DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Maureen O'Brien Griffin
Hall, Render, Killian, Heath & Lyman, P.C.
500 North Meridian Street, Suite 400
Indianapolis, IN 46204

RE: ***Jurisdictional Decision***
Franciscan Alliance CY 2015 Appeal of Uncomp. Care Pymnts. Involving S-10 Audits CIRP
Case No. 20-0460GC

Dear Ms. O'Brien Griffin,

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

Pertinent Facts:

The Providers are appealing original or revised Notices of Program Reimbursement ("NPRs" or "RNPRs") for various fiscal years ending in calendar year ("CY") 2015. The issue being appealed is a challenge to the Disproportionate Share Hospital ("DSH") payment for Uncompensated Care Costs ("UCC"). Specifically, Providers are appealing the Medicare Contractor's alleged failure to include appropriate costs on their S-10 worksheets for CY 2015, which impacts their FY 2020 UCC DSH payments. They claim that their S-10's were arbitrarily audited without issuing adequate UCC reporting guidelines or going thorough adequate notice and comment requirements. They state that audits of hospitals' S-10's was inconsistent and unfair. The Providers raise several arguments about the accuracy of the S-10 data used, and the methodology in auditing those worksheets. While they acknowledge that the estimates used by the Secretary for the UCC DSH payment is not subject to review, they claim "whether the underlying data [CMS] use[s] for making their estimates is 'adequate' IS subject to review." Providers claim the disparate treatment the Medicare Contractor's showed in auditing different hospitals' S-10 worksheets is unlawful and *ultra vires*, and that a statutory bar on administrative and judicial review does not extend to these types of actions. Finally, the Providers state that *Allina*[1] holds that "when CMS does anything affecting benefits, payment, or eligibility, it must first through [sic] the notice-and-comment requirement under the Medicare statute."[2]

The Medicare Contractor filed a letter pursuant to Board Rule 15.2 arguing that the appeal is precluded from review by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2). As a result,

[1] *Allina Health Servs. v. Sebelius*, 746 F.3d 1102, 1111 (D.C. Cir. 2014).
[2] Group Issue Statement.

the Medicare Contractor argues that the Board lacks jurisdiction over this group appeal and that it should be dismissed.

The Providers have replied to the jurisdictional challenge.[3] They argue that CMS' failure to undertake appropriate notice and comment procedures related to the S-10 audit methodology renders the resulting data inadequate, and that the bar on review does not extend to matters that violate the Medicare Statute's notice and comment requirements. They clarify that the appeals "center[] on two key agency errors: (1) CMS's failure to fulfill its requirements under the APA and Medicare Statute's notice and comment requirements; and (2) appealing a patently unlawful agency action." For support they cite a recent case, stating the following:

> The Connecticut District court recently reviewed an [Uncompensated Care] payment issue in *Yale New Haven Hospital v. Azar*[, 2019 WL 3387041 (July 25, 2019)] and applied the Supreme Court's recent ruling in *Allina*. (Exhibit P-6). In Yale New Haven, the only surviving claim stemmed from the question of:
>
> > whether the preclusion provision [of 42 U.S.C. § 1395ww(r)(3)] encompasses procedural aspects involved in the adoption of the rule that governed the determination by the Secretary of the "estimates."
>
> Despite the judicial bar in the UC DSH statute, the Court pulled from the *Allina* decision in agreeing that the Hospital's claims challenging "the procedure by which the Secretary established" a FFY 2014 policy is "separate from the substance of any such rules or policies or the determination of its estimates based on the substance of those rules or policies" and is thus not barred by judicial review.

Board's Decision:

The Board finds that it does not have jurisdiction over the Uncompensated Care DSH payment issue because jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2). Based on these provisions, judicial and administrative review is not available under 42 U.S.C. §§ 1395ff and 1395oo for:

> (A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).[4]
> (B) Any period selected by the Secretary for such purposes.

[3] Provider's Response to the Medicare Administrative Contractor's Jurisdictional Challenge (Jan. 30, 2020).
[4] Paragraph (2) is a reference to the three factors that make up the uncompensated care payment. Factor 1 represents 75 percent of estimated DSH payments that would be paid in absence of § 1395ww(r). 78 Fed. Reg. 504945, 50627-28 (Aug. 19, 2013). Factor 2, for FY 2014, is one (1) minus the percentage of individuals under age 65 who are uninsured in 2013 for the FY 2014 calculation. *Id.* at 50631. Factor 3 is a hospital-specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital with the potential to receive DSH payments relative to the estimated uncompensated care amount for all hospitals estimated to receive DSH payments in the fiscal year for which the uncompensated care payment is to be made. *Id.* at 50634.

Further, case law from the U.S. Circuit Court of Appeals for the District of Columbia Circuit ("D.C. Circuit') supports the Board's finding. Specifically, in *Fla. Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Servs.* ("*Tampa General*"),[5] the D.C. Circuit Court upheld a D.C. District Court decision[6] that there is no judicial or administrative review of UCC DSH payments. In *Tampa General*, the provider challenged the calculation of the amount it would receive for uncompensated care for fiscal year 2014. The provider claimed that the Secretary used inappropriate data when she selected the hospital cost data updated in March 2013, instead of data updated in August 2013, when calculating its uncompensated care payments. The provider argued that it was not challenging the estimate of its uncompensated care, but rather the underlying data on which the Secretary relied, judicial review of which is not barred.

The District Court found that there was specific language in the statute that precluded administrative or judicial review of the provider's claims because, in challenging the use of the March 2013 update data, the provider was seeking review of an "estimate" used by the Secretary to determine the factors used to calculate additional payments. The D.C. Circuit Court went on to hold that, "the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well."[7] The D.C. Circuit also rejected the provider's argument that it could challenge the underlying data, finding that there cannot be judicial review of the underlying data because they are "indispensable" and "integral" to, and "inextricably intertwined" with, the Secretary's estimate of uncompensated care.[8]

The District Court went on to address Tampa General's attempt to reframe its challenge to something other than an estimate of the Secretary. Specifically, it rejected the characterization as a challenge to the "general rules leading to the estimate rather than as a challenge to the estimate itself []" because it was merely an attempt to undo a shielded determination.[9] Finally, it addressed the argument that the estimate made by the Secretary was *ultra vires*, or beyond the scope of statutory authority, but plainly found that "the Secretary's choice of data is not obviously beyond the terms of the statute."[10]

The D.C. Circuit Court addressed the judicial and administrative bar on review of uncompensated care DSH payments again in *DCH Regional Med. Ctr. V. Azar*, 925 F.3d 503 (D.C. Cir. 2019) ("*DCH v. Azar*"). In *DCH v. Azar*, the provider alleged that it was challenging the methodology adopted and employed by the Secretary to calculate Factor 3 of the DSH payment. They stated that the bar on review applied only to the estimates themselves, and not the methodology used to make the estimates. The D.C. Circuit disagreed, stating that "a challenge to the methodology for estimating uncompensated care is unavoidably a challenge to the estimates themselves" and that there is "no way to review the Secretary's method of

[5] 830 F.3d 515 (D.C. Cir. 2016).
[6] 89 F. Supp. 3d 121 (D.D.C. 2015).
[7] 830 F.3d 515, 517.
[8] *Id.* at 519.
[9] *Id.* at 521-22.
[10] *Id.* at 522.

estimation without reviewing the estimate itself." It continued that allowing an attack on the methodology "would eviscerate the statutory bar, for almost any challenge to an estimate could be recast as a challenge to its underlying methodology." Recalling that the court had held in *Tampa General* that the choice of data used to estimate an uncompensated care DSH payment was not reviewable because the data is "inextricably intertwined" with the estimates themselves, it found the same relationship existed with regard to the methodology used to generate the estimates.

The District Court for the District of Connecticut ("Court") subsequently considered the bar on review of UCC DSH payments in *Yale New Haven Hospital v. Azar*.[11] There, the Court dismissed all of the providers' counts in their federal complaint except one. Those that clearly sought to "undo the Secretary's estimate of its uncompensated care by recasting its challenge to that estimate as an attack on the underlying methodology" were dismissed.[12] The remaining count, the Court held, did "not challenge the Secretary's estimate of [the provider's] DSH payment, any of the underlying data, or the Secretary's choice of such data. Instead, it [was] a challenge to the procedure by which the Secretary established the" issue under appeal. The court noted that it was a close call, but there was no bar on review of "the *promulgation* of the Secretary's rules and policies, separate from the *substance* of any such rules or policies or the determination of its estimates based on the substance of those rules or policies."[13]

The Board finds that the same findings of the D.C. Circuit in *Tampa Bay* and *DCH v. Azar* are applicable to the Providers' challenge to their 2020 uncompensated care payments. The Providers are appealing from NPRs and RNPRs related to fiscal years ending in 2015, appealing the amount of UCC DSH payments they will receive for FY 2020. The Providers claim to be challenging arbitrary and capricious or *ultra vires* actions of CMS in their failure to provide notice and receive comments on how the data for FY 2020 would be collected. It is ultimately a direct attack against the underlying methodology used to generate the Secretary's estimates for DSH purposes, which is not reviewable.[14] It is true that the district court case cited by the Providers[15] permitted a direct attack against a policy that failed to follow notice and comment procedures. This is because it was not a challenge to the Secretary's estimate of that hospital's payment or any specific underlying data. Here, the Providers have listed an amount in controversy related to their specific hospitals, which they believe should be higher based on different S-10 worksheet data. They are "simply trying to undo the Secretary's estimate of [their] uncompensated care by recasting [their] challenge to that estimate as an attack on the underlying methodology."[16]

The Board concludes that it does not have jurisdiction over the Uncompensated Care DSH issue in this appeal because judicial and administrative review of the calculation is barred by statute and regulation. In making these findings, the Board notes that, for purposes of the Board's review,

---

[11] 2019 WL 3387041 (July 25, 2019).
[12] *Id.* at *8 (quoting *DCH Regional Med. Ctr. v. Azar* at 508).
[13] *Id.* at *9.
[14] *DCH v. Azar* at 507.
[15] *Yale New Haven Hospital v. Azar*, 2019 WL 3387041 (July 25, 2019).
[16] *DCH v. Azar* at 508.

the D.C. Circuit's decisions in both *Tampa General* and *DCH v. Azar* are controlling precedent for the interpretation of the statutory and regulatory provisions at issue because the Provider could bring suit in the D.C. Circuit.[17] As the Uncompensated Care DSH issue is the only issue in the appeal, the Board hereby closes the referenced appeal and removes it from the Board's docket.

