	HRS SCHS 2012 DSH SSI Fraction Dual Eligible Days CIRP
15-1969GC	HRS SCHS 2012 DSH Medicaid Fraction Dual Eligible Days CIRP
16-1743GC	HRS FMOLHS 2013 DSH Medicaid Fraction Dual Eligible Days CIRP
15-1980GC	HRS ECHN 2011 DSH SSI Fraction Dual Eligible Days CIRP
15-1981GC	HRS ECHN 2011 DSH Medicaid Fraction Dual Eligible Days CIRP
15-2335GC	HRS UHHS 2010 DSH SSI Fraction Dual Eligible Days CIRP
15-2482GC	HRS FMOLHS 2011 DSH SSI Fraction Dual Eligible Days CIRP
15-2483GC	HRS FMOLHS 2011 DSH Medicaid Fraction Dual Eligible Days CIRP
15-3345G	HRS 2013 DSH SSI Fraction Dual Eligible Days Group
15-2336GC	HRS UHHS 2010 DSH Medicaid Fraction Dual Eligible Days CIRP
16-1742GC	HRS FMOLHS 2013 DSH SSI Fraction Dual Eligible Days CIRP
17-0070GC	HRS DCH 2013 DSH Medicaid Fraction Dual Eligible Days CIRP Group
17-0071GC	HRS DCH 2013 DSH SSI Fraction Dual Eligible Days CIRP Group
15-3346G	HRS 2013 DSH Medicaid Fraction Dual Eligible Days Group
17-0225G	HRS 2013 DSH Medicaid Fraction Dual Eligible Days Group II
17-0226G	HRS 2013 DSH SSI Fraction Dual Eligible Days Group II
17-0732G	HRS 2006 DSH SSI Fraction Dual Eligible Days Group II
13-3264GC	HRS SCHS 2008 DSH Payment Dual Eligible Days CIRP Group
13-3304GC	HRS FMOLHS 2009 DSH Payment Dual Eligible Days
13-3443GC	HRS FMOLHS 2007 DSH Payment Dual Eligible Days CIRP Group
13-3464GC	HRS LSU 2008 DSH Payment Dual Elig Days CIRP Group
13-3496GC	HRS LSU 2007 DSH Payment Dual Eligible Days CIRP Group[85]
17-0734G	HRS 2006 DSH Medicaid Fraction Dual Eligible Days Group II
17-0831GC	HRS Prime Healthcare 2005 DSH SSI Fraction Dual Eligible Days CIRP
17-0832GC	HRS Prime Healthcare 2005 DSH Medicaid Fraction Dual Eligible Days CIRP
19-0203GC	Eastern Connecticut HN CY 2015 DSH SSI Fraction Dual Eligible Days CIRP Group
19-0216GC	Eastern Connecticut HN CY 2015 DSH Medicaid Fraction Dual Eligible Days CIRP Grp
13-3612GC	HRS Willis-Knighton Health Systems 2008 DSH Payment Dual Eligible Days
14-0366G	HRS 2007 DSH Payment Medicaid Fraction Dual Elig Days Group
14-1059GC	HRS SCHS 2007 DSH SSI Fraction Dual Eligible Days CIRP
14-1061GC	HRS SCHS 2007 DSH Medicaid Fraction Dual Eligible Days CIRP
14-1526GC	HRS Willis Knighton Health Systems 2007 DSH SSI Fraction Dual Eligible Days CIRP
14-1593GC	HRS Willis Knighton Health Systems 2007 Medicaid Fraction Dual Eligible Days CIRP
15-0802GC	HRS LSU 2007 SSI Fraction Dual Eligible Days CIRP
14-1668GC	HRS SCHS 2009 DSH SSI Fraction Dual Eligible Days CIRP
14-1669GC	HRS SCHS 2009 DSH Medicaid Fraction Dual Eligible Days CIRP

[85] By letter dated January 17, 2017, the Board dismissed Case No. 13-3496GC for failure to timely file a preliminary position paper.

14-2018GC	HRS Willis-Knighton Health Systems 2009 DSH SSI Fraction Dual Elig. Days CIRP
14-2025GC	HRS Willis-Knighton Health Systems 2009 DSH Medicaid Fraction Dual Elig. Days CIRP
14-2992GC	HRS LSU 2011 DSH SSI Fraction Dual Eligible Days CIRP
14-2993GC	HRS LSU 2011 DSH Medicaid Fraction Dual Eligible Days CIRP
14-3194GC	HRS SCHS 2010 DSH Medicaid Fraction Dual Eligible Days CIRP Group
14-3281GC	HRS SCHS 2011 DSH SSI Fraction Dual Eligible Days CIRP Group
14-3519G	HRS 2007 DSH SSI Fraction/Dual Eligible Days Group
14-3195GC	HRS SCHS 2010 DSH SSI Fraction Dual Eligible Days CIRP Group
15-0280GC	HRS WKHS 2010 DSH SSI Fraction Dual Eligible Days CIRP Group
14-3276GC	HRS SCHS 2011 DSH Medicaid Fraction Dual Eligible Days CIRP Group
19-0308GC	Lafayette General Health CY 2015 DSH SSI Fraction Dual Eligible Days CIRP Group
19-0310GC	Lafayette General Health CY 2015 DSH Medicaid Fraction Dual Elig. Days CIRP Group
19-1269G	HRS CY 2013 DSH SSI Fraction Dual Eligible Days 3 Group
19-1271G	HRS CY 2013 DSH Medicaid Fraction Dual Eligible Days 3 Group
15-0285GC	HRS WKHS 2010 DSH Medicaid Fraction Dual Eligible Days CIRP Group
15-0595GC	HRS Prime Healthcare 2012 DSH Medicaid Fraction Dual Eligible Days CIRP Group
15-0337GC	HRS WKHS 2011 DSH SSI Fraction Dual Eligible Days CIRP Group
15-0338GC	HRS WKHS 2011 DSH Medicaid Fraction Dual Eligible Days CIRP Group
15-0369GC	HRS SCHS 2008 DSH SSI Fraction Dual Eligible Days CIRP Group
15-0371GC	HRS WKHS 2008 DSH SSI Fraction Dual Eligible Days CIRP Group
15-0542GC	HRS LSU 2012 DSH SSI Fraction Dual Eligible Days CIRP Group
15-0543GC	HRS LSU 2012 DSH Medicaid Fraction Dual Eligible Days CIRP Group

APPENDIX B

Grouping B – List of the 40 Group Cases Covered by the Consolidated Request for EJR Filed on January 17, 2022

14-0416G	HRS 2006 DSH Medicaid Fraction Dual Eligible Days Group
14-0860GC	HRS FMOLHS 2010 DSH SSI Fraction Dual Eligible Days CIRP Group
14-0864GC	HRS FMOLHS 2010 DSH Medicaid Fraction Dual Eligible Days CIRP Group
14-1276GC	HRS LSU 2009 DSH SSI Fraction Dual Eligible Days CIRP
14-1277GC	HRS LSU 2009 DSH Medicaid Fraction Dual Eligible Days CIRP
14-1522GC	HRS Prime Healthcare 2009 DSH SSI Fraction Dual Eligible Days CIRP Group
14-1523GC	HRS Prime Healthcare 2009 DSH Medicaid Fraction Dual Eligible Days CIRP
14-1768GC	HRS UHHS 2006 DSH Medicaid Fraction Dual Eligible Days CIRP Group
14-1769GC	HRS UHHS 2006 DSH SSI Fraction Dual Eligible Days CIRP Group
14-2107GC	HRS LSU 2010 DSH Medicaid Fraction Dual Eligible Days CIRP Group
14-2108GC	HRS LSU 2010 DSH SSI Fraction Dual Eligible Days CIRP Group
14-2310GC	HRS UHHS 2009 DSH SSI Fraction Dual Eligible Days CIRP Group
14-2311GC	HRS UHHS 2009 DSH Medicaid Fraction Dual Eligible Days CIRP Group
14-2930GC	HRS Prime Healthcare 2010 DSH Medicaid Fraction Dual Eligible Days CIRP
14-2931GC	HRS Prime Healthcare 2010 DSH SSI Fraction Dual Eligible Days CIRP Group
14-3522G	HRS 2006 DSH SSI Fraction Dual Eligible Days Group
15-0671GC	HRS FMOLHS 2012 DSH SSI Fraction Dual Eligible Days CIRP Group
15-0672GC	HRS FMOLHS 2012 DSH Medicaid Fraction Dual Eligible Days CIRP Group
15-0800GC	HRS FMOLHS 2007 SSI Fraction Dual Eligible Days CIRP
15-2188GC	HRS UHHS 2011 DSH SSI Fraction Dual Eligible Days CIRP Group
15-2189GC	HRS UHHS 2011 DSH Medicaid Fraction Dual Eligible Days CIRP Group
15-2656G	HRS 2011 DSH SSI Fraction Dual Eligible Days Group II
15-2657G	HRS 2011 DSH Medicaid Fraction Dual Eligible Days Group II
17-1236G	HRS 2014 DSH Medicaid Fraction Dual Eligible Days Group
17-1240G	HRS 2014 DSH SSI Fraction Dual Eligible Days Group
19-0049G	HRS CY 2015 DSH SSI Fraction Dual Eligible Days Group
19-0051G	HRS CY 2015 DSH Medicaid Fraction Dual Eligible Days Group
19-0129GC	HRS Sisters of Charity Health CY 2015 DSH SSI Fraction Dual Eligible Days
19-0131GC	HRS Sisters of Charity Health CY 2015 DSH Medicaid Fraction Dual Eligible
19-2065G	HRS CY 2016 DSH SSI Fraction Dual Eligible Days Group
19-2067G	HRS CY 2016 DSH Medicaid Fraction Dual Eligible Days Group
19-2521G	HRS CY 2017 DSH SSI Fraction Dual Eligible Days Group
19-2524G	HRS CY 2017 DSH Medicaid Fraction Dual Eligible Days Group
19-2527GC	HRS Willis-Knighton CY 2017 DSH SSI Fraction Dual Eligible Days CIRP
19-2529GC	HRS Willis-Knighton CY 2017 DSH Medicaid Fraction Dual Eligible Days
19-2644GC	HRS Sisters of Charity Health CY 2016 DSH SSI Fraction Dual Eligible Days
19-2646GC	HRS Sisters of Charity Health CY 2016 DSH Medicaid Fraction Dual Eligible
20-0259GC	HRS Lafayette General Health CY 2016 DSH SSI/Medicaid Dual Eligible Days
20-1801GC	HRS The Queens Health Systems CY 2017 DSH SSI Fraction Dual Eligible[86]
20-1803GC	HRS The Queens Health Systems CY 2017 DSH Medicaid Fraction Dual Eligible[87]

[86] *See supra* note 26 and accompanying text.
[87] *See supra* note 26 and accompany text.

APPENDIX C

Grouping C – List of the 17 Group Cases Covered by the Consolidated Request for EJR Filed on February 27, 2022

15-0007GC	HRS Prime Healthcare 2011 DSH Medicaid Fraction Dual Eligible Days Group
15-0008GC	HRS Prime Healthcare 2011 DSH SSI Fraction Dual Eligible Days Group
15-2680GC	HRS Prime Healthcare 2013 DSH SSI Fraction Dual Eligible Days Group
15-2402GC	HRS DCH 2012 DSH SSI Fraction Dual Eligible Days Group
15-2403GC	HRS DCH 2012 DSH Medicaid Fraction Dual Eligible Days Group
15-2629GC	HRS UHHS 2012 DSH Medicaid Fraction Dual Eligible Days Group
15-2630GC	HRS UHHS 2012 DSH SSI Fraction Dual Eligible Days Group
15-2681GC	HRS Prime Healthcare 2013 DSH Medicaid Fraction Dual Eligible Days Group
16-1317GC	HRS UHHS 2013 DSH SSI Fraction Dual Eligible Days Group[88]
16-1318GC	HRS UHHS 2013 DSH Medicaid Fraction Dual Eligible Days Group[89]
16-2439GC	HRS LSU 2013 DSH Medicaid Fraction Dual Eligible Days Group
16-2442GC	HRS LSU 2013 DSH SSI Fraction Dual Eligible Days Group
17-0438GC	HRS WKSH 2013 DSH SSI Fraction Dual Eligible Days Group
17-0439GC	HRS WKSH 2013 DSH Medicaid Fraction Dual Eligible Days Group
19-2147G	HRS CY 2014 DSH SSI Fraction Dual Eligible Days Group
19-2149G	HRS CY 2014 2013 DSH Medicaid Fraction Dual Eligible Days Group
20-0056GC	HRS Willis-Knighton CY 2016 DSH SSI/Medicaid Dual Eligible Days Group

[88] By letter dated April 4, 2022, the Board expanded Case Nos. 15-2629GC and 15-2630GC to include CY 2012 and consolidated them with Case Nos. 16-1317GC and 16-1318GC respectively. As a result of this consolidation, the Board closed Case Nos. 16-1317GC and 16-1318GC.

[89] *See supra* note 88.

APPENDIX D

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

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

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

Dear Mr. Berends and Ravindran:

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

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

[2] *See supra* note 1.

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

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

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

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

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

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

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

Procedural Background

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

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

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

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

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

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

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

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

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

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

[17] (Emphasis in original.)

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

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

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

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

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

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

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[18] *See supra* note 3.

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

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

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

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

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

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

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

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

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

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

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

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

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

Board Findings and Ruling:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. *Prohibited Duplicate Appeals*

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

2. *Providers With No Appeal Rights*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4. Prohibited Participation of CIRP Providers in Optional Groups

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

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

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

5. *Unauthorized Representation of Participants*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[93] 42 C.F.R. § 405.1868 states:

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

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

(1) Dismiss the appeal with prejudice;

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

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

(Emphasis added.)

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

* * * * *

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

Board Members Participating:

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For the Board:

6/10/2022

X Clayton J. Nix

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

Enclosures: List of Groups

cc: Bill Tisdale, Novitas Solutions
Judith Cummings, CGS
Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators
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Wilson Leong, FSS
Jacqueline Vaughn, OAA

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

LIST OF 80 GROUP CASES

09-1903GC	BHCS 07 DSH Dual Eligible Days
13-1419G	QRS 2006 DSH SSI Fraction Denominator/Dual Eligible Group
13-1440G	QRS 2006 DSH Medicaid Fraction/Dual Eligible Group
13-1720GC	Scott & White 2008 Medicaid Fraction Dual Elig Days CIRP Group
13-1722GC	Scott & White 2008 DSH SSI Fraction Dual Elig Days CIRP Group
13-2678G	QRS 2007 DSH Medicaid Fraction Dual Eligible Days Group (2)
13-2693G	QRS 2008 DSH Medicaid Fraction Dual Eligible Days Group
13-2901GC	QRS BJC 2007 DSH SSI Fraction Dual Eligible Days CIRP Group
13-2903GC	QRS Novant 2007 SSI Fraction Dual Eligible Days CIRP Group
13-2904GC	QRS Novant 2007 Medicaid Fraction Dual Eligible Days CIRP Group
13-3061GC	QRS WFHC 2009 Medicaid Fraction Dual Eligible CIRP Group
13-3191GC	QRS Novant 2006 DSH Dual Eligible Days
13-3942G	QRS 2009 DSH Medicaid Fraction/Dual Eligible Days Group
13-3944G	QRS 2009 DSH SSI Fraction/Dual Eligible Days Group
14-1171G	QRS 2008 DSH SSI Fraction Dual Eligible Days Group
14-1174G	QRS 2007 DSH SSI Fraction Dual Eligible Days Group
14-1816G	QRS 2010 DSH SSI Fraction Dual Eligible Days Group
14-1818G	QRS 2010 DSH Medicaid Fraction Dual Eligible Days Group
14-2217GC	QRS Novant 2009 DSH Medicaid Fraction Dual Eligible Days CIRP Group
14-3306G	QRS 2011 DSH Medicaid Fraction Dual Eligible Days Group
14-3308G	QRS 2011 DSH SSI Fraction Dual Eligible Days Group
15-0018G	QRS 2012 DSH Medicaid Fraction/Dual Eligible Days Group
15-1067G	QRS 2006 DSH Medicaid Fraction Dual Eligible Days Group (2)
15-1147G	QRS 2006 DSH SSI Fraction Dual Eligible Days Group (2)
15-1152GC	QRS Novant 2010 DSH Medicaid Fraction Dual Eligible Days CIRP Group
15-1419G	QRS 2012 DSH SSI Fraction Dual Eligible Days Group
15-2385G	QRS 2010 DSH SSI Fraction Dual Eligible Days Group II
15-2386G	QRS 2010 DSH Medicaid Fraction Dual Eligible Days Group II
15-3031G	QRS 2011 DSH Medicaid Fraction Dual Eligible Days Group 2
15-3039G	QRS 2011 DSH SSI Fraction Dual Eligible Days Group 2
15-3073GC	QRS Progressive Acute Care 2011 DSH Medicaid Fraction/Dual Eligible Days
16-0091GC	HRS DCH 2010 DSH SSI Fraction Dual Eligible Days CIRP Group
16-0092GC	HRS DCH 2010 Medicaid Fraction Dual Eligible Days CIRP Group
16-1142G	QRS 2013 DSH SSI Fraction Dual Eligible Days Group
16-1145G	QRS 2013 DSH Medicaid Fraction Dual Eligible Days Group
16-1750G	QRS 2012 DSH SSI/Medicaid Dual Eligible Days Group II
17-0867G	QRS 2014 DSH SSI/Medicaid Dual Eligible Days Group
17-1405G	QRS 2013 DSH SSI Fraction Dual Eligible Days Group (2)
17-1406G	QRS 2013 DSH Medicaid Fraction Dual Eligible Days Group (2)
17-1409G	QRS 2005 DSH SSI Fraction Dual Eligible Days Group
17-1412G	QRS 2005 DSH Medicaid Fraction Dual Eligible Days Group
17-1426G	QRS 2006 DSH SSI Fraction Dual Eligible Days Group 3

17-1427G	QRS 2006 DSH Medicaid Fraction Dual Eligible Days Group
18-0270G	QRS 2007 DSH SSI Fraction Dual Eligible Days Group (3)
18-0730G	QRS 2011 DSH SSI Fraction Dual Eligible Days Group III
18-1259G	QRS 2014 DSH SSI Fraction Dual Eligible Days Group 2
18-1260G	QRS 2014 DSH Medicaid Fraction Dual Eligible Days Group 2
18-1405G	QRS 2015 DSH Medicaid Fraction Dual Eligible Days Group
18-1408G	QRS 2015 DSH SSI Fraction Dual Eligible Days Group
18-1738GC	AHMC Healthcare CY 2012 DSH Medicaid Fraction Dual Eligible Days CIRP
19-0012GC	AHMC Healthcare CY 2015 DSH SSI Fraction Dual Eligible Days CIRP Group
19-0014GC	AHMC Healthcare CY 2015 DSH Medicaid Fraction Dual Eligible Days CIRP
19-0164GC	AHMC Healthcare CY 2013 DSH Medicaid Fraction Dual Eligible Days CIRP Group
19-0195GC	Houston Methodist CY 2014 DSH SSI Fraction Dual Eligible Days CIRP Group
19-0235GC	Houston Methodist CY 2014 DSH Medicaid Fraction Dual Eligible Days CIRP
19-0270GC	Mercy CY 2016 DSH SSI Fraction Dual Eligible Days CIRP Group
19-0272GC	Mercy CY 2016 DSH Medicaid Fraction Dual Eligible Days CIRP Group
19-0534G	QRS CY 2011 DSH Medicaid Fraction Dual Eligible Days (3) Group
19-0704G	QRS CY 2012 DSH SSI Fraction Dual Eligible Days (3) Group
19-0706G	QRS CY 2012 DSH Medicaid Fraction Dual Eligible Days (3) Group
19-2131GC	Hartford Health CY 2015 DSH SSI Fraction Dual Eligible Days CIRP Group
19-2134GC	Hartford Health CY 2015 DSH Medicaid Fraction Dual Eligible Days CIRP
19-2513G	QRS CY 2016 DSH SSI Fraction Dual Eligible Days Group
19-2515G	QRS CY 2016 DSH Medicaid Fraction Dual Eligible Days Group
19-2594G	QRS CY 2015 DSH SSI Fraction Dual Eligible Days (2) Group
19-2596G	QRS CY 2015 DSH Medicaid Fraction Dual Eligible Days (2) Group
20-0107G	QRS CY 2013 DSH SSI Fraction Dual Eligible Days (3) Group
20-0112G	QRS CY 2013 DSH Medicaid Fraction Dual Eligible (3) Group
20-0209G	QRS CY 2010 DSH SSI Fraction Dual Eligible Days (3) Group
20-0211G	QRS CY 2010 DSH Medicaid Fraction Dual Eligible (3) Group
20-0244G	QRS CY 2007 DSH Medicaid Fraction Dual Eligible Days (4) Group
20-0248G	QRS CY 2006 DSH SSI Fraction Dual Eligible Days (4) Group
20-0250G	QRS CY 2006 DSH Medicaid Fraction Dual Eligible Days (4) Group
20-0367G	QRS CY 2005 DSH SSI Fraction Dual Eligible Days (2) Group
20-0368G	QRS CY 2005 DSH Medicaid Fraction Dual Eligible Days (2) Group
20-0409GC	AHMC Healthcare CY 2016 DSH SSI Fraction Dual Eligible Days CIRP Group
20-0411GC	AHMC Healthcare CY 2016 DSH Medicaid Fraction Dual Eligible Days CIRP
20-1511G	QRS CY 2014 DSH SSI Fraction Dual Eligible Days (2) Group
20-1513G	QRS CY 2014 DSH Medicaid Fraction Dual Eligible Days (2) Group
20-1655G	QRS CY 2007 DSH SSI Fraction Dual Eligible Days (4) Group

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Dismissal of Duplicate Appeal***
13-3812GC Carolinas Healthcare System 2007 DSH Medicaid Fraction Part C Days CIRP Group

Dear Mr. Ravindran and Ms. Johnson:

The above-referenced common issue related party ("CIRP") group appeal for Carolinas Healthcare System includes a challenge to the inclusion of Medicare Part C days in the Medicare fraction of the disproportionate share ("DSH") percentage and/or the exclusion of Medicare Part C days for patients who are dually eligible for Medicaid from the Medicaid fraction of the DSH percentage, for patient discharges *before* October 1, 2013. In reviewing the documentation, the Provider Reimbursement Review Board (the "Board") noted that the common owner of this group has an identical case for the Medicaid Fraction Part C Days issue for this specific fiscal year, in another CIRP group case. Specifically, PRRB Case No. 17-1562GC, has all six providers included in the group appeal for the identical fiscal year and cost reports.[1] As such, the above CIRP group appeal violates the CIRP regulation, is duplicative, and must be dismissed.

Background

This case was created by the Board via bifurcation from PRRB Case No. 13-1377GC on September 26, 2013, regarding CMS's inclusion of Part C Days in the Medicaid Fraction calculation.[2] In communication to the parties, the Board said:

> Board Rules require one FYE per group unless FYEs must be combined to meet the amount in controversy threshold, or by special permission. Therefore, since this Provider is appealing FYE 12/31/2007, a new group appeal is being established for the 2007 year.

There are six remaining providers:

[1] **Note:** PRRB Case No. 17-1562GC has pending documentation to be remanded to the Medicare Contractor under 1739-R.

- Carolinas Medical Center – University (Prov. No. 34-0166);
- Union Memorial Regional Medical Center (Prov. No. 34-0130);
- Carolinas Medical Center (Prov. No. 34-0113);
- Carolinas Medical Center – Lincolnton (Prov. No. 34-0145);
- Valdese General Hospital, Inc. (Prov. No. 34-0055); and
- Cleveland County Healthcare System (Prov. No. 34-0021).

These six (6) Providers are also participants in Case No. 17-1562GC. However, Case No. 17-1562GC includes additional providers not included in the instant appeal. As there are additional Providers in Case No. 17-1652GC, the Board will allow that case to remain open for these six (6) Providers, ***and*** the additional Providers in that group.

Board's Analysis and Decision

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

> Two or more providers under common ownership or control that wish to appeal to the Board a specific matter at issue that involves a question of fact or interpretation of law, regulations, or CMS Rulings that is common to the providers, and that arises in cost reporting periods that end in the same calendar year, and for which the amount in controversy is $50,000 or more in the aggregate, must bring the appeal as a group appeal.[3]

Subsection (e) requires that the group provider provide notice that the group is fully formed and complete.[4] Once the group is certified as complete, restrictions are placed on the ability for additional providers under common ownership:

> When the Board has determined that a group appeal brought under paragraph (b)(1) of this section is fully formed, absent an order from the Board modifying its determination, no other provider under common ownership or control may appeal to the Board the issue that is the subject of the group appeal with respect to a cost reporting period that falls within the calendar year(s) covered by the group appeal.[5]

Pursuant to the CIRP regulations at 42 C.F.R. 405.1837(b)(1) and (e), any additional providers outside of this group would be part of a duplicate case, violating those same CIRP regulations.[6] As PRRB Case No. 17-1562GC was part of the same common ownership, for the

[3] 42 C.F.R. § 405.1837(b)(1).
[4] 42 C.F.R. § 405.1837(e)(1).
[5] *Id*.
[6] *See* 42 C.F.R. § 405.1837(e) ("[w]hen the Board has determined that a group appeal brought under paragraph (b)(1) of this section is fully formed, absent an order from the Board modifying its determination, no other provider

same issue (Medicaid Fraction Part C Days), and for the same fiscal year, any providers within this case are in violation of 405.1837(b)(1) and (e), and thus must be dismissed.

As such, the Board dismisses the DSH Part C Days issue from PRRB Case No. 13-3812GC because the providers violated the CIRP regulations 42 C.F.R. § 405.1837(b)(1) and (e), and dismisses the case.

The Board hereby closes the group appeal and removes it from the Board's docket. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

9/28/2022

X Kevin D. Smith, CPA

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

cc: Wilson Leong, FSS

under common ownership or control may appeal to the Board the issue that is the subject of the group appeal with respect to a cost reporting period that falls within the calendar year(s) covered by the group appeal.").

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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Dana Johnson
Palmetto GBA c/o Nat. Gov. Servs. Inc.
P.O. Box 6474 Mailpoint INA101-AF-42
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RE: ***Jurisdictional Decision***
Healthcare Partners at Home LLC (Prov. No. 14-7958, FYE 03/31/2018)
Case No. 19-2694

Dear Mr. Kunio and Ms. Johnson,

The Provider Reimbursement Review Board ("PRRB or Board") has reviewed the documents in the above-referenced appeal involving Healthcare Partners at Home LLC ("Healthcare Partners" or "Provider") and the Home Health Quality Reporting Program ("HH-QRP"). As set forth below, the Board finds that it does not have jurisdiction over Healthcare Partners' appeal and, as a result, dismisses the appeal.[1]

Background

Healthcare Partners is a home health agency ("HHA") located in Chicago, Illinois.[2] The Provider's assigned Medicare contractor[3] is Palmetto GBA ("Medicare Contractor").

On March 27, 2018, Healthcare Partners was acquired by the holding company, Wellness Partners of Illinois ("Wellness Partners") which is owned and/or controlled by Robert Kunio ("current owner/administrator" or "Mr. Kunio").[4] Following the acquisition, Mr. Kunio used the following address to receive mail for Healthcare Partners: 2912 North Lincoln Avenue, Suite 2A, Chicago Illinois 60657-4109 (hereinafter the "Chicago address").[5] During the time period at issue Wellness Partners owned 100 percent of Healthcare Partners.[6]

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[1] Prior to the hearing (and reaffirmed at the start of the hearing), the Board notified the parties that the Board had identified the jurisdictional issue discussed herein and would be using the hearing, in part, to develop the record for that issue. Hearing Transcript ("Tr.") at 7-8. The Board further notes that: (1) parties are required to brief jurisdiction as part of their positions papers per 42 C.F.R. § 405.1853(b)(2); (2) Board review of jurisdiction may occur at any time even after a Board hearing, whether on the Board's initiation or upon filing of a jurisdictional challenge per 42 C.F.R. § 405.1840(a) and Board Rules 4.1 and 44.4; and that "[t]he Board may revise a preliminary determination of jurisdiction at any subsequent stage of the proceedings in a Board appeal" per § 405.1840(a)(3).
[2] Medicare Contractor's Final Position Paper ("Medicare Contractor's FPP") at 3 (Dec. 16, 2020).
[3] Formerly known as fiscal intermediaries ("FIs"), CMS' payment/audit functions under the Medicare program are now contracted to organizations known as Medicare administrative contractors ("MACs"). However, the term "intermediary" is still used in various statutes and regulations, and is interchangeable with the terms MAC or "Medicare contractor."
[4] Tr. at 42.
[5] Tr. at 72, 110; Exhibit P-7 (copy of the July 24, 2018 Palmetto GBA 855A application closure).
[6] Tr. at 42.