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

Board Members Participating:

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

For the Board:

10/2/2020

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: Clayton J. Nix -A

cc: Wilson C. Leong, Esq., Federal Specialized Services
Byron Lamprecht, WPS Government Health Administrators (J-8)

[17] The CMS Administrator generally has applied as controlling precedent the law of the Circuit in which the provider is located. *See, e.g., QRS CHW DSH Labor room Days Groups v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (Apr. 13, 2009), affirming, PRRB Dec. No. 2009-D11 (Feb. 27, 2009); *St. Vincent Mercy Med. Ctr. v. BlueCross BlueShield Ass'n*, Adm'r Dec. (Nov. 17, 2008), *affirming in part and reversing in part*, PRRB Dec. No. 2008-D35 (Sept. 15, 2008). However, in recognizing that providers may file suit with the appropriate District Court either in the Circuit in which they are located or the D.C. Circuit, the Administrator also applies as controlling precedent the law of the D.C. Circuit. *See, e.g., Jordan Hosp. v. Blue Cross Blue Shield Ass'n.*, Adm'r Dec. (Apr. 30, 2007), *vacating*, PRRB Dec. No. 2007-D23 (Feb. 28, 2007). It is true that the district court case cited by the Providers (*Yale New Haven Hospital v. Azar*, 2019 WL 3387041 (D. Conn. 2019)) permitted a direct attack against a policy that failed to follow notice and comment procedures. This is because it was not a challenge to the Secretary's estimate of that hospital's payment or any specific underlying data. Here, the Providers have listed an amount in controversy related to their specific hospitals, which they believe should be higher based on different S-10 worksheet data. They are "simply trying to undo the Secretary's estimate of [their] uncompensated care by recasting [their] challenge to that estimate as an attack on the underlying methodology." *DCH v. Azar* at 508.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Leslie Demaree Goldsmith, Esq.
Baker, Donelson, Bearman, Caldwell & Berkowitz, PC
100 Light St.
Baltimore, MD 21202

RE: ***Baker Donelson Direct Graduate Medical Education ("DGME") Appeals***
18-1458GC Penn Medicine 2015 DGME Penalty Group
19-2765GC UPMC CY 2016 DGME Penalty to FTE Count Group
20-0005GC Univ. of Rochester CY 2015 DGME Penalty to FTE Count Group
20-1462GC Hackensack Meridian CY 2016 DGME Penalty to FYE Count Group
20-1602GC Univ. of PA Health System CY 2018 DGME Penalty to FTE Count Group

Dear Ms. Goldsmith:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' June 17, 2019 request for expedited judicial review ("EJR") for the appeals referenced above which was filed through the Office of Hearings Case and Document Management System ("OH CDMS").

On March 26, 2020, prior to the submission of the EJR request, the Board issued Alert 19, notifying affected parties "Temporary COVID-19 Adjustments to PRRB Processes." On June 29, 2020, subsequent to the submission of the EJR request, the Board notified you of the relevance of Alert 19 to the EJR request. Specifically, the Board notified you that, "[a]s the Board does not have access to the hard copy Schedules of Providers filed in the above-referenced list of . . . cases (regardless of whether they were filed shortly before the EJR, after the EJR, or at some point in the past), the Board is not able to process them in the usual manner and establish jurisdiction, *i.e.*, whether "a provider of services may obtain a hearing under' the PRRB statute, which is a necessary jurisdictional prerequisite for a case to eligible for EJR. 42 U.S.C. § 1395oo(f); see also 42 C.F.R. § 405.1842(b)." Accordingly, the Board stayed the 30-day period for responding to the EJR request for the above-captioned appeals.

Although the Schedule of Providers was delivered to the Centers for Medicare & Medicaid Services mailroom on June 18, 2020, the Board did not receive the Schedules in its office until September 17, 2020. Further, the Board has not resumed normal operations, but is attempting to process EJR requests expeditiously and is still governed by the standards set forth in 42 C.F.R.

§ 405.1801(d)(2) when calculating the 30-day time period for issuing an EJR by excluding all days where the Board is not able to conduct its business in the usual manner. The decision of the Board is set forth below.[1]

The Providers in these cases are challenging:

> . . .the validity of the regulation at 42 C.F.R. § 413.79(c)(2) implementing the direct graduate medical education ("DGME") cap on full-time equivalent ("FTE") residents and the FTE weighting factors. . . . [The Providers assert that] [t]he regulation at 42 C.F.R. § 413.79(c)(2) is contrary to the statute because it determines the cap after application of the weighting factors. . . .The effect of the . . .regulation is to impose on the Providers a weighting factor that results in a reduction of greater than 0.5 for many residents who are beyond the initial residency period (IRP), and it prevents the Providers from claiming their full unweighted FTE caps authorized by statute. . . . [The Providers contend that] the calculation of the current, prior year, and penultimate-year weighted DGME FTEs and the FTE caps is contrary to the statutory provision at 42 U.S.C. § 1395ww(h) . . . .[2]

Background

The Medicare statute requires the Secretary[3] to reimburse hospitals for the "direct" costs of hosting graduate medical training programs for physician residents (direct graduate medical education or "DGME").[4] These costs include the salaries of teaching physicians and stipends paid to resident physicians.[5]

The Medicare statute prescribes a formula for computing annual DGME payments to hospitals. The statutory formula consists of three components:

1. The hospital's number of FTE residents, or "FTE count;"
2. The hospital's average cost per resident (*i.e.* the per resident amount or "PRA"); and
3. The hospital's patient load, which is the percentage of a hospital's inpatient treatment days attributable to Medicare Part A and Part C beneficiaries.[6]

[1] This EJR request also included Case Nos. 19-2187G and 20-1315G. Under separate cover, the Board is seeking additional information from the Group Representative in these cases.
[2] Providers' EJR requests at 1.
[3] of the Department of Health and Human Services.
[4] 42 U.S.C. § 1395ww(h).
[5] *See* S. Rep. No. 404, 89th Cong. 1st Sess 36 (1965); H.R. No 213, 89th Cong., 1st Sess. 32 (1965).
[6] 42 U.S.C. § 1395(h).

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

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

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

Pursuant to this statutory provision, FTEs attributable to residents who are training in their initial residency period[7] ("*IRP residents*") are weighted at 100 percent or 1.0 while FTEs attributable to residents who are not in their initial residency period (commonly referred to as "*fellows*") are weighted at 50 percent or 0.5. The sum of the weighted FTEs for IRP residents and fellows in a given year is known as a hospital's "weighted FTE count." For example, under this weighting assignment, a hospital that trained 10 IRPs and 10 fellows in a given year would have a weighted FTE count of 15.

On August 5, 1997, Congress enacted § 4623 of the Balanced Budget Act of 1997 ("BBA")[8] which added 42 U.S.C. § 1395ww(h)(4)(F) to establish a limit on the number of osteopathic and allopathic residents that a hospital can be included in its FTE count for DGME payments. For cost reporting periods beginning on or after October 1, 1997, a hospital's unweighted DGME FTE count could not exceed the hospital's unweighted FTE count for its most recent cost reporting period ending on or before December 31, 1996. In this regard, § 1395(h)(4)(F)(i) states:

> [F]or purposes of a cost reporting period beginning on or after October 1, 1997 . . . the total number of full-time equivalent residents before the application of the weighting factors (as determined under this paragraph) with respect to a hospital's approved medical residency training program in the fields of allopathic and osteopathic medicine *may not exceed* the number (or 130 percent of such number in the case of a hospital located in a rural area) of such full-time equivalent residents for the hospital's

[7] "Initial residency period" is defined in the statute as the minimum number of years required for Board eligibility. 42 U.S.C. § 1395ww(h)(5)(F).
[8] Pub. L. 105–33, § 4623, 111 Stat. 251, 477 (1997).

> most recent cost reporting period ending on or before December 31, 1996.[9]

Further, 42 U.S.C. § 1395ww(h)(4)(G)(i) provides that residents are counted on a three year average. Finally, 42 U.S.C. § 1395ww(h)(4)(A) directs the Secretary to "establish rules consistent with [§ 1395ww(h)(4)] for the computation of the number of full-time equivalent residents in an approved medical residency training program."

CMS implemented BBA § 4623, in part, by promulgating regulations at 42 C.F.R. § 413.86(g)(4) to implement the unweighted FTE cap.[10] Specifically, in the FY 1998 inpatient prospective payment system ("IPPS") final rule published on August 20, 1997 ("FY 1998 IPPS Final Rule"), CMS promulgated revisions to 42 C.F.R. § 413.86(g)(4) and included the following explanation in the preamble to that rule:

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

[9] 42 U.S.C. § 1395ww(h)(4)(F)(i) (emphasis added). Further, 42 U.S.C. § 1395ww(h)(4)(H) directs the Secretary to establish rules for determining the caps of hospitals that establish *new* programs after December 31, 1996.
[10] 62 Fed. Reg. 45966, 45967, 46004 (Aug. 29, 1997).

> 1998 cost reporting period (that is, of the 110 unweighted residents, 20 are beyond the initial residency period and are weighted as 0.5 FTE), the hospital's weighted FTE count for determining direct GME payment is equal to (100/110) [x] 100, or 90.9 FTE residents. . . .
>
> *****
>
> We believe this ***proportional*** *reduction* in the hospital's unweighted FTE count is an equitable mechanism for implementing the statutory provision.[11]

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

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

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

> Add the two products to determine the hospital's *reduced cap*.[13]

To codify this change, the Secretary added clause (iii) to § 413.86(g)(4). In the final rule published on the August 11, 2004, CMS relocated 42 C.F.R. § 413.86(g)(4)(iii) to 42 C.F.R. § 413.79(c)(2)(iii).[14] This regulation is the focus of these appeals and this EJR request, and it states the following:

> If the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 2001 exceeds the limit described in this section [*i.e.*, the FTE cap or limit], the hospital's weighted FTE count (before application of the limit) for primary care and obstetrics and gynecology residents and nonresidents, respectively, will be reduced in the same proportion that the number of FTE residents for that cost reporting period exceeds the number of FTE residents for the most recent cost reporting period ending on or before December 31, 1996.[15]

As previously noted, this regulation addresses how to reduce a hospital's weighted FTE count for a fiscal year when the unweighted FTE count for that fiscal year exceeds the hospital's unweighted FTE cap.

On their cost reports, hospitals report the number of allopathic and osteopathic FTE residents (before applying the weighting factors mentioned above) that were actually trained at the facility that year.[16] This information is used to determine whether the hospital exceeds its unweighted FTE cap.

In addition, the statute sets the number of FTEs a hospital can claim for reimbursement as the hospital's average FTE count between the present, prior and penultimate years. The statute states:

> [T]he total number of full-time equivalent residents for determining a hospital's graduate medical education payment shall equal the average of the actual full-time equivalent resident counts for the cost reporting period and the preceding two cost reporting periods.[17]

---

[13] *Id.* at 39894 (emphasis added).
[14] *See* 69 Fed. Reg. 48916, 49258-64. As part of the relocation, CMS modified the language slightly by removing the references to "paragraph (g)" that were in the prior version of the regulation and replacing them with reference to "the limit described in this section."
[15] 42 C.F.R. § § 413.79(c)(2)(iii) (2011). The Secretary has not made any changes to § 413.79(c)(2)(iii) since the FY 2005 IPPS final rule.
[16] 77 Fed. Reg. 53258, 53423 (Aug. 31, 2012) (stating that when a hospital trains residents in excess of its cap, "it should report those FTE residents on its cost report regardless of whether or not it is training over its caps.")
[17] 42 U.S.C. § 1395ww(h)(4)(G)(i).

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

The Providers' Position

The Providers contend that the regulation, 42 C.F.R. § 413.79(c)(2)(iii), is contrary to the statute at 42 U.S.C. § 1395ww(h) for several reasons. First, the regulation creates a weight FTE cap. The Providers believe that the statute plainly requires the Secretary to determine the cap "before the application of weighting factors," which is an unweighted cap.[18] The Secretary instead determines a weighted FTE cap for the current year that is based on the ratio of the 1996 unweighted FTE count to the current year unweighted FTE count. The resulting equation, WFTE (UCap/UFTE) = WCAP, is applied to the weighted FTE count in the current year, which creates a second FTE cap that is an absolute limit on the number of FTEs that can go into the DGME payment calculation. This second cap is determined after the application of the weighting factors to fellows in the current year, which the Providers allege violates Congress' directive to determine the cap before the application of the weighting factors.

Second, the Secretary's weighted FTE cap prevents a hospital from ever reaching its 1996 unweighted FTE cap if it trains any fellows. The downward impact on the FTE count increases as a hospital trains more residents beyond the IRP.

Third, the Providers assert, the regulation imposes a weighting factor that reduces the FTE time by more the 0.5 contrary to the statute. In these cases, all of the Providers are over their FTE caps and train residents that are beyond the IRP and are prevented from reaching their full FTE caps due to the Secretary's regulation. The Providers suffered a downward payment adjustment that is greater than may be imposed by the statutory 0.5 weighting factor. By establishing the cap based on the hospital's unweighted FTE count for 1996, Congress entitled the Providers to claim FTEs up to that cap. The Providers contend that the regulation renders this impossible for these Providers simply because they trained residents who are beyond the IRP. The Providers assert that the regulation, 42 C.F.R. § 412.79(c)(2)(iii), is contrary to the statute, is arbitrary and capricious and is, therefore, invalid.

Decision of the Board

Pursuant to 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R.§ 405.1842(f)(1) (2017), the Board is required to grant an EJR request if it determines that: (i) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (ii) the Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute or to the substantive or procedural validity of a regulation or CMS Ruling.

[18] 42 U.S.C. § 1395ww(h)(4)(F)(i).

A. Background on Appeals of Self-Disallowed Costs

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hosp. Ass'n v. Bowen* ("*Bethesda*").[19] In that case, the Supreme Court concluded that a cost report submitted in full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.[20]

On August 21, 2008, new regulations governing the Board were effective.[21] Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hosp. v. Burwell* ("*Banner*") before the D.C. District Court.[22] In *Banner*, the provider filed its cost report in accordance with the applicable outlier regulations and did not protest the additional outlier payment it was seeking. The provider's request for EJR was denied because the Board found that it lacked jurisdiction over the issue. The D.C. District Court concluded that, under *Bethesda*, the 2008 self-disallowance regulation could not be applied to appeals raising a legal challenge to a regulation or other policy that the Medicare Contractor could not address.[23]

The Secretary did not appeal the D.C. District Court's decision in *Banner* and instead decided to largely apply the holding to certain similar administrative appeals. Effective April 23, 2018, the CMS Administrator implemented CMS Ruling CMS-1727-R which involves dissatisfaction with the Medicare Contractor determinations for cost report periods ending on December 31, 2008 and which began before January 1, 2016, Under this Ruling, where the Board determines that the specific item under appeal was subject to a regulation or payment policy that bound the Medicare Contractor and left it with no authority or discretion to make payment in the manner sought by the provider on appeal, the protest requirements of 42 C.F.R. § 405.1835(a)(1)(ii) were no longer applicable. However, a provider could elect to self-disallow a specific item deemed non-allowable by filing the matter under protest.

---

[19] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).
[20] *Bethesda*, 108 S. Ct. at 1258-59.
[21] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[22] 201 F. Supp. 3d 131 (D.D.C. 2016).
[23] *Id.* at 142.

The Board finds that the Providers' appeals with cost report periods which began before January 1, 2016 are governed by CMS Ruling 1727-R. The Board has determined that, in the instant appeals and associated EJR request, the Providers' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal[24] and the appeals were timely filed.[25] Based on the above, the Board finds that it has jurisdiction over the above-captioned appeals. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount.

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

In Case No. 20-1602GC, Providers appealed from the Medicare Contractor's failure to time issue a final determination for cost reporting periods ending June 30, 2018.[26] In Case No. 20-1462GC, the Providers appealed from the issuance of their NPRs for the cost report period ending December 31, 2016. Both appeals are subject to the regulations on the "substantive reimbursement requirement" for an appropriate cost report claim.[27] Specifically, effective January 1, 2016, the Secretary enacted both 42 C.F.R. §§ 413.24(j) and 405.1873. The regulation at § 413.24(j)(1) specifies that, in order to receive or potentially qualify for reimbursement for a specific item for its cost reporting period, a provider must include an appropriate claim on its cost report by either claiming the item in accordance with Medicare policy or self-disallow the specific item in the cost report if it believes it may not be allowable.[28]

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

The Board interprets the regulation at 42 C.F.R. § 405.1873 to only require the Board to review a provider's "compliance"[29] with the reimbursement requirement of an appropriate cost report claim for the specific item under appeal (and the supporting factual evidence and legal argument) ***if*** a party to the appeal questions whether there was an appropriate claim made.[30] As no party to

[24] *See* 42 C.F.R. § 405.1837(a)(3).
[25] *See* 42 C.F.R. § 405.1835(a)(d).
[26] *See* 42 C.F.R. § 405.1835(c) (2018).2z
[27] 42 C.F.R. § 413.24(j) (entitled "Substantive reimbursement requirement of an appropriate cost report claim"). *See also* 42 C.F.R. § 405.1873 (entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim").
[28] 42 C.F.R. § 413.24(j)(2) sets forth the procedures for self-disallowing a specific item on the cost report.
[29] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."
[30] *See* 42 C.F.R. § 405.1873(a).

the appeal has questioned, pursuant to § 405.1873(a), whether an appropriate claim was made,[31] the Board finds there was no regulatory obligation for the Board to affirmatively, on its own, review the appeal documents to determine whether an appropriate claim was made.[32] As a result, Board review under 42 C.F.R. § 405.1873(b) has not been triggered. Accordingly, the Board may proceed to rule on the EJR request pursuant to 42 C.F.R. § 405.1873(d).

C. Board Jurisdiction

The Board has determined that the participants in Case Nos. 18-1458GC, 19-2765GC and 20-0005GC included in the instant EJR request are governed by CMS Ruling CMS-1727-R since they are challenging a regulations as described more fully below. In each of the cases, the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[33] The appeals were timely filed. Based on the above, the Board finds that it has jurisdiction for the above-captioned appeals and the underlying participants. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

D. Board's Analysis of the Appealed Issue

The Providers assert that the regulation at 42 C.F.R. § 413.79(c)(2)(iii) penalizes hospitals which exceed their FTE caps because of the perceived disparate treatment between IRP residents (*i.e.*, residents in their initial training period) and fellows. The Providers assert that § 413.79(c)(2)(iii) states the following equation for calculating the weighted cap (*i.e.* "Allowable FTE Count") for a particular fiscal year ("FY") and that this equation results in the perceived disparate treatment between IRP residents and fellows. Specifically, the Providers present the following equation in their request for EJR used to calculate the allowable count for residents (*i.e.*, IRP residents and fellows) in primary care and obstetrics and gynecology programs and separately for residents (*i.e.*, IRP resents and fellows) in nonprimary care programs:

$$\textbf{\textit{Allowable FTE count}} = \frac{Unweighted\ \ FTE\ Cap}{Unweighted\ FTE\ Count} \times Weighted\ FTE\ Count$$ [34]

Accordingly, the Board set out to confirm the Providers' assertion that § 413.79(c)(2)(iii) does in fact set forth the above equation.

---

[31] The Board notes that Board Rule 10.2 states: "If the Medicare contractor opposes a provider's expedited judicial review request, . . . its response must be timely filed in accordance with Rules 42, 43, and 44."

[32] Although no question was raised in this appeal regarding whether an appropriate claim was made, the Board recognizes that the Providers' cost reports included a claim for the disputed DGME payment as a protested amount on its as-filed cost reports as evidenced by the documentation under Tab D for each Provider in the Providers' Schedule of Providers in both cases. The documentation included in Case No. 20-1602GC included Worksheet Es, protested amounts descriptions and workpapers demonstrating the DGME issue had been included as a protested amount for each of the Providers in the group. In Case No.20-1462GC, all the Providers identified the audit adjustment related to protested amounts and included the supporting documentation for the DGME issue that was protested when they filed their respective cost reports.

[33] *See* 42 C.F.R. § 405.1837.

[34] *See* Provider's EJR Request at 4.

At the outset, the Board notes that, pursuant to the introductory phrase in § 413.79(c)(2)(iii) (*i.e.*, "[i]f the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 2001 exceeds the limit described in this section [*i.e.*, the FTE cap or limit]"), the above equation is used ***only*** when the "Unweighted FTE Count" for a FY exceeds the "Unweighted FTE Cap" in order to determine what the Providers describe as the "Allowable [weighted] FTE count" for the FY.[35] As such, the equation would logically appear to be a method used to translate the "Unweighted FTE Cap" into a *weighted* context where the "Allowable FTE count" for a FY is really a "weighted FTE cap" for the FY because it is ***only*** used when the unweighted FTE count exceeds the unweighted FTE cap. Indeed, the Board's description of the product of the equation as a "cap" is consistent with the Secretary's description of it as a "reduced cap" in the preamble to the FY 2002 IPPS Final Rule.[36] Accordingly, the Board will refer to the variable "Allowable FTE count" for the FY as the "Weighted FTE Cap" to facilitate the Board's discussion below on how the equation is conceptually set forth in the text of § 413.79(c)(2)(iii).