Prior to March 27, 2018, Healthcare Partners was owned by Manish Patel ("previous owner/administrator" or "Mr. Patel"). Mr. Patel used the following address which was his home address to receive for Healthcare Partners: 532 North Oaklawn Avenue, Elmhurst, Illinois 60126-1827 (hereinafter the "Elmhurst address").[7]

On May 28, 2018, Mr. Kunio submitted a CMS-855A form to the Medicare Contractor's Provider Enrollment Department to inform the Medicare Program that the ownership of Healthcare Partners had changed to Wellness Partners and that the address had changed to the Chicago address.[8] By letter dated July 24, 2018, the Medicare Contractor's Provider Enrollment Department sent notice to Healthcare Partners at the Chicago address notifying it that the CMS-855A form had been rejected because 42 C.F.R. § 424.550(b)(1) specifies that the Medicare provider agreement and Medicare billing privileges do not convey to a new owner if there is a change in the majority ownership of an HHA within 36 months after the effective date of the HHA's initial enrollment. Accordingly, the Medicare Contractor inactivated Healthcare Partners' PTAN (or Provider Transaction Access Number) which is a Medicare-only number issued to providers by their Medicare contractor upon enrollment to Medicare. Mr. Kunio appealed the denial and inactivation. On January 11, 2019, the Medicare Contractor sent Health Partners a letter informing it that the change of ownership had been processed and that its PTAN had been reactivated.[9]

In the interim, by letter dated September 12, 2018, the Medicare Contractor sent a HH-QRP final determination to Mr. Patel of Healthcare Partners using Healthcare Partners' prior Elmhurst address. The final determination notified Healthcare Partners that the Centers for Medicare and Medicaid Services ("CMS") had determined that the HHA would be subject to a 2 percent reduction in the annual payment update ("APU") for episodes of care that ended on or after January 1, 2019, and prior to January 1, 2020, for not meeting the Deficit Reduction Act ("DRA") of 2005 requirement for HHAs to submit certain quality data during the reporting period of April 1, 2017 through March 31, 2018. The final determination further notified Healthcare Partners that, if it did not agree with the CMS' decision, it must submit a letter requesting reconsideration via email to CMS and provide documentation of its compliance postmarked *no later than 30 days* ***from the date of the notification***.[10] Significantly, the final determination stated "[an HHA must submit a request for reconsideration and receive a decision on that request before they can file an appeal with the Provider Reimbursement Review Board (PRRB)."[11] The letter did indicate that Healthcare Partners had a right to appeal the final determination to the Board without requesting reconsideration and receiving a decision on that request.

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[7] Tr. at 28, 42, 106-07; Exhibit P-2 (copy of the Sept. 12, 2018 HH-QRP final determination).
[8] Tr. at 65.
[9] Exhibit P-7. The January 11, 2019 letter was mailed to the Chicago address, but noted that the Practice Location was the Elmhurst address. It also noted that the Special Payments Address was updated from the Elmhurst address to the Chicago address, and requested that the Provider "verify the accuracy of your enrollment information." Any verification made by Mr. Kunio as a result of this letter would have been after the HH-QRP determination letter, and does not influence the decision in the present appeal.
[10] Exhibit P-2 at 1-3.
[11] *Id.* at 3.

On August 13, 2019, Mr. Kunio, via email to the CMS HHAPU reconsideration team, inquired about filing a reconsideration of the September 12, 2018 letter stating, "[s]ince the agency was first made aware of this penalty on 08/05/2019, are we still within the 30 day period to appeal this penalty to you folks?"[12] The quality reporting program ("QRP") Help Desk (a contractor for CMS) responded to Mr. Kunio's email stating:

> Good morning, Thank you for your email. The reconsideration for Home Health Agencies is the same time period for all providers. This 30-day period occurs in the fall of each year. . . . Providers may only request a reconsideration during the 30-day reconsideration window.[13]

On September 6, 2019, after numerous email exchanges between the QRP Help Desk and Mr. Kunio, the QRP Help Desk wrote to Mr. Kunio stating that, while the Healthcare Partners email exchange with the QRP Help Desk did not constitute an official reconsideration decision, CMS shared that Healthcare Partners could reach out to the PRRB indicating that that the Medicare Contractor's use of an incorrect address prevented Healthcare Partners from filing a reconsideration request within the required 30-day timeframe.[14]

On September 17, 2019, Healthcare Partners submitted an appeal request to the Board and attached the September 6, 2019 email from the QRP Help Desk as the determination being appealed.[15] The Board assigned the appeal to Case No. 19-2694. Following the parties' submission of Position Papers, the Board held a video hearing on April 1, 2021. Healthcare Partners was represented by Robert Kunio, Esq. The Medicare Contractor was represented by Joseph Bauers, Esq. and Charles Moreland, Esq. of Federal Specialized Services, LLC.

Provider's Position

In March of 2017, the previous administrator of the HHA, Mr. Patel, "started discharging patients in anticipation of putting the HHA up for sale and the HHA's patient census was brought down to zero in May of 2017."[16] Healthcare Partners contends that Mr. Patel assumed that zero active patients eliminated the need to conduct and report Home Health Care Consumer Assessment of Healthcare Providers Systems ("HHCAHPS") surveys and, as a result, he instructed NRC Health of Omaha, the HHA's survey contractor, to stop conducting surveys after the second quarter 2017 reporting cycle. "The last submission that NRC made to the HHCAHPS website was for zero completed surveys covering the June 2017 sample month,"[17] because, Healthcare Partners asserts that the HHA had no active patients for the remaining nine months of the reporting period "and no data was uploaded to the HHCAHPS website to report this absence of patients."[18] Healthcare Partners contends "[t]his lack of

[12] Exhibit P-8.
[13] Exhibit P-9.
[14] *Id.*
[15] Exhibit P-10.
[16] Provider's Final Position Paper ("Provider's FPP") at 3.
[17] *Id.*
[18] *Id.*

survey reporting for the nine-month period of July 1, 2017 to March 31, 2018 caused the HHA to be out of compliance for the full twelve-month period from April 1, 2017, to March 31, 2018."[19]

In March of 2018, the HHA was sold to Robert Kunio through the holding company, Wellness Partners, which became the new owner.[20] Further, Mr. Kunio became the new administrator, and the HHA was moved from the Elmhurst address to the Chicago address. In May of 2018, Healthcare Partners sent a CMS Form 855A informing the Medicare Contractor's Provider Enrollment Department "that the address, owners, and management of the HHA had changed."[21] Healthcare Partners asserts by doing so it "met its obligation to provide the Medicare Contractor with its current address and updated contact information."[22] Healthcare Partners contends that, *in a letter dated July 24, 2018*, addressed to it at the Chicago address, the Medicare Contractor's Provider Enrollment Department confirmed that it had received and processed the CMS-855A Form. In this letter, the Medicare Contractor also informed Healthcare Partners that its PTAN was inactivated based on change of ownership information contained in the Form 855A, even though the ownership change met an exception to the 36-month change of ownership rule. Healthcare Partners argues this letter contradicts the Medicare Contractor's assertion that it failed to update enrollment information with the Medicare Contractor on a timely basis.[23]

On September 12, 2018, two months after the Medicare Contractor's Provider Enrollment Department sent the July 24, 2018 letter using the Chicago address, the Medicare Contractor's Provider Reimbursement Department sent the HH-QRP final determination at issue to the attention of Healthcare Partners' previous administrator, Mr. Patel, using Healthcare Partners' prior Elmhurst address. As previously noted, this final determination informed Healthcare Partners that a 2 percent penalty had been imposed on claims for all episodes ending in 2019 as a result of non-compliance with HHCAHPS reporting requirements in the period of April 1, 2017, to March 31, 2018. It also informed Healthcare Partners that it had 30 days to request a reconsideration of the 2 percent penalty. Healthcare Partners asserts that, because the Elmhurst address was no longer its address, the final determination never found its way to its new Chicago address and new administrator, Mr. Kunio. Healthcare Partners also maintains that Mr. Patel claims he never received the letter (however, there is no statement or testimony from Mr. Patel in the record).[24] On that same date, Healthcare Partners' asserts that it requested a reconsideration of the July 24, 2018 letter that it had received from the Medicare Contractor advising of its enrollment (PTAN) deactivation. The date of this letter, filed by Healthcare Partners' attorney, Michael J. Raiz, is verified in the CMS letter dated December 18, 2018 as Exhibit 2 of the documents evaluated by CMS in their reconsideration of the PTAN deactivation.[25]

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[19] *Id.*
[20] Tr. at 42; Provider's FPP at 3.
[21] Provider's FPP at 3.
[22] *Id.*
[23] *Id.* at 4.
[24] *Id.*
[25] Exhibit P-11 at 3.

On December 12, 2018, a CMS Hearing Officer sent a letter to Healthcare Partners, at its Chicago address, advising that CMS reviewed all correspondence related to its appeal of its PTAN inactivation, a favorable decision had been reached, and its PTAN would be reactivated by the Medicare Contractor. Healthcare Partners contends the letter acknowledged that an error had been made by the Medicare Contractor in deactivating the PTAN because the HHA qualified for an exception to the 36-month change of ownership rule. Healthcare Partners concludes that this letter shows that the Medicare Contractor and CMS were both aware that the HHA had been located at the Chicago address since the CMS-855A Form was filed in May 2018.[26]

Healthcare Partners contends that it only learned of the September 12, 2018 HH-QRP final determination after the 2 percent penalty was being assessed on claims in July 2019. Specifically, after noticing that episodes ending in 2019 were being penalized 2 percent, on July 2, 2019, Healthcare Partners sent an email to the Medicare Contractor requesting an investigation. "The Medicare Contractor responded by emailing Mr. Kunio a copy of the letter it had sent to Mr. Patel on September 12, 2018," which Healthcare Partners maintains "was the first time Mr. Kunio had seen this letter."[27] Beginning August 13, 2019, through September 6, 2019, Mr. Kunio engaged in several email exchanges with the team in charge of CMS reconsiderations asking for approval to submit a formal reconsideration request and was told that "the 30-day window for reconsideration was closed and could not be reopened."[28] Healthcare Partners contends the emails ended with the QRP Help Desk advising it that the email conversations do not constitute an official reconsideration decision and that it could reach out to the PRRB. Healthcare Partners maintains "[e]xcept for not being sent within 30 days of the letter announcing the 2% penalty, the information in these emails met all the requirements of 42 C.F.R. § 484.245(d)(ii)."[29] The Provider filed an appeal with the Board on September 17, 2019.[30]

Healthcare Partners argues that it "met its responsibilities to update its enrollment information on a timely basis [and that] the [Medicare Contractor's] Provider Enrollment Department was fully aware of the Provider's new address but it appears that this information may not have been shared with other departments including the Provider Reimbursement Department."[31] Healthcare Partners maintains 42 C.F.R. § 484.245 "is silent on what to do when an HHA finds itself with zero active patients" and that "[a] reasonable person could easily assume that zero active patients in a quarter could mean zero reporting requirements for that quarter."[32] Healthcare Partners maintains had the letter dated September 12, 2018, "been sent to the correct address," the request for reconsideration . . . would have been made within the required 30-day window."[33] Furthermore, the reconsideration request would have cited § 484.245(c)(1) which provides:

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[26] Provider's FPP at 4.
[27] *Id.* at 5.
[28] *Id.*
[29] *Id.*
[30] *Id.*
[31] *Id.*
[32] *Id.*
[33] *Id.* at 6.

> An HHA may request and CMS may grant exceptions and extensions to the reporting requirements...when there are certain extraordinary circumstances beyond the control of the HHA.

Healthcare Partners asserts that "the actions of the [Medicare Contractor] in deactivating the PTAN, which later had to be reversed by the Provider Enrollment and Oversight Group . . . constitutes extraordinary circumstances that were clearly beyond the HHA's control."[34] Healthcare Partners maintains the erroneous deactivation was "most likely the root cause of the [Medicare Contractor's] Reimbursement Department not being informed by the Provider Enrollment Department that the HHA's ownership and address had changed."[35] Healthcare Partners requests that the Board retroactively grant it an HHCAHPS reporting exception for the nine-month period. Healthcare Partners also requests that the Board instruct the Medicare Contractor to remit to it the money it withheld as part of the 2 percent penalty that was applied to all episodes that ended in 2019.[36]

Board Decision

Healthcare Partners' right to appeal determinations involving the HH-QRP is provided in 42 C.F.R. § 484.245(d)-(e), Requirements under the Home Health Quality Reporting Program, which states:

> (d) *Reconsiderations*. (1)(i) HHAs that do not meet the quality reporting requirements under this section for a program year will receive a letter of noncompliance via the United States Postal Service and the CMS-designated data submission system.
>
> (ii) An HHA may request reconsideration no later than 30 calendar days after the date identified on the letter of non-compliance.
>
> (2) Reconsideration requests may be submitted to CMS by sending an email to CMS HHAPU reconsiderations at HHAPureConsiderations@cms.hhs.gov . . . .
>
> (3) CMS does not consider a reconsideration request unless the HHA has complied fully with the submission requirements in paragraphs (d)(1) and (2) of this section.
>
> (4) CMS makes a decision on the request for reconsideration and provide notice of the decision to the HHA via letter sent via the United States Postal Service.

[34] *Id.*
[35] *Id.*
[36] *Id.* at 6.

> (e) *Appeals*. An HHA that is dissatisfied with CMS' decision on a request for reconsideration submitted under paragraph (d) of the section may file an appeal with the Provider Reimbursement Review Board (PRRB).

Accordingly, the regulation specifies that an HHA may appeal a CMS decision on a request to reconsider a HH-QRP final determination.

In this case, Healthcare Partners alleges that it did not receive the Medicare Contractor's September 12, 2018 HH-QRP final determination until August 5, 2019, because it was sent to the previous administrator using Healthcare Partners prior address.[37] The Board finds the record reflects that an email with the attached noncompliance letter was sent by the Medicare Contractor to Mr. Kunio on August 2, 2019.[38] On August 13, 2019, after receiving the noncompliance notice, Healthcare Partners sent an email to the CMS HHAPU reconsideration team at HHAPUreconsiderations@cms.hhs.gov, inquiring about filing a reconsideration of the September 12, 2018 letter as follows:

> Since the agency was first made aware of this penalty on 08/05/2019, are we still within the 30 day period to appeal this penalty to you folks?
>
> . . . .
>
> If the 30 day window is still open I can have the formal appeal letter with OASIS transmission logs that prove all were within 30 days in your hands on or before September 4th.[39]

The QRP Help Desk responded to Healthcare Partners' inquiry stating:

> Good morning,
>
> Thank you for your email. The reconsideration for Home Health Agencies is the same time period for all providers. This 30-day period occurs in the fall of each year. The dates for the period are outlined in the notice of non-compliance as well as on the QRP web page . . .
>
> Providers may only request a reconsideration during the 30-day reconsideration window.

[37] Provider's FPP at 4.
[38] Exhibit P-8 at 1-2.
[39] *Id.* at 1.

> You may submit an exemption/extension request at any time. That process is also outlined at the link shared above.[40]

On September 6, 2019, after numerous email exchanges between the QRP Help Desk and Healthcare Partners, the QRP Help Desk wrote to Healthcare Partners and stated:

> I have already heard back from CMS. While the email conversations we have had to [*sic*] not constitute an official reconsideration decision, CMS shared that you can reach out to the PRRB and indicate that the MAC's use of an incorrect address created the situation thus preventing you from filing for reconsideration within the required timeframe.[41]

On September 17, 2019, Healthcare Partners filed an appeal request with the Board and identified the September 6, 2019 email from the QRP Help Desk as the "final determination" being appealed.[42]

The Board finds the September 6, 2019 email from which Healthcare Partners filed its appeal with the Board is a not a CMS decision on a request for reconsideration under 42 C.F.R. § 484.245(e), much less a Contractor determination as that term is defined in 42 C.F.R. § 405.1801. In this case, CMS never made "a decision on the request for reconsideration and provide notice of the decision to the HHA via letter sent via the United States Postal Service [USPS]" as specified in § 484.245(d)(4). Accordingly, the Board finds that Healthcare Partners appeal of the QRP Help Desk's September 6, 2019 email was not proper because it was not a CMS reconsideration decision that conferred appeal rights to the Board. Indeed, that email specifically stated that the email conversations do ***not*** constitute an official reconsideration decision. The Board finds the regulation at 42 C.F.R. § 484.245(e) grants providers a right to a hearing, but only with respect to CMS reconsideration decisions. The Board finds Healthcare Partners admits that the September 6, 2019 email does not constitute a CMS decision of a request for reconsideration. "[T]he Provider states that there was no official reconsideration decision made by CMS and that CMS merely avoided such a decision and suggested via the QRP desk that the Provider reach out to the PRRB."[43] As Healthcare Partners did not file its appeal with the Board from a final CMS decision on a request for reconsideration, the Board concludes that it does not have jurisdiction over the Healthcare Partners' appeal of the September 6, 2019 HHCAHPS quality data reporting program payment adjustment email/issue and dismisses the issue from the appeal. As the HHCAHPS quality data reporting program payment adjustment issue is the only issue in this appeal, the Board hereby closes Case No. 19-2694.[44]

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[40] Exhibit P-9 at 8.
[41] *Id*. at 1.
[42] *Id*. Ex. P-10. Per 42 C.F.R. § 405.1835(a)(3), an appeal request must be filed within 180 days of the provider's receipt of the determination where receipt is presumed to be 5 days from the date of the determination (per the definition of date of receipt in § 405.1801). Accordingly, it is clear that Healthcare Partners' September 17, 2019 appeal to the Board would not be timely if it were based on the September 12, 2018 HH-QRP final determination.
[43] Provider's Post Hearing Brief at 4 (May 28, 2021).
[44] The Board is sympathetic to the Provider due to the confusion surrounding the Provider's submission of CMS Form 855A to the Medicare Contractor which informed the Medicare Contractor that its address, owners and management of the HHA had changed; the subsequent July 24, 2018 letter sent by the Medicare Contractor to the

Finally, *the Board formally refers this matter to CMS HHAPU reconsiderations* to consider, as appropriate, whether circumstances warrant processing a belated request for reconsideration. Specifically, the Board refers this matter to CMS HHAPU reconsiderations for its consideration of the facts and circumstances to determine if good cause is present to issue a CMS reconsideration decision, outside of the 30-day deadline for reconsideration requests, as the status of this situation is unclear.[45] Accordingly, the Board is carbon copying CMS on this decision.

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

Board Members participating:

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

FOR THE BOARD

9/29/2022

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services
Jerrod Olszewski, Federal Specialized Services
Jackie Vaughn, Office of the Attorney Advisor
CMS HHAPU reconsiderations (*HHAPUReconsiderations@cms.hhs.gov*)

Provider informing the Provider that it had received the Provider's CMS Form 855A but had closed its application without processing because its PTAN had been inactivated based on the change of ownership information contained in the CMS Form 855A; and the subsequent December 12, 2018 letter sent from CMS reversing the July 24, 2018 decision and reactivating the Provider's PTAN because the Provider qualified for an exception to the 36 month change of ownership rule which resulted in the Provider's address not being updated by the Medicare Contractor until after the September 12, 2018 notice was mailed. However, the Board is bound by the regulation at 42 C.F.R. § 484.245(e) which provides that only HHAs dissatisfied with "CMS' decision on a request for reconsideration" can file appeals to the Board. The Provider's appeal was not filed from a CMS decision on a request for reconsideration.

[45] The Board recognizes that it may not require or order CMS to take any actions in this case. The Board's remand authority is located at 42 C.F.R. § 405.1845(h) and this regulation specifies only that "[t]he Board may order a remand requiring specific actions ***of a party*** to the appeal." (Emphasis added.) However, this regulation is not applicable to CMS because 42 C.F.R. § 405.1843(b) specifies that CMS is never a party in Board appeals or proceedings.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Jurisdictional Determination***
Santa Clara Valley Medical Center (Prov. No. 05-0038)
FYE 6/30/2017,
Case No. 21-1521

Dear Ms. Giberti and Ms. Frewert:

The Provider Reimbursement Review Board ("Board") has reviewed the subject individual appeal filed by Toyon Associates, Inc. ("Toyon" or "Representative") and the request to transfer the Provider to a fully formed optional group appeal. The pertinent facts with regard to the Provider's appeal and the jurisdictional determination of the Board, are set forth below.

Pertinent Facts

On August 2, 2021, Toyon filed a request to establish an individual appeal under Case No. 21-1521 for Santa Clara Valley Medical Center (Prov. No. 05-0038) ("Santa Clara" or "Provider") for calendar year ("CY") 6/30/2017. The individual appeal includes one issue involving the DSH Accuracy of CMS Developed SSI Ratio. Toyon also requested that the Board reopen the status of the optional group under Case No. 20-0956G to allow the transfer of the Accuracy of CMS Developed SSI Ratio issue from Case No. 21-1521.

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

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

- On June 26, 2020, Toyon requested a Reopening for Santa Clara "request[ing] a recalculation of its SSI ratio based on its cost reporting period rather than the federal fiscal year." This reopening request was made "pursuant to 42 CFR 412.106(b)(3)" which is the regulation governing requests to realign the SSI ratio (as used in the DSH adjustment calculation) from the federal fiscal year to a provider's fiscal year.

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

- On December 15, 2020, the MAC issued the Notice of Reopening "To adjust the SSI ratio used to calculate the Provider's disproportionate share adjustment based on the data from the hospital's actual cost reporting period *rather than the federal fiscal year and to amend the disproportionate share adjustment to account for the change in SSI ratio*."[2]

- On February 5, 2021, the Medicare Contractor issued the RNPR.

- The adjustment being appealed from the RNPR is Audit Adjustment No. 5. Adjustment No. 5 adjusted the SSI recipient patient days from 16.69 to 19.84 for purposes of the realignment.

On June 28, 2022, Federal Specialized Services, Inc. ("FSS") filed a jurisdictional challenge in which it objected to the Board's jurisdiction over the issue under appeal. FSS contends that it did not adjust the SSI Ratio Data Accuracy in the RNPR. In addition, FSS contends that the issue appealed is duplicative of the issue being pursued in optional group, Case No. 20-0956G.

On July 28, 2022, Toyon responded to the jurisdictional challenge. Toyon contends that the Board does have jurisdiction because when the new SSI ratio was issued as a result of the realignment, new days were added to the calculation of the SSI ratio from the period 10/1/2016 through 6/30/2017.

Board's Determination:

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

The Code of Federal Regulations provides for an opportunity for a reopening and RNPR at 42 C.F.R. § 405.1885 (2018), which provides in relevant part:

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

Additionally, 42 C.F.R. § 405.1889 (2018) explains the effect of a cost report revision:

[2] (Emphasis added.)

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

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

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

Accordingly, pursuant to 42 C.F.R. § 405.1889(b) (and § 405.1835(a)(1) which references that regulation), the Board has jurisdiction only over those matters that have been "specifically revised" in a revised determination. More specifically, when a final determination is reopened

[3] (Emphasis added.)

and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[4]

Here, the Board finds that it does not have jurisdiction over the SSI Accuracy issue for Santa Clara (Prov. No. 05-0038) appealed from the RNPR because the RNPR was issued as a result of the Provider's SSI Realignment request, and did not adjust the sole issue under appeal in this individual appeal. As a result, the Provider does not have the right to appeal this determination under 42 C.F.R. § 405.1889(b) as referenced in §405.1835(a)(1).

As noted in 42 C.F.R. § 412.106(b)(2), CMS gathers data to be used in the SSI fraction on a month-by-month basis:

> (2) *First computation: Federal fiscal year*. **For each month** of the Federal fiscal year in which the hospital's cost reporting period begins,CMS -
> (i) Determines the number of patient days that –
> (A) Are associated with discharges occurring **during each month**; and
>
> (B) Are furnished to patients who **during that month** were entitled to both Medicare Part A (including Medicare Advantage (Part C)) and SSI, excluding those patients who received only State supplementation;
>
> (ii) Adds the results for the whole period; and
>
> (iii) Divides the number determined under paragraph (b)(2)(ii) of this section by the total number of days that -
>
> (A) Are associated with discharges that occur during that period; and
>
> (B) Are furnished to patients entitled to Medicare Part A (including Medicare Advantage (Part C)).[5]

The data matching process by which CMS gathers this monthly data is described in the FY 2011 IPPS Final Rule.[6] As described in the Federal Register, under the realignment process, CMS calculates the SSI fraction using the *previously-gathered* data for the months included in the published SSI fractions for 2 Federal fiscal years that encompass the hospital's cost reporting period:

1. *75 Fed. Reg. 50042, 50279 (Aug. 16, 2010)*.—"[W]e publish these [SSI fraction] data for every hospital based on the Federal fiscal year but, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period

[4] 42 C.F.R. § 405.1889(b)(1).
[5] (Emphasis Added.)
[6] 75 Fed. Reg. 50042, 50275-85 (Aug. 16, 2010).

rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived f*rom the data match process* ***for the two Federal fiscal years thatspanned the hospital's cost reporting period***."[7]

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

   Beginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108–173), we will arrange to furnish, consistent with the Privacy Act, MedPAR LDS data for a hospital's patients eligible for both SSI and Medicare at the hospital's request, regardless of whether there is a properly pending appeal relating to DSH payments. *We will make the information available for either the Federal fiscal year or, if the hospital's fiscal year differs from the Federal fiscal year, for the* ***months included in the 2 Federal fiscal years that encompass the hospital's cost reporting period***. Under this provision, *the hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year*. The data set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year."[8]

Accordingly, the realignment process does not change any of the data underlying the realigned SSI fraction (*e.g*., Part C days) because that data had been *previously* gathered on a month-by-month basis and *there is no need for CMS to rerun the data matching process* in order to effectuate a realignment (*i.e*., realigning the SSI fraction from the federal fiscal year to the provider's fiscal year and does not use any data matching process to achieve the new SSI value). Indeed, as noted in the second Federal Register excerpt, CMS' stated realignment policy is that the provider "must accept" the realigned SSI percentage.

Since the only matter specifically revised in the RNPR was an adjustment related to realigning the SSI percentage from the Federal fiscal year to the hospital's fiscal year, the Provider (Santa Clara) does not have a right to appeal the SSI Accuracy issue under 42 C.F.R. §§ 405.1889(b) and 405.1835(a)(1). The Board hereby denies the transfer to 20-0956G and closes Case No. 21-1521 and removes it from the docket. In making this ruling, the Board notes that its application of 42 C.F.R. § 405.1889(b) has been upheld by courts on review.[9]

The Board notes that the Provider already previously appealed this issue *from its original NPR* where: (a) it was transferred to Case No. 20-0956G for the SSI Accuracy Issue. The Provider is still an active participant in this case based on the *original NPR* appeal.

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

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

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For the Board:

9/30/2022

X Clayton J. Nix

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

James Ravindran
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RE: ***Closure of Group Appeals Pursuant to 42 C.F.R. § 405.1842(h)(3)(iii)***
Case Nos. 13-3842GC, *et. al* (*see* attached listing marked as Appendix A)
Case Nos. 17-2150GC, *et. al* (*see* attached listing marked as Appendix B)
Case Nos. 18-0037GC, *et. al* (*see* attached listing marked as Appendix C)

Dear Mr. Ravindran:

As the parties are aware, Quality Reimbursement Services ("QRS"), the Providers' designated representative, filed the following 3 separate *consolidated* requests for expedited judicial review ("EJR") identified as "Groupings" A, B, and C and involving, in the aggregate, 150 group cases and 696 participants:

Date of EJR Request	Lead Case	Groups	Participants in Aggregate	*Hereinafter Referred To As*
April 8, 2022	Case No. 13-3842GC	21 (*see* Appendix A)	70	"Grouping A"
April 20, 2022	Case No. 17-2150GC	33 (*see* Appendix B)	80	"Grouping B"
April 20, 2022	Case No. 18-0037GC	96 (*see* Appendix C)	546	"Grouping C"

Due to each grouping's sheer size, the recent closure of the groups in each grouping, the number of Medicare contractors involved with each grouping, and anticipated jurisdictional challenges, Federal Specialized Services ("FSS"), the Medicare Contractors' representative, requested an extension of time to review the cases covered by Grouping A on April 15, 2022 and Groupings B and C on April 20, 2022. QRS did not oppose the extension requests FSS made in any of the groupings.

On April 26, 2022 for Groupings A and B, and on May 20, 2022 for Groupings B[1] and C, the Board issued a Notice of Stay and Scheduling Order ("Scheduling Order") taking the following actions for each group:

[1] On May 20, 2022, the Board issued an extension request ruling for Grouping C and for 18 of the 33 group cases in Grouping B. For those 18 cases in Grouping B, the May 20, 2022 letter essentially duplicated the earlier April 26, 2022 letter previously issued. The primary difference is that it expounded on the basis for the stay of the 30-day period in which the Board is required to process an EJR request.

1. Granting FSS' extension in light of the number of cases involved in the EJR request, the number of participants within those cases, the number of Medicare contractors involved in those cases and the fact that the final SOP for the vast majority of these cases was filed *within 60 days* of QRS' EJR request. The Board also took administrative notice of the hundreds of similar jurisdictional and substantive claim reviews already being conducted with hundreds of other EJR requests filed prior to or concurrent with the instant EJR requests for the same issue. In the ruling for Groupings A and B, the Board further noted that "[i]n the aggregate, these other unrelated EJR requests involve multiple thousands of participants and QRS has filed a significant share of these pending EJR requests."[2]

2. Issuing a Scheduling Order to manage the jurisdictional review process for the cases within the relevant grouping and assigning ongoing tasks to *both* parties; and

3. Issuing notice to the parties that the 30-day period for ruling on 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 regarding the Scheduling Order*. As a result, the Board and the Medicare Contractors continued to take actions consistent with that Scheduling Order.

On July 6, 2022 for Grouping A and on July 20, 2022 for Groupings B and C, QRS requested "the Board to proceed to grant EJR for all the groups" but also "notif[ied] the Board that they have commenced action in federal court."[3] A review of public records confirmed that, on April 20, 2022, without notice to the Board or the opposing parties in these cases, QRS filed a Complaint in the U.S. District Court for the Central District of California ("California Central District Court") under Case No. 22-cv-02648. QRS bypassed and abandoned the Board's jurisdictional and EJR review process by prematurely seeking judicial review *on the merits* of its consolidated EJR request in these 150 group cases encompassed by Groupings A, B, and C. It was ***concurrent*** because this litigation was filed ***on the <u>same</u> day*** *that QRS filed its consolidated EJR request for Groupings B and C* ***<u>and</u> only 12 days after*** *it had filed its consolidated request in Grouping A*. This timing demonstrates that QRS had no intention of allowing the Board to process its EJR requests pursuant to 42 C.F.R. § 405.1842. QRS' failure to immediately notify the Board and the opposing party of this concurrent filing demonstrates QRS' lack of good faith and the disingenuous nature of its filings before the Board.

QRS' egregious action in these cases is not new to the Board. To provide context for these cases, and the ongoing malfeasance by QRS, the Board hereby attaches and incorporates a copy of the

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[2] Notice of Stay for Grouping A at n.9 (Apr. 26, 2022); Notice of Stay for Grouping B at n.9 (Apr. 26, 2022).
[3] The Complaint in the California Central District Court for Case No. 22-cv-02648 makes clear at ¶¶ 3, 6, 34 with references to Exhibits C, D, and E (copies of the consolidated EJR requests for Groupings A, B, and C respectively) that litigation applies to all 150 cases included in the consolidated EJR requests for Groupings A, B and C and the directive in 42 C.F.R. § 405.1842(h)(3)(iii) is clear as discussed *infra*. The Board is reviewing and reconciling OAA's request for records with the Complaint.

Board's June 10, 2022 closure letter, in response to QRS initiating federal litigation in connection with a consolidated EJR request QRS filed on January 12, 2022 involving 80 group cases for the same issue with 950+ participants in the aggregate, as **Appendix E**.

Procedural Background

The Scheduling Order issued in Groupings A and B 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.[4] 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. 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 decision. Accordingly, the Scheduling Order for Groupings A and B 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. The notice for Grouping A and B[5] was as follows:

> The 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)**. In this regard, 42 C.F.R. § 405.1842(a)(4)(ii) states that a provider may seek EJR review in federal court without an EJR determination by the Board, "*only if* . . . [t]he Board fails to make a determination of its authority to decide the legal question no later than 30 days *after* finding jurisdiction over the matter at issue and notifying the provider that the provider's EJR request is complete." Consistent with 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

[4] 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.
[5] The Scheduling Order for Groupings A and B was virtually identical.

> challenges pertaining to the cost report at issue *prior to* granting an EJR request (see Rule 44.5). . . . The Board will make an EJR determination within 30 days *after* it determines whether it has jurisdiction and the request for EJR is complete. See 42 C.F.R. § 405.1842.
>
> Thus, it is clear that the 30-day clock does not start until *after* the Board determines that it has jurisdiction over the relevant providers (*as well as* any associated group(s) in which these providers participate) underlying an EJR request.[6]

The Scheduling Order for Grouping C (and also issued in 18 cases within Grouping B) included a more extensive discussion on when the 30-day deadline for a Board determination on EJR request commences. This discussion explained, in significant detail, the basis for the Secretary's policy in 42 C.F.R. § 405.1842(b)(2) 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.

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. 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).[7]

Under Board Rule 44.3, if a party intends to respond to a motion, it must do so within 30 days, unless the Board imposes a different deadline. Significantly, QRS did not file any objection to FSS' extension requests in Groupings A, B, and C. Nor did QRS file any objection to the Scheduling Order issued for Groupings A, B, and C, much less notify the Board or the opposing party that it had filed litigation in federal district court concurrent with the filing of its EJR requests. Rather, QRS was simply silent.

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[6] (Footnote omitted and bold and underline emphasis added.)
[7] (Emphasis in original.)

On June 7, 2022, July 18, 2022, and June 21, 2022, FSS complied with the Board's Scheduling Order and filed jurisdictional challenges in distinct group cases.[8] These challenges were different from, and in addition to, pending, unresolved, jurisdictional challenges.

On July 6, 2022 for Grouping A and on July 20, 2022 for Groupings B and C, QRS requested "the Board to proceed to grant EJR for all the groups" but then "notif[ied] the Board that they have commenced action in federal court." However, QRS' notice did *not* give the date that it filed the Complaint in federal district court. This omission is significant since QRS filed it on April 20, 2022 the same date as QRS filed the EJR request for Groupings B and C and only 12 days after it filed the EJR request for Grouping A. Similarly, QRS did not reference the following directive in 42 C.F.R. § 405.1837(h)(3)(iii) that prevents further Board proceedings once a "lawsuit is filed":

> 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.

Notwithstanding the numerous jurisdictional issues and concerns identified by the Medicare Contractors and the Board,[9] QRS made clear by filing the Complaint in federal district court on April 20, 2022, that it was bypassing and abandoning the Board's jurisdictional review process. Even though QRS made this filing the same day it filed the consolidated EJR request in Groupings B and C and only 12 days after it filed the consolidated EJR request in Grouping A, QRS waited until July 6, 2022 (2½ months later) to notify the Board of this litigation for Grouping A and until July 20, 2022 (3 months later) to notify the Board of this litigation for Groupings B and C.

The delay in learning of QRS' bypassing and abandoning the Board's jurisdictional and EJR review process by virtue of the OAA request for records has caused a significant waste of the Board's limited resources, as well as those of FSS and the Medicare Contractors servicing the 669 participants in the 150 group cases.[10] More concerning is QRS' concurrent filing of litigation without notice to the Board because it demonstrates QRS' bad faith and lack of intention to comply with the Board's Scheduling Order and the administrative review process for EJR requests as mandated by 42 U.S.C. § 1395oo(f)(1). Through its actions, QRS essentially self-declared that, concurrent with the filing of the EJR request in federal court, the participants in these groups have an immediate right to pursue EJR in federal district court (regardless of whether the Board has 30 days to review the EJR request, much less has jurisdiction over such providers). Indeed, if the

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[8] In many cases, jurisdictional and/or substantive claim challenges were filed, some of which were not specifically noted in the global response. For example, the response for cases in Grouping A did not reference the substantive claim challenge later filed on July 24, 2022 in Case No. 21-0800GC.

[9] *See* **Appendix D**.

[10] The Board takes administrative notice that it has a very large docket of pending cases (9142 as of May 1, 2022) and was then processing many EJR requests involving multiple thousands of participants. As of April 8, 2022, ***in addition to*** *the 150 cases covered in this notice*, the Board had 270 cases with EJR requests pending. On or after April 20th, 2022, when the last of these 3 EJR requests were filed, an additional 15 EJRs were file in April, 54 in May and 72 in June. As these cases were primarily group cases, they involved thousands of participants in the aggregate.

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 D**, a non-exhaustive listing of open jurisdictional challenges and substantive claim challenges and some of the jurisdictional issues that the Board had identified thus far. In particular, **Appendix D** details 15 group cases in which the Board ***denied*** the EJR request within 30 days of that EJR request being filed. The Board expects that additional material jurisdictional 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 150 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.[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:

[11] (Emphasis added.)

(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).

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(4) **The provider has a right to seek EJR** of the legal question under section 1878(f)(1) of the Act ***only if***—

(i) **The final EJR decision of the Board or the Administrator, as applicable, includes a finding of Board jurisdiction over the specific matter at issue a**nd a determination by the Board that it has no authority to decide the relevant legal question; or

(ii) The Board fails to make a determination of its authority to decide the legal **question no later than 30 days <u>after finding jurisdiction</u> over the matter at issue <u>and</u> notifying the provider that the provider's EJR request is complete**.

(b) *General*—(1) *Prerequisite of Board jurisdiction*. The Board (or the Administrator) **must find that the Board has jurisdiction over the specific matter at issue <u>before</u> the Board may determine its authority to decide the legal question**.

(2) *Initiating EJR procedures*. A provider or group of providers may request the Board to grant EJR of a specific matter or matters under appeal . . . . Under paragraphs (d) and (e) of this section, **a provider may request** a determination of the Board's authority to decide a legal question, but **<u>the 30-day period</u> for the Board to make a determination under section 1878(f)(1) of the Act** [*i.e.*, 42 U.S.C. § 1395oo(f)(1)] **<u>does not begin to run</u>**

> **<u>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) 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."[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 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 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 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 "***<u>if</u>*** [it] ***may obtain a hearing***

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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)).

[14] (Emphasis added.)

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 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

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[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).
[17] *Alexandria Hosp. v. Bowen*, 631 F. Supp. at 1244.

jurisdictional disputes.[18] 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 150 group cases, with 696 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[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 150 group cases.

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. QRS' filing of the Complaint in federal district court essentially concurrent with the filing of its EJR request without notice to the Board or opposing party is contemptuous of the Board's authority and 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 even under the interpretation of 42 U.S.C. § 1395oo(f)(1) that it is advocating.

B. Effect of QRS' Concurrent Filing of the Complaint on the 150 Group Cases

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

[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 April 20, 2022***, QRS continued to take actions in the Board proceedings in these group cases (*e.g*., withdraw participants, file position papers, file a request for consolidation of one group case with another, file a request that a group case failing to meet the group requirements be converted to an individual appeal, file jurisdictional documents or briefs) 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."

> allegedly not within the Board's authority to decide, the Office of the Attorney Advisor must promptly provide the Board with written notice of the lawsuit and a copy of the complaint.
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> ****
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> (iii) *If the lawsuit is filed before a final EJR request is issued on the legal question*, ***the Board may not conduct any further proceedings*** on the legal question or the matter at issue until the lawsuit is resolved.[20]

This regulation ***bars any further Board proceedings*** in these 150 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 150 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,[21] and the May 23, 2008 final rule[22] 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.[23]

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

[20] (Emphasis added.)
[21] 69 Fed. Reg. 35716 (June 25, 2004).
[22] 73 Fed. Reg. 30190 (May 23, 2008).
[23] 69 Fed. Reg. at 3572.

> 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.[24]

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 California Central District Court on April 20, 2022 prohibits the Board from conducting any further proceedings on the consolidated EJR requests for Groupings A, B, and C as filed, including any proceedings related to the prerequisite jurisdiction.

C. QRS' Actions

The Board finds that QRS' decision to withhold notice from the Board and the opposing party of its concurrent filing of the litigation from the Board and the opposing party is tantamount to bad faith and actively created the 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

[24] 73 Fed. Reg at 30214-15.

the Board or the opposing party demonstrate that QRS had no intention of exhausting its administrative remedies before the Board. Pursuant to Board Rule 1.3 (Nov. 1, 2022),[25] 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)):

> **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;

[25] 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).

- 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.[26]

Indeed, the following inaction on QRS' part reinforces 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 Groupings A, B, or C.

2. QRS failed to notify the Board of its objection to the Board's ruling on the extension, and the associated Scheduling Order for Groupings A, B, and C. QRS' failure to file and preserve its objection to the Board's 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.[27]

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)[28] and Board Alert 19. Specifically, the Board notified the parties that the Board had the authority to stay the start of the 30-day period since 42

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[26] (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."

[27] 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).

[28] 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).

C.F.R. § 405.1842(b)(2) specifies jurisdiction is a prerequisite to Board consideration of an EJR request. The Board was not able to operate 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 Orders for Groupings A, B, and C 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 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 ruling and, if necessary, correct or clarify it,[29] or take other actions, ***prior to*** QRS filing its April 20, 2022 Complaint. Indeed, QRS' preemptive actions did not even allow completion of the 30-day EJR review deadline, ***as alleged by QRS to be established in 42 U.S.C. § 1395oo(f)(1) (and which QRS alleges in its litigation the Board missed)***, to pass, and, under QRS' strained interpretation that ignores the Secretary's regulations, permitted federal litigation to be pursued.[30]

4. QRS' failure to promptly notify the Board that it had filed the lawsuit in the 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). The following circumstances make it clear that QRS had an affirmative obligation to notify the Board of the Complaint being filed, and that QRS should have been aware of that affirmative obligation:

    a. The Board, in its Scheduling Orders issued for these cases (as well as for cases well prior to April 20, 2022 as set forth in **Appendix E**), made clear the Board's position that the 30-day period for responding to the EJR request would not commence until the Board completed its jurisdictional review and issued its jurisdictional findings.

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

    c. Notwithstanding its April 20, 2022 filing of the litigation in the California Central District Court, QRS subsequently filed preliminary position papers ("PPPs) in certain cases and included *disingenuous* "Good Faith" statements that "[w]e herewith notify the Board that good faith effort was made to confer with the MAC." The following are examples of cases in which PPPs were filed subsequent to litigation being filed:

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[29] For example, the Board could have explained how reliance solely on 42 U.S.C. § 1395oo(f)(1) would be misplaced given the Secretary's implementation of that statute at 42 C.F.R. § 405.1842 (including in particular § 405.1842(b)(2)) as promulgated in the May 23, 2008 final rule and the Secretary's explanation of that regulation in the June 25, 2004 proposed rule. *See supra* note 13, and accompanying text.

[30] *See supra* note 27 (discussing how the FRCP supports the Board's position).

- On May 24, 2022 for Case Nos. 21-0800GC and 21-0802GC.[31]

- On June 23, 2022, for in Case No. 19-2718GC.[32]

In this regard, Board Rule 25.3 specifies "[t]he Board requires the parties file a complete preliminary position paper that includes . . . a statement indicating ***how a good faith effort to confer was made*** in accordance with 42 C.F.R. § 405.1853." Notwithstanding, QRS failed to disclose that, on April 20, 2022, it had initiated the litigation in the California Central District Court.

5. QRS made the following disingenuous statement in ¶ 34 of the Complaint:

> The Hospitals now file this civil action in lieu of the PRRB's ruling on the five (5) requests for EJR . . . 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 statue, or alternatively, should they so decide, they will as in past cases with identical issues grant EJR.

It is disingenuous because QRS failed to notify the Board of its objection to the Board's faithful application of 42 C.F.R. § 405.1842(b)(2) and did not permit the Board to potentially alter its planned course of action. Moreover, contrary to QRS' representation, the Board *did* take action on 15 groups within 30 days by denying EJR. QRS should have known that an EJR request on the 15 groups was invalid since they had clear fatal jurisdictional defects in that they failed to meet either the minimum $50,000 AiC requirement, failed to have the minimum number of participants, or failed to properly file the final SoP needed for the Board's pre-requisite jurisdictional review.[33] Significantly, it is unclear how the Board denials of the EJR request on these 15 groups affects QRS' pursuit of the merits of that EJR request for these cases as part of the litigation that QRS initiated (without notice to the Board) prior to the Board issuing these denials. It highlights the procedural quagmire that QRS created when it concurrently pursued litigation in federal court without concurrently notifying the Board.

D. Board Actions

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." Indeed, QRS' failure to comply with Board Rule 1.3, by

[31] The Good Faith Statement was made in the cover letter.
[32] The Good Faith Statement was made in the cover letter.
[33] *See infra* note 61 and accompanying text (discussing cases where QRS recognized in Board filings made prior to filing the relevant consolidated EJR request that the certain groups failed to meet the minimum number of participants for a jurisdictionally proper group and requested the Board take certain actions to cure the jurisdictional defect.)

promptly notifying the Board, FSS and the Medicare Contractors of the lawsuit on, or about, April 20, 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 150 group cases and the underlying 696 participants in favor of other time-sensitive work such as ***other*** EJR requests filed by QRS and other representatives. Indeed, QRS' failure to ***timely*** notify the Board, and the opposing parties, of this lawsuit filed in the California Central District Court as well as the earlier litigation initiated on February 14, 2022 (as discussed in great detail in **Appendix E**) 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 that have joined QRS in its litigation in the California Central District Court.[34] In this regard, it is the Board's understanding that QRS had, on February 14, 2022, established the ongoing litigation in the California Central District Court covering 80 group cases with 950+ participants in the aggregate, and that another representative, Healthcare Reimbursement Services ("HRS"), *joined* QRS in that lawsuit when an Amended Complaint was filed on March 30, 2022 incorporating 120 cases involving 550+ participants into that lawsuit (without any notice to the Board or the opposing party). For a point of reference and context for these serious violations by QRS, the Board has included as **Appendix E** a copy of the closure letter it issued in those 80 QRS group cases. Finally, it is the Board's understanding that HRS has joined the Complaint that QRS filed in the California Central District Court on April 20, 2022 establishing Case No. 22-cv-02648 and that HRS' joinder covers other EJR requests without completing the jurisdictional review process and without notice to the Board.[35]

It is clear the Providers are pursuing the merits of their cases in Groupings A, B, and C as part of the lawsuit (even as it relates to the 15 group cases in which the Board denied EJR within 30 days of the EJR request being filed for clear fatal jurisdictional defects as discussed in **Appendix D**). 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

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[34] *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.").

[35] The Board will be addressing the status of these other cases under separate cover shortly.

[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.

review process, and its disregard for the Board's authority, orders and process, to remain unanswered. Accordingly, *if these cases are remanded to it for further proceedings*, 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 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 vindicate the authority of the Board based upon QRS' numerous, egregious regulatory violations and abuses include, but are not limited to:

1. Dismissal of the 150 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:

> 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

[37] The Board's planned actions are consistent with those planned for QRS as laid out in **Appendix E**.

[38] 42 C.F.R. § 405.1868 states:

> (a) The Board has full power and authority to make rules and establish procedures, not inconsistent with the law, regulations, and CMS Rulings, that are necessary or appropriate to carry out the provisions of section 1878 of the Act and of the regulations in this subpart. The Board's powers include the authority to take *appropriate actions in response to the failure of a party to a Board appeal to comply with Board rules and orders or for inappropriate conduct during proceedings in the appeal*.
> (b) If a provider fails to meet a filing deadline or other requirement established by the Board in a rule or order, the Board may -
> (1) Dismiss the appeal with prejudice;
> (2) Issue an order requiring the provider to show cause why the Board should not dismiss the appeal; or
> (3) Take any other remedial action it considers appropriate.

(Emphasis added.)

> procedures to carry out its function. Moreover, we note that the Board will have broad discretion to weigh the particular facts at hand in order to decide whether or not an offense merits remedial action.
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> Again, we are clarifying that the proposed rule did not identify a complete listing of all potential Board sanctions. The Board has the authority to take appropriate action against either party for procedural violations, but appropriate action does not necessarily mean a dismissal or the early issuance of a decision by the Board. We believe that these provisions will alert both parties that the Board has a mechanism in place to effectively stop a delaying tactic, or to redress other procedural violations. As a result, the parties should be less inclined to ignore procedural requirements and, accordingly, be more motivated to meet the deadlines set by the Board.[39]

Pursuant to the above, the Board has broad authority to sanction QRS for its repeated, and ongoing, malfeasance.

Board Decision and Order

Based on QRS' misconduct, the Board hereby takes the following actions:

1. Closes these 150 group cases consistent with 42 C.F.R. § 405.1842(h)(3)(iii); and
2. Suspends completion of:

    - The ongoing jurisdictional review process;

    - The ongoing substantive claim review process under 42 C.F.R. § 405.1873(b) which was triggered by "Substantive Claim Challenges"[40] filed in Case Nos. 20-1801GC and 20-1803GC and, as a result, must issue findings pursuant to § 405.1873(d)(2) on these particular participants' compliance with the "appropriate cost report claim" requirements in § 413.24(j), if the Board were to find jurisdiction and issue an EJR decision;[41] and

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[39] 73 Fed. Reg. at 30225.

[40] As explained in Board Rule 44.5, "the Board adoption of the term 'Substantive Claim Challenge' simply refers to any question raised by a party concerning whether the cost report at issue included an appropriate claim for one or more of the specific items being appealed in order to receive or potentially qualify for reimbursement for those specific items" ***as required*** *by 42 C.F.R. § 413.24(j).*

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

3. Defers consideration of citing QRS for contempt and dismissing these group cases (and/or taking other remedial action to vindicate 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.[42]

Accordingly, the Board hereby closes these cases and removes them from the Board's docket. No further proceedings will occur, except upon remand from the Administrator, pursuant to 42 C.F.R. § 405.1877(g)(2).

Board Members Participating:

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Ratina Kelly, CPA

For the Board:

9/30/2022

X Clayton J. Nix

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

Enclosures:

Appendix A – Case List for Grouping A
Appendix B – Case List for Grouping B
Appendix C – Case List for Grouping C
Appendix D – Interim List of Potential Jurisdictional, Substantive Claim, & Procedural Violations Under Review
Appendix E – June 10, 2022 Board Letter to QRS Deferring Show Cause Order & Closure of Cases

cc: Bill Tisdale, Novitas Solutions
Judith Cummings, CGS
Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators
Danielle Decker, NGS
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Byron Lamprecht, WPS
John Bloom, Noridian Healthcare Solutions
Wilson Leong, FSS
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[42] FRCP 62.1 is entitled "Indicative Ruling on a Motion for Relief That is Barred by a Pending Appeal." While FRCP 62.1 is not directly applicable to the Board, the procedural developments in these cases are similar those addressed in FRCP 62.1 and the Board looked to it for guidance,

APPENDIX A

Grouping A – List of the 21 Group Cases Covered by the Consolidated Request for EJR Filed on April 8, 2021

13-3842GC	YNHHS 2008 DSH Medicaid Fraction Dual Eligible Days CIRP Group
13-3956GC	YNHHS 2008 DSH Medicare Fraction Dual-Eligible Days CIRP Group
13-3958GC	YNHHS 2006-2007 DSH Medicare Fraction Dual-Eligible Days CIRP Group
14-0473GC	YNHHS 2009 DSH Medicaid Fraction Dual Eligible Days CIRP Group
14-0474GC	YNHHS 2009 DSH Medicare Fraction Dual Eligible Days CIRP Group
14-1439GC	YNHHS 2010 DSH Medicaid Fraction Dual Eligible Days CIRP Group
14-1440GC	YNHHS 2010 DSH Medicare Fraction Dual Eligible Days CIRP Group
15-0679GC	YNHHS 2011 DSH Medicare Fraction Dual Eligible Days CIRP Group
15-0680GC	YNHHS 2011 DSH Medicaid Fraction Dual Eligible Days CIRP Group
15-2527GC	YNHHS 2012 DSH Medicare Fraction Dual Eligible Days CIRP Group
15-2528GC	YNHHS 2012 DSH Medicaid Fraction Dual Eligible Days CIRP Group
16-1978GC	YNHHS 2013 DSH Medicaid Fraction Dual Eligible Days CIRP Group
16-1980GC	YNHHS 2013 DSH Medicare Fraction Dual Eligible Days CIRP Group
17-2304GC	YNHHS 2014 DSH Medicare Fraction Dual Eligible Days CIRP Group
17-2305GC	YNHHS 2014 DSH Medicaid Fraction Dual Eligible Days CIRP Group
19-0229GC	Yale-New Haven CY 2015 YNHHS DSH Medicaid Fraction Dual Elig. Days CIRP Grp.
19-0230GC	Yale-New Haven CY 2015 YNHHS 2015 DSH Medicare Fract. Dual Elig. Days CIRP
19-2395GC	Yale-New Haven FFY 2016 Medicaid Fraction Dual Eligible Days CIRP Group
19-2396GC	Yale-New Haven FFY 2016 DSH Medicare Fraction Dual Eligible Days CIRP Group
21-0800GC	AHMC Healthcare CY 2017 DSH SSI Fraction Dual Eligible Days CIRP Group
21-0802GC	AHMC Healthcare CY 2017 DSH Medicaid Fraction Dual Eligible Days CIRP Group

APPENDIX B

Grouping B – List of the 33 Group Cases Covered by the Consolidated Request for EJR Filed on April 20, 2022

17-2150GC	QRS WVUHS 2006 DSH Medicaid Fraction Dual Eligible Days CIRP Group
14-1025GC	QRS WVUHS 2007 DSH SSI Fraction Dual Eligible Days CIRP Group
14-1029GC	QRS WVUHS 2007 DSH Medicaid Fraction Dual Eligible Days CIRP Group
14-3226GC	QRS WVUHS 2008 DSH SSI Fraction Dual Eligible Days CIRP Group
14-3228GC	QRS WVUHS 2008 DSH Medicaid Fraction Dual Eligible Days CIRP Group
14-2888GC	QRS WVUHS 2009 DSH SSI Fraction Dual Eligible Days CIRP Group
14-2889GC	QRS WVUHS 2009 DSH Medicaid Fraction Dual Eligible Days CIRP Group
16-1531GC	QRS WVUHS 2010 DSH SSI Fraction Dual Eligible Days CIRP Group
16-1533GC	QRS WVUHS 2010 DSH Medicaid Fraction Dual Eligible Days CIRP Group
16-0640GC	QRS WVUHS 2011 DSH SSI Fraction Dual Eligible Days Group
16-0644GC	QRS WVUHS 2011 DSH Medicaid Fraction Dual Eligible Days CIRP Group
16-1697GC	QRS WVUHS 2012 DSH SSI Fraction Dual Eligible Days CIRP Group
16-1685GC	QRS WVUHS 2012 DSH Medicaid Fraction Dual Eligible Days CIRP Group
17-0570GC	QRS WVUHS 2013 DSH SSI Fraction Dual Eligible Days CIRP Group
17-0569GC	QRS WVUHS 2013 DSH Medicaid Fraction Dual Eligible Days CIRP Group
13-3830GC	QRS VCHS 2008 DSH SSI Fraction/Dual Eligible Days Group
13-3834GC	QRS VCHS 2008 DSH Medicaid Fraction/Dual Eligible Days Group
14-0627GC	QRS VCHS 2009 DSH SSI Fraction Dual Eligible Days CIRP Group
14-0634GC	QRS VCHS 2009 DSH Medicaid Fraction Dual Eligible Days Group
15-1396GC	QRS VCH 2010 DSH SSI Fraction Dual Eligible Days CIRP Group
15-1398GC	QRS VCH 2010 DSH Medicaid Fraction Dual Eligible Days CIRP Group
15-2331GC	QRS VCH 2011 DSH SSI Fraction Dual Eligible Days CIRP Group
15-2332GC	QRS VCH 2011 DSH Medicaid Fraction Dual Eligible Days CIRP Group
16-0191GC	QRS VCH 2012 DSH SSI Fraction Dual Eligible Days CIRP Group
16-0194GC	QRS VCH 2012 DSH Medicaid Fraction Dual Eligible Days CIRP Group
16-1475GC	QRS VCH 2013 DSH SSI Fraction Dual Eligible Days CIRP Group
16-1488GC	QRS VCH 2013 DSH Medicaid Fraction Dual Eligible Days CIRP Group
15-1157GC	QRS HHC 2008 DSH SSI Fraction Dual Eligible Days CIRP Group
15-1159GC	QRS HHC 2008 DSH Medicaid Fraction Dual Eligible Days CIRP Group
14-3851GC	QRS HHC 2009 DSH Medicaid Fraction Dual Eligible Days CIRP Group
14-3853GC	QRS HHC 2009 DSH SSI Fraction Dual Eligible Days CIRP Group
21-0427GC	Hartford Health CY 2017 DSH SSI Fraction Dual Eligible Days CIRP Group
21-0429GC	Hartford Health CY 2017 DSH Medicaid Fraction Dual Eligible Days CIRP Group

APPENDIX C

Grouping C – List of the 96 Group Cases Covered by the Consolidated Request for EJR Filed on April 20, 2022