Bearing this concept in mind, the Board reviewed the regulation closely and agrees with the Providers that § 413.79(c)(2)(iii) essentially states the above equation, albeit in a slightly different form where the difference is inconsequential and it gives the same results. In its entirety, § 413.79(c)(2)(iii) states:

> If the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 2001 exceeds the limit described in this section [*i.e.*, the FTE cap or limit], the hospital's weighted FTE count (before application of the limit) for primary care and obstetrics and gynecology residents and nonprimary care residents, respectively, *will be reduced* ***in the same proportion*** that the number of FTE residents for that cost reporting period exceeds the number of FTE residents for the most recent cost reporting period ending on or before December 31, 1996 [*i.e.*, the FTE cap or limit].[37]

At first blush, it would not appear that the equation is specifically stated in the regulation. However, once the regulation is unpacked around the words "in the same proportion," it is clear that the regulation is relying on ratios as the basis for the equation used to calculate the Weighted FTE Cap applicable for the fiscal year.[38] Indeed, CMS reiterates this in the preamble to the FY 1998 Final Rule by rationalizing § 413.79(c)(2)(iii) as follows: "We believe this ***proportional reduction*** in the hospital's unweighted FTE count is an equitable

---

[35] *See also* 62 Fed. Reg. at 46005 (describing the purpose of the regulation being adopted in the final rule as follows: "To address situations in which a hospital increases the number of FTE residents over the cap, notwithstanding the limit established under section 1886(h)(4)(F), we are establishing the following policy for determining the hospital's *weighted* direct GME FTE count for cost reporting periods beginning on or after October 1, 1997." (Emphasis added.)).
[36] 66 Fed. Reg. at 39894 (emphasis added).
[37] (Emphasis added.)
[38] *See* 62 Fed. Reg. at 46005 (emphasis added).

mechanism for implementing the statutory provision."[39] Essentially, the regulation is stating that the Weighted FTE Cap is to the FY's Weighted FTE Count as the Unweighted FTE Cap is to the FY's Unweighted FTE Count. The calculation of the Weighted FTE Cap is achieved through the operation of the following simple algebraic principle of equivalent fractions[40] (*i.e.*, ratios) using variables a, b, c, and d:

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

On first side of the initial algebraic equation (*i.e.*, the ratio of "a / b") is the following phrase: "the number of FTE residents for that cost reporting period exceeds [the FTE cap or limit]." This phrase (the ***Unweighted FTE Cap*** is to the ***FY's Unweighted FTE Count***) expressed as a ratio ("a/b") is the Unweighted FTE Cap over the FY's Unweighted FTE Count.[41]

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

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

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

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

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

---

[39] *Id.* (emphasis added). *See also* 66 Fed. Reg. at 3984 ("[F]or primary care and obstetrics and gynecology residents and nonprimary care residents, respectively, will be reduced *in the same* ***proportion*** that the number of these FTE residents for that cost reporting period exceeds the unweighted FTE count in the cap. The ***proportional reduction*** is calculated *for primary care* ***and*** *obstetrics and gynecology residents and nonprimary care residents separately…."* (Emphasis added.)).

[40] Two alternative ways to express the algebraic principle of equivalent functions include:
If a/b = c/d, then c = (a x d) / b ; and
If a/b = c/d, then c = (a/b) x d.

[41] Note that, in using equivalent ratios, the key is the relationship of the ratios. As such, the relation between the ratios does not change if they are flipped. For example, if these ratios are flipped, then the initial equation becomes the FY's Weighted FTE Count (variable d) over the Weighted FTE Cap (variable c) equals the FY's Unweighted FTE Count (variable b) over the Unweighted FTE Cap (variable a). The unknown variable is still "c" and you would get the same results where rule would then be: If b/a = d/c, then c = (a/b) x d.

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

Board's Decision Regarding the EJR Request

The Board finds that:

1) It has jurisdiction over the matter for the subject years and that the participants in these appeals are entitled to a hearing before the Board;

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

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

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

Accordingly, the Board finds that the question of the validity of 42 C.F.R. § 413.79(c)(2)(iii) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for EJR for the issue and the subject years. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in this case, the Board hereby closes the cases.

Enclosures: Schedules of Providers

Board Members Participating:

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

For the Board:

10/6/2020

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: Clayton J. Nix -A

cc: Bruce Snyder, Novitas Solutions
Pam VanArsdale, NGS
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Maureen O' Brien Griffin
Hall, Render, Killian, Heath & Lyman, P.C.
500 North Meridian Street
Suit 400
Indianapolis, IN 46204

Cecille Huggins
Palmetto GBA
Internal Mail Code 380
P.O. Box 100307
Camden, SC 29202-3307

RE: ***Hall Render CY 2012 DSH Medicare/Medicaid Part C Days V Group***
Specifically Weirton Medical Center (Prov. No. 51-0023, FYE 6/30/12)
Case No. 19-0624G

Dear Ms. Griffin and Ms. Huggins,

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above referenced appeal in order to process a remand pursuant to CMS Ruling 1739-R for the Part C Days issues.

BACKGROUND:

The Provider was issued a revised Notice of Program Reimbursement ("NPR") on August 10, 2018, for fiscal year end ("FYE") 6/30/2012. On February 4, 2019, the Provider was directly added to the above-captioned appeal. The group appeal request, submitted on January 10, 2019, identified the following Part C Days issue related to calculation of the disproportionate share ("DSH") adjustment:

1) The Medicare Proxy is improperly understated due to CMS's erroneous inclusion of inpatient days attributable to Medicare Advantage (MA) patients in both the numerator and denominator of the DSH fraction.

2) Any Medicare Advantage (MA or Medicare Part C Days) that are also Dual Eligible Days must be counted in the Medicaid numerator.

BOARD'S DECISION:

The Code of Federal Regulations provides for an opportunity for a revised NPR. 42 C.F.R. § 405.1885 (2011) provides in relevant part:

> (a) General. (1) A Secretary determination, an intermediary determination, or a decision by a reviewing entity (as described in

> § 405.1801(a) of this subpart) may be reopened, for findings on matters at issue in a determination or decision, by CMS (with respect to Secretary determinations), by the intermediary (with respect to intermediary determinations) or by the reviewing entity that made the decision (as described in § 405.1885(c) of this subpart).

42 C.F.R. § 405.1889 (2011) explains the effect of a cost report revision:

> (a) If a revision is made in a Secretary or intermediary determination or a decision by a reviewing entity after the determination or decision is reopened as provided in §405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the provisions of 42 C.F.R. §§ 405.1811, 405.1834, 405.1835, 405.1837, 405.1875, 405.1877 and 405.1885 of this subpart are applicable.
>
> (b)(1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.
>
> (2) Any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision.

Finally, 42 C.F.R. § 405.1835(a)(1) provides:

> …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)).

The Board finds that it does not have jurisdiction over Weirton's appeal from a revised NPR, for the Part C Days issues because they were not specifically adjusted in the Provider's revised NPR.

42 C.F.R. § 405.1889(b) make clear that a Provider can only appeal items that are specifically adjusted from a revised NPR. The Group has appealed the inclusion of Medicare Part C days in the SSI fraction (also known as the Medicare fraction) of the DSH percentage and 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, which were not adjusted in the revised NPR. However, Weirton's revised NPR was issued as the result of a reopening to include additional Medicaid paid and eligible days in the Medicaid fraction of the DSH adjustment calculation.[1] The reopening did not encompass Part C days and there was no

[1] Medicare Contractor's Notice of Reopening dated April 20, 2016.

adjustment to either Part C days (which, per 42 C.F.R. § 412.106(b)(2), are included in the SSI fraction of the DSH adjustment calculation) or even the SSI fraction generally. Accordingly, pursuant to 42 C.F.R. §§ 405.1835(a)(1) and 405.1889(b), the Board finds that it does not have the right to appeal the Part C days issue from the revised NPR. The Board notes that Courts have upheld the Board's application of provider's limited appeal rights under 42 C.F.R. § 405.1889(b), including in the context of appeals involving different aspects of the DSH calculation.[2]

CONCLUSION:

The Board finds that, pursuant to 42 C.F.R. §§ 405.1835(a)(1) and 405.1889(b), it does not have jurisdiction over Weirton's appeal of the inclusion of Medicare Part C days in the Medicare fraction of the DSH percentage and 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. Accordingly, the Board hereby dismisses Weirton Medical Center from the group appeal.

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

Board Members Participating:

Clayton J. Nix, Esq.
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

For the Board:

10/7/2020

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: Clayton J. Nix -A

cc: Wilson Leong, Federal Specialized Services

[2] *See, e.g., 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) ("*HCA Health*").

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Roy Breitenbach
Garfunkel Wild, P.C.
111 Great Neck Road
Great Neck, NY 11021

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

RE: ***Jurisdictional Decision***
Fletcher Allen Healthcare, Inc. (Prov. No. 47-0003)
FYE 9/30/2009
Case No. 14-2392

Dear Mr. Breitenbach and Ms. VanArsdale,

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above referenced appeal in response to the Medicare Contractor's ("MAC") Jurisdictional Challenge of Fletcher Allen Healthcare, Inc.'s ("Provider") Part C Days issues in its individual appeal. The Board's decision is set forth below.

Background:

This case involves Fletcher Allen Healthcare, Inc., where the MAC has filed a jurisdictional challenge challenging what it alleges is a "new" aspect of the DSH Part C Days issue which remains in the case.

The Notice of Program Reimbursement ("NPR") for this cost reporting period was issued on August 28, 2013.[1] The Provider filed a hearing request with the Board on February 10, 2014.[2] The Provider appealed the following issue:

> Issue 1: Improper Inclusion of Medicare Part C (Medicare Advantage) Days in Part A/SSI Fraction….[3]

The MAC filed a jurisdictional challenge on August 17, 2015, alleging that the Provider untimely and improperly added a second issue in the Preliminary Position Paper, Part C days in the Medicaid Fraction.[4] The MAC contends that this is a completely new issue: It was not

[1] Provider's Request for Hearing (Feb. 10, 2014).
[2] *Id*.
[3] MAC's Jurisdictional Challenge, at 1 (Aug. 17, 2015).
[4] *Id*.

specifically identified within the Provider's appeal request nor was it timely added in accordance with 42 C.F.R. § 405.1835(c).[5]

Medicare Contractor's Jurisdictional Challenge

Timeliness

The Provider's request to add the issue of the exclusion of the Medicare Part C days from the numerator of the Medicaid fraction has not been timely filed. In accordance with 42 C.F.R. § 405.1835 (a)(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 is no later than 180 days after the date of receipt by the provider of the final contractor or Secretary determination.

and (e) and (e)(3):

> *Adding issues to the hearing request.* After filing a hearing request in accordance with paragraphs (a) and .... , 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) . . . .