18-0037GC	AHMC Healthcare 2013 DSH SSI Ratio - Medicare Part A Exhausted Days CIRP Grp.
14-0073GC	QRS Asante 2007 DSH Medicaid Fraction Dual Eligible Days CIRP Group
14-0076GC	QRS Asante 2007 DSH SSI Fraction Dual Eligible Days CIRP Group
14-3063GC	QRS Asante 2008 DSH SSI Fraction Dual Eligible Days CIRP Group
14-3064GC	QRS Asante 2008 DSH Medicaid Fraction Dual Eligible Days CIRP Group
14-3074GC	QRS Asante 2009 DSH SSI Fraction Dual Eligible Days CIRP Group
14-3075GC	QRS Asante 2009 DSH Medicaid Fraction Dual Eligible Days CIRP Group
14-3080GC	QRS Asante 2010 DSH SSI Fraction Dual Eligible Days CIRP Group
14-3082GC	QRS Asante 2010 DSH Medicaid Fraction Dual Eligible Days CIRP Group
14-3100GC	QRS Asante 2011 DSH SSI Fraction Dual Eligible Days CIRP Group
14-3102GC	QRS Asante 2011 DSH Medicaid Fraction Dual Eligible Days CIRP Group
15-2274GC	QRS Asante 2012 DSH SSI Fraction Dual Eligible Days CIRP Group
15-2275GC	QRS Asante 2012 DSH Medicaid Fraction Dual Eligible Days CIRP Group
16-1241GC	QRS Asante 2013 DSH SSI Fraction Dual Eligible Days CIRP Group
16-1242GC	QRS Asante 2013 DSH Medicaid Fraction Dual Eligible Days CIRP Group
18-0866GC	QRS Asante 2014 DSH SSI Fraction Dual Eligible Days CIRP Group
18-0867GC	QRS Asante 2014 DSH Medicaid Fraction Dual Eligible Days CIRP Group
14-0913GC	Carolinas Healthcare System 2009 DSH SSI Fraction Dual Eligible Days CIRP Group
14-3515GC	QRS Carolinas HealthCare System 2009 Medicaid Fraction/Dual Eligible Days CIRP
14-2603GC	Carolinas Healthcare Sys. 2010 DSH SSI Fraction Denominator/Dual Elig. Days CIRP
14-4412GC	Carolinas HealthCare System 2010 Medicaid Fraction/Dual Eligible Days CIRP Group
14-4267GC	Carolinas Healthcare System 2011 DSH-SSI Fraction Dual Eligible Days CIRP Group
14-4269GC	Carolinas Healthcare System 2011 DSH Medicaid Fraction Dual Eligible Days CIRP
15-3315GC	QRS Carolinas HealthCare 2012 DSH Medicaid Fraction Dual Eligible Days CIRP
15-3318GC	QRS Carolinas HealthCare 2012 DSH SSI Fraction Dual Eligible Days CIRP Group
17-1507GC	QRS Carolinas HealthCare Sys. 2013 DSH SSI Fraction Dual Elig. Days CIRP Group
17-1512GC	QRS Carolinas HealthCare Sys. 2013 DSH Medicaid Fraction Dual Elig. Days CIRP
13-2706GC	QRS TMH 2007 DSH Dual Eligible Days CIRP Group
14-4097GC	QRS Houston Methodist 2008 DSH Medicaid Fraction Dual Eligible Days CIRP Group
14-4098GC	QRS Houston Methodist 2008 DSH SSI Fraction Dual Eligible Days CIRP Group
14-4345GC	QRS Houston Methodist 2009 DSH SSI Fraction Dual Eligible Days CIRP Group
14-4362GC	QRS Houston Methodist 2009 DSH Medicaid Fraction Dual Eligible Days CIRP Group
15-2918GC	QRS Houston Methodist 2010 DSH SSI Fraction Dual Eligible Days CIRP Group
15-2919GC	QRS Houston Methodist 2010 DSH Medicaid Fraction Dual Eligible Days CIRP Group
15-2929GC	QRS Houston Methodist 2011 DSH SSI Fraction Dual Eligible Days CIRP Group
15-2931GC	QRS Houston Methodist 2011 DSH Medicaid Fraction Dual Eligible Days CIRP Group
16-0447GC	QRS Houston Methodist 2012 DSH Medicaid Fraction Dual Eligible Days CIRP Group
16-0449GC	QRS Houston Methodist 2012 DSH SSI Fraction Dual Eligible Days CIRP Group
17-1806GC	QRS Houston Methodist 2013 DSH SSI Fraction Dual Eligible Days CIRP Group
17-1807GC	QRS Houston Methodist 2013 DSH Medicaid Fraction Dual Eligible Days CIRP Group
14-0665GC	QRS MSHA 2007 DSH SSI Fraction Dual Elig Days CIRP Group

14-0666GC QRS MSHA 2007 DSH Medicaid Fraction Dual Elig Days CIRP Group
14-0185GC QRS MSHA 2008 DSH Medicaid Fraction/Dual Eligible Days Group
14-0186GC QRS MSHA 2008 DSH SSI Fraction/Dual Eligible Days Group
14-3114GC QRS MSHA 2009 DSH SSI Fraction Dual Eligible Days CIRP Group
14-3117GC QRS MSHA 2009 DSH Medicaid Fraction Dual Eligible Days CIRP Group
14-3954GC QRS MSHA 2010 DSH SSI Fraction Dual Eligible Days CIRP Group
14-3955GC QRS MSHA 2010 DSH Medicaid Fraction Dual Eligible Days CIRP Group
14-4294GC QRS MSHA 2011 DSH Medicaid Fraction Dual Eligible Days CIRP Group
14-4295GC QRS MSHA 2011 DSH SSI Fraction Dual Eligible Days CIRP Group
16-0291GC QRS MSHA 2012 DSH SSI Fraction Dual Eligible Days CIRP Group
16-0292GC QRS MSHA 2012 DSH Medicaid Fraction Dual Eligible Days CIRP Group
16-2032GC QRS MSHA 2013 DSH SSI Fraction Dual Eligible Days CIRP Group
16-2033GC QRS MSHA 2013 DSH Medicaid Fraction Dual Eligible Days CIRP Group
18-0205GC QRS MSHA 2014 DSH SSI Fraction Dual Eligible Days CIRP Group
18-0206GC QRS MSHA 2014 DSH Medicaid Fraction Dual Eligible Days CIRP Group
18-0263GC QRS Providence 2015 No Pay Part A CIRP Group
18-0272GC QRS Providence 2015 SSI-Dual Eligible CIRP Group
19-2718GC Providence Health CY 2016 DSH SSI Fraction Dual Eligible Days CIRP Group
19-2720GC Providence Health CY 2016 DSH Medicaid Fraction Dual Eligible Days CIRP Group
14-0943GC QRS Saint Luke's HS 2008 DSH SSI Fraction Dual Eligible Days CIRP Group
14-0944GC QRS Saint Luke's HS 2008 DSH Medicaid Fraction Dual Eligible Days CIRP Group
14-0952GC QRS Saint Luke's HS 2009 DSH SSI Fraction Dual Eligible Days Group
14-0956GC QRS Saint Luke's HS 2009 DSH Medicaid Fraction Dual Eligible Days Group
15-2623GC QRS St. Luke's Health 2010 DSH SSI Fraction Dual Eligible Days CIRP Group
15-2624GC QRS St. Luke's Health 2010 DSH Medicaid Fraction Dual Eligible Days CIRP Group
15-1368GC QRS St. Luke's Health 2011 DSH SSI Fraction Dual Eligible Days CIRP Group
15-1369GC QRS St. Luke's Health 2011 DSH Medicaid Fraction Dual Eligible Days CIRP Group
16-1007GC QRS St. Luke's Health 2012 DSH SSI Fraction Dual Eligible Days CIRP Group
16-1006GC QRS St. Luke's Health 2012 DSH Medicaid Fraction Dual Eligible Days CIRP Group
17-2236GC QRS St. Luke’s Health 2013 DSH SSI Medicaid Dual Eligible Days CIRP Group
19-1005GC St. Luke's Health CY 2016 DSH SSI Fraction Dual Eligible Days CIRP Group
19-1007GC St. Luke's Health CY 2016 DSH Medicaid Fraction Dual Eligible Days CIRP Group
14-0241GC QRS Wellmont HS 2007 DSH SSI Fraction/Dual Eligible Days CIRP Group
14-0243GC QRS Wellmont HS 2007 DSH Medicaid Fraction/Dual Eligible Days CIRP Group
14-0405GC QRS Wellmont HS 2008 DSH SSI Fraction/Dual Eligible Days CIRP Group
14-0408GC QRS Wellmont HS 2008 DSH Medicaid Fraction /Dual Eligible Days CIRP Group
14-3123GC QRS Wellmont HS 2009 DSH SSI Fraction Dual Eligible Days CIRP Group
14-3124GC QRS Wellmont HS 2009 DSH Medicaid Fraction Dual Eligible Days CIRP Group
14-3944GC QRS Wellmont HS 2010 DSH Medicaid Fraction Dual Eligible Days CIRP Group
14-3946GC QRS Wellmont HS 2010 DSH SSI Fraction Dual Eligible Days CIRP Group
15-0525GC QRS Wellmont HS 2011 DSH Medicaid Fraction Dual Eligible Days CIRP Group
15-0526GC QRS Wellmont HS 2011 DSH SSI Fraction Dual Eligible Days CIRP Group
16-0246GC QRS Wellmont HS 2012 DSH SSI Fraction Dual Eligible Days CIRP Group
16-0249GC QRS Wellmont HS 2012 DSH Medicaid Fraction Dual Eligible Days CIRP Group
17-0327GC QRS Wellmont HS 2013 DSH Medicaid Fraction Dual Eligible Days CIRP Group
17-0334GC QRS Wellmont HS 2013 DSH SSI Fraction Dual Eligible Days CIRP Group

13-3256GC QRS WFHC 2008 DSH Dual Eligible Days CIRP Group
13-3283GC QRS WFHC 2010 DSH SSI Fraction/Dual Eligible Days CIRP Group
13-3271GC QRS WFHC 2010 DSH Medicaid Fraction/Dual Eligible CIRP Group
14-4103GC QRS WFHC 2011 DSH SSI Fraction Dual Eligible Days CIRP Group
14-4105GC QRS WFHC 2011 DSH Medicaid Fraction Dual Eligible Days CIRP Group
15-1021GC QRS WFHC 2012 DSH SSI Fraction Dual Eligible Days Grp. (Late Issuance of NPR)
15-1022GC QRS WFHC 2012 DSH Medicaid Fract. Dual Elig. Days Grp. (Late Issuance of NPR)
16-1837GC QRS WFHC 2013 DSH SSI Fraction Dual Eligible Days CIRP Group
16-1836GC QRS WFHC 2013 DSH Medicaid Fraction Dual Eligible Days CIRP Group

APPENDIX D

INTERIM LIST OF POTENTIAL JURISDICTIONAL, SUBSTANTIVE CLAIM, AND PROCEDURAL VIOLATIONS UNDER REVIEW[43]

The following summary of jurisdictional, substantive claim and procedural concerns and issues is preliminary and highlights the complexity of the jurisdictional review process. This process is exponentially more complex when consolidated EJR requests are concurrently filed involving 150 group cases with 696 participants.[44]

In compliance with the Board's Scheduling Order in Groupings A, B, and C, the Medicare Contractors began submitting Jurisdictional Challenges in their respective cases. These challenges, as well as separate challenges or jurisdictional issues 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 were raised 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. 17-2150GC and 16-1533GC.

- A jurisdictional challenge to Case No. 17-2150GC claims that the group failed to meet the minimum number of participants required to form a valid group under 42 U.S.C. §§ 1395oo(b) and 1395oo(f)(1) and 42 C.F.R. § 405.1837.

- Jurisdictional issues were raised in Case No. 14-3515GC claiming that QRS failed to include in the SoP proof of when 9 participants filed their appeal request and as a result, the Medicare Contractor is unable to confirm from the final SoP whether these participants had timely appeals. Similarly, in Case No. 14-4267GC, QRS failed to include proof of delivery for the direct add requests for 3 participants. Similarly, in Case No. 14-4412GC, QRS failed to provide: (1) copies of the direct add requests (and/or proof of delivery of that direct add request) for 4 participants who were consolidated from another CIRP group; and (2) a copy of the Board ruling confirming that the CIRP group was consolidated into 14-4412GC.

- A jurisdictional issue was raised in Case Nos. 14-3515GC and 14-4269GC claiming that QRS failed to include the direct add request (as well as the proof of delivery for that request) for one or more participants to confirm that the participant was properly part of this group.

- A jurisdictional challenge in Case No. 14-4267GC and 14-4269GC alleges that a participant is also improperly a participant in an optional group for the same issue and year for which QRS has already requested EJR (which is covered by the Board's ruling in **Appendix E**).

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[43] This listing is not exhaustive and only reflects preliminary findings and the Board has not yet completed or finalized its jurisdictional findings in these 150 group cases.
[44] *See supra* notes 13, 18.

- Jurisdictional challenges filed in Case Nos. 14-0634GC, 16-0194GC, 16-1531GC, 16-1533GC, 16-1697GC, 14-2603GC, 14-3075GC, 14-3082GC, 14-3102GC, 15-3315GC, 16-0292GC, 16-1242GC 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 jurisdictional challenge filed in Case No. 14-1029GC alleges that QRS failed to provide records in the final SoP to establish that one participant was timely, and properly added to the group and, thus, that provider should be dismissed.

- Jurisdictional challenges in Case Nos. 14-2889GC, 16-1685GC, and 21-0427GC assert that one participant in the group improperly transferred not just the group issue but also another issue that is not common to the group that further improperly duplicates its participation in another CIRP group.[45]

- A jurisdictional challenge in Case No. 21-0427GC asserts that one participant in the group improperly transferred not just the group issue but also another issue that is not common to the group and that should have been transferred to the companion CIRP group under Case No. 21-0429GC (*i.e*., the provider is not a participant in Case No. 21-0429GC). Accordingly, the Medicare Contractor seeks dismissal of the additional issue improperly transferred to Case No. 21-0427GC.

- A jurisdictional challenge in Case No. 14-1029GC claiming that QRS failed to provide record of transfer for a participant; and that, if this participant was not properly transferred, then the group would fail to meet the minimum $50,000 AiC threshold requirement.

- A jurisdictional challenge in Case No. 14-2603GC claims that QRS failed to provide a proper letter of representation for one of the participants and, as such, the Board should dismiss that participant. Similarly, in Case No. 14-4412GC, the Medicare Contractor alleges QRS failed to include in the final SoP proper proof that QRS was authorized to file the transfer requests for these 2 participants.[46]

- A jurisdictional challenge in Case No. 14-2603GC claims that QRS was not the authorized representative to add a participant to the group resulting in QRS' withdrawal of that participant and that, notwithstanding that history, QRS continues to *improperly* list the participant on the SoP for this group.

- Substantive claim challenges[47] were filed in Case Nos. 21-0800GC, 21-0802GC, 21-0427GC, 21-0429GC, 19-1005GC, 19-1007GC claiming that one or more of the

[45] A common situation is where: (1) a health chain has CIRP groups related to the Secretary's policy on no pay Part A days, one related to the SSI fraction and the other related to the Medicaid fraction; (2) a provider is a participant in both CIRP groups but, in one of those CIRP groups, it also transferred in both the Medicaid fraction and SSI fraction issues.
[46] Indeed, there are no letters of authorization or other proof behind Tab H for these participants
[47] *See supra* note 19 (discussing what the Board's use of the term "substantive claim challenge" means).

participants failed to include an appropriate claim for the appealed item in dispute, as required under 42 C.F.R. § 413.24(j).

The Board, through its ongoing review of jurisdiction, and other procedural issues, in these 150 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 (thus far) include, but are not limited to, the following:

1. *Providers With No Appeal Rights*.—The instant cases do contain participants that appealed revised NPRs. The regulation at 42 C.F.R. §405.1889(b) instructs that these participants have appeal rights and may only appeal matters that are specifically adjusted. The Board is reviewing the revised NPR appeals to confirm whether the Board has jurisdiction over these participants. This review encompasses but is not limited to those revised NPR appeals cited by the Medicare Contractor.

2. *Invalid Appeals Due to Failure to Timely Appeal or Provide the Requisite Documentation*.— Pursuant to 42 C.F.R. § 405.1835(a)(3), "[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 must be *no later than 180 days* after the date of receipt by the provider of the final contractor or Secretary determination." As the date of receipt is presumed to be 5 days after the date the final determination is issued,[48] an appeal request effectively must be filed with the Board within 185 days of the determination in order to be considered timely. The Board expects that it will identify participants that failed to timely appeal given the fact the Medicare Contractor has alleged that, for numerous participants, QRS failed to include in the relevant final SoP copies of the direct add request, transfer request, and/or appeal request (and/or proof of filing therefor).

3. *Improper Pursuit of Previously Withdrawn/Dismissed Participants*.— There are a significant number of participants in these 150 groups for whom QRS is ***improperly*** pursuing reimbursement by including them on the Schedule of Providers even though either ***QRS*** had ***previously withdrawn*** them from the relevant group case,[49] ***or*** the Board dismissed them and/or denied their transfer to the group appeal. Although the Board has not yet completed its review, the following is an example showing where QRS is ***improperly*** pursuing reimbursement. Such action on the part of QRS raises significant fraud and abuse concerns,[50] and the Board takes administrative notice that this is not an isolated concern as

[48] 42 C.F.R. § 405.1801(a) includes the definition for "date of receipt" and paragraph (1)(iii) of that definition explains that "[t]his [5-day] presumption, which is otherwise conclusive, may be overcome if it is established by a preponderance of the evidence that such materials were actually received on a later date."

[49] *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 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.").

[50] Based on its preliminary review of just some of these cases, the Board fully expects to identify other situations where QRS failed to remove withdrawn/dismissed providers from the SoPs, particularly in light of the age of some of the SoPs that QRS refiled and is relying upon for its consolidated EJR requests.

discussed in **Appendix E** at pages 11 to 16. 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[51] 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*. Included on pages 14 to 16 of **Appendix E** are 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. These examples highlight, *at a minimum*, QRS' reckless disregard for its ***basic*** responsibilities and due diligence as a representative appearing before the Board. As a representative with more than 1,500 open cases as of early June (of which there were 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 as well as Board Rule 47 addressing how a dismissed or withdrawn provider may be reinstated to an appeal.[52] An example in these cases includes Case No. 14-0913GC where Carolinas Healthcare System withdrew Grace Hospital from Case No. 14-0915GC on September 2, 2016 before it was merged with Case No. 14-0913GC and, notwithstanding the withdrawal, is still listed as a participant in 14-0913GC.[53]

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

[52] The Board takes administrative notice of the following example where 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.

[53] The Board merged the two cases as it stated in error that the two cases contained the same issue. If that were true, then it would be inappropriate for Grace Hospital to remain in Case No. 14-0913GC. The Board takes administrative notice that it has been reversing mergers of companion SSI fraction dual eligible days cases with Medicaid fraction dual eligible days cases because the Board views these two separate legal issues as exemplified by the Ninth Circuit's decision in *Empire* where they overturned the 2004 policy change but simply reverted to the prior policy that resulted in no-pay Part A days being counted in neither fraction. *See Empire Health Found. v. Azar*, 958 F.3d 873, 886 (9th Cir. 2020) ("reinstat[ing] the version of 42 C.F.R. § 412.106(b)(2)(i) which embraced only 'covered' patient days", *i.e.*, reinstating the rule previously in force); CMS Ruling 1498-R2 at 3 (stating "Under our *original* DSH policy, inpatient days were included in the numerator of the Medicare-SSI fraction only if the inpatient hospital days were "covered" under Medicare Part A and the patient was entitled to SSI benefits; Part A coverage of inpatient days alone was required for inclusion in the denominator of the Medicare-SSI fraction. (See, for example, 42 CFR 412.106(b)(2)(i) (2003).) Our *original* policy further provided that non-covered inpatient hospital days of patients entitled to Medicare Part A, including days for which the patient's Part A inpatient hospital benefits were exhausted, were ***excluded*** from the numerator of the Medicaid fraction (even when the patient was eligible for Medicaid), but such non-covered or exhausted benefit inpatient hospital days were included in the Medicaid fraction denominator (to the extent that the hospital reported such days on its Medicare cost report). See the August 11, 2004 final rule entitled Changes to the

4. *Unauthorized Representation of Participants*.— The Board has also identified situations where QRS ***failed*** to obtain proper authorization from the provider to be a participant in the relevant group. The Board notes that FSS has raised unauthorized representation issues and the Board expects it will identify additional unauthorized representation issues once it completes the jurisdictional review process based on its recent experiences with QRS' SoP filings in group cases.

5. *Failure to have the minimum number of participants in a group*.—As explained in 42 C.F.R. §§ 405.1837(b)(1)(i) and 405.1837(b)(2)(i), a group must have at least 2 participants at full formation. If the group is not properly formed with at least 2 participants then pursuant to 42 C.F.R. §§ 405.1837(b) and 405.1840(b), the Board would not have jurisdiction over the group and, without jurisdiction, the Board would not be able to grant an EJR request involving such a group. There are multiple cases in Groupings B and C for which QRS improperly filed an EJR request even though the group only contained one participant at full formation including the below cases.

   a. Case No. 14-1025GC entitled "QRS WVUHS 2006 Medicaid Fraction Dual Eligible Days CIRP Group"—The group appears to pertain only to the Medicaid fraction. However, with respect to the sole participant in this group, QRS failed to include in the final SoP a proper AiC *for the group issue* behind Tab E. Rather, the AiC calculation included behind Tab E shows *only* an AiC calculation for the SSI fraction in the amount of $12,192.[54]

   b. Case Nos. 14-1029GC (entitled "QRS WVUHS 2007 DSH Medicaid Fraction Dual Eligible Days CIRP Group") and 14-1025GC (entitled "QRS WVUHS 2007 DSH SSI Fraction Dual Eligible Days CIRP Group")—For Participant ## 1 and 2, QRS included the exact same AiC calculation in the final SoP for Case No. 14-1029GC and 14-1025GC. Specifically, behind Tab E, the AIC calculation for Participant ##1 and 2 are $72,646 and $13,859 respectively for both Case No. 14-1029GC and 14-1025GC. As each case involves a different issue and necessarily has a different reimbursement impact, the AiC calculation can only be a calculation for one of these CIRP groups per 42 C.F.R. § 405.1839(b). Accordingly, the Board is reviewing whether to dismiss these participants from one or both groups and, if so, whether to dismiss the impacted group(s) as the impacted group(s) would fail to meet the minimum $50,000 AiC threshold once these two participants were dismissed.[55]

   c. Case Nos. 16-0640GC (entitled "QRS WVUHS 2011 SSI Fraction Dual Eligible Days CIRP Group") and 16-0644GC (entitled "QRS WVUHS 2011 Medicaid Fraction Dual

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Hospital Inpatient Prospective Payment Systems and Fiscal Year 2005 Rates (FY 2005 IPPS final rule) (69 FR 48916 and 49098)." (emphasis added)). *See also* CMS Ruling 1498-R.

[54] This AiC would only relates to the companion case under Case No. 14-1029GC.

[55] A comparison of the AiC calculations done for Participant #3 in these cases supports the Board's findings on Participant ##1 and 2. Moreover, the Medicare Contractor has raised other jurisdictional issues regarding these groups that could also provide other bases for dismissal of one or more participants.

Eligible Days CIRP Group")— For Participant ## 1 and 2, QRS included the exact same AiC calculation in the final SoP for Case No. 16-0640GC and 16-0644GC. Specifically, behind Tab E, the AIC calculation for Participant ##1 and 2 are $74,370 and $24,408 respectively for both Case No. 16-0640GC and 16-0644GC. As each case involves a different issue and necessarily has a different reimbursement impact, the AiC calculation can only be a calculation for one of these CIRP groups per 42 C.F.R. § 405.1839(b). Accordingly, the Board is reviewing whether to dismiss these participants from one or both groups and, if so, whether to dismiss the impacted group(s) as the impacted group(s) would fail to meet the minimum $50,000 AiC threshold once these two participants were dismissed.

d. Case Nos. 16-1697GC (entitled "QRS WVUHS 2012 SSI Fraction Dual Eligible Days CIRP Group") and 16-1685GC (entitled "QRS WVUHS 2012 Medicaid Fraction Dual Eligible Days CIRP Group")— There are the same three participants in each of these groups. For all three participants, QRS included the exact same AiC calculation in the final SoP for Case No. 16-1697GC and 16-1685GC. Specifically, behind Tab E, the AIC calculation for Participant ##1, 2, and 3 are $85,098, $21,550, and $16,468 respectively for both Case No. 16-1697GC and 16-1685GC. As each case involves a different issue and necessarily has a different reimbursement impact, the AiC calculation can only be a calculation for one of these CIRP groups per 42 C.F.R. § 405.1839(b). Accordingly, the Board is reviewing whether to dismiss these participants from one or both groups which in turn would result in dismissal of the impacted group since there would be no more participants.[56]

e. Case No. 18-0205GC (entitled "QRS MSHA 2014 DHS SSI Fraction Dual Eligible Days CIRP Group") and 18-0206GC (entitled "QRS MSHA 2014 DSH Medicaid Fraction Dual Eligible Days CIRP Group").—There are the same 2 participants in each of these groups. For one participant, QRS included the exact same AiC calculation in the final SoP for Case Nos. 18-0205GC and 18-0206GC and this AiC calculation entitled "Impact of SSI Fraction Dual Eligible Days" only shows an estimated impact for the SSI fraction piece. An additional issue is QRS' AiC calculation which concerns QRS' assumption of 1.00 percent change as this was adopted without explanation and raises concerns about whether the alleged estimate is a good faith AiC calculation.[57] As such, the Board is reviewing whether to dismiss this participant from one or both groups which in turn would result in the dismissal of the impacted group since the minimum $50,000 AiC threshold would no longer be met.

6. *Failure to meet minimum $50,000 AiC requirement for a group appeal*. —As explained in 42 C.F.R. § 405.1839(b), "[i]n order to satisfy the amount in controversy [or AiC]

[56] Moreover, the Medicare Contractor has raised other jurisdictional issued regarding these groups that could also provide other bases for dismissal of one or more participants.

[57] The Board expects that this concern impacts multiple group cases, particularly in smaller groups where there is only one participant and the AiC becomes critical in determining whether a group meets the minimum $50,000 AiC threshold required for a group.

requirement . . . 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." Further, it explains that, "[f]or purposes of satisfying the amount in controversy requirement, group members are ***not*** allowed to aggregate claims involving different issues" because "[a] group appeal must involve a single question of fact or interpretation of law, regulations, or CMS Ruling that is common to each provider . . . ." The following are examples of group cases that failed to meet the minimum $50,000 AiC requirement. The Board expects that it would identify additional AiC issues if it were to complete its jurisdictional review, and such issues may include: (1) failure to document in the final SoP that the group meets the minimum $50,000 threshold ***for the group issue*** as explained at 42 C.F.R. § 405.1839(b);[58] and (2) the dismissal of participants for other reasons which may cause the group to fail below the minimum $50,000 AiC threshold.[59]

a. On May 20, 2022, ***before 30 days had passed from the filing of the consolidated EJR request in Groupings B and C***, the Board *denied* the EJR request for Case Nos. 17-1806GC and 17-1807GC for failure to meet the minimum $50,000 AiC requirement. Significantly, on March 28, 2022, the Board notified QRS of the groups' failure to meet this requirement and requested comments on potential proposed actions to cure this jurisdictional defect. Notwithstanding this jurisdictional defect and the Board's pending proposals to cure it, QRS proceeded to file an EJR request 3 weeks later on April 20, 2022. In denying the EJR request, the Board required QRS to file certain information within 30 days to allow the Board to determine what actions were appropriate (*e.g*., cure the jurisdictional defects by establishing individual appeals where appropriate, or dismiss the group and underlying participants). In its response filed on July 19, 2022, QRS failed to notify the Board of the litigation it had filed on April 20, 2022.

b. Case No. 14-1025 is another example of where QRS is pursuing EJR in a case that fails to meet the minimum $50,000. This CIRP group has only 2 participants and it fails to meet the minimum $50,000 amount in controversy required for a group in that the SoP for each case lists a total AiC of $9,092 (2,878 for one provider and $6,214 for the other provider). Significantly, both participants were direct adds and neither provider would meet the minimum $10,000 AiC required for an individual appeal.

7. *Failure to meet minimum number of participants for a group appeal.*—As explained in 42 C.F.R. § 405.1837(b)(1)(i) and (b)(2)(i),[60] a valid group appeal must include 2 or

[58] The Board is aware of situations where the AiC calculation in the SoP is not for the group issue or fails to be a good faith calculation (*i.e*., fails to explain the basis for the AiC calculation). Indeed, the Medicare Contractors have identified such situations for Board review.

[59] As many of the groups are small or close to the minimum $50,000 AiC threshold, it is likely that a significant number of groups may fail to meet this threshold once the Board completes its jurisdictional review. Indeed, the Board has highlighted elsewhere in this letter some examples where this may arise.

[60] *See also* 42 U.S.C. §§ 1395oo(b), (f)(1).

more participants. Notwithstanding, QRS' April 20, 2022 consolidated EJR request for Groupings B and C contained the following 12 CIRP groups that only had one participant and clearly failed to this basic jurisdictional requirement for group appeals: 17-2236GC, 17-0569GC, 14-0943GC, 14-0944GC, 16-0194GC, 16-0191GC, 14-3853GC, 14-3851GC, 14-0666GC, 16-1241GC, 16-1242GC, 17-2150GC.[61] Accordingly, on May 20, 2022, ***before 30 days had passed from the filing of the consolidated EJR request in Groupings B and C***, the Board *denied* the EJR request as it relates to the following group cases, making the following findings and orders:

> As the 12 CIRP group appeals addressed in this determination do not meet the requirements of the group appeal regulations, the Board finds it does not have jurisdiction over these CIRP groups (*i.e.*, the providers in these CIRP groups have no right to a hearing as part of these CIRP groups). 42 C.F.R. § 405.1842(f)(2) specifies that the Board must deny an EJR request if the Board does not have jurisdiction to conduct a hearing on the specific matter at issue. Accordingly, the Board hereby ***denies*** EJR over the above-mentioned group appeals pursuant to 42 C.F.R. § 405.1842(f)(2). . . . .
>
> As the Group Representative has prematurely requested EJR, the Board requires that the single Provider remaining in each of these 12 CIRP group appeals first establish a valid *individual* appeal . . . . Until the Providers' appeals meet the regulatory requirements by getting each single provider transferred into an appropriate and valid individual appeal, the Board will not entertain another EJR request as such an EJR can only be made for and, filed in, the individual appeal to be established for each of the Providers underlying these 12 CIRP groups. ***Accordingly, within 30 days of this denial's signature date***, the Group Representative must file for each Provider underlying the above-captioned 12 CIRP groups a request with the Board identifying if an individual appeal exists (either pending or eligible for reinstatement), to which these participants can be transferred, and the status

[61] Indeed, some of the SoPs recognized that the group failed to meet the minimum number of participants and request that the Board convert the group to an individual appeal (but without identifying whether an individual appeal was open or had been closed within 3 years). *See, e.g.,* Case No. 17-2150GC, 17-0569C, 16-1241GC, 16-1242GC, Notwithstanding, QRS did not wait for the Board to rule on its request before filing the consolidated EJR request days later on April 20, 2022. The following cases are examples where, *prior to the EJR request being filed*, QRS included such a request in the cover letter to the final SoP and the Board responded requesting comments on potential proposed actions to cure the jurisdictional defect. *See, e.g.,* Case No. 17-2150GC, 17-0569C. Finally, the Board notes that, in Case Nos. 14-0944 and 17-2236GC, QRS recognized in the cover letter to the final SoP that it did not meet the minimum number of participants required for a group appeal but failed to request any Board action to correct the jurisdictional defect.

> of those cases (if the individual cases are open/closed and, if closed, the date of closure). If no eligible individual appeal exists, then the Group Representative may request conversion of the CIRP group to an individual appeal but that request must confirm that there is no eligible individual appeal (open or closed within 3 years) to which the Provider can be transferred and confirm whether the provider meets the minimum $10,000-threshold for an individual appeal.

Significantly, when QRS responded to the Board's ruling and requested that certain individual appeals be established, it failed to notify the Board of the litigation it had filed on April 20, 2022

8. *Failure to File An Electronic Copy of the final SoP*.—Effective November 1, 2021, the Board implemented mandatory electronic filing and this applies to all Board filings, including SoPs unless an exception applies. The following are cases where QRS failed to electronically file the requisite final SoP in OH CDMS even though this documentation is the foundation upon which the Board and the Medicare Contractors review whether the group and the group's participants are in compliance with the jurisdictional requirements.

    a. In Case No. 14-3117GC, QRS was required to file a hard copy of the SoP in addition to the requisite electronic copy pursuant to Board Rule 20.1.1 and 42.3. As there was no proper filing of the SOP with supporting jurisdictional documentation in compliance with Board Rules governing groups in general and governing EJR requests, the Board found that, pursuant to 42 C.F.R. § 405.1842(f)(2)(iii), the request for EJR for this group was fatally flawed and premature because the EJR request has not been filed in compliance with Board Rule 42.3 and there is insufficient information to determine whether jurisdiction exists. Based on the finding, the Board ***denied*** EJR over the above-mentioned group appeal as required by § 405.1842(f)(2). The Board noted that there was still time for QRS to cure the defective filing since 60 days had not yet expired since the group was fully formed. Accordingly, 29 minutes after this EJR denial, QRS cured the defect by filing the SoP in OH CDMS; however, QRS failed to discuss why the error had occurred and did not refile the EJR request. Nor was there any discussion of the litigation that QRS had filed a month earlier on April 20, 2022.

    b. In Case No. 14-0943GC, the Board has discovered that QRS only filed the summary SoP cover sheet on April 20, 2022 and did not include any jurisdictional documentation. As the 60 day period for filing the requisite final SoP has since expired, the Board is reviewing whether to dismiss Case No. 14-0943GC and the sole participant in that group for QRS' failure to supply the requisite SoP documents necessary to establish jurisdiction per the Board Rules.

9. *The Compliance of Commonly Owned/Controlled Providers with the CIRP group requirements*.—Pursuant to 42 C.F.R. § 405.1837(b)(1):

> Two or more providers *under common ownership or control* that wish to appeal to the Board a specific matter at issue that involves a question of fact or interpretation of law, regulations, or CMS Rulings *that is common to the providers*, and that arises in cost reporting periods that end in the same calendar year, and for which the amount in controversy is $50,000 or more in the aggregate, ***must bring the appeal as a group appeal***.[62]

In these situations, the commonly owned/controlled providers must establish a common issue related party ("CIRP") group. The following are examples of participants in optional groups that the Board has, to date, identified as being potentially subject to the mandatory CIRP group requirements.

a. Case Nos. 14-4267GC and 14-4269GC.—On September 17, 2014, Carolinas Healthcare System ("Carolinas") established the 2011 CIRP groups under Case Nos. 14-4267GC (entitled "Carolinas Healthcare System 2011 DSH SSI Fraction Dual Eligible Days CIRP Group") and 14-4269GC (entitled "Carolinas Healthcare System 2011 DSH Medicaid Fraction Dual Eligible Days CIRP Group"). One of the participants in this 2011 CIRP group is Wilkes Regional Medical Center ("Wilkes"). However, Wilkes is also a participant in the 2011 *optional* groups under 15-3031G and 15-3039G for the same issue and year as Case Nos. 14-4267GC and 14-4269GC respectively. Significantly, QRS transferred Wilkes from its individual appeal under Case No. 15-3162 and the copy of the individual appeal request form *that QRS filed* ***on April 8, 2015*** *to establish that case* confirms that Wilkes is commonly owned or controlled by the Carolinas Healthcare System. The certifications include with the individual appeal request further confirmed that QRS understood that the CIRP regulations were applicable to Wilkes:

> There may be other providers to which this provider is related by common ownership or control that have or will have a pending request for a Board hearing on the same issues now being appealed for this cost reporting period that ends in the same calendar year covered in this appeal request. Accordingly, the Provider intends to transfer all such issues to appropriate CIRP group appeals once this appeal of the NPR is established. See 42 C.F.R. § 405.1835(b)(4)(i).

Notwithstanding these certifications and the facts that Carolinas already had established CIRP groups for the relevant issues and *that QRS had already*

[62] (Emphasis added.)

transferred Wilkes into those CIRP groups on April 8, 2015, QRS filed transfer requests on November 4, 2015 to transfer Wilkes from its individual appeal to the *optional* groups under Case Nos. 15-3031G and 15-3039, thereby creating improper duplicate appeals. Significantly, in the transfer requests, QRS *improperly* certified that Wilkes was ***not*** commonly owned and not subject to the mandatory CIRP group rules and that "[t]his issue is not pending in any other appeal for the same period."[63] Complicating matters, QRS filed an EJR request in Case Nos. 15-3031GC and 15-3039GC on January 12, 2022 and then abandoned the Board's jurisdictional process in those optional groups on February by filing suit in the California Central District Court, as more fully explained in **Appendix E**.[64] In light of fact the Carolinas has a provider pursuing a common issue as part of litigation in federal court based on the *optional* groups, the Board is reviewing whether 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. §§ 405.1837(b)(1) and (e)(1) otherwise preclude Carolinas from pursuing the common issues as part of the EJR request for Case Nos. 14-4267GC and 14-4269GC and support dismissal of those CIRP groups.

b. Case No. 14-4412GC— The Board needs clarification from QRS whether it continues to be appropriate for Scotland Memorial Hospital ("Scotland") to participate in this CIRP group. Scotland transferred to this CIRP from its individual appeal under Case No. 15-2234. Significantly, QRS is the representative in both the individual case as well as the CIRP group case. On December 30-31, 2015, QRS filed requests to rescind 2 separate transfer to Carolinas CIRP groups as "erroneous."[65] Significantly, one of the rescinded transfers was to Case No. 14-2603GC (SSI Fraction Denominator/Dual Eligible Days) which is the companion case to Case No. 14-4412GC. This rescission was prompted by a Jurisdictional Challenged filed by the Medicare Contractor in the individual case claiming that Scotland had duplicate appeals in Case No. 15-2385G and Case No. 14-2603GC for the same issue and year. The Board is reviewing whether to dismiss Scotland from Case No. 14-4412GC given that Scotland was (and still may be) a participant in Case No. 15-2385 (for which QRS is pursuing litigation in federal court as explained in **Appendix E**); however, prior to doing so, the Board would seek documentation from Carolinas regarding the appropriateness of Scotland's participation in this CIRP group. Even if valid, the Board needs to assess whether

[63] Indeed, the letter of representation included in the final SoPs for Case Nos. 15-3031G and 15-3039G was a global letter from Carolinas for all of Carolinas authorizing representation for Wilkes as well as 30 other Carolinas facilities for the years 1999 through 2013.

[64] Had QRS followed the normal jurisdictional process the Board could have potentially resolved this conflict without dismissing Wilkes and/or the CIRP groups. In this regard, the Board notes that the Medicare Contractor filed a jurisdictional challenge in Case Nos. 15-3031G and 15-3039G on March 10, 2022 challenging the participation of Wilkes in those optional groups because Wilkes was commonly owned by Carolinas and Carolinas had CIRP groups for the same year and issue under Case Nos. 14-4267GC and 14-4269GC. However, because QRS filed suit on February 14, 2022 without notice to the Board or the opposing party, the Board was precluded by 42 C.F.R. § 405.1842(h)(3)(iii) from ruling on this jurisdictional challenge and taking appropriate remedial actions. *See* **Appendix E**.

[65] QRS rescinded transfers to Case Nos. 14-2601GC (SSI fraction – Baystate Errors) and 14-2603GC (SSI Fraction Denominator/Dual Eligible Days).

Scotland could continue to participate given the fact that this CIRP group pertains to the Medicaid fraction and Scotland is not a participant in the companion CIRP group under 14-2603GC pertaining to the SSI fraction and, as such, the key portion of the EJR request relating to the invalidation of the Secretary's policy to count no pay part A days in the SSI fraction would not be applicable to Scotland.

10. *Participants That Did Not Properly Transfer Into the Group or Only Transferred a Portion of the Issue/Issues Covered By the Group*.— A significant number of the participants in these 150 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.[66] The Board expects it would identify multiple participants with these types of jurisdictional transfer issues if it were to complete its jurisdictional review.

11. *Participants For Which There Was No Copy of Transfer Request or Direct Add Request*.—In addition to those concerns raised by the Medicare Contractors, the Board has identified additional participants for which QRS has failed to include the documentation establishing that those participants were properly transferred or directly added to the group. Case No. 14-1440GC provides an example. The Board expects to identify additional examples upon completion of its jurisdictional review process.

12. *Filing a "Corrected" Final SoP With Supporting Documentation Without Leave of the Board*.—In Case No. 14-0627GC, QRS filed its final SoP with supporting documentation consisting of 82 PDF pages on April 19, 2022. The next day, on April 20, 2022, QRS filed its consolidated EJR request with the Board as well as its Complaint with the California Central District Court. Roughly 3 weeks later, on May 20, 2022, QRS filed another SoP consisting of 84 PDF pages. It is unclear to what extent there are any changes as QRS failed to include an explanation of why the second SoP was being filed and did not include an errata sheet. A similar situation occurred in Case No. 16-1837GC where, after the filing of the EJR request, a "corrected" SoP was filed without leave of the Board and without an errata sheet or explanation. In each case, the Board is reviewing whether to strike the second SoP filing.

13. *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; 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

[66] 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.

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. An example is in Case No. 13-3958GC (entitled "YNHHS 2006-2007 DSH Medicare Fraction Dual-Eligible Days CIRP Group") where the Board is reviewing the extent to which the EJR request applies to this case since, more than 5 years earlier on November 15, 2016, the Board dismissed the companion case under Case No. 13-3927GC (entitled "YNHHS 2006-2007 DSH Medicaid Fraction Dual-Eligible Days CIRP Group").

14. *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.[67] Pursuant to 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. § 405.1837(a)(1), a group may only contain one legal issue. In pertinent part, § 405.1837(a)(1) states that "[a] provider . . . has a right to a Board hearing, as part of a group appeal with other providers, with respect to a final contractor or Secretary determination for the provider's cost reporting period, ***only if*** - . . . (2) The matter at issue in the group appeal involves ***a single*** question of fact or ***interpretation*** *of law, regulations, or CMS Rulings* that is common to each provider in the group.[68] The Board is reviewing whether the Providers' consolidated EJR requests filed for Groupings A, B and C are 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[69]) in addition to the no-pay Part A days issue (as embodied in the *Empire* litigation decided

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[67] *See* 42 C.F.R. §§ 405.1842(a), 405.1842(f); 73 Fed. Reg. 30190, 30212 (May 23, 2008) (in response to comment that "the Board should have the authority to handle more than one question of fact or law in a group appeal" because "sometimes there is more than one disputed fact or question of law pertaining to a single item on the cost report" where "[a] common example of this is the [DSH] adjustment, which is determined by a combination of calculations, each of which may have more than one element in dispute", the Secretary affirmed that [t]he regulations at § 405.1837(a)(2) . . . specify that a group appeal involve a single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group" and that "[w]hat constitutes an appropriate group appeal issue in a given case will be determined by the Board."). The Board further notes that 42 C.F.R. § 405.1839(b) (underline and bole 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).

[68] (Emphasis added.)

[69] *Hall Render Optional and CIRP DSH Dual/SSI Eligible Group Appeals – Medicare Fraction v. Wisconsin Physicians Services*, PRRB Dec. No. 2017-D11 (Mar. 27, 2017).

before the Supreme Court[70]). If true, it raises immediate jurisdictional problems of whether the additional challenges are *properly* part of the relevant groups[71] and, if true, requires determining: (1) whether each of the participants properly appealed additional issues and, as relevant, whether it requested transfer of those additional issues to the group; and (2) whether the additional issues should be bifurcated from the group per 42 C.F.R. § 405.1837(f)(2).[72] 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.

Notwithstanding the above jurisdictional issues and concerns, QRS made clear with the April 20, 2022 filing of the Complaint in federal district court that it was bypassing and abandoning the Board's jurisdictional review process (as discussed above). Even though QRS made this filing the same day it filed the consolidated EJR request in Groupings B and C and only 12 days after it filed the consolidated EJR request in Grouping A, QRS waited until July 6, 2022 (2 ½ months later) to notify the Board of this litigation for Grouping A and until July 20, 2022 (3 months later) to notify the Board of this litigation for Groupings B and C.

The delay in learning of QRS' bypassing and abandoning the Board's jurisdictional and EJR review process by virtue of the OAA request for records has caused significant waste of the Board's limited resources, as well as those of FSS and the Medicare contractors servicing the 696 participants in the 150 group cases.[73] More concerning is QRS' concurrent filing of litigation without notice to the Board because it is tantamount to bad faith and demonstrates that QRS had no intention of complying with the administrative review process for EJR requests as mandated by 42 U.S.C. § 1395oo(f)(1) which necessarily includes first determining whether an EJR request is ripe (*i.e*, whether the Board has jurisdiction). QRS essentially self-declared that, concurrent with the filing of the EJR request in federal court, the participants in these groups have an immediate right to pursue EJR in federal district court (regardless of whether the Board has 30 days to review the EJR request, much less has jurisdiction over such providers). Indeed, 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.

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[70] *Becerra v. Empire Health Foundation*, 142 S. Ct. 2354 (2022), *reversing*, 958 F.3d 873 (9th Cir. 2020).

[71] 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.

[72] Indeed, the Board is aware that, notwithstanding the fact that it is pursing the merits of its EJR requests in federal district court, it subsequently filed preliminary position papers in the following cases and that these position papers include not just the *Empire* issue but also the SSI eligibility code issue embodied in PRRB Dec. No. 2017-D11:

- On April 11, 2022 for Case Nos. 15-1890GC, 15-1968GC, 14-1526GC, 14-2992GC, and 14-3281GC.
- On April 13, for Case No. 14-1668GC.
- On May 13, 2022, for Case Nos. 15-0008GC, 15-2402GC, 15-2629GC, and 17-0438GC.

[73] The Board takes administrative notice that it has a very large docket of pending cases (9142 as of May 1, 2022) and was then processing many EJR requests involving multiple thousands of participants. As of April 8, 2022, ***in addition to*** *the 150 cases covered in this notice*, the Board had 270 cases with EJR requests pending. On or after April 20th, 2022, when the last of these 3 EJR requests were filed, an additional 15 EJRs were file in April, 54 in May and 72 in June. As these cases were primarily group cases, they involved thousands of participants in the aggregate.

APPENDIX E

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

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

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

Dear Mr. Berends and Ravindran:

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

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

[2] *See supra* note 1.

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

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

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

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

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

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

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

Procedural Background

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

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

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

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

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

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

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

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

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

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

[17] (Emphasis in original.)

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

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

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

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

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

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

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[18] *See supra* note 3.

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

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

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

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

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

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

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

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

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

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

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

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

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

Board Findings and Ruling:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. *Prohibited Duplicate Appeals*

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

2. *Providers With No Appeal Rights*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4. Prohibited Participation of CIRP Providers in Optional Groups

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

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

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

5. *Unauthorized Representation of Participants*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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For the Board:

6/10/2022

X Clayton J. Nix

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Chair
Signed by: PIV

Enclosures: List of Groups

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

LIST OF 80 GROUP CASES

09-1903GC	BHCS 07 DSH Dual Eligible Days
13-1419G	QRS 2006 DSH SSI Fraction Denominator/Dual Eligible Group
13-1440G	QRS 2006 DSH Medicaid Fraction/Dual Eligible Group
13-1720GC	Scott & White 2008 Medicaid Fraction Dual Elig Days CIRP Group
13-1722GC	Scott & White 2008 DSH SSI Fraction Dual Elig Days CIRP Group
13-2678G	QRS 2007 DSH Medicaid Fraction Dual Eligible Days Group (2)
13-2693G	QRS 2008 DSH Medicaid Fraction Dual Eligible Days Group
13-2901GC	QRS BJC 2007 DSH SSI Fraction Dual Eligible Days CIRP Group
13-2903GC	QRS Novant 2007 SSI Fraction Dual Eligible Days CIRP Group
13-2904GC	QRS Novant 2007 Medicaid Fraction Dual Eligible Days CIRP Group
13-3061GC	QRS WFHC 2009 Medicaid Fraction Dual Eligible CIRP Group
13-3191GC	QRS Novant 2006 DSH Dual Eligible Days
13-3942G	QRS 2009 DSH Medicaid Fraction/Dual Eligible Days Group
13-3944G	QRS 2009 DSH SSI Fraction/Dual Eligible Days Group
14-1171G	QRS 2008 DSH SSI Fraction Dual Eligible Days Group
14-1174G	QRS 2007 DSH SSI Fraction Dual Eligible Days Group
14-1816G	QRS 2010 DSH SSI Fraction Dual Eligible Days Group
14-1818G	QRS 2010 DSH Medicaid Fraction Dual Eligible Days Group
14-2217GC	QRS Novant 2009 DSH Medicaid Fraction Dual Eligible Days CIRP Group
14-3306G	QRS 2011 DSH Medicaid Fraction Dual Eligible Days Group
14-3308G	QRS 2011 DSH SSI Fraction Dual Eligible Days Group
15-0018G	QRS 2012 DSH Medicaid Fraction/Dual Eligible Days Group
15-1067G	QRS 2006 DSH Medicaid Fraction Dual Eligible Days Group (2)
15-1147G	QRS 2006 DSH SSI Fraction Dual Eligible Days Group (2)
15-1152GC	QRS Novant 2010 DSH Medicaid Fraction Dual Eligible Days CIRP Group
15-1419G	QRS 2012 DSH SSI Fraction Dual Eligible Days Group
15-2385G	QRS 2010 DSH SSI Fraction Dual Eligible Days Group II
15-2386G	QRS 2010 DSH Medicaid Fraction Dual Eligible Days Group II
15-3031G	QRS 2011 DSH Medicaid Fraction Dual Eligible Days Group 2
15-3039G	QRS 2011 DSH SSI Fraction Dual Eligible Days Group 2
15-3073GC	QRS Progressive Acute Care 2011 DSH Medicaid Fraction/Dual Eligible Days
16-0091GC	HRS DCH 2010 DSH SSI Fraction Dual Eligible Days CIRP Group
16-0092GC	HRS DCH 2010 Medicaid Fraction Dual Eligible Days CIRP Group
16-1142G	QRS 2013 DSH SSI Fraction Dual Eligible Days Group
16-1145G	QRS 2013 DSH Medicaid Fraction Dual Eligible Days Group
16-1750G	QRS 2012 DSH SSI/Medicaid Dual Eligible Days Group II
17-0867G	QRS 2014 DSH SSI/Medicaid Dual Eligible Days Group
17-1405G	QRS 2013 DSH SSI Fraction Dual Eligible Days Group (2)
17-1406G	QRS 2013 DSH Medicaid Fraction Dual Eligible Days Group (2)
17-1409G	QRS 2005 DSH SSI Fraction Dual Eligible Days Group
17-1412G	QRS 2005 DSH Medicaid Fraction Dual Eligible Days Group
17-1426G	QRS 2006 DSH SSI Fraction Dual Eligible Days Group 3

17-1427G	QRS 2006 DSH Medicaid Fraction Dual Eligible Days Group
18-0270G	QRS 2007 DSH SSI Fraction Dual Eligible Days Group (3)
18-0730G	QRS 2011 DSH SSI Fraction Dual Eligible Days Group III
18-1259G	QRS 2014 DSH SSI Fraction Dual Eligible Days Group 2
18-1260G	QRS 2014 DSH Medicaid Fraction Dual Eligible Days Group 2
18-1405G	QRS 2015 DSH Medicaid Fraction Dual Eligible Days Group
18-1408G	QRS 2015 DSH SSI Fraction Dual Eligible Days Group
18-1738GC	AHMC Healthcare CY 2012 DSH Medicaid Fraction Dual Eligible Days CIRP
19-0012GC	AHMC Healthcare CY 2015 DSH SSI Fraction Dual Eligible Days CIRP Group
19-0014GC	AHMC Healthcare CY 2015 DSH Medicaid Fraction Dual Eligible Days CIRP
19-0164GC	AHMC Healthcare CY 2013 DSH Medicaid Fraction Dual Eligible Days CIRP Group
19-0195GC	Houston Methodist CY 2014 DSH SSI Fraction Dual Eligible Days CIRP Group
19-0235GC	Houston Methodist CY 2014 DSH Medicaid Fraction Dual Eligible Days CIRP
19-0270GC	Mercy CY 2016 DSH SSI Fraction Dual Eligible Days CIRP Group
19-0272GC	Mercy CY 2016 DSH Medicaid Fraction Dual Eligible Days CIRP Group
19-0534G	QRS CY 2011 DSH Medicaid Fraction Dual Eligible Days (3) Group
19-0704G	QRS CY 2012 DSH SSI Fraction Dual Eligible Days (3) Group
19-0706G	QRS CY 2012 DSH Medicaid Fraction Dual Eligible Days (3) Group
19-2131GC	Hartford Health CY 2015 DSH SSI Fraction Dual Eligible Days CIRP Group
19-2134GC	Hartford Health CY 2015 DSH Medicaid Fraction Dual Eligible Days CIRP
19-2513G	QRS CY 2016 DSH SSI Fraction Dual Eligible Days Group
19-2515G	QRS CY 2016 DSH Medicaid Fraction Dual Eligible Days Group
19-2594G	QRS CY 2015 DSH SSI Fraction Dual Eligible Days (2) Group
19-2596G	QRS CY 2015 DSH Medicaid Fraction Dual Eligible Days (2) Group
20-0107G	QRS CY 2013 DSH SSI Fraction Dual Eligible Days (3) Group
20-0112G	QRS CY 2013 DSH Medicaid Fraction Dual Eligible (3) Group
20-0209G	QRS CY 2010 DSH SSI Fraction Dual Eligible Days (3) Group
20-0211G	QRS CY 2010 DSH Medicaid Fraction Dual Eligible (3) Group
20-0244G	QRS CY 2007 DSH Medicaid Fraction Dual Eligible Days (4) Group
20-0248G	QRS CY 2006 DSH SSI Fraction Dual Eligible Days (4) Group
20-0250G	QRS CY 2006 DSH Medicaid Fraction Dual Eligible Days (4) Group
20-0367G	QRS CY 2005 DSH SSI Fraction Dual Eligible Days (2) Group
20-0368G	QRS CY 2005 DSH Medicaid Fraction Dual Eligible Days (2) Group
20-0409GC	AHMC Healthcare CY 2016 DSH SSI Fraction Dual Eligible Days CIRP Group
20-0411GC	AHMC Healthcare CY 2016 DSH Medicaid Fraction Dual Eligible Days CIRP
20-1511G	QRS CY 2014 DSH SSI Fraction Dual Eligible Days (2) Group
20-1513G	QRS CY 2014 DSH Medicaid Fraction Dual Eligible Days (2) Group
20-1655G	QRS CY 2007 DSH SSI Fraction Dual Eligible Days (4) Group

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Jurisdictional Determination***
Carolinas Rehabilitation (34-3026, FYE 12/31/2009), *as a participant in*
Case No. 14-0918GC – Carolinas Healthcare Sys. 2009 DSH SSI Fraction Part C Days CIRP

Dear Mr. Ravindran and Ms. Johnson:

The above-captioned common issue related party CIRP group case includes a rehabilitation facility Provider, namely Carolinas Rehabilitation (Prov. No. 34-3026) for the fiscal year ending ("FYE") 12/31/2009. The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the documentation as the group issue is subject to remand pursuant to CMS Ruling 1739-R. Following review of the documentation, the Board finds that it does not have jurisdiction over Carolinas Healthcare System as a participant in this group appeal.

Pertinent Facts

Case No. 14-0918GC was established on November 15, 2013, with one Provider. Subsequently, a number of other Providers were added to the group appeal, including Carolinas Rehabilitation, which was directly added to the group on November 24, 2014. The Provider appealed an original Notice of Program Reimbursement ("NPR"), and appealed audit adjustment 15 which is, "To adjust the PPS [inpatient rehabilitation facility "IRF"] data to the amount determined by the MAC."

Board's Analysis and Decision

Applicable Regulatory Provisions and Board Rules

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1840 (2014), a provider has a right to a Board hearing 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 ($50,000 for a group), and the request for hearing is filed within 180 days of the date of receipt of the final determination. Under 42 C.F.R. § 405.1835(a)(1) (2012), a provider has preserved its right to claim dissatisfaction with the amount of Medicare payment for a specific item at issue by either (i) including a claim for the specific item on its cost report for the period where the provider seeks payment that it believes to be in accordance with Medicare

policy; or (ii) effective with cost reporting periods that end on or after December 31, 2008, self-disallowing the specific item by following the applicable procedures for filing a cost report under protest where the provider seeks payment that it believes may not be in accordance with Medicare policy.

Rehab Days in LIP Adjustment Calculations

Under 42 U.S.C. § 1395ww(j)(8)(B), Congress specifically precludes administrative or judicial review of the prospective payment rates ("PPS") for inpatient rehabilitation facilities ("IRFs"). Although providers have attempted to dispute exactly what rate-setting "steps" Congress intended to shield from review under the statute, the United States Court of Appeals, District of Columbia Circuit's decision in *Mercy Hospital, Inc. v. Azar*, answers this question and clarifies what is shielded from review in its analysis of this issue.[1]

In *Mercy*, the D.C. Circuit describes CMS' two-step rate-setting process for Medicare reimbursement for IRFs. The first step takes place prior to the beginning of the fiscal year and involves CMS' establishment of a standardized reimbursement rate, while the second step involves CMS' adjustments (calculated by the Medicare contractor) to "the standardized rates to reflect the particular circumstances of each hospital for that year."[2] One of the ways in which CMS adjusts a hospital's IRF Medicare payment is by taking into account the number of low income patients ("LIP") served by the hospital, also known as the LIP adjustment. The D.C. Circuit in *Mercy* affirmed the U.S. District Court, wherein the District Court concluded that 42 U.S.C. § 1395ww(j)(8) prohibits administrative or judicial review of the Medicare Contractor's determination of the LIP adjustment, because such review amounts to review of the establishment of the hospital's prospective payment rates.[3] The D.C. Circuit concluded that the Statute's plain language prohibits administrative and judicial review of not only the statutory adjustments, but also the "step two rates" utilized by the Medicare Contractor when adjusting the standardized reimbursement rate and then calculating a hospital's final payment.[4]

In the instant appeal, Carolinas Rehabilitation seeks Board review of the Part C days in the SSI fraction, as appealed from the PPS IRF adjustment. Because, pursuant to 42 U.S.C. § 1395ww(j)(8)(B), Congress has prohibited administrative and judicial review of the prospective payment rates for IRFs, including the LIP adjustment, the Board lacks the jurisdiction to hear the Provider's appeal of the LIP adjustment and dismisses the Provider from the instant group appeal that challenges this adjustment. In making this finding, the Board relied on the *Mercy* decision and notes that the D.C. Circuit's decision in *Mercy* is controlling precedent for the interpretation of 42 U.S.C. § 1395ww(j)(8)(B) because the Provider could bring suit in the D.C. Circuit.[5]

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[1] *Id*.
[2] *Id.* at 1064.
[3] *Mercy Hosp., Inc. v. Burwell,* 206 F. Supp. 3d 93, 102 (D.D.C. 2016).
[4] *Mercy*, 891 F.3d at 1068.
[5] The CMS Administrator generally has applied as controlling precedent the law of the Circuit in which the Provider is located. *See, e.g., QRS CHW DSH Labor room Days Groups v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (Apr. 13, 2009), affirming, PRRB Dec. No. 2009-D11 (Feb. 27, 2009); *St. Vincent Mercy Med. Ctr. v. BlueCross BlueShield Ass'n*, Adm'r Dec. (Nov. 17, 2008), *affirming in part and reversing in part*, PRRB Dec. No. 2008-D35 (Sept. 15, 2008). However, in recognizing that providers may file suit with the appropriate District Court

Accordingly, the Board hereby dismisses Carolinas Rehabilitation from this group appeal. The remaining providers will be remanded to the Medicare Contractor pursuant to CMS Ruling 1739-R under separate cover. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877 upon final disposition of the case.