The MAC sent the Provider's Notice of Program Reimbursement (NPR) on August 28, 2013**.** This is the final determination in question. The Provider filed its appeal request on February 7, 2014. The Provider did not include the issue of the exclusion of the Medicare Part C Days from the Numerator of the Medicaid Fraction in its appeal request. Rather, the Provider added this issue to the appeal via its Preliminary Position Paper filed on October 29, 2014, i.e., 427 days from the date of the NPR. The MAC concludes that the Provider has clearly failed to meet the timeliness requirements relative to the inclusion of this issue in the instant appeal.[6]

Identification of Specific Item in Dispute

The MAC argues that the Provider failed to identify this specific item in dispute, exclusion of the Medicare Part C Days from the numerator of the Medicaid fraction, in accordance with PRRB Rule 8.1 which states that for issues with multiple components "each contested component must be appealed as a separate issue and described as narrowly as possible". *NOTE*: PRRB Rule 8.2

[5] *Id*.
[6] *Id*.

Disproportionate Share Cases specifically cites HMO days, i.e., Medicare Part C (Medicare Advantage) Days as an issue with multiple components.[7]

No Protest

The MAC also argues that the Board lacks specific jurisdiction over the issue of the exclusion of the Medicare Part C Days from the numerator of the Medicaid Fraction as the Provider failed to preserve their right to appeal this issue by not following the PRM15-2 rules governing cost reports filed under protest in compliance with 42 C.F.R § 405.1835(a)(1)(ii) and Board Rules Section 7.2C.

Provider's Jurisdictional Response

The Provider filed a Response to Jurisdictional Challenge on September 10, 2015. They contend that the Board has jurisdiction over the Part C Days issue. The Provider argues the following:

> In its Request for Board Hearing, the Provider stated that **it** was appealing the improper inclusion of Part C days in the Medicare Fraction. When it subsequently filed its Preliminary Position Paper, it explained in detail how the Intermediary improperly counted the days, which of course impacted both the Medicare and the Medicaid Fractions, as set forth above. The Intermediary has now asserted that the Provider was improperly attempting to add a new issue by pointing out that correctly counting the Part C days would impact both fractions. This overly technical reading is illogical.[8]

The Provider continues:

> There is no dispute that the Provider correctly appealed whether Part C days were properly included in the definition of Part A days in the Medicare Fraction. The Intermediary is now taking the untenable position that resolution of such a request would not also require revision of the Medicaid Fraction. In other words, what the Intermediary is effectively requesting is authorization to correctly count the Part C days in one fraction, but leave the other uncorrected. This inconsistent and unreasonable approach should not be permitted. This is not, as the Intermediary would have the Board believe, two separate issues for consideration. It is one issue: whether the Intermediary improperly included Medicare Part C beneficiaries in its definition of beneficiaries entitled to Medicare Part A. If Board agrees that Part C beneficiaries were improperly included and adjusts the Medicare Fraction

[7] *Id*.
[8] Provider's Jurisdictional Response (Sep. 10, 2015).

> accordingly, the Intermediary's treatment of Medicare Part C days in the Medicaid Fraction portion must also be adjusted as a matter of course in order to fully resolve the issue at hand.[9]

The Provider respectfully requests that the Board accept jurisdiction over the Medicare Part C issue, as applicable to the Medicaid Fraction of DSH, in the instant appeal.

Board's Analysis and Decision

As set forth below, the Board finds that it has the jurisdiction over the complete Part C days issue in this appeal (Medicare and Medicaid fractions). The Provider properly appealed the first issue in this case, Part C days in the Medicare fraction, and Part C days must be included in either the SSI fraction or the Medicaid fraction per the 2014 decision of the D.C. Circuit in *Allina Health Servs. v. Azar* ("*Allina*").[10]

The appeal was filed with the Board in February of 2014 and the regulations required the following:

> (b) *Contents of request for a Board hearing on final contractor determination.* The provider's request for a Board hearing…must be submitted in writing to the Board, and the request must include…
>
> (2) An explanation…of the provider's dissatisfaction with the contractor's or Secretary's determination, including an account of…
>
> (i) why the provider believes Medicare payment is incorrect for each disputed item...[and]
> (ii) how and why the provider believes Medicare payment must be determined differently for each disputed item…[11]

PRRB Rules elaborated on this regulatory requirement as follows:

> 8.1 – General. Some issues may have multiple components. To comply with regulatory requirement to specifically identify the items in dispute, each contested component must be appealed as a separate issue and described as narrowly as possible using the applicable format outlined in Rule 7. . . .

[9] *Id*.
[10] 746 F.3d 1102, 1108 (D.C. Cir. 2014).
[11] 42 C.F.R. § 405.1835(b) (2008).

8.2 – Disproportionate Share Cases (e.g., dual eligible, general assistance, charity care, HMO days, etc.).[12]

While the Part C Days (Medicare Fraction) issue in this case does not specify that Part C Days (Medicaid Fraction) are included as a part of this issue, Part C days must be included in either the Medicare fraction or the Medicaid fraction. Specifically, as the D.C. Circuit explained in 2014 in *Allina Health Servs. v. Azar*, the Part C days included must go in either the Medicare or Medicaid fraction.[13] Here, the SSI fraction was adjusted in the revised NPR as required by 42 C.F.R. § 405.1889 and the Provider is dissatisfied with where the additional Part C days were included. Given the Court's decision in *Allina*, as well as CMS' issuance of ruling 1739-R, the Part C Days issue as stated in the original appeal request (Medicare fraction) is to be construed to include Part C Days (Medicaid Fraction). Accordingly, the Board finds jurisdiction over any Part C Days (Medicaid Fraction) as a component of the Part C Days issue (Medicare fraction).

This appeal remains open as the Part C Days issue remains. The Board will remand this issue 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 appeal.

Board Members Participating:

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

For the Board:

10/15/2020

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: Clayton J. Nix -A

cc: Wilson Leong, Federal Specialized Services

[12] Provider Reimbursement Review Board Rules, Rule 8 (March 1, 2013), *available at* https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/Downloads/PRRBRules_03_01_2013.pdf.
[13] 746 F.3d 1102, 1108 (D.C. Cir. 2014).

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
1508 Woodlawn Drive, Suite 100
Baltimore, MD 21207
410-786-2671

Via Electronic Delivery

Carolinas Healthcare System
L. Rene Shannon
Director of Reimbursement
4400 Golf Acres Drive, Building J, Suite A
Charlotte, NC 28208

National Government Services, Inc,
Laurie Polson
Appeals Lead
MP: INA 101-AF42
P.O. Box 6474
Indianapolis, IN 46206-6474

RE: ***Jurisdictional Decision***
Carolinas Health CY 2010 Atrium Health IPPS Standardized Amount CIRP Group
Case No. 19-2639GC

Dear Ms. Shannon and Ms. Polson,

The Provider Reimbursement Review Board ("Board") has reviewed the above-captioned common issue related party ("CIRP") group appeal on its own motion. The pertinent facts of the case and the Board's jurisdictional determination are set forth below.

Background:

On September 11 2019, the Provider filed this CIRP group appeal with the Provider Reimbursement Review Board ("Board"). The CIRP group issue statement as submitted:

> Whether the Providers are entitled to an additional payment because inclusion of transfers in the 1981 data used for computing the Medicare Inpatient Prospective Payment System ("IPPS") standardized amount reduced the Providers' IPPS payment?[1]

There are three Participants in this group appeal. The Participants appealed from Revised Notices of Program Reimbursement ("RNPRs").

1. ***Participant #1 – Carolinas Health Care System - Anson***

The Notice of Reopening of Cost Report (October 21, 2014) states the cost report was reopened:

> In the event of unfavorable final nonappealable decision in Allina Health Services v. Sebelius, the cost report will be reopened to adjust the Disproportionate Share payment calculation.

[1] *Group Appeal Request* (September 11, 2019).

***

> Certain PS&R reports were found to include negative charge amounts. Report Type 130 has been excluded from the contractor's review of Medicare settlement data. Once the negative charge issue is resolved, the cost report will be reopened to revise the Medicare settlement data.[2]

Carolinas Health Care System – Anson received its RNPR on March 15, 2019. The Provider did not submit an adjustment report. The Board sent a request for information requesting an audit adjustment report on September 3, 2020. However, on September 29, 2020, the Provider responded but did not submit an audit adjustment report. The Provider stated "[a]n audit adjustment is not applicable to an appeal from the Federal Register."[3]

2. Participant #2 – Carolinas Health Care System – Blue Ridge

The Notice of Reopening of Cost Report (June 2, 2017) states the cost report was reopened

1. To review the additional Medicaid eligible days for propriety;

2. To revise Medicaid days on Worksheet S-3, Part I based on the review findings;

3. To update the allowable operating DSH percentage on Worksheet E, Part A, Lines 4.01 and
4.03 to reflect changes in the Medicaid days;

4. To update the allowable capital DSH percentage on Worksheet L, Part I, Line 5.03 to reflect changes in the Medicaid days;

5. To incorporate settlement amounts from the previous cost report settlement to ensure proper determination of payments, as necessary.

6. To address any cost report software updates and edits, mathematical and flow items and carry forward amounts, as necessary.[4]

Carolinas Health Care System – Blue Ridge received its RNPR on March 15, 2019. The Provider did not submit an adjustment report. In place of an audit adjustment report, the Provider stated "[a]n audit adjustment is not applicable to an appeal from the Federal Register."[5]

---

[2] See Notice of Reopening submitted September 29, 2020.
[3] See Audit Adjustment document submitted September 29, 2020.
[4] *Group Appeal Request – Notice of Reopening* (September 11, 2019).
[5] *Group Appeal Request – Audit Adjustment Document* (September 11, 2019).

3. Participant #3 – Carolinas Medical Center – Behavioral Health

The Notice of Reopening of Cost Report (March 13, 2019) states the cost report was reopened:

> 1. Provider requested that CMS recalculate their SSI percentage based on the providers fiscal year instead of the federal fiscal year.
> 2. To incorporate settlement amounts from the previous cost report settlement to ensure proper determination of payments, as necessary.
> 3. To address any cost report software updates and edits, mathematical and flow items and carry forward amounts, as necessary.[6]

Carolinas Medical Center – Behavioral Health received its RNPR on March 14, 2019. The Provider did not submit an adjustment report. The Board sent a request for information requesting an audit adjustment report on September 3, 2020. However, on September 29, 2020, the Provider responded but did not submit an audit adjustment report. The Provider stated "[a]n audit adjustment is not applicable to an appeal from the Federal Register."[7]

Board Decision

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

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

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

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

[6] *See* Notice of Reopening (September 29 2020).
[7] *See* Audit Adjustment Document (September 29, 2019).

> 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.

Finally, 42 C.F.R. § 405.1835(a)(1) provides:

> 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)).

The Board finds that it does not have jurisdiction over the participants in this appeal because they appealed from RNPRs that did not adjust the standardized payment amount (*i.e.*, the base rates underling the DRG rates published annually in the Federal Register).

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] Further, consistent with 42 C.F.R. § 405.1835(b), Board Rules 7.1.2.1 and 7.2 require that, whenever a provider appeals from a revised NPR, the appeal request must include a copy of the revised NPR, the adjustments at issue, and the notice of reopening.[9]

Each of the three participants, filed an appeal based on a revised NPR and the associated notices of reopening in this case identified a number of issues to be revised but did not otherwise relate to reviewing or adjusting the standardized payment rates. Notwithstanding Board Rules 7.1.2.1, 7.2, and 21.2.2, the Group Representative did not include audit adjustment reports on each of the three participants because it alleges that each of three participants appealed from the Federal Register (*i.e.*, the FY 2019 IPPS Final Rule published on August 17, 2018 and as corrected on October 3, 2018). However, while it is clear that the three participants are dissatisfied with the published FY 2019 IPPS rates, the record is clear that none of them appealed from that Federal Register but rather each appealed from a revised NPRs.[10] Accordingly, the Board finds that it

[8] 42 C.F.R. § 405.1889(b)(1).
[9] *See also* Board Rule 21.2.2.
[10] The record reflects that the determination that each of the participants attached to their direct-add request (i.e., appeal request) was the revised NPR and not the FY 2019 IPPS Final Rule. Indeed, had the three participants appealed from that FY 2019 IPPS Final Rule, it is clear that each of their appeal request (*i.e.*, direct adds) would

does not have jurisdiction over the participants in the subject group appeal because the revised NPRS at issue for the three participants did not adjust the standardized payment amount and, as a result, no participant had a right to appeal under 42 C.F.R. §§ 405.1835(a) and 405.1889(b). The Board notes that Courts have upheld the Board's application of provider's limited appeal rights under 42 C.F.R. § 405.1889(b).[11]

In conclusion, the participants are dismissed from the appeal because pursuant to 42 C.F.R. §§ 405.1835(a) and 405.1889(b), they do not have the right to appeal the RNPRs at issue. As there are no participants remaining, the Board hereby closes Case No. 19-2639GC 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.
Susan A. Turner, Esq.

FOR THE BOARD:

10/15/2020

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: Clayton J. Nix -A

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

have been untimely and well beyond the 180 day filing deadlines since each participant was directly added more than a year later in September 2019.

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Karl Holderman
The Center for Hospice & Palliative Care, Inc.
501 Comfort Place
Mishawaka, IN 46545

RE: ***Jurisdictional Decision***
The Center for Hospice & Palliative Care, Inc. (Prov. No. 15-7067)
FYE CY 2020
Case No. 20-2119

Dear Mr. Holderman,

The Provider Reimbursement Review Board ("Board") has reviewed the documents in the above referenced appeal. The Board finds that it does not have jurisdiction over the appeal, due to a failure to meet the jurisdictional threshold of amount in controversy.

Pertinent Facts:

On October 1, 2019, CMS sent a letter to the Provider to inform of a failure to meet one or more of the Home Health Quality Reporting Program requirements for Calendar Year (CY) 2020. The letter detailed the program requirement issue was failure to collect monthly HHCAHPS data and submit data to the HHCAHPS Data Center from April 1, 2018 through March 31, 2019. As a result of this issue, the Provider faced a 2 percentage point reduction in the CY 2020 Annual Payment Update.

On October 11, 2019, the Provider submitted a request for reconsideration. CMS sent a letter, dated December 11, 2019, to the Provider to advise the reconsideration was reviewed, and the initial decision of a 2 percentage point reduction in the CY 2020 Annual Payment Update was upheld.

The Provider is appealing from a Quality Reporting Payment Reduction dated December 11, 2019. On March 16, 2020, the Board received the Provider's individual appeal request, on the MBU Payment Reduction CY2020.

In the Appeal Request, the Provider included a stated amount in controversy of $4,730, based on their own 2020 budgeted Medicare Home Health Revenue of $236,500 and the 2 percent reduction.

Provider's Contentions

In its appeal letter submitted on March 11, 2020, the Provider posited they are exempt from HHCAHPS for Home Health, as they are primarily a hospice provider, a significant number of their home health patients are discharged to hospice care, and they fall below the threshold for participating in HHCAHPS. Further, the Provider stated they have filed for the appropriate exemption from the program each year, and included a receipt of the CY2020 filing, along with a copy of the exempted calculation.

The appeal letter stated, "Based on our 2020 budgeted Medicare Home Health revenue of $236,500 the amount in controversy would be 2% of that figure or $4,730."[1]

Board's Decision:

The Board finds that it does not have jurisdiction over the Provider because it does not meet the $10,000 amount in controversy threshold.

42 C.F.R. § 1835(a) specifies that the right to a hearing before the Board is conditioned, in pertinent part, on the amount in controversy being $10,000 or more. 42 C.F.R. § 405.1839(a)(1) specifies that, for single provider appeals: "In order to satisfy . . . the amount in controversy requirement under § 405.1835(a)(2) or § 405.1835(c)(3) for a Board hearing for a single provider, the provider *must demonstrate* that if its appeal were successful, the provider's total program reimbursement for each cost reporting period under appeal would increase . . . by at least $10,000 for a Board hearing, as applicable."[2] 42 C.F.R. § 405.1840(a)(2) specifies that "[t]he Board must make a preliminary determination of the scope of its jurisdiction (that is, whether the request for hearing was timely, and whether the amount in controversy requirement has bee met), if any, over the matters at issue in the appeal before conducting any . . . proceedings . . . ."

Accordingly, an individual appeal request must have a total amount in controversy of at least $10,000 and the Provider must supply a calculation or support demonstrating the amount in controversy for each issue.[3] In this case, the Provider did *not* supply support of their calculation with the appeal request contrary to 42 C.F.R. §§ 405.1835(b) and 405.1839(a)(1) and Board Rule 6.4. Additionally, the Provider's stated amount in controversy of $4,730 falls well below the amount in controversy threshold for Board jurisdiction. Accordingly, the Board closes the individual appeal and removes it from the Board's docket.

Conclusion

The Board concludes that it does not have jurisdiction because the Provider's appeal does not meet the $10,000 amount in controversy threshold specified in 42 C.F.R. § 405.1835(a). The Board closes the individual appeal 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.

---

[1] Model Form A – Individual Appeal Request, Page 10 (Mar. 16, 2020).
[2] (Emphasis added). *See also* 42 C.F.R. § 405.1835(b) (specifying that the provider must demonstrate that it satisfies the requirements for a Board hearing as specified in paragraph (a) which necessarily include the amount in controversy requirement).
[3] PRRB Rule 6.4; 42 C.F.R. §§ 405.1835 and 405.1839.

Board Members Participating:

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

For the Board:

10/19/2020

X Clayton J. Nix

Clayton J. Nix, Esq.

Signed by: Clayton J. Nix -A

cc: Wilson C. Leong, Esq., Federal Specialized Services
Laurie Polson, Palmetto GBA c/o National Government Services, Inc.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Leslie Demaree Goldsmith, Esq.
Baker, Donelson, Bearman, Caldwell & Berkowitz, PC
100 Light St.
Baltimore, MD 21202

RE: ***Baker Donelson Direct Graduate Medical Education ("DGME") Appeals***
19-2187G Baker Donelson CY 2010, 2012, 2013, 2015 & 2016 DGME Group
20-1315G Baker Donelson CY 2016 DGME Penalty to FTE Count Group[1]

Dear Ms. Goldsmith:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' June 17, 2019 request for expedited judicial review ("EJR") for the two (2) optional group appeals referenced above which was filed through the Office of Hearings Case and Document Management System ("OH CDMS"). On October 7, 2020, the Board requested the Group Representative determine if common issue related party ("CIRP") groups were required for some of the Providers in these appeals. The Group Representative responded on October 14, 2020 confirming that CIRP groups were not required for any of the Providers in the group. This request for additional information affected the 30 day time period for responding to the EJR request.[2]

On March 26, 2020, prior to the submission of the EJR request, the Board issued Alert 19, notifying affected parties "Temporary COVID-19 Adjustments to PRRB Processes." On June 29, 2020, subsequent to the submission of the EJR request, the Board notified you of the relevance of Alert 19 to the EJR request. Specifically, the Board notified you that, "[a]s the Board does not have access to the hard copy Schedules of Providers filed in the above-referenced list of . . . cases (regardless of whether they were filed shortly before the EJR, after the EJR, or at some point in the past), the Board is not able to process them in the usual manner and establish jurisdiction, *i.e.*, whether 'a provider of services may obtain a hearing under' the PRRB statute, which is a necessary jurisdictional prerequisite for a case to eligible for EJR. 42 U.S.C. § 1395oo(f); see also 42 C.F.R. § 405.1842(b)."' Accordingly, the Board stayed the 30-day period for responding to the EJR request for the above-captioned appeals.

Although the Schedule of Providers was delivered to the Centers for Medicare & Medicaid Services mailroom on June 18, 2020, the Board did not receive the Schedules in its office until September 17, 2020. Further, although the Board has not resumed normal operations, it is

[1] The EJR request included five other cases for which an EJR decision was issued on October 7, 2020.
[2] *See* 42 C.F.R. § 405.1842(b)(2), (e)(2)(ii) and (e)(3)(ii).

attempting to process EJR requests expeditiously and is still governed by the standards set forth in 42 C.F.R. § 405.1801(d)(2) when calculating the 30-day time period for issuing an EJR by excluding all days where the Board is not able to conduct its business in the usual manner.

On October 7, 2020, the Board issued a request for additional information, to which the provider representative responded on October 14, 2020. This request also stayed the deadline responding to the EJR request.[3]

The Providers in these cases are challenging:

> . . .the validity of the regulation at 42 C.F.R. § 413.79(c)(2) implementing the direct graduate medical education ("DGME") cap on full-time equivalent ("FTE") residents and the FTE weighting factors. . . . [The Providers assert that] [t]he regulation at 42 C.F.R. § 413.79(c)(2) is contrary to the statute because it determines the cap after application of the weighting factors. . . .The effect of the . . .regulation is to impose on the Providers a weighting factor that results in a reduction of greater than 0.5 for many residents who are beyond the initial residency period (IRP), and it prevents the Providers from claiming their full unweighted FTE caps authorized by statute. . . . [The Providers contend that] the calculation of the current, prior year, and penultimate-year weighted DGME FTEs and the FTE caps is contrary to the statutory provision at 42 U.S.C. § 1395ww(h) . . . .[4]

The decision of the Board is set forth below.

Background

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

The Medicare statute prescribes a formula for computing annual DGME payments to hospitals. The statutory formula consists of three components:

1. The hospital's number of FTE residents, or "FTE count;"
2. The hospital's average cost per resident (*i.e.* the per resident amount or "PRA"); and

[3] See 42 C.F.R. §§ 405.1842(b)(2), (e)(2)(ii) and (e)(3)(ii).
[4] Providers' EJR requests at 1.
[5] of the Department of Health and Human Services.
[6] 42 U.S.C. § 1395ww(h).
[7] *See* S. Rep. No. 404, 89th Cong. 1st Sess 36 (1965); H.R. No 213, 89th Cong., 1st Sess. 32 (1965).