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For the Board:

9/30/2022

X Clayton J. Nix

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Chair
Signed by: PIV

cc: Wilson Leong, Federal Specialized Services

either in the Circuit in which they are located or the D.C. Circuit, the Administrator also applies as controlling precedent the law of the D.C. Circuit. *See, e.g., Jordan Hosp. v. Blue Cross Blue Shield Ass'n.*, Adm'r Dec. (Apr. 30, 2007), *vacating*, PRRB Dec. No. 2007-D23 (Feb. 28, 2007).

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RE: ***Jurisdictional Decision***
14-2932GC HRS Prime Healthcare 2010 DSH SSI Fraction Medicare Managed Care CIRP
14-2933GC HRS Prime Healthcare 2010 DSH Medicaid Fraction Medicare Managed Care Part C Days CIRP Group

Dear Ms. Goron and Ms. Frewert:

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the jurisdictional documentation in the common issue related party ("CIRP") groups under Case Nos. 14-2932GC and 14-2933GC. The Board's decision is set forth below.

Background

The group appeal requests were filed on March 13, 2014. On September 6, 2019, Suburban Community Hospital (39-0116, FYE 12/31/2010) was directly added to both group appeals. The Provider filed its appeal request from a revised Notice of Program Reimbursement ("NPR") that was issued on March 15, 2019. The Provider's Notice of Reopening indicates that the cost report was reopened in order:

> To review your request to recalculate the hospital's Acute SSI percentage based on the hospital's fiscal year 12/31/2010. Please be advised that we have forwarded your request to CMS and will communicate any necessary changes to you when we receive a reply.

The Provider's audit adjustment report shows that there was an adjustment to the Provider's SSI percentage "to account for CMS' recalculation of the Provider's SSI percentage."

Board's Analysis and Decision

The Board finds that it does not have jurisdiction over Suburban Community Hospital as a participant in Case Nos. 14-2932GC or 14-2933GC.

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2019), a provider has a right to a hearing before the Board with respect to specific items claimed on a timely filed cost report if: (1) it is dissatisfied with the final determination of the Medicare contractor; (2) the amount in controversy is $10,000 or more ($50,000 for a group); and (3) the request for a hearing is filed within 180 days of the date of receipt of the final determination.

The Code of Federal Regulations provides for an opportunity for a reopening and revised NPR at 42 C.F.R. § 405.1885 (2018), which provides in relevant part:

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

Additionally, 42 C.F.R. § 405.1889 (2018)[1] explains the effect of a cost report revision:

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

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

> (a) *Right to hearing on final contractor determination*. A provider . . . has a right to a Board hearing, as a single provider appeal,

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

> 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 Board has consistently found that it does not have jurisdiction over revised NPRs that were issued as a result of a provider's request for realignment of its SSI percentage. As noted in 42 C.F.R. § 412.106(b)(2), CMS gathers data to be used in the SSI fraction on a month-by-month basis:

> (2) *First computation: Federal fiscal year*. **For each month** of the Federal fiscal year in which the hospital's cost reporting period begins, CMS -
>
> (i) Determines the number of patient days that -
>
> (A) Are associated with discharges occurring **during each month**; and
>
> (B) Are furnished to patients who **during that month** were entitled to both Medicare Part A (including Medicare Advantage (Part C)) and SSI, excluding those patients who received only State supplementation;
>
> (ii) Adds the results for the whole period; and
>
> (iii) Divides the number determined under paragraph (b)(2)(ii) of this section by the total number of days that -
>
> (A) Are associated with discharges that occur during that period; and
>
> (B) Are furnished to patients entitled to Medicare Part A (including Medicare Advantage (Part C)).[3]

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

The data matching process by which CMS gathers this *monthly* data is described in the FY 2011 IPPS Final Rule.[4] As described in the Federal Register, under the realignment process, CMS calculates the SSI fraction using the *previously-gathered* data for the months included in the published SSI fractions for 2 Federal fiscal years that encompass the hospital's cost reporting period:

1. *75 Fed. Reg. 50042, 50279 (Aug. 16, 2010)*.—"[W]e publish these [SSI fraction] data for every hospital based on the Federal fiscal year but, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived *from the data match process* ***for the two Federal fiscal years that spanned the hospital's cost reporting period***."[5]

2. *70 Fed. Reg. 47278, 47439 (Aug. 12, 2005)*.—"Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period, and *the hospital* ***must accept*** *the resulting DSH percentage for that year, whether or not it is a more favorable number than the DSH percentage based on the Federal fiscal year*. . . .

   Beginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108–173), we will arrange to furnish, consistent with the Privacy Act, MedPAR LDS data for a hospital's patients eligible for both SSI and Medicare at the hospital's request, regardless of whether there is a properly pending appeal relating to DSH payments. *We will make the information available for either the Federal fiscal year or, if the hospital's fiscal year differs from the Federal fiscal year, for the* ***months*** ***included in the 2 Federal fiscal years that encompass the hospital's cost reporting period***. Under this provision, *the hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year*. The data set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year."[6]

[4] 75 Fed. Reg. 50042, 50275-85 (Aug. 16, 2010).
[5] (Emphasis added.)
[6] (Emphasis added.)

Accordingly, the realignment process does not change any of the data underlying the realigned SSI fraction (*e.g*., Part C days or Part A days) because that data had been previously gathered on a month-by-month basis and *there is no need for CMS to rerun the data matching process* in order to effectuate a realignment (*i.e*., realigning the SSI fraction from the federal fiscal year to the provider's fiscal year). Indeed, as noted in the second Federal Register excerpt, CMS' stated realignment policy is that the provider "must accept" the realigned SSI percentage.

In other words, the determination was only being reopened to include realigned SSI percentages. Since the only matters specifically revised in the revised NPR was the adjustment to realign the SSI percentage from the federal fiscal year to the provider's fiscal year, the Board does not have jurisdiction over the revised NPR appeal of the DSH Part C days issue. In making this ruling, the Board notes that its application of 42 C.F.R. § 405.1889(b) has been upheld by courts on review.[7]

As Part C days were not adjusted in the revised NPR as required by 42 C.F.R. § 405.1889, the Board finds that it does not have jurisdiction over Suburban Community Hospital. Accordingly, the Board dismisses Suburban Community Hospital from Case Nos. 14-2932GC and 14-2933GC.

The remaining providers in the cases will be remanded pursuant to CMS Ruling 1739-R under separate cover.

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

Board Members Participating:

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

For the Board:

9/30/2022

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Nicholas Putnam
Strategic Reimbursement Group, LLC
360 West Butterfield Rd., Ste. 310
Elmhurst, IL 60126

RE: ***Jurisdictional Decision***
SRI Presence Health 2006 Unmatched Medicaid Days CIRP Group
Case No. 14-3037GC

Dear Mr. Putnam:

The Provider Reimbursement Review Board ("Board" or "PRRB") has reviewed the above-referenced common issue related party ("CIRP") group appeal in response to the Medicare Contractor's Jurisdictional Challenge. The Board's decision is set forth below.

Procedural History

Strategic Reimbursement Group, LLC ("SRG") is the designated representative for Presence Health and its commonly owned providers. On March 24, 2014, SRG established the CIRP group under Case No. 14-3037GC for Presence Health with the following two participants commonly owned by Presence Health:

1. Presence Provena Covenant Medical Center (Prov. No. 14-0113) appealing from a Revised Notice of Program Reimbursement ("RNPR") dated February 25, 2013, and

2. Presence Provena Saint Mary's Hospital (Prov. No. 14-0155) appealing from a RNPR dated February 20, 2013.

On April 29, 2014, SRG transferred from an individual appeal under Case No. 13-3001 a third participant, Mercy Hospital (Prov. No. 14-0174) appealing from a RNPR dated February 25, 2013.

All three participants included documentation confirming that none of them requested the reopening of their initial cost report. This documentation reads, in pertinent part:

> The reopening of this cost report and issuance of Revised Notice of Program Reimbursement (RNPR) for the applicable cost report was initiated by the fiscal intermediary and not by the provider. As such, the provider has included the NPR or RNPR that immediately precedes the RNPR under appeal. But, no request for

> reopening or resulting acceptance and notice of reopening exists. As such, this documentation is not applicable.

The Statement of Group Issues included with the group appeal request summarizes its Unmatched Medicaid Days issue as follows:

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

On April 29, 2014, the Medicare Contractor filed a jurisdictional challenge claiming that the group improperly had multiple issues. Based upon their review of the group formation, the Medicare Contractor maintained that the inclusion of dually eligible days in the DSH [Disproportionate Share Hospital] and LIP [Low Income Payment] Medicaid fractions were separate and distinct issues.[2] The argument went on to argue that this puts the appeal in violation of Board Rule 13 – requiring a Common Group issue be one in which the matter at issue involves one single common question of fact or interpretation of law, regulation or CMS policy ruling, and challenging the jurisdiction of the appeal.[3]

On May 21, 2014, the Provider filed its response to the Jurisdiction Challenge. The Provider conceded that DSH and LIP payments are separate and any resolution would result in "[s]eparate reconciliation of the DSH and LIP calculations . . ."[4] However, the Provider argued:

> Instead, the single common issue raised in this appeal disputes one of three issues: is the SSI calculation properly accumulated and calculated, are the proper days included in the Medicare Fraction, or are the proper days included in the Medicaid Fraction? The treatment of each of the issues is the same between both the DSH and LIP adjustments.[5]

On April 14, 2022, SRG filed the Providers' Preliminary Position Paper ("PPP").

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[1] Statement of Group Issues (Mar. 24, 2014).
[2] Medicare Contractor's 30-Day Letter at 1 (Apr. 29, 2014).
[3] *Id*.
[4] Provider Group Jurisdictional Response at 1-2 (May 21, 2014).
[5] *Id.* at 2.

On August 5, 2022, the Medicare Contractor filed its PPP. In particular, the Medicare Contractor's PPP contends that the Providers did not address LIP calculations in their PPP and, as a result, the Board should find the issue to be abandoned.[6] The Medicare Contractor further stated that should the LIP issue be pursued in the future, it would challenge jurisdiction as this is a separate issue and should be bifurcated from the case, at which point the Medicare Contractor should be allowed to brief the issue at that time.[7]

Additionally, the Medicare Contractor asserted that the DSH calculation in dispute included all Medicaid eligible days submitted by the Providers on their cost reports prior to the issuance of the NPR.[8] The Medicare Contractor goes on:

> Per our review of the schedule of providers, the MAC noted a jurisdictional impediment for all providers in the case due to a lack of dissatisfaction. The appeals for all of the included Providers were based on Revised Notices of Program Reimbursement (RNPR). None of the adjustments cited by the providers were to removed Medicaid days. The RNPRs were issued to update the SSI percentages to the revised SSI percentages issued by CMS. The cited SSI adjustments fail to show dissatisfaction with the providers' claim that the Medicaid ratio is understated. As such, the MAC intends to file a jurisdictional challenge for all the providers in the Group and request the case be dismissed.[9]

Board Decision

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

LIP Sub-issue

The regulation at 42 C.F.R. § 405.1853(b)(2) specifies that "[e]ach position paper must set forth 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*."[10] Consistent with this regulation, Board Rule 25.3 (Nov. 2021) mandates that position papers must be complete, and that "[i]f the provider fails to brief an appealed issue in its position paper, the Board will consider the unbriefed issue abandoned and effectively withdrawn."

---

[6] Medicare Contractor's Preliminary Position Paper (hereinafter "Medicare Contractor's PPP") at 5 (Aug. 5, 2022).
[7] *Id*.
[8] *Id*. at 4.
[9] *Id*. at 5.
[10] (Emphasis added.)

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

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

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

> (a) The Board has full power and authority to make rules and establish procedures, not inconsistent with the law, regulations, and CMS Rulings, that are necessary or appropriate to carry out the provisions of section 1878 of the Act and of the regulations in this subpart. The Board's powers include the authority to take appropriate actions in response to the failure of a party to a Board appeal to comply with Board rules and orders or for inappropriate conduct during proceedings in the appeal.
>
> (b) If a provider fails to meet a filing deadline or other requirement established by the Board in a rule or order, the Board may—
>
> (1) Dismiss the appeal with prejudice;
>
> (2) Issue an order requiring the provider to show cause why the Board should not dismiss the appeal; or
>
> (3) Take any other remedial action it considers appropriate.

For these reasons, the Board considers the LIP issue abandoned and effectively withdrawn from the group appeal.

Even if the Providers had not abandoned the LIP issue, the Board would have still dismissed it. Under 42 U.S.C. § 1395ww(j)(8)(B), Congress specifically precludes administrative or judicial review of the prospective payment rates under the IRF-PPS. Although providers have attempted to dispute exactly what rate-setting "steps" Congress intended to shield from review under the statute, the D.C. Circuit's decision in *Mercy Hosp., Inc. v. Azar,* 891 F. 3d 1062 (June 8, 2018) ("*Mercy*") answers this question and clarifies what is shielded from review in its analysis of this issue.

In *Mercy*, the Court describes CMS' two-step rate-setting process for Medicare reimbursement for IRFs. The first step takes place prior to the beginning of the fiscal year and involves CMS' establishment of a standardized reimbursement rate, while the second step involves CMS' adjustments (calculated by the Medicare contractor) to "the standardized rates to reflect the particular circumstances of each hospital for that year." One of the ways in which CMS adjusts a hospital's IRF Medicare payment is by taking into account the number of low-income patients ("LIP") served by the hospital, also known as the LIP adjustment. The Court in *Mercy* affirmed the District Court's decision, wherein the District Court concluded that 42 U.S.C. § 1395ww(j)(8) prohibits administrative or judicial review of the Medicare Contractor's determination of the LIP adjustment, because such review amounts to review of the establishment of the hospital's prospective payment rates.[11] The D.C. Circuit concluded that the Statute's plain language prohibits administrative and judicial review of not only the statutory adjustments, but also the "step two rates" utilized by the Medicare Contractor when adjusting the standardized reimbursement rate and then calculating a hospital's final payment.[12]

DSH Medicaid Eligible Days Sub-issue

The Code of Federal Regulations provides for an opportunity for a reopening of a determination and the issuance of a revised determination 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 revised determination such as an RNPR:

> (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.

[11] *Mercy Hosp., Inc. v. Burwell*, No. 15-1236 (JDB), 2016 WL 4007072, at *8 (D.D.C. July 25, 2016).
[12] *Mercy*, 891 F.3d at 1068.

> (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.[13]

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.[14]

The Board finds that it does not have jurisdiction over the DSH Medicaid Eligible Days issue in this appeal from providers that filed from revised NPRs because the revised NPRs were issued to update the SSI percentage to the revised SSI percentages issued by CMS. Thus, pursuant to 42 C.F.R. § 405.1889(b) as referenced in § 405.1835(a)(1), the providers do not have the right to appeal the Medicaid Fraction in connection with the Unmatched Medicaid Eligible Days issue under appeal.

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[13] 42 C.F.R. § 405.1889(b).
[14] (Emphasis added).

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[.]"[15] In this case, the RNPRs were issued to update the SSI percentages to the revised SSI percentages issued by CMS. The number of Medicaid eligible days in the numerator of the Medicaid fraction was not specifically revised. Accordingly, the Board finds that it lacks jurisdiction over this issue because, pursuant to C.F.R. § 405.1889(b), the Providers had no right to appeal the Unmatched Medicaid Eligible Days issue based on the relevant RNPRs. In making this ruling, the Board notes that its application of 42 C.F.R. § 405.1889(b) has been upheld by courts on review.[16]

Conclusion

The Board finds that the LIP sub-issue was abandoned by the providers as that issue was not briefed in its preliminary position paper. Additionally, this issue is otherwise precluded from administrative review under 42 U.S.C. § 1395ww(j)(8)(B) and affirmed in *Mercy*. The Board dismisses this issue from the appeal.

Further, the Board finds that, pursuant to 42 C.F.R. § 405.1889(b), none of the participants in the CIRP group had a right to appeal the relevant RNPR for the group issue under appeal because those RNPRs did not adjust Medicaid Eligible Days as used in the Medicaid fraction, much less adjust the Medicaid fraction for the group issue. Therefore, the Board lacks jurisdiction over the issue for each of the participants in Case No. 14-3037GC and dismisses them from the group appeal. As there are no remaining participant in the Case No. 14-3037GC, the Board closes it and removes it from the Board's docket.

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

Board Members:

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

For the Board:

9/30/2022

X Clayton J. Nix

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

cc: Wilson C. Leong, Esq. Federal Specialized Services
Pamela VanArsdale, National Government Services, Inc. (J-6)

[15] 42 C.F.R. § 405.1889(b)(1).
[16] *See St. Mary's of Mich. V. Azar*, No. 18-01790, 2020 WL 4049912 (D.D.C. July 20, 2020); *McLaren Flint v. Azar*, No. 18-2005, 2020 WL 2838566 (D.D.C. May 31, 2020), *Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F.Supp.3d 348 (D.D.C. 2014); *HCA Health Servs. of OK v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Lori Rubin, Esq.
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RE: ***Notice of Dismissal***
All Saints Medical Center (Prov. No. 52-0096)
FYE 6/30/2012
Case No. 14-3559

Dear Ms. Rubin,

The Provider Reimbursement Review Board ("Board") has reviewed the documents filed in the above-captioned case.

Background

The Provider submitted a request for hearing on March 5, 2020, based on a Notice of Program Reimbursement ("NPR") dated September 11, 2019. This appeal was merged with an already pending appeal for the Provider under Case No. 14-3559.

The sole remaining issue in the appeal is DSH – Medicaid Eligible Days. In its appeal request the Provider stated the issue as follows:

> Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation?

The Provider stated the legal basis of the appeal as follows:

> 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 share percentage, set forth a 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 dates and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.

Provider's Final Position Paper

On May 19, 2021, QRS filed a final position paper in Case No. 14-3559. With respect to the DSH – Medicaid Eligible Days issue, the final position paper contained the following conclusion:

> The Provider requests that the MAC review the Medicaid eligible days listing being sent under separate cover and provide a sample listing as soon as practicable. Further, upon completion of that review, the Provider requests that the MAC administratively resolve this issue by computing the Medicaid Fraction using patient days applicable to all Medicaid eligible patients to comply with the decisions of the Federal Courts and HCFAR 97-2.

Medicare Contractor's Final Position Paper

The Medicare Contractor filed a final position paper in this case on June 18, 2021. The Medicare Contractor stated the following:

> The Provider submitted a list of additional Medicaid eligible days on February 28, 2020. The listing contains 124 accounts totaling 300 days. The MAC was in the process of reviewing a sample of the accounts from the listing *when the Provider filed a **new** appeal request on March 5, 2020*, based on the September 11, 2019 NPR issued. The Provider submitted a supplemental position paper on October 24, 2020, and a final position paper on May 19, 2021. In the Provider's supplemental position paper and final position paper, the Provider states that a listing of Medicaid eligible days ***is being** sent under separate cover*. The MAC has ***not*** received that listing. The MAC reached out to the Provider to inquire if the list sent on February 28, 2020 is the same list that the Provider references in its supplemental and final position papers. *The Provider has not responded to the MAC's request*. As a result, it is not clear to the MAC what Medicaid eligible days remain at issue.[1]

Controlling Regulations and Board Rules

The regulation at 42 C.F.R. § 405.1853(b) provides the following base requirements regarding the submission and content of position papers:

> (b) *Position papers*. (1) After any preliminary narrowing of the issues, the parties must file position papers in order to narrow the issues further. In each case, and as appropriate, the Board establishes the deadlines as to when the provider(s) and the contractor must submit position papers to the Board.

[1] (Emphasis added.)

> (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 . . . ***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]

The Board has developed Rules consistent with these requirements. With regard to the filing of an individual appeal, Board Rule 7 (Support for Appealed Final Determination, Issue-Related Information and Claim of Dissatisfaction) (Jul. 2015) states:

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

Similarly, with regard to position papers,[3] Board Rule 25.2.1 requires that "the parties must exchange ***all*** available documentation as exhibits to fully support your position."[4]

Board Rule 25.2.2 provides the following instruction on the content of position papers:

> *If documents necessary to support your position are still unavailable,* then provide the following information in the position papers:
>
> 1. Identify the missing documents;
> 2. Explain why the documents remain unavailable;
> 3. State the efforts made to obtain the documents; and
> 4. Explain when the documents will be available.
>
> Once the documents become available, promptly forward them to the Board and the opposing party.[5]

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:

---

[2] (Emphasis added.)
[3] The minimum requirements for Final Position Paper narratives and exhibits is the same as those for Preliminary Position Papers. *See* PRRB Rule 27.2.
[4] (Emphasis added).
[5] (Emphasis added).

> 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.

Decision of the Board

The Provider is required to provide documentation to prove the additional Medicaid Eligible days to which it may be entitled. 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"[6] 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. Moreover, the Provider has failed to even present ***basic*** relevant facts regarding the merits of its claim, namely the specific number of Medicaid eligible days that are at issue in compliance with 42 C.F.R. § 405.1853(b)(2) and Board Rule 25 governing the content of position papers.

Based on the record before the Board, the Board finds that the Provider has failed to provide a listing or other supporting documentation for the Medicaid Eligible Days issue as required by the controlling regulations and Board Rules. Nor has the Provider provided any explanation as to why the documentation was absent or what is being done to obtain it. The Board notes that in the Provider's supplemental position paper and final position paper, the Provider states that a listing of Medicaid eligible days is being sent under separate cover. The Medicare Contractor states that it has not received that listing. The Medicare Contractor states that it reached out to the Provider

[6] (Emphasis added).

to inquire if the list sent on February 28, 2020, *prior to the filing of the appeal on March 5, 2020*, is the same list that the Provider references in its supplemental and final position papers.[7] The Provider has not responded to the Medicare Contractor's request. As a result, the Medicare Contractor is unclear on what Medicaid eligible days remain at issue.

The Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of Board Rules 25.2.1 and 25.2.2 related to the submission of documentary evidence required to support its claims or describe why said evidence is unavailable.[8] Indeed, the Medicare Contractor attempted to confer with the Provider in good faith on multiple occasions about the deficient record but the Provider has been nonresponsive.

As such, the Board hereby dismisses the DSH - Medicaid Eligible Days issue from the appeal. As this was the last remaining issue in the appeal, the Board closes Case No. 14-3559, and removes it from the Board's docket.

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

Board Members Participating:

Clayton J. Nix, Esq.
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For the Board:

9/30/2022

X Clayton J. Nix

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

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

[7] The Board emphasizes that the alleged February 28, 2020 listing occurred *prior to* the instant Board appeal on March 5, 2020 and is ***not*** part of the record before the Board and, more importantly, is neither part of nor referenced in the Provider's Final Position Paper. The Board notes that the days in the Provider's impact calculations (filed on March 5, 2020 with the appeal) indicate 1% (or 733) additional Medicaid days are at issue, while the listing allegedly sent to the Medicare Contractor on February 28, 2020 included only 300 days. It is unclear whether the 1% estimate for the instant appeal is based on a listing, a guesstimate, or some combination; and, if it is based wholly on a listing, the extent to what that listing has changed since the appeal was filed (or even overlaps with the alleged February 2020 listing). None of this critical factual information is included in the final position paper as required under § 405.1853(b) and Board Rule 25. It has been more than 10 years since the Provider's FY 2012 closed and this information should have been determined at this late stage.

[8] Board Rule 25, of which 25.2.1 and 25.2.2 are a part, is applicable to final position papers via Board Rule 27.2.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Jurisdictional Decision***
Mayo Clinic Health System - Fairmont (Prov. No. 24-0166)
FYE 12/31/2013
Case No. 17-1569

Dear Mr. Miller and Ms. VanArsdale:

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the jurisdictional documentation in individual Case No. 17-1569, pursuant to a jurisdictional challenge filed by the Medicare Contractor.[1] The Board's decision is set forth below.

Background:

Mayo Clinic Health System – Fairmont ("Fairmont" or "Provider") is a Sole Community Hospital ("SCH") located in Fairmont, Minnesota.[2] The Medicare contractor[3] assigned to Fairmont for this appeal is National Government Services, Inc. ("MAC").

On July 8, 2015, Fairmont initially requested a VDA adjustment, after having experienced a 9.48 percent decrease in discharges in its fiscal year ending December 31, 2013 ("FY 2013").[4] On August 7, 2015, the MAC approved "a *tentative* final [VDA] adjustment amount for [FY 2013] in the amount of $1,411,986" since the notice of program reimbursement ("NPR") had not yet been issued.[5] On December 1, 2015, the MAC issued Fairmont's NPR for FY 2013. On March 22, 2016, the MAC issued its "final determination" on the FY 2013 VDA request and approved a VDA

[1] The Board notes that this case was approved for a record hearing on August 24, 2021. At that time, the Board had not reviewed the jurisdictional challenge or response. The Board notes that: (1) parties are required to brief jurisdiction as part of their positions papers per 42 C.F.R. § 405.1853(b)(2); (2) Board review of jurisdiction may occur at any time even after a Board hearing, whether on the Board's initiation or upon filing of a jurisdictional challenge per 42 C.F.R. § 405.1840(a) and Board Rules 4.1 and 44.4; and that "[t]he Board may revise a preliminary determination of jurisdiction at any subsequent stage of the proceedings in a Board appeal" per § 405.1840(a)(3).
[2] Stipulation of Facts at ¶ 1 (Jul. 16, 2021) [hereinafter Stipulations].
[3] CMS' payment and audit functions under the Medicare program were historically contracted to organizations known as fiscal intermediaries ("FIs") and these functions are now contracted with organizations known as Medicare administrative contractors ("MACs"). The term "Medicare contractor" refers to both FIs and MACs as appropriate and relevant.
[4] Stipulations at ¶ 2; Exhibit P-1.
[5] MAC's Jurisdictional Challenge (hereinafter "JC"), Exhibit I-2 at 1 (emphasis added) (copy of the Aug. 7, 2015 tentative final adjustment determination). The workpaper attached to the August 7, 2015 tentative final adjustment determination (JC Exhibit I-2 at 2) shows that: (1) the MAC calculated a VDA payment in the amount of $1,764,983; and (2) since the cost report had not yet been settled, issued a tentative payment representing 80 percent of this amount, *i.e.*, $1,411,986.

payment of $1,813,524 and this resulted in an additional payment of $401,538 to Fairmont.[6] As a result, at this point, Fairmont had been paid $1,813,524 (*i.e.*, $1,411,986 + $401,538).

Subsequently, on October 11, 2016 the Medicare issued both a revised *tentative* determination and then a revised ***final*** determination. In the October 11, 2016 revised *tentative* determination, the MAC calculated:

1. A revised tentative VDA payment of $390,006; and
2. An overpayment of $1,021,980 due from Fairmont as a result of a previous tentative payment of $1,411,986.[7]

In the October 11, 2016 revised ***final*** determination, the MAC further revised the tentative findings and calculated:

1. A revised ***final*** VDA payment of $486,038; and
2. An overpayment of $535,942 due from Fairmont as a result of a previous tentative payment of $1,021,980.[8]

The Board hereinafter will refer to the October 11, 2016 revised final determination as the "October 2016 Determination."

Between October 31, 2016 and December 1, 2016, Fairmont exchanged emails with the MAC regarding its disagreement with the revised ***final*** determination.[9] On December 1, 2016, the MAC issued a *second* revised ***final*** determination that made no revisions to the revised ***final*** VDA payment of $486,038. However, in this determination, the MAC revised the overpayment amount due from Fairmont and determined that it was $791,544 based upon the corrections it made to its accounting of previous payments paid to Fairmont and/or to the Medicare program which were as follows:

1. $1,411,986 paid to Fairmont based on the August 7, 2015 tentative final determination;
2. $401,538 paid to Fairmont based on the March 22, 2016 final determination; and
3. $535,942 paid by Fairmont to the Medicare program based on the October 11, 2016 revised final determination.[10]

Thus, the overpayment assessed in this determination was computed as follows:

$486,038 - $1,411,986 - $401,538 + $535,942 = the overpayment of $791,544.

The Board will hereinafter refer to the second revised determination as the "December 2016 Determination."

---

[6] JC Exhibit I-2 at 3-4. The workpaper attached to the March 22, 2016 final determination (JC Exhibit I-2 at 4) shows that: (1) FY 2013 VDA payment was $1,813,524; and (2) since $1,411,986 had already been tentatively paid to Fairmont, an additional payment of $401,538 was due.
[7] JC Exhibit I-2 at 5-6 (copy of the revised *tentative* determination).
[8] JC Exhibit I-2 at 7-8 (copy of the revised ***final*** determination).
[9] Exhibit P-6 (copy of the email exchange occurring between Oct. 31, 2016 and Dec. 1, 2016).
[10] JC Exhibit I-2 at 9-10 (copy of the second revised ***final*** determination).

On May 30, 2017, Fairmont filed its appeal request with the Board citing its disagreement with its "Final Determination – VDA" *dated December 1, 2016* in ¶ 1 of the Model Form A – Individual Appeal Request.[11] To this end, Fairmont's appeal request included a copy of the December 2016 Determination.[12] Specifically Fairmont stated that it was "challenging the MAC's application of the Fixed Cost Percentage to the Hospital's Inpatient Operating Costs, while failing to adjust the Hospital's Inpatient Operating Payments by the same Fixed Cost Percentage."[13]

On April 17, 2018, the MAC filed a jurisdictional challenge, challenging what it alleges is the lack of a determination *for the issue appealed*. The MAC contends that the December 2016 Determination did not render a final determination over the removal of variable costs from Medicare Inpatient Operating Costs or over the inclusion of variable costs in the DRG or SCH payments. The MAC asserts that Fairmont fails to show how the disputed handling of the variable costs originated with the December 2016 Determination appealed by Fairmont. In the instant case, the MAC's handling of the variable costs in dispute originated *in an earlier determination*, namely the October 2016 Determination. Thus, the MAC contends that, logically, Fairmont cannot show dissatisfaction for an issue that was not specifically revised *in the appealed determination*. As such, the MAC argues that the appeal itself was not timely filed.

On May 17, 2018, Fairmont filed its brief in opposition to the jurisdictional challenge.

MAC's Contentions

Timeliness

The core of this appeal is the MAC's methodology to calculate the revised VDA payment amount due to Fairmont.[14] Fairmont requested a VDA adjustment under the Provider Reimbursement Manual, CMS Pub. 15-1 ("PRM 15-1"), § 2810.1:

> If a Hospital that is classified as a SCH experiences, due to circumstances beyond its control, a decrease of more than 5 percent in its total number of discharges compared to the immediately preceding cost reporting period, the hospital may receive a payment adjustment.

The Medicare cost report for the discharges for FY 2012 compared with that for FY 2013 reflects a decline of 188 discharges or 9.48 percent. On July 8, 2015, the Provider requested a VDA payment in the amount of $1,648,353.[15] The MAC determined the VDA payment as chronicled below:

[11] JC Exhibit I-1 at 2 (copy of Model Form A – Individual Appeal Request dated May 26, 2016). The Model Form A instructions at ¶ 1 direct the provider to include copies of any prior NPRs or revised NPRS if the provider is appealing from a revised NPR. Accordingly, Fairmont also included copies of the prior VDA tentative and final determinations issued prior to the December 2016 Determination.
[12] JC Exhibit I-1 at 7.
[13] JC Exhibit I-1 at 11 (copy of the issue statement included with the individual appeal request).
[14] MAC's Jurisdictional Challenge at 1 (Apr. 17, 2018).
[15] A copy of the VDA request is included at Exhibit P-1.

Summary of Volume Decrease Adjustments (VDA) and Payment[16]

Date	Description	VDA Amount	Payment Due (Overpayment Due)
8/07/2015	Tentative	$1,411,986	$1,411,986
3/22/2016	Final	$1,813,524	$ 401,538
10/11/2016	Revised Tentative	$ 390,006	NA – Rolled to 10/11/2016 Revised Final
10/11/2016	1st Revised Final	$ 486,038	($ 535,942)
12/01/2016	2nd Revised Final	$ 486,038	($ 791,544)

On May 26, 2017, Fairmont filed its appeal request based on the December 2016 Determination. The MAC asserts that, per the above chart, there was no change *in the determined VDA amount of $486,038* from the October 2016 Determination to the December 2016 Determination.[17] The MAC contends that Fairmont's right to appeal the December 2016 Determination is limited to those revisions made between the October and December 2016 Determinations. The MAC alleges that the revisions made in the December 2016 Determination were only to correct the accounting of previous payments and, as such, the MAC contends that it did not render an adverse determination over *the calculation* of the VDA amount of $486,038 as that remained unchanged. As such, the MAC contends that, by appealing the December 2016 Determination, Fairmont cannot properly be dissatisfied *with the previously-determined VDA amount of $486,038*.

The MAC asserts that, if Fairmont is dissatisfied with the $468,038 VDA amount, then it should have appealed the October 2016 Determination as that was the determination which last revised the VDA payment calculation. In the earlier calculations, the MAC had removed variable cost from the difference between the Medicare inpatient hospital cost and the DRG payments. In the October 2016 Determination, the MAC removed the variable cost *only* from the Medicare inpatient hospital cost component of the calculation. The MAC asserts that this is the final determination where the Provider first had dissatisfaction with the VDA calculation.[18] As a result, the MAC contends that the deadline for filing an appeal request from that determination for its handling of variable costs in the VDA calculation was Sunday, April 9, 2017 (*i.e.*, 180 days from October 11, 2016). However, Fairmont did not file an appeal request from the October 2016 Determination and the filing period for such a request has expired. In accordance with 42 C.F.R. § 405.1835(a)(3):

> (i) No later than 180 days after the date of receipt by the provider of the intermediary or Secretary determination; or

The Board received Fairmont's appeal request on May 26, 2017. This is 227 days after Fairmont received the October 2016 Determination, and thus, the Provider has clearly failed to meet the timeliness requirements related to that determination.

[16] Medicare Contractor's FPP at 7.
[17] MAC's Jurisdictional Challenge at 2
[18] *Id.*

Provider's Response

On May 17, 2018, Fairmont filed its response to the jurisdictional challenge. It contends that the Board has jurisdiction over the VDA adjustment because the October 2016 Determination was not a "final contractor determination" under 42 C.F.R. §§ 405.1835 and 405.1801, from which Fairmont could base its appeal.[19] Fairmont argues that the December 2016 Determination set forth *another revision* to the VDA calculation and increased the total amount of the VDA payment due from it, so as to qualify as the "final contractor determination."[20] Fairmont concludes that, since it filed its appeal request within 180 days of the December 2016 Determination, that request must be considered timely.

Moreover, Fairmont argues that, even if the Board deems the October 2016 Determination to be a "final contractor determination," Fairmont remains satisfied the jurisdictional requirements for a Board hearing under 42 C.F.R. § 405.1889, which states that a revised contractor determination must be considered "a separate and distinct determination."[21]

Fairmont adds that the December 2016 Determination was issued before its opportunity to appeal from the October 2016 Determination had lapsed. Fairmont contends that the MAC's issuance of the December 2016 Determination replaced, *in total*, the VDA calculation and amount in controversy the MAC had set forth in the October 11, 2016 revised final determination.[22] If the Board views the December 2016 Determination as a revised contractor determination for purposes of 42 C.F.R. § 405.1889, then Fairmont maintains that the changes in amount in controversy and the revised methodology are within the scope of its appeal.

Additionally, Fairmont asserts that the Board should reject the MAC's attempt to qualify the October 2016 Determination as a "final contractor determination" under § 405.1889 because the MAC failed to provide notice to it of its right to a hearing or the applicable filing period, as required by federal regulations at 42 C.F.R. § 405.1803(b).[23]

Finally, Fairmont argues that, if the Board determines that the October 2016 Determination was a "final contractor determination" under § 405.1889, then the December 2016 Determination must be viewed as a "revised determination" under 42 C.F.R. § 405.1889(a) which states:

> 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.[24]

[19] Provider's Response Brief to MAC's Jurisdictional Challenge, at 2 (May 17, 2018).
[20] *Id*.
[21] *Id*.
[22] *Id*.
[23] *Id*. at 3.
[24] *Id*. at 7-8.

Consequently, Fairmont maintains that, under this provision, its appeal would still be considered filed timely from the December 2016 Determination. Fairmont maintains that, *regardless of whether or not any methodology was changed* between the October and December 2016 Determinations, the December 2016 Determination otherwise revised the final payment amount and adjusted the specific number at issue in this appeal. Accordingly, Fairmont concludes that its appeal of those specific adjustments based on the December 2016 Determination was proper under § 405.1889.[25]

Board Analysis and Decision

Notwithstanding Fairmont's suggestion otherwise in its briefing on the jurisdictional challenge, it is clear from the record that Fairmont is challenging the MAC's calculation of the VDA amount of $486,038 as reinforced by the fact that the amount in controversy stated in Fairmont's request is $1,327,486 which is calculated as follows:

$1,813,524	– the original final VDA amount in the March 22, 2016 final determination
- $ 486,038	– the revised final VDA amount in the October 2016 Determination
$1,327,486	

As set forth below, the Board finds that it does not have jurisdiction over the VDA calculation issue because, pursuant to 42 C.F.R. § 405.1889(b), Fairmont had no right to appeal the December 2016 Determination for the issue appealed. Additionally, even if Fairmont had intended to appeal the October 2016 Determination, the appeal would not have been timely filed and the good cause exception under § 405.1836(b) would not have been met.

According to the VDA regulation, at 42 C.F.R. § 412.92(e)(3)(iii) (2013), "*[t]he intermediary determination* [on a provider's VDA request] is subject to review under subpart R of part 405 of this chapter."[26] Under 42 C.F.R. § 405.1835(a)(3), a provider has a right to a hearing on "an intermediary or Secretary determination" before the Board, provided that the provider's hearing request is received by the Board "[n]o later than 180 days after the date of receipt by the provider of the intermediary or Secretary determination." Stated differently, the 180-day filing period in which a provider must file its hearing request commences only upon the provider's receipt of the "intermediary or Secretary determination' and, per § 405.1801, a provider's receipt is presumed to be 5 days from the date of the "intermediary or Secretary determination."

Under the regulations, a "contractor determination" is defined as:

> With respect to a hospital that receives payments for inpatient hospital services under the prospective payment system, 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.[27]

[25] *Id*. at 8.
[26] (Emphasis added.)
[27] 42 C.F.R. § 405.1801; (emphasis added).

The Board finds that the October 2016 Determination was a "contractor determination" as that term is defined in § 405.1801 because it gave the total amount of payment due Fairmont for a VDA as provided in § 412.92(e). To this end, the issuance has a caption stating "SCH Volume Adjustment – Revised Final Determination" and identifies the overpayment amount of $535,942 as the "revised final adjustment amount."

Similarly, the Board finds that the December 2016 Determination was a "contractor determination" as that term is defined in § 405.1801 because it also had a caption stating "SCH Volume Adjustment – Revised Final Determination" and identifies the overpayment amount of $791,544 as the "2nd revised final adjustment amount." It further explains that the revised adjustment amount "incorporates ***all*** previous payments to the provider and the program."[28]

The record is clear that Fairmont appealed the December 2016 Determination as that is the determination identified in the appeal request as being appealed. Further, Fairmont's appeal request included a copy of the December 2016 Determination in compliance with the requirement in § 405.1835(b)(3) that an appeal request include a copy of the determination being appealed. As the determination is a revised determination, it is clear that 42 C.F.R. § 405.1889 dictates the appeal rights of revised determinations. The decision thus rests on whether the revisions made in the December 2016 Determination would be considered a specific revision under 42 C.F.R. § 405.1889(b):

> (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.

Here, the Board finds that the matter specifically revised in the December 2016 Determination did not encompass the VDA payment methodology that Fairmont is disputing in this appeal. As previously discussed, prior to December 1, 2016, the MAC had issued a series of VDA determinations (both tentative and final) for FY 2013. These determinations resulted in three payments being made -- one before the NPR dated December 1, 2015 and two after that NPR. The first two payments were made on August 7, 2015 and March 22, 2016 by the Medicare program to Fairmont and the final one was made by Fairmont to the Medicare program following the October 11, 2016 revised final determination:

- *A payment of $1,411,986 to Fairmont*.—In the August 7, 2015 tentative final determination, the MAC calculated a VDA amount of $1,764,983 using the old methodology that did not adjust the Medicare operating cost by the fixed cost percentage. The MAC then paid Fairmont 80 percent of that amount, *i.e.*, $1,411,986, and referred to this payment as a tentative settlement. In this regard the Board notes that, in making this calculation, the MAC pulled unsettled data from Worksheet D-1, Line 53 for the 2013 Medicare inpatient operating costs.

[28] (Emphasis added.)

- *A payment of $401,538 to Fairmont*.—In the March 22, 2016 final determination, the MAC revised its VDA amount by updating its calculation with the settled 2013 Medicare Program inpatient operating costs. The MAC continued to use the old methodology that did not adjust the Medicare operating costs by the fixed cost percentage. As a result of this update, the VDA amount increased to $1,813,524. The MAC then paid Fairmont $401,538 after deducting the prior tentative amount paid (*i.e.*, $1,411,986).

- *A payment of $535,942 to the Medicare program*.—In the October 11, 2016 revised final determination, the MAC calculated the VDA amount using the *revised* methodology and adjusted the Medicare inpatient operating costs by the fixed cost percentage. This resulted in a VDA amount of $486,038. The MAC again had to offset this amount by previous payments made and identified as the "previous tentative overpayment" of $1,021,980. This resulted in an overpayment of $535,942 being assessed against Fairmont.

On December 1, 2016, the MAC determined that the October 2016 Determination did not accurately account for previous payments and the amount it offset from the $486,038 VDA amount was incorrect (*i.e.*, the MAC determined that offsetting the $486,038 VDA amount by $1,021,980 for "previous tentative overpayment" was incorrect). In fact, Fairmont's email dated November 2, 2016 brings this to the MAC's attention.[29] Fairmont notes that the MAC incorrectly accounted for the initial final payment from March 22, 2016 and the Revised initial payment from October 11, 2016. Of importance is the fact that, in the Provider's email, the "Final Determination" amount is listed as $486,036 in both the "Mayo" and "NGS" calculations being discussed. Fairmont states "I still think there is a discrepancy in the calculated payback."[30] However, Fairmont's calculation examples do not identify any discrepancy in the "Final Determination" amount. Accordingly, in the December 2016 Determination, the MAC corrected its accounting of previous payments to reflect the above three payments resulting in a net offset of $1,277,582 (*i.e.*, 535,942 - $1,411,986 - $401,538). The MAC then offset the $486,038 VDA amount by $1,277,582 resulting in an overpayment of $791,544 due from Fairmont. The record is clear that only the accounting of previous payments and the resulting overpayment amount changed between the October and December 2016 Determinations, at Fairmont's instigation, and that the $486,038 VDA amount and the calculation of that amount were *not* revised. Accordingly, the Board finds that, pursuant to § 405.1889(b), Fairmont did not have a right to appeal the VDA payment methodology from the December 2016 Determination because that determination did not specifically revise the $486,038 VDA amount or the methodology used to calculate that amount. Rather, it only revised the accounting of previous payments that were made for purposes of determining how much Fairmont had been overpaid.

The Board's finding is reinforced by the fact that the October 2016 Determination is where Fairmont's dissatisfaction lies. The VDA payment regulation, at 42 C.F.R. § 412.92(e), dictates how the adjustment is calculated in subsection (3):

> (i) In determining the adjustment amount, the MAC considers -

[29] Exhibit P-6 at 5.
[30] *Id.*

> (A) The individual hospital's needs and circumstances, including the reasonable cost of maintaining necessary core staff and services in view of minimum staffing requirements imposed by State agencies;
>
> (B) The hospital's fixed (and semi-fixed) costs, other than those costs paid on a reasonable cost basis under part 413 of this chapter; and
>
> (C) The length of time the hospital has experienced a decrease in utilization.[31]

The calculation worksheets attached to the October and December 2016 Determinations confirm that the VDA Payment amount was last changed in the October 2016 Determination. The December 2016 Determination corrects the accounting of the previous payments, to determine the final amount due from Fairmont, and is the sole change from the October 2106 Determination. The Board's review confirms that the December 2016 Determination did not revise the VDA calculation or data inputs listed on the worksheet and, as such, the actual VDA amount of $486,038 remained unchanged.

Fairmont has presented another argument that, if the Board finds that the October 11, 2016 issuance is a final determination, the Board should find that it is fatally flawed and cannot be considered a final determination since it did not include an explanation of appeal rights. The Board declines to make that finding as it does not find support in the Board's governing regulations upon which to base that finding. The fact remains that, even though the October 2016 Determination is where Fairmont's dissatisfaction arises, Fairmont did not appeal that determination. Moreover, neither the December 2016 Determination nor the October 2016 Determination included appeal rights but each is appropriately identified as a revised final determination similar to the manner in which revised NPRs are identified.[32] Finally, notwithstanding the cited deficiency, Fairmont's representative, Hall Render Killian Health & Lyman, did file a timely appeal from the December 2016 Determination. The real dispute is which determination should have been appealed *for the issue at hand* and the Board finds that it was the October 2016 Determination.

Even if Fairmont had appealed the October 2016 Determination and had filed a proper request under § 405.1836(a) to extend the 180-day timeframe for filing an appeal, the Board would find that Fairmont did not meet the standards for such an extension. Subsection (b) of that regulation provides the following standards for assessing whether an extension may be granted:

> The Board may find good cause to extend the time limit *only if the provider demonstrates* in writing *it could not reasonably be expected to file timely due to extraordinary circumstances beyond its control* (such as a natural or other catastrophe, fire, or strike), and the provider's written request for an extension is received by the Board within a reasonable time (as determined by the Board

[31] 42 C.F.R. § 412.92(e)(3)(i).
[32] Indeed, in reciting the procedural history, the issue statement that Fairmont attached to its appeal request refers to the October 2016 Determination as the "revised Final VDA Determination[]".

> under the circumstances) after the expiration of the applicable 180-day limit specified in § 405.1835(a)(3) or § 405.1835(c)(2)."[33]

The Board finds that Fairmont has not established any extraordinary circumstances here as defined in § 405.1836(b) and, in particular, the lack of an explanation of appeal rights would not meet this standard since the October 2016 Determination was clearly presented as an "SCH Volume Adjustment – Revised Final Determination." Regardless, Board review under § 405.1836(b) has not been triggered since Fairmont has not filed such a request.
In summary, the Board finds that, for purposes of 42 C.F.R. § 405.1889(b), the "second revised final adjustment amount" in the December 2016 Determination did not specifically adjust the VDA calculation as required under § 412.92(e) and the resulting VDA amount of $486,038. Rather, the revisions made in that determination solely reflect a corrected accounting of *previously-made* payments that result in an updated net amount due from the provider, at the Provider's request. While the December 2016 Determination is sufficient in qualifying as "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," Fairmont is not challenging the corrected accounting of the previously-made payment amounts and, thus, its reliance on the December 2016 Determination is made in error. The fact remains that the methodology to calculate the VDA and the VDA amount did ***not*** change between the October and December 2016 Determinations. As the October 2016 Determination was the latest determination that included specific adjustments to the VDA calculation itself (and the resulting $486,038 VDA amount), it is that determination that is of concern for the issue appealed. However, Fairmont failed to appeal the October 2016 Determination. Even if it had, it would not have been timely as the 185-day mark for that determination was Friday, April 14, 2017 well after Fairmont's May 30, 2017 appeal filing. As such, the Board is precluded from hearing the appeal pursuant to both 42 C.F.R. §§ 405.1885 and 405.1835, denies jurisdiction, and dismisses the appeal. In making this ruling the Board notes that its application of 42 C.F.R. § 405.1889(b) has been upheld by courts on review.[34]

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

Board Members Participating:

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Gregory H. Ziegler, CPA
Robert A. Evarts, Esq.
Kevin D. Smith, CPA

For the Board:

9/30/2022

X Clayton J. Nix

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Chair
Signed by: PIV

cc: Wilson Leong, Federal Specialized Services

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Kathleen Giberti
Toyon Associates, Inc.
1800 Sutter St., Ste. 600
Concord, CA 94520

RE: ***Jurisdictional Decision***
St. Joseph Hospital (Prov. No. 05-0006)
FYE 06/30/2015
Case No. 22-1102

Dear Ms. Giberti:

The Provider Reimbursement Review Board ("Board" or "PRRB") received St. Joseph Hospital's ("Provider") Individual Appeal Request on appeal on June 9, 2022, appealing from a Revised Notice of Program Reimbursement ("RNPR") dated December 15, 2021 for fiscal year ending June 30, 2015. The decision of the Board is set forth below.

Procedural History

The Provider was issued a Notice of Reopening of Cost Report on April 30, 2021, which indicated that the cost report was being reopened for the following issues:

- To correct mathematical and flow through errors in cost reporting forms and pages as necessary.
- To make adjustments to correct for cost report software updates and edits as necessary.
- To adjust previous cost report settlement payments as necessary.
- To adjust the SSI ratio used to calculate the providers [sic] disproportionate share adjustment based on the data from the hospital's actual cost reporting period rather than the federal fiscal year and to amend the disproportionate share adjustment to account for the change in SSI ratio.

The Individual Appeal Request contained two (2) issues:

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

In their Individual Appeal Request, the Provider summarizes its DSH – Accuracy of CMS Developed SSI Ratio issue as follows:

> The Provider disputes the SSI Ratio developed by CMS and utilized by the MAC in their calculation of Medicare DSH payment. The SSI ratio is understated due to flaws and inaccuracies in CMS's matching process of Medicare patient records with Social Security Administration records.
>
> Furthermore, CMS refuses to allow Providers access to SSA records, prohibiting the research Providers could take to ensure an accurate SSI ratio.
>
> . . .
>
> The accuracy of CMS' updated SSI ratio is in question both because of the flaws and inaccuracies present in CMS' matching process of patient records with SSA records, and because CMS violates Providers' legal right to access data necessary to ensure that an accurate SSI Ratio is being calculated.[1]

Additionally, the Provider is appealing DSH – Inclusion of Medicare Part C Days in the SSI Ratio, which the Provider describes as follows:

> The Provider disputes the SSI percentage and the Medicaid percentage utilized by the MAC in its calculation of the Medicare DSH payment. Contrary to the MAC's calculations, all Medicare Part C days should be removed from the SSI Ratio calculation and all dual eligible Medicare Part C days should be included in the numerator of the Medicaid Ratio calculation
>
> CMS' interpretation of including Medicare Part C Days in the SSI ratio and excluding dual eligible Medicare Part C Days from the Medicaid Ratio is tantamount to retroactive rule making, which the D.C. Circuit held impermissible in the *Northeast Hospital* decision.
>
> Under the law, only Medicare paid Part A days should be included in the SSI Ratio and Medicare Part C days should be excluded. Further, certain dual eligible Medicare/Medicaid patient day should have been included in the Medicaid ratio portion of the disproportionate share entitlement calculation. Specifically, the patient days pertaining to Medicaid eligible patients who were enrolled in the Medicare Part C Program (HMO, Managed Care, Medicare Plus Choice, etc.) should have been included in the

[1] Issue Statement at 1-2. (June 9, 2022).

> Medicaid eligible days used to calculate the disproportionate share amount.[2]

Board Decision

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

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

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

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

> (a) If a revision is made in a Secretary or contractor determination or a decision by a reviewing entity after the determination or decision is reopened as provided in §405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the provisions of §§ 405.1811, 405.1834, 405.1835, 405.1837, 405.1875, 405.1877 and 405.1885 of this subpart are applicable.
>
> (b)(1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.
>
> (2) Any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision.[3]

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

---

[2] *Id*. at 2-3.
[3] 42 C.F.R. § 405.1889(b).

> (a) *Right to hearing on final contractor determination*.
> A provider . . . has a right to a Board hearing, as a single provider appeal, with respect to a final contractor or Secretary determination for the provider's cost reporting period, if -
>
> (1) The provider is dissatisfied with the contractor's final determination of the total amount of reimbursement due the provider, as set forth in the contractor's written notice specified under § 405.1803. **Exception**: If a final contractor determination is reopened under § 405.1885, **any review by the Board must be limited solely to those matters that are specifically revised in the contractor's revised final determination** (§§ 405.1887(d), 405.1889(b), and the "Exception" in § 405.1873(c)(2)(i)).
>
> (2) The amount in controversy (as determined in accordance with § 405.1839) must be $10,000 or more.
>
> (3) Unless the provider qualifies for a good cause extension under § 405.1836, the date of receipt by the Board of the provider's hearing request must be no later than 180 days after the date of receipt by the provider of the final contractor or Secretary determination.[4]

The Board finds that it does not have jurisdiction over either the Accuracy of CMS Developed SSI Ratio or the Part C Days issues that were appealed from the Provider's RNPR because the RNPR was issued as a result of the Provider's SSI Realignment request, and did not make adjustments related to the Part C days issue. Thus, the provider does not have the right to appeal under 42 C.F.R. § 405.1889(b) as referenced in § 405.1835(a)(1).

When a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[5] The reopening in this case were a result of the Provider's request to realign its SSI percentage from the federal fiscal year end to their individual cost reporting fiscal year end. The audit adjustment associated with the RNPR under appeal clearly only revise the SSI percentage in order to realign it from a federal fiscal year to the provider's respective fiscal year. The Board has consistently found that it does not have jurisdiction over revised NPRs that were issued as a result of a provider's request for realignment of its SSI percentage. As noted in 42 C.F.R. § 412.106(b)(2), CMS gathers data to be used in the SSI fraction on a month-by-month basis:

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

> (2) *First computation: Federal fiscal year*. **For each month** of the Federal fiscal year in which the hospital's cost reporting period begins, CMS -
>
> (i) Determines the number of patient days that -
>
> (A) Are associated with discharges occurring **during each month**; and
>
> (B) Are furnished to patients who **during that month** were entitled to both Medicare Part A (including Medicare Advantage (Part C)) and SSI, excluding those patients who received only State supplementation;
>
> (ii) Adds the results for the whole period; and
>
> (iii) Divides the number determined under paragraph (b)(2)(ii) of this section by the total number of days that -
>
> (A) Are associated with discharges that occur during that period; and
>
> (B) Are furnished to patients entitled to Medicare Part A (including Medicare Advantage (Part C)).[6]

The data matching process by which CMS gathers this *monthly* data is described in the FY 2011 IPPS Final Rule.[7] As described in the Federal Register, under the realignment process, CMS calculates the SSI fraction using the *previously-gathered* data for the months included in the published SSI fractions for 2 Federal fiscal years that encompass the hospital's cost reporting period:

1. *75 Fed. Reg. 50042, 50279 (Aug. 16, 2010)*.—"[W]e publish these [SSI fraction] data for every hospital based on the Federal fiscal year but, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived *from the data match process* ***for the two Federal fiscal years that spanned the hospital's cost reporting period***."[8]

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

2. *70 Fed. Reg. 47278, 47439 (Aug. 12, 2005)*.—"Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period, and *the hospital* ***must accept*** *the resulting DSH percentage for that year, whether or not it is a more favorable number than the DSH percentage based on the Federal fiscal year*. . . .

   Beginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108–173), we will arrange to furnish, consistent with the Privacy Act, MedPAR LDS data for a hospital's patients eligible for both SSI and Medicare at the hospital's request, regardless of whether there is a properly pending appeal relating to DSH payments. *We will make the information available for either the Federal fiscal year or, if the hospital's fiscal year differs from the Federal fiscal year, for the* ***months*** ***included in the 2 Federal fiscal years that encompass the hospital's cost reporting period***. Under this provision, *the hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year*. The data set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year."[9]

Accordingly, the realignment process does not change any of the data underlying the realigned SSI fraction (*e.g*., Part C days or Part A days) because that data had been previously gathered on a month-by-month basis and *there is no need for CMS to rerun the data matching process* in order to effectuate a realignment (*i.e*., realigning the SSI fraction from the federal fiscal year to the provider's fiscal year). Indeed, as noted in the second Federal Register excerpt, CMS' stated realignment policy is that the provider "must accept" the realigned SSI percentage.

In other words, the determination was only being reopened to include realigned SSI percentages. Since the only matters specifically revised in the RNPR were the adjustments related to realigning the SSI percentages from federal fiscal year to the provider fiscal year, the Provider does not have a right *to appeal the RNPR*[10] under 42 C.F.R. §§ 405.1889(b) and 405.1835(a)(1) for the SSI percentage or 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.[11]

---

[9] (Emphasis added.)

[10] The Provider had an opportunity to appeal these issues based on its original NPR and presumably forewent that opportunity.

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

Conclusion

The Board finds that it lacks jurisdiction over the two issues on appeal because they were not specifically revised in the RNPR which is the basis for the appeal. Since these are the only issues in the case, the Board hereby closes the case 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.

Board Members:

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

For the Board:

9/30/2022

X Clayton J. Nix

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Jurisdictional Decision***
St. Joseph Hospital (Prov. No. 05-0006)
FYE 06/30/2016
PRRB Case No. 22-1103

Dear Ms. Giberti:

The Provider Reimbursement Review Board ("Board" or "PRRB") received St. Joseph Hospital's ("Provider") Individual Appeal Request on appeal on June 9, 2022, appealing from a Revised Notice of Program Reimbursement ("RNPR") dated December 15, 2021 for fiscal year ending June 30, 2016. The decision of the Board is set forth below.