3. The hospital's patient load, which is the percentage of a hospital's inpatient treatment days attributable to Medicare Part A and Part C beneficiaries.[8]

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

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

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

Pursuant to this statutory provision, FTEs attributable to residents who are training in their initial residency period[9] ("*IRP residents*") are weighted at 100 percent or 1.0 while FTEs attributable to residents who are not in their initial residency period (commonly referred to as "*fellows*") are weighted at 50 percent or 0.5. The sum of the weighted FTEs for IRP residents and fellows in a given year is known as a hospital's "weighted FTE count." For example, under this weighting assignment, a hospital that trained 10 IRPs and 10 fellows in a given year would have a weighted FTE count of 15.

On August 5, 1997, Congress enacted § 4623 of the Balanced Budget Act of 1997 ("BBA")[10] which added 42 U.S.C. § 1395ww(h)(4)(F) to establish a limit on the number of osteopathic and allopathic residents that a hospital can be included in its FTE count for DGME payments. For cost reporting periods beginning on or after October 1, 1997, a hospital's unweighted DGME FTE count could not exceed the hospital's unweighted FTE count for its most recent cost reporting period ending on or before December 31, 1996. In this regard, § 1395(h)(4)(F)(i) states:

> [F]or purposes of a cost reporting period beginning on or after October 1, 1997 . . . the total number of full-time equivalent residents before the application of the weighting factors (as determined under this paragraph) with respect to a hospital's approved medical residency training program in the fields of allopathic and osteopathic medicine *may not exceed* the number (or

[8] 42 U.S.C. § 1395(h).
[9] "Initial residency period" is defined in the statute as the minimum number of years required for Board eligibility. 42 U.S.C. § 1395ww(h)(5)(F).
[10] Pub. L. 105–33, § 4623, 111 Stat. 251, 477 (1997).

> 130 percent of such number in the case of a hospital located in a rural area) of such full-time equivalent residents for the hospital's most recent cost reporting period ending on or before December 31, 1996.[11]

Further, 42 U.S.C. § 1395ww(h)(4)(G)(i) provides that residents are counted on a three year average. Finally, 42 U.S.C. § 1395ww(h)(4)(A) directs the Secretary to "establish rules consistent with [§ 1395ww(h)(4)] for the computation of the number of full-time equivalent residents in an approved medical residency training program."

CMS implemented BBA § 4623, in part, by promulgating regulations at 42 C.F.R. § 413.86(g)(4) to implement the unweighted FTE cap.[12] Specifically, in the FY 1998 inpatient prospective payment system ("IPPS") final rule published on August 20, 1997 ("FY 1998 IPPS Final Rule"), CMS promulgated revisions to 42 C.F.R. § 413.86(g)(4) and included the following explanation in the preamble to that rule:

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

[11] 42 U.S.C. § 1395ww(h)(4)(F)(i) (emphasis added). Further, 42 U.S.C. § 1395ww(h)(4)(H) directs the Secretary to establish rules for determining the caps of hospitals that establish *new* programs after December 31, 1996.
[12] 62 Fed. Reg. 45966, 45967, 46004 (Aug. 29, 1997).

> two cost reporting periods equals 100/110. If the hospital's weighted FTE count is 100 FTE residents in the December 31, 1998 cost reporting period (that is, of the 110 unweighted residents, 20 are beyond the initial residency period and are weighted as 0.5 FTE), the hospital's weighted FTE count for determining direct GME payment is equal to (100/110) [x] 100, or 90.9 FTE residents. . . .
>
> *****
>
> We believe this ***proportional*** *reduction* in the hospital's unweighted FTE count is an equitable mechanism for implementing the statutory provision.[13]

Section 413.86(g)(4) remained unchanged until the FY 2002 IPPS final rule was published on August 1, 2001 ("FY 2002 IPPS Final Rule").[14] Therein, the Secretary modified the allowable FTEs formula so that the proportionate reduction to the weighted FTE count would be calculated separately for FTEs attributable to residents trained in primary care, obstetrics and gynecology programs and residents training in nonprimary care programs. In that final rule, the modified methodology, effective for cost report periods beginning on or after October 1, 2001 was:

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

[13] 62 Fed. Reg. at 46005 (emphasis added).
[14] 66 Fed. Reg. 39826 (Aug. 1, 2001).

> (FTE cap/unweighted total FTEs in the cost reporting period) × (weighted nonprimary care FTEs in the cost reporting period).
>
> Add the two products to determine the hospital's *reduced cap*.[15]

To codify this change, the Secretary added clause (iii) to § 413.86(g)(4). In the final rule published on the August 11, 2004, CMS relocated 42 C.F.R. § 413.86(g)(4)(iii) to 42 C.F.R. § 413.79(c)(2)(iii).[16] This regulation is the focus of these appeals and this EJR request, and it states the following:

> If the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 2001 exceeds the limit described in this section [*i.e.*, the FTE cap or limit], the hospital's weighted FTE count (before application of the limit) for primary care and obstetrics and gynecology residents and nonresidents, respectively, will be reduced in the same proportion that the number of FTE residents for that cost reporting period exceeds the number of FTE residents for the most recent cost reporting period ending on or before December 31, 1996.[17]

As previously noted, this regulation addresses how to reduce a hospital's weighted FTE count for a fiscal year when the unweighted FTE count for that fiscal year exceeds the hospital's unweighted FTE cap.

On their cost reports, hospitals report the number of allopathic and osteopathic FTE residents (before applying the weighting factors mentioned above) that were actually trained at the facility that year.[18] This information is used to determine whether the hospital exceeds its unweighted FTE cap.

In addition, the statute sets the number of FTEs a hospital can claim for reimbursement as the hospital's average FTE count between the present, prior and penultimate years. The statute states:

> [T]he total number of full-time equivalent residents for determining a hospital's graduate medical education payment shall equal the average of the actual full-time equivalent resident counts

[15] *Id.* at 39894 (emphasis added).
[16] *See* 69 Fed. Reg. 48916, 49258-64. As part of the relocation, CMS modified the language slightly by removing the references to "paragraph (g)" that were in the prior version of the regulation and replacing them with reference to "the limit described in this section."
[17] 42 C.F.R. § § 413.79(c)(2)(iii) (2011). The Secretary has not made any changes to § 413.79(c)(2)(iii) since the FY 2005 IPPS final rule.
[18] 77 Fed. Reg. 53258, 53423 (Aug. 31, 2012) (stating that when a hospital trains residents in excess of its cap, "it should report those FTE residents on its cost report regardless of whether or not it is training over its caps.")

> for the cost reporting period and the preceding two cost reporting periods.[19]

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

The Providers' Position

The Providers contend that the regulation, 42 C.F.R. § 413.79(c)(2)(iii), is contrary to the statute at 42 U.S.C. § 1395ww(h) for several reasons. First, the regulation creates a weight FTE cap. The Providers believe that the statute plainly requires the Secretary to determine the cap "before the application of weighting factors," which is an unweighted cap.[20] The Secretary instead determines a weighted FTE cap for the current year that is based on the ratio of the 1996 unweighted FTE count to the current year unweighted FTE count. The resulting equation, WFTE (UCap/UFTE) = WCAP, is applied to the weighted FTE count in the current year, which creates a second FTE cap that is an absolute limit on the number of FTEs that can go into the DGME payment calculation. This second cap is determined after the application of the weighting factors to fellows in the current year, which the Providers allege violates Congress' directive to determine the cap before the application of the weighting factors.

Second, the Secretary's weighted FTE cap prevents a hospital from ever reaching its 1996 unweighted FTE cap if it trains any fellows. The downward impact on the FTE count increases as a hospital trains more residents beyond the IRP.

Third, the Providers assert, the regulation imposes a weighting factor that reduces the FTE time by more the 0.5 contrary to the statute. In these cases, all of the Providers are over their FTE caps and train residents that are beyond the IRP and are prevented from reaching their full FTE caps due to the Secretary's regulation. The Providers suffered a downward payment adjustment that is greater than may be imposed by the statutory 0.5 weighting factor. By establishing the cap based on the hospital's unweighted FTE count for 1996, Congress entitled the Providers to claim FTEs up to that cap. The Providers contend that the regulation renders this impossible for these Providers simply because they trained residents who are beyond the IRP. The Providers assert that the regulation, 42 C.F.R. § 412.79(c)(2)(iii), is contrary to the statute, is arbitrary and capricious and is, therefore, invalid.

Decision of the Board

Pursuant to 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R.§ 405.1842(f)(1) (2017), the Board is required to grant an EJR request if it determines that: (i) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (ii) the Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute or to the substantive or procedural validity of a regulation or CMS Ruling.

---

[19] 42 U.S.C. § 1395ww(h)(4)(G)(i).
[20] 42 U.S.C. § 1395ww(h)(4)(F)(i).

A. Background on Appeals of Self-Disallowed Costs

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hosp. Ass'n v. Bowen* ("*Bethesda*").[21] In that case, the Supreme Court concluded that a cost report submitted in full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.[22]

On August 21, 2008, new regulations governing the Board were effective.[23] Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hosp. v. Burwell* ("*Banner*") before the D.C. District Court.[24] In *Banner*, the provider filed its cost report in accordance with the applicable outlier regulations and did not protest the additional outlier payment it was seeking. The provider's request for EJR was denied because the Board found that it lacked jurisdiction over the issue. The D.C. District Court concluded that, under *Bethesda*, the 2008 self-disallowance regulation could not be applied to appeals raising a legal challenge to a regulation or other policy that the Medicare Contractor could not address.[25]

The Secretary did not appeal the D.C. District Court's decision in *Banner* and instead decided to largely apply the holding to certain similar administrative appeals. Effective April 23, 2018, the CMS Administrator implemented CMS Ruling CMS-1727-R which involves dissatisfaction with the Medicare Contractor determinations for cost report periods ending on December 31, 2008 and which began before January 1, 2016, Under this Ruling, where the Board determines that the specific item under appeal was subject to a regulation or payment policy that bound the Medicare Contractor and left it with no authority or discretion to make payment in the manner sought by the provider on appeal, the protest requirements of 42 C.F.R. § 405.1835(a)(1)(ii) were no longer applicable. However, a provider could elect to self-disallow a specific item deemed non-allowable by filing the matter under protest.

---

[21] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).
[22] *Bethesda*, 108 S. Ct. at 1258-59.
[23] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[24] 201 F. Supp. 3d 131 (D.D.C. 2016).
[25] *Id.* at 142.