Procedural History

The Provider was issued a Notice of Reopening of Cost Report on April 30, 2021, which indicated that the cost report was being reopened for the following issues:

- To correct mathematical and flow through errors in cost reporting forms and pages as necessary.
- To make adjustments to correct for cost report software updates and edits as necessary.
- To adjust previous cost report settlement payments as necessary.
- To adjust the SSI ratio used to calculate the providers [sic] disproportionate share adjustment based on the data from the hospital's actual cost reporting period rather than the federal fiscal year and to amend the disproportionate share adjustment to account for the change in SSI ratio.

The initial Individual Appeal Request contained two (2) issues:

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

In their Individual Appeal Request, the Provider summarizes its DSH – Accuracy of CMS Developed SSI Ratio issue as follows:

> The Provider disputes the SSI Ratio developed by CMS and utilized by the MAC in their calculation of Medicare DSH payment. The SSI ratio is understated due to flaws and inaccuracies in CMS's matching process of Medicare patient records with Social Security Administration records.
>
> Furthermore, CMS refuses to allow Providers access to SSA records, prohibiting the research Providers could take to ensure an accurate SSI ratio.
> . . .
>
> The accuracy of CMS' updated SSI ratio is in question both because of the flaws and inaccuracies present in CMS' matching process of patient records with SSA records, and because CMS violates Providers' legal right to access data necessary to ensure that an accurate SSI Ratio is being calculated.[1]

Additionally, the Provider is appealing DSH – Inclusion of Medicare Part C Days in the SSI Ratio, which the Provider describes as follows:

> The Provider disputes the SSI percentage and the Medicaid percentage utilized by the MAC in its calculation of the Medicare DSH payment. Contrary to the MAC's calculations, all Medicare Part C days should be removed from the SSI Ratio calculation and all dual eligible Medicare Part C days should be included in the numerator of the Medicaid Ratio calculation
>
> CMS' interpretation of including Medicare Part C Days in the SSI ratio and excluding dual eligible Medicare Part C Days from the Medicaid Ratio is tantamount to retroactive rule making, which the D.C. Circuit held impermissible in the *Northeast Hospital* decision.
>
> . . .
>
> Under the law, only Medicare paid Part A days should be included in the SSI Ratio and Medicare Part C days should be excluded. Further, certain dual eligible Medicare/Medicaid patient day should have been included in the Medicaid ratio portion of the disproportionate share entitlement calculation. Specifically, the patient days pertaining to Medicaid eligible patients who were enrolled in the Medicare Part C Program (HMO, Managed Care, Medicare Plus Choice, etc.) should have been included in the

[1] Issue Statement at 1-2. (June 9, 2022).

> Medicaid eligible days used to calculate the disproportionate share amount.[2]

Board Decision

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

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

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

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

> (a) If a revision is made in a Secretary or contractor determination or a decision by a reviewing entity after the determination or decision is reopened as provided in §405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the provisions of §§ 405.1811, 405.1834, 405.1835, 405.1837, 405.1875, 405.1877 and 405.1885 of this subpart are applicable.
>
> (b)(1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.
>
> (2) Any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision.[3]

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

---

[2] *Id*. at 2-3.
[3] 42 C.F.R. § 405.1889(b).

> (a) *Right to hearing on final contractor determination*.
> A provider . . . has a right to a Board hearing, as a single provider appeal, with respect to a final contractor or Secretary determination for the provider's cost reporting period, if -
>
> (1) The provider is dissatisfied with the contractor's final determination of the total amount of reimbursement due the provider, as set forth in the contractor's written notice specified under § 405.1803. **Exception**: If a final contractor determination is reopened under § 405.1885, **any review by the Board must be limited solely to those matters that are specifically revised in the contractor's revised final determination** (§§ 405.1887(d), 405.1889(b), and the "Exception" in § 405.1873(c)(2)(i)).
>
> (2) The amount in controversy (as determined in accordance with § 405.1839) must be $10,000 or more.
>
> (3) Unless the provider qualifies for a good cause extension under § 405.1836, the date of receipt by the Board of the provider's hearing request must be no later than 180 days after the date of receipt by the provider of the final contractor or Secretary determination.[4]

The Board finds that it does not have jurisdiction over either the Accuracy of CMS Developed SSI Ratio or the Part C Days issue that the Provider appealed from the RNPR because it was issued as a result of the Provider's SSI Realignment request, and did not make adjustments related to the Part C days issue. Thus, the providers do not have the right to appeal under 42 C.F.R. § 405.1889(b) as referenced in § 405.1835(a)(1).

When a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[5] The reopening in this case were a result of the Provider's request to realign its SSI percentage from the federal fiscal year end to its individual cost reporting fiscal year end. The audit adjustments associated with the RNPR under appeal clearly only revise the SSI percentage in order to realign it from a federal fiscal year to the provider's respective fiscal year. The Board has consistently found that it does not have jurisdiction over revised NPRs that were issued as a result of a provider's request for realignment of its SSI percentage. As noted in 42 C.F.R. § 412.106(b)(2), CMS gathers data to be used in the SSI fraction on a month-by-month basis:

---

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

> (2) *First computation: Federal fiscal year*. **For each month** of the Federal fiscal year in which the hospital's cost reporting period begins, CMS -
>
> (i) Determines the number of patient days that -
>
> (A) Are associated with discharges occurring **during each month**; and
>
> (B) Are furnished to patients who **during that month** were entitled to both Medicare Part A (including Medicare Advantage (Part C)) and SSI, excluding those patients who received only State supplementation;
>
> (ii) Adds the results for the whole period; and
>
> (iii) Divides the number determined under paragraph (b)(2)(ii) of this section by the total number of days that -
>
> (A) Are associated with discharges that occur during that period; and
>
> (B) Are furnished to patients entitled to Medicare Part A (including Medicare Advantage (Part C)).[6]

The data matching process by which CMS gathers this *monthly* data is described in the FY 2011 IPPS Final Rule.[7] As described in the Federal Register, under the realignment process, CMS calculates the SSI fraction using the *previously-gathered* data for the months included in the published SSI fractions for 2 Federal fiscal years that encompass the hospital's cost reporting period:

1. *75 Fed. Reg. 50042, 50279 (Aug. 16, 2010)*.—"[W]e publish these [SSI fraction] data for every hospital based on the Federal fiscal year but, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived *from the data match process* ***for the two Federal fiscal years that spanned the hospital's cost reporting period***."[8]

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

2. *70 Fed. Reg. 47278, 47439 (Aug. 12, 2005)*.—"Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period, and *the hospital* ***must accept*** *the resulting DSH percentage for that year, whether or not it is a more favorable number than the DSH percentage based on the Federal fiscal year*. . . .

   Beginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108–173), we will arrange to furnish, consistent with the Privacy Act, MedPAR LDS data for a hospital's patients eligible for both SSI and Medicare at the hospital's request, regardless of whether there is a properly pending appeal relating to DSH payments. *We will make the information available for either the Federal fiscal year or, if the hospital's fiscal year differs from the Federal fiscal year, for the* ***months included in the 2 Federal fiscal years that encompass the hospital's cost reporting period***. Under this provision, *the hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year*. The data set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year."[9]

Accordingly, the realignment process does not change any of the data underlying the realigned SSI fraction (*e.g*., Part C days or Part A days) because that data had been previously gathered on a month-by-month basis and *there is no need for CMS to rerun the data matching process* in order to effectuate a realignment (*i.e*., realigning the SSI fraction from the federal fiscal year to the provider's fiscal year). Indeed, as noted in the second Federal Register excerpt, CMS' stated realignment policy is that the provider "must accept" the realigned SSI percentage.

In other words, the determination was only being reopened to include realigned SSI percentages. Since the only matters specifically revised in the RNPR were the adjustments related to realigning the SSI percentages from federal fiscal year to the provider fiscal year, the Providers do not have a right *to appeal the RNPR*[10] under 42 C.F.R. §§ 405.1889(b) and 405.1835(a)(1) for the Accuracy of CMS Developed SSI Ratio or the Part C Days issue. In making this ruling, the Board notes that its application of 42 C.F.R. § 405.1889(b) has been upheld by courts on review.[11]

---

[9] (Emphasis added.)

[10] The Provider had an opportunity to appeal these issues based on its original NPR and presumably forewent that opportunity.

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

Conclusion

The Board finds that it lacks jurisdiction over the two issues on appeal because they were not specifically revised in the RNPR which is the basis for the appeal. Since these are the only issues in the case, the Board hereby closes the case 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.

Board Members:

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

For the Board:

9/30/2022

X Clayton J. Nix

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Christine Ponce
Toyon Associates, Inc.
1800 Sutter Street, Suite 600
Concord, CA 94520

RE: ***Jurisdictional Decision***
Essentia Health Virginia (Prov. No. 24-0084)
FYE 06/30/2015
PRRB Case No. 22-1395

Dear Ms. Ponce:

The Provider Reimbursement Review Board ("Board" or "PRRB") received Essentia Health Virginia's ("Provider") Individual Appeal Request on appeal on September 1, 2022, appealing from a Revised Notice of Program Reimbursement ("RNPR") dated March 8, 2022 for fiscal year ending June 30, 2015. The decision of the Board is set forth below.

Procedural History

The Provider was issued a Notice of Reopening of Cost Report on July 19, 2021, which indicated that the cost report was being reopened to recalculate the DSH payment for the realigned SSI based on the cost reporting period. The Individual Appeal Request contained two (2) issues:

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

In their Individual Appeal Request, the Provider summarizes its DSH – Accuracy of CMS Developed SSI Ratio issue as follows:

> The Provider disputes the SSI Ratio developed by CMS and utilized by the MAC in their calculation of Medicare DSH payment. The SSI ratio is understated due to flaws and inaccuracies in CMS's matching process of Medicare patient records with Social Security Administration records.
>
> Furthermore, CMS refuses to allow Providers access to SSA records, prohibiting the research Providers could take to ensure an accurate SSI ratio.
> . . .

> The accuracy of CMS' updated SSI ratio is in question both because of the flaws and inaccuracies present in CMS' matching process of patient records with SSA records, and because CMS violates Providers' legal right to access data necessary to ensure that an accurate SSI Ratio is being calculated.[1]

Additionally, the Provider is appealing DSH – Inclusion of Medicare Part C Days in the SSI Ratio, which the Provider describes as follows:

> The Provider disputes the SSI percentage and the Medicaid percentage utilized by the MAC in its calculation of the Medicare DSH payment. Contrary to the MAC's calculations, all Medicare Part C days should be removed from the SSI Ratio calculation and all dual eligible Medicare Part C days should be included in the numerator of the Medicaid Ratio calculation
>
> CMS' interpretation of including Medicare Part C Days in the SSI ratio and excluding dual eligible Medicare Part C Days from the Medicaid Ratio is tantamount to retroactive rule making, which the D.C. Circuit held impermissible in the *Northeast Hospital* decision.
> . . .
>
> Under the law, only Medicare paid Part A days should be included in the SSI Ratio and Medicare Part C days should be excluded. Further, certain dual eligible Medicare/Medicaid patient day should have been included in the Medicaid ratio portion of the disproportionate share entitlement calculation. Specifically, the patient days pertaining to Medicaid eligible patients who were enrolled in the Medicare Part C Program (HMO, Managed Care, Medicare Plus Choice, etc.) should have been included in the Medicaid eligible days used to calculate the disproportionate share amount.[2]

Board Decision

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 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.

[1] Issue Statement at 1-2. (Sept. 1, 2022).
[2] *Id*. at 2-3.

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

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

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

> (a) If a revision is made in a Secretary or contractor determination or a decision by a reviewing entity after the determination or decision is reopened as provided in §405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the provisions of §§ 405.1811, 405.1834, 405.1835, 405.1837, 405.1875, 405.1877 and 405.1885 of this subpart are applicable.
>
> (b)(1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.
>
> (2) Any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision.[3]

Further, this regulatory limitation is cross-referenced in the provider 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**

[3] 42 C.F.R. § 405.1889(b).

> **the contractor's revised final determination** (§§ 405.1887(d), 405.1889(b), and the "Exception" in § 405.1873(c)(2)(i)).
>
> (2) The amount in controversy (as determined in accordance with § 405.1839) must be $10,000 or more.
>
> (3) Unless the provider qualifies for a good cause extension under § 405.1836, the date of receipt by the Board of the provider's hearing request must be no later than 180 days after the date of receipt by the provider of the final contractor or Secretary determination.[4]

The Board finds that it does not have jurisdiction over either the Accuracy of CMS Developed SSI Ratio or the Part C Days issues in this appeal that the Provider appealed from its RNPR which was issued as a result of the Providers' SSI Realignment request, and did not make adjustments related to the Part C days issue. Thus, the Provider does not have the right to appeal under 42 C.F.R. § 405.1889(b) as referenced in § 405.1835(a)(1).

When a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[5] The reopening in this case was a result of the Provider's request to realign its SSI percentage from the federal fiscal year end to its individual cost reporting fiscal year end. The audit adjustment associated with the RNPR under appeal clearly only revise the SSI percentage in order to realign it from a federal fiscal year to the provider's fiscal year. The Board has consistently found that it does not have jurisdiction over revised NPRs that were issued as a result of a provider's request for realignment of its SSI percentage. As noted in 42 C.F.R. § 412.106(b)(2), CMS gathers data to be used in the SSI fraction on a month-by-month basis:

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

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

> (iii) Divides the number determined under paragraph (b)(2)(ii) of this section by the total number of days that -
>
> (A) Are associated with discharges that occur during that period; and
>
> (B) Are furnished to patients entitled to Medicare Part A (including Medicare Advantage (Part C)).[6]

The data matching process by which CMS gathers this *monthly* data is described in the FY 2011 IPPS Final Rule.[7] As described in the Federal Register, under the realignment process, CMS calculates the SSI fraction using the *previously-gathered* data for the months included in the published SSI fractions for 2 Federal fiscal years that encompass the hospital's cost reporting period:

1. *75 Fed. Reg. 50042, 50279 (Aug. 16, 2010)*.—"[W]e publish these [SSI fraction] data for every hospital based on the Federal fiscal year but, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived *from the data match process* ***for the two Federal fiscal years that spanned the hospital's cost reporting period***."[8]

2. *70 Fed. Reg. 47278, 47439 (Aug. 12, 2005)*.—"Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period, and *the hospital* ***must accept*** *the resulting DSH percentage for that year, whether or not it is a more favorable number than the DSH percentage based on the Federal fiscal year. . . .*

   Beginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108–173), we will arrange to furnish, consistent with the Privacy Act, MedPAR LDS data for a hospital's patients eligible for both SSI and Medicare at the hospital's request, regardless of whether there is a properly pending appeal relating to DSH payments. *We will make the information available for either the Federal fiscal year or, if the hospital's fiscal year differs from the Federal fiscal year, for the* ***months included in the 2 Federal fiscal years that encompass the hospital's cost reporting period***. Under this provision, *the*

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

> *hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year*. The data set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year."[9]

Accordingly, the realignment process does not change any of the data underlying the realigned SSI fraction (*e.g*., Part C days or Part A days) because that data had been previously gathered on a month-by-month basis and *there is no need for CMS to rerun the data matching process* in order to effectuate a realignment (*i.e*., realigning the SSI fraction from the federal fiscal year to the provider's fiscal year). Indeed, as noted in the second Federal Register excerpt, CMS' stated realignment policy is that the provider "must accept" the realigned SSI percentage.

In other words, the determination was only being reopened to include realigned SSI percentages. Since the only matters specifically revised in the RNPR were the adjustments related to realigning the SSI percentages from federal fiscal year to the provider fiscal year, the Provider does not have a right *to appeal the RNPR*[10] under 42 C.F.R. §§ 405.1889(b) and 405.1835(a)(1) for the Accuracy of CMS Developed SSI Ratio or 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.[11]

Conclusion

The Board finds that it lacks jurisdiction over the two issues on appeal because they were not specifically revised in the RNPR which is the basis for the appeal. Since these are the only issues in the case, the Board hereby closes the case 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.

Board Members:

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

For the Board:

9/30/2022

X Clayton J. Nix

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

cc: Wilson C. Leong, Esq. Federal Specialized Services
Pamela VanArsdale, National Government Services, Inc. (J-6)

[9] (Emphasis added.)
[10] The Provider had an opportunity to appeal these issues based on its original NPR and presumably forewent that opportunity.
[11] *See St. Mary's of Mich. V. Azar*, No. 18-01790, 2020 WL 4049912 (D.D.C. July 20, 2020); *McLaren Flint v. Azar*, No. 18-2005, 2020 WL 2838566 (D.D.C. May 31, 2020), *Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F.Supp.3d 348 (D.D.C. 2014); *HCA Health Servs. of OK v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994).

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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

RE: ***Notice of Dismissal***
St. Francis Hospital (Prov. No. 52-0078)
FYEs 6/30/2008, 6/30/2009, 6/30/2010, 6/30/2011, 6/30/2013
Case No. 13-3022, 13-3211, 14-2506, 14-4313, 16-1712

Dear Mr. Ravindran,

The Provider Reimbursement Review Board ("Board") has reviewed the documents filed in the above-captioned cases. In its Final Position Papers, the Medicare Contractor asks the Board to dismiss the DSH – Medicaid Eligible Days issue in each appeal as the Provider has not submitted a complete final position paper with all exhibits or proven its position with relevant documentation in accordance with 42 C.F.R. § 405.1853 and Board Rules 25.2 and 25.3. The Board's decision is set forth below.

Background

The Provider submitted requests for hearings as follows:

- 13-3022 – August 23, 2013 (NPR dated February 26, 2013)
- 13-3211 – August 27, 2013 (NPR dated May 7, 2013)
- 14-2506 – February 18, 2014 (NPR dated August 29, 2013)
- 14-4313 – September 19, 2014 (NPR dated March 25, 2014)
- 16-1712 – May 23, 2016 (NPR dated November 25, 2015)

The sole remaining issue in each of the appeals is DSH – Medicaid Eligible Days. In its appeal requests the Provider stated the issue as follows:

> Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation?

The Provider stated the legal basis of the appeals as follows:

> 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 share percentage, set forth a 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 dates and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.

Provider's Final Position Paper

The Provider filed final position papers in each case as follows:

- 13-3022 – November 16, 2020
- 13-3211 – November 24, 2020
- 14-2506 – February 13, 2021
- 14-4313 – February 13, 2021
- 16-1712 – November 2, 2021

With respect to the DSH – Medicaid Eligible Days issue, the final position papers each contained the following identical conclusion:

> The Provider requests that the MAC review the Medicaid eligible days listing being sent under separate cover and provide a sample listing as soon as practicable. Further, upon completion of that review, the Provider requests that the MAC administratively resolve this issue by computing the Medicaid Fraction using patient days applicable to all Medicaid eligible patients to comply with the decisions of the Federal Courts and HCFAR 97-2.

In each final position paper, the Provider stated that the Medicaid eligible days listing was being sent under separate cover.

Medicare Contractor's Final Position Papers

The Medicare Contractor filed final position papers in each case as follows:

- 13-3022 – December 10, 2020
- 13-3211 – December 11, 2020
- 14-2506 – March 12, 2021
- 14-4313 – March 12, 2021
- 16-1712 – November 12, 2021

The Medicare Contractor set forth an identical argument in each of the final position papers. The Medicare Contractor asserts that it used the best available data at the time of review, in the settlement of the Provider's cost report. The Provider had ample opportunity to review CMS

Ruling 97-2, the cost report instructions, and to accumulate an accurate listing of Medicaid days for the possibility of inclusion in its cost report. The Provider has also had ample opportunity to provide adequate documentation supporting any additional Medicaid days. The Medicare Contractor asserts that the Provider did not file a **complete** final position paper in accordance with 42 C.F.R. § 405.1853 and Board Rules 25.2 and 25.3.[1]

The Medicare Contractor points to 42 C.F.R. § 405.1853(b)(2) which states:

> 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.

The Medicare Contractor then points to Board Rule 25 which states the following:

> **Rule 25 Preliminary Position Papers**
>
> **25.1 Content of Position Paper Narrative**
>
> The text of the position papers must contain the elements addressed in the following subsections.
>
> **25.1.1 Provider's Position Paper**
>
> A. Identify any issues that were raised in the appeal but are already resolved (whether by administrative resolution, agreement to reopen, transfer, withdrawal, dismissal, etc.) and require no further documentation to be submitted.
>
> B. For each issue that has not been fully resolved, state the material facts that support the provider's claim.
>
> C. Identify the controlling authority, (e.g., statutes, regulations, policy, or case law) supporting the provider's position.
>
> D. Provide a conclusion applying the material facts to the controlling authorities.
>
> **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

[1] Emphasis included.

> (see 42 C.F.R. § 405.18539(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, identify the missing documents, explain why the documents remain unavailable, state the efforts made to obtain the documents, and explain when the documents will be available.* Once the documents become available, promptly forward them to the Board and the opposing party. **(emphasis added)**

The Medicare Contractor observes that in the Board's filing requirements at Board Rule 25.3, parties should file a **complete** position paper with a fully developed narrative, *all exhibits*, a listing of exhibits and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. Any issue appealed, but not briefed by the Provider in its position paper, will be withdrawn. The Board also added commentary to its rules which state that failure to file a complete position paper with the Board will result in dismissal of the appeal or other actions.

The Medicare Contractor concludes by stating that no Medicaid eligible days listings have been received from the Provider to date. As such, the DSH – Medicaid Eligible Days issue should be dismissed from the appeals, as the Provider has not submitted a **complete** final position paper with all exhibits or proven its position with relevant documentation in accordance with 42 C.F.R. § 405.1853 and Board Rules 25.2 and 25.3.

Controlling Regulations and Board Rules

The regulation at 42 C.F.R. § 405.1853(b) provides the following base requirements regarding the submission and content of position papers:

> (b) *Position papers*. (1) After any preliminary narrowing of the issues, the parties must file position papers in order to narrow the issues further. In each case, and as appropriate, the Board establishes the deadlines as to when the provider(s) and the contractor must submit position papers to the Board.
>
> (2) The Board has the discretion to extend the deadline for submitting a position paper. *Each position paper* ***must set forth the relevant facts*** and arguments . . . ***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]

The Board has developed Rules consistent with these requirements. With regard to the filing of an individual appeal, Board Rule 7 (Support for Appealed Final Determination, Issue-Related Information and Claim of Dissatisfaction) (Jul. 2015) states:

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

Similarly, with regard to position papers,[3] Board Rule 25.2.1 requires that "the parties must exchange ***all*** available documentation as exhibits to fully support your position."[4]

Board Rule 25.2.2 provides the following instruction on the content of position papers:

> *If documents necessary to support your position are still unavailable,* then provide the following information in the position papers:
>
> 1. Identify the missing documents;
> 2. Explain why the documents remain unavailable;
> 3. State the efforts made to obtain the documents; and
> 4. Explain when the documents will be available.
>
> Once the documents become available, promptly forward them to the Board and the opposing party.[5]

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.

---

[2] (Emphasis added.)
[3] The minimum requirements for Final Position Paper narratives and exhibits is the same as those for Preliminary Position Papers. *See* PRRB Rule 27.2.
[4] (Emphasis added).
[5] (Emphasis added).

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.

Decision of the Board

The Board concurs with the Medicare Contractor that the Provider is required to provide documentation to prove the additional Medicaid Eligible days to which it may be entitled. 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"[6] 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. Moreover, the Provider has failed to even present ***basic*** relevant facts regarding the merits of its claim, namely the specific number of Medicaid eligible days that are at issue in compliance with 42 C.F.R. § 405.1853(b)(2) and Board Rule 25 governing the content of position papers.

Based on the record before the Board, the Board finds that the Provider has failed to provide a listing or other supporting documentation for the Medicaid Eligible Days issue as required by the controlling regulations and Board Rules. Nor has the Provider provided any explanation as to why the documentation was absent or what is being done to obtain it. The Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of Board Rules 25.2.1 and 25.2.2 related to the submission of documentary evidence required to support its claims or describe why said evidence is unavailable.[7] In this regard, the Board notes that the Provider represented in its final position

[6] (Emphasis added).
[7] Board Rule 25, of which 25.2.1 and 25.2.2 are a part, is applicable to final position papers via Board Rule 27.2.

papers that "the Listing of Medicaid Eligible days [was] being sent under separate cover."[8] However, no such listing has ever been received by either the Board or the Medicare Contractor notwithstanding the Provider's representation that such a listing was available and ready. The Board notes that these appeals have been pending between 6 and 9 years involving fiscal years as early as 2008 but no later than 2013. Accordingly, it has been between 9 and 14 years since the fiscal years at issue closed and the Provider's final position paper should have either provided a listing or explained why this information was not available at this late stage (along with an explanation of its efforts to obtain the information during the years that these appeals have been pending and when the information will become available).

As such, the Board hereby dismisses the DSH Medicaid Eligible Days issue from the appeals. As this was the last remaining issue in each appeal, the Board closes Case Nos. 13-3022, 13-3211, 14-2506, 14-4313, and 16-1712 and removes them from the Board's docket.

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

Board Members Participating:

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

For the Board:

9/30/2022

X Clayton J. Nix

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

cc: Pamela VanArsdale, National Government Services, Inc. (J-6)
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[8] Final Position Paper at 11.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Jurisdictional Decision*** **– RNPR Medicaid Days Adjustment**
QRS Pre 10/01/2013 DSH SSI Fraction Medicare Managed Care Part C Days Group
QRS Pre 10/01/2013 DSH Medicaid Fraction Medicare Managed Care Part C Days Group
Case Nos. 17-0869GC, 17-0872GC

Dear Mr. Ravindran and Mr. Lamprecht:

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the jurisdictional documentation in the common issue related party ("CIRP") groups under Case Nos. 17-0869GC and 17-0872GC. The Board's decision is set forth below.

Background

Both group appeal requests were filed on January 23, 2017. The group appeal requests initially included two Providers: PN 39-0147, Monongahela Valley Hospital, FYE 06/30/2014 and PN 07-0029, Bristol Hospital, FYE 09/30/2014. On July 25, 2019 the Providers requested Expedited Judicial Review ("EJR") in each of the cases, which the Provider Reimbursement Review Board ("PRRB" or "Board") denied as there were fiscal periods both before and after October 1, 2013.[1]

In response to the EJR denial, the group representative requested bifurcation[2] of each case into the following groups:

1. All Providers/Fiscal Year Periods (or partial fiscal periods) prior to 10/1/2013;
2. All Providers/Fiscal Year Periods (or partial fiscal periods) on or after 10/1/2013;

Further, the group representative requested that the cases be comprised solely of the Providers with fiscal periods (or partial fiscal periods) prior to 10/1/2013. This bifurcation was intended to facilitate the Providers' later request for Expedited Judicial Review. On September 13, 2019, the Board bifurcated the post-10/1/2013 period and established new groups. The appeals before the Board were updated to include only providers with full or partial fiscal years ending prior to 10/1/2013.

[1] EJR Denial (Aug. 23, 2019).
[2] Request for Bifurcation (Aug. 26, 2019); *Id*., PRRB Case no. 17-0872G.

The following Provider appealed both from an original NPR ***and*** from a RNPR, with the following adjustments:

1) Monongahela Valley Hospital, PN 39-0147 – Adj. 5, 6, 7, 8, 9, 10, s-d

The Provider did *not* include a Notice of Reopening even though Board Rules require it. However, it appears that the DSH adjustment (Adj. No. 7) is due to the additional Medicaid eligible days it received (per Adj. No. 6). The adjustment to increase Medicaid eligible days would not have include an adjustment to the Part C issue.

Board's Analysis and Decision

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

The Code of Federal Regulations provides for an opportunity for a reopening and revised NPR at 42 C.F.R. § 405.1885 (2017), which provides in relevant part:

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

Additionally, 42 C.F.R. § 405.1889 (2017)[3] explains the effect of a cost report revision:

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

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

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

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

> (a) *Right to hearing on final contractor determination*. A provider . . . has a right to a Board hearing, as a single provider appeal, with respect to a final contractor or Secretary determination for the provider's cost reporting period, if -
>
> (1) The provider is dissatisfied with the contractor's final determination of the total amount of reimbursement due the provider, as set forth in the contractor's written notice specified under § 405.1803. **Exception**: If a final contractor determination is reopened under § 405.1885, **any review by the Board must be limited solely to those matters that are specifically revised in the contractor's revised final determination** (§§ 405.1887(d), 405.1889(b), and the "Exception" in § 405.1873(c)(2)(i)).[4]

As described below, the Board finds that it does not have jurisdiction over the participant that filed from a revised NPR, because the adjustment at issue in the revised NPR adjusted DSH Medicaid days, and did not make adjustments related specifically to Part C days in either the Medicaid fraction or the SSI fraction.

When a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[5] The audit adjustments associated with the revised NPR under appeal revised DSH Medicaid eligible days. The Board has consistently found that it does not have jurisdiction over revised NPRs where the adjustments were not specifically related to the Part C Days issue.

In conclusion, the Board is dismissing the RNPR appeal for Provider No. 39-0147 – Monongahela Valley Hospital (FYE 6/30/2014, but for the already bifurcated pre-10/1/2013 period only), from the CIRP groups in 17-0869GC and 17-0872GC, because they do not have the right to appeal the revised NPR at issue under 42 C.F.R. § 405.1889 for the DSH Part C days issue. It should be noted, however, that the Provider will remain pending in the appeal based on its original NPR appeal.

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

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

Board Members Participating:

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

For the Board:

9/30/2022

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services
Attachment A – Schedule of Providers