The Board finds that the Providers' appeals with cost report periods which began before January 1, 2016 are governed by CMS Ruling 1727-R. The Board has determined that, in the instant appeals and associated EJR request, the Providers' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal[26] and the appeals were timely filed.[27] Based on the above, the Board finds that it has jurisdiction over the above-captioned appeals. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount.

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

In Case Nos.19-2187G and 20-1315G, several Providers appealed from the Medicare Contractor's failure to time issue a final determination for cost reporting periods beginning on or after January 1, 2016.[28] Those providers would be subject to the regulations on the "substantive reimbursement requirement" for an appropriate cost report claim.[29] Specifically, effective January 1, 2016, the Secretary enacted both 42 C.F.R. §§ 413.24(j) and 405.1873. The regulation at § 413.24(j)(1) specifies that, in order to receive or potentially qualify for reimbursement for a specific item for its cost reporting period, a provider must include an appropriate claim on its cost report by either claiming the item in accordance with Medicare policy or self-disallow the specific item in the cost report if it believes it may not be allowable.[30]

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

The Board interprets the regulation at 42 C.F.R. § 405.1873 to only require the Board to review a provider's "compliance"[31] with the reimbursement requirement of an appropriate cost report claim for the specific item under appeal (and the supporting factual evidence and legal argument) ***if*** a party to the appeal questions whether there was an appropriate claim made.[32] As no party to

[26] *See* 42 C.F.R. § 405.1837(a)(3).
[27] *See* 42 C.F.R. § 405.1835(a)(d).
[28] *See* 42 C.F.R. § 405.1835(c) (2018).2z
[29] 42 C.F.R. § 413.24(j) (entitled "Substantive reimbursement requirement of an appropriate cost report claim"). *See also* 42 C.F.R. § 405.1873 (entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim").
[30] 42 C.F.R. § 413.24(j)(2) sets forth the procedures for self-disallowing a specific item on the cost report.
[31] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."
[32] *See* 42 C.F.R. § 405.1873(a).

the appeal has questioned, pursuant to § 405.1873(a), whether an appropriate claim was made,[33] the Board finds there was no regulatory obligation for the Board to affirmatively, on its own, review the appeal documents to determine whether an appropriate claim was made.[34] As a result, Board review under 42 C.F.R. § 405.1873(b) has not been triggered. Accordingly, the Board may proceed to rule on the EJR request pursuant to 42 C.F.R. § 405.1873(d).

C. Non-issuance of an NPR

Pursuant to 42 C.F.R. § 405.1835(c) a provider has the right to a hearing where:

> (1) A final contractor determination for the provider's cost reporting period is not issued (through no fault of the provider) within 12 months after the date of receipt by the contractor of the provider's perfected cost report or amended cost report (as specified in § 413.24(f) of this chapter). The date of receipt by the contractor of the provider's perfected cost report or amended cost report is presumed to be the date the contractor stamped "Received" on such cost report unless it is shown by a preponderance of the evidence that the contractor received the cost report on an earlier date.
>
> (2) 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 is no later than 180 days after the expiration of the 12 month period for issuance of the final contractor determination . . .

D. Board Jurisdiction

In summary, the Board has determined that the participants in Case Nos. 19-2187G and 20-1315G with cost report periods beginning on or after December 31, 2008 and ending before January 1, 2016 included in the instant EJR request are governed by CMS Ruling CMS-1727-R since they are challenging a regulations as described more fully below. Those Providers appealing under the provision of 42 C.F.R. § 405.1835(c), timely filed their appeals from the one year anniversary of the Medicare Contractors' receipt of their respective cost reports. In each of the cases, the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[35] The appeals were timely filed. Based on the

[33] The Board notes that Board Rule 10.2 states: "If the Medicare contractor opposes a provider's expedited judicial review request, . . . its response must be timely filed in accordance with Rules 42, 43, and 44."
[34] Although no question was raised in this appeal regarding whether an appropriate claim was made, the Board recognizes that the Providers' cost reports included a claim for the disputed DGME payment as a protested amount on its as-filed cost reports as evidenced by the documentation under Tab D for each Provider in the Providers' Schedule of Providers in both cases. The documentation included in both cases included Worksheet Es, protested amounts descriptions and workpapers demonstrating the DGME issue had been included as a protested amount for each of the Providers in the group with cost report period beginning on or after January 1, 2016.
[35] *See* 42 C.F.R. § 405.1837.

above, the Board finds that it has jurisdiction for the above-captioned appeals and the underlying participants. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

E. Board's Analysis of the Appealed Issue

The Providers assert that the regulation at 42 C.F.R. § 413.79(c)(2)(iii) penalizes hospitals which exceed their FTE caps because of the perceived disparate treatment between IRP residents (*i.e.*, residents in their initial training period) and fellows. The Providers assert that § 413.79(c)(2)(iii) states the following equation for calculating the weighted cap (*i.e.* "Allowable FTE Count") for a particular fiscal year ("FY") and that this equation results in the perceived disparate treatment between IRP residents and fellows. Specifically, the Providers present the following equation in their request for EJR used to calculate the allowable count for residents (*i.e.*, IRP residents and fellows) in primary care and obstetrics and gynecology programs and separately for residents (*i.e.*, IRP resents and fellows) in nonprimary care programs:

$$\textbf{\textit{Allowable FTE count}} = \frac{Unweighted\ \ FTE\ Cap}{Unweighted\ FTE\ Count} \times Weighted\ FTE\ Count$$ [36]

Accordingly, the Board set out to confirm the Providers' assertion that § 413.79(c)(2)(iii) does in fact set forth the above equation.

At the outset, the Board notes that, pursuant to the introductory phrase in § 413.79(c)(2)(iii) (*i.e.*, "[i]f the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 2001 exceeds the limit described in this section [*i.e.*, the FTE cap or limit]"), the above equation is used ***only*** when the "Unweighted FTE Count" for a FY exceeds the "Unweighted FTE Cap" in order to determine what the Providers describe as the "Allowable [weighted] FTE count" for the FY.[37] As such, the equation would logically appear to be a method used to translate the "Unweighted FTE Cap" into a *weighted* context where the "Allowable FTE count" for a FY is really a "weighted FTE cap" for the FY because it is ***only*** used when the unweighted FTE count exceeds the unweighted FTE cap. Indeed, the Board's description of the product of the equation as a "cap" is consistent with the Secretary's description of it as a "reduced cap" in the preamble to the FY 2002 IPPS Final Rule.[38] Accordingly, the Board will refer to the variable "Allowable FTE count" for the FY as the "Weighted FTE Cap" to facilitate the Board's discussion below on how the equation is conceptually set forth in the text of § 413.79(c)(2)(iii).

Bearing this concept in mind, the Board reviewed the regulation closely and agrees with the Providers that § 413.79(c)(2)(iii) essentially states the above equation, albeit in a slightly

[36] *See* Provider's EJR Request at 4.
[37] *See also* 62 Fed. Reg. at 46005 (describing the purpose of the regulation being adopted in the final rule as follows: "To address situations in which a hospital increases the number of FTE residents over the cap, notwithstanding the limit established under section 1886(h)(4)(F), we are establishing the following policy for determining the hospital's *weighted* direct GME FTE count for cost reporting periods beginning on or after October 1, 1997." (Emphasis added.)).
[38] 66 Fed. Reg. at 39894 (emphasis added).

different form where the difference is inconsequential and it gives the same results. In its entirety, § 413.79(c)(2)(iii) states:

> If the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 2001 exceeds the limit described in this section [*i.e.*, the FTE cap or limit], the hospital's weighted FTE count (before application of the limit) for primary care and obstetrics and gynecology residents and nonprimary care residents, respectively, *will be reduced* ***in the same proportion*** that the number of FTE residents for that cost reporting period exceeds the number of FTE residents for the most recent cost reporting period ending on or before December 31, 1996 [*i.e.*, the FTE cap or limit].[39]

At first blush, it would not appear that the equation is specifically stated in the regulation. However, once the regulation is unpacked around the words "in the same proportion," it is clear that the regulation is relying on ratios as the basis for the equation used to calculate the Weighted FTE Cap applicable for the fiscal year.[40] Indeed, CMS reiterates this in the preamble to the FY 1998 Final Rule by rationalizing § 413.79(c)(2)(iii) as follows: "We believe this ***proportional reduction*** in the hospital's unweighted FTE count is an equitable mechanism for implementing the statutory provision."[41] Essentially, the regulation is stating that the Weighted FTE Cap is to the FY's Weighted FTE Count as the Unweighted FTE Cap is to the FY's Unweighted FTE Count. The calculation of the Weighted FTE Cap is achieved through the operation of the following simple algebraic principle of equivalent fractions[42] (*i.e.*, ratios) using variables a, b, c, and d:

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

On first side of the initial algebraic equation (*i.e.*, the ratio of "a / b") is the following phrase: "the number of FTE residents for that cost reporting period exceeds [the FTE cap or limit]." This phrase (the ***Unweighted FTE Cap*** is to the ***FY's Unweighted FTE Count***) expressed as a ratio ("a/b") is the Unweighted FTE Cap over the FY's Unweighted FTE Count.[43]

---

[39] (Emphasis added.)

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

[41] *Id.* (emphasis added). *See also* 66 Fed. Reg. at 3984 ("[F]or primary care and obstetrics and gynecology residents and nonprimary care residents, respectively, will be reduced *in the same* ***proportion*** that the number of these FTE residents for that cost reporting period exceeds the unweighted FTE count in the cap. The ***proportional reduction*** is calculated *for primary care* ***and*** *obstetrics and gynecology residents and nonprimary care residents separately…."* (Emphasis added.)).

[42] Two alternative ways to express the algebraic principle of equivalent functions include:
If a/b = c/d, then c = (a x d) / b ; and
If a/b = c/d, then c = (a/b) x d.

[43] Note that, in using equivalent ratios, the key is the relationship of the ratios. As such, the relation between the ratios does not change if they are flipped. For example, if these ratios are flipped, then the initial equation becomes the FY's Weighted FTE Count (variable d) over the Weighted FTE Cap (variable c) equals the FY's Unweighted

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

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

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

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

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

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

Board's Decision Regarding the EJR Request

The Board finds that:

1) It has jurisdiction over the matter for the subject years and that the participants in these appeals are entitled to a hearing before the Board;

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

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

FTE Count (variable b) over the Unweighted FTE Cap (variable a). The unknown variable is still "c" and you would get the same results where rule would then be: If b/a = d/c, then c = (a/b) x d.

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

Accordingly, the Board finds that the question of the validity of 42 C.F.R. § 413.79(c)(2)(iii) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for EJR for the issue and the subject years. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in this case, the Board hereby closes the cases.

Board Members Participating

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

FOR THE BOARD:

10/20/2020

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: Clayton J. Nix -A

Enclosures: Schedules of Providers

cc: Bruce Snyder, Novitas Solutions
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Terri Roche
Director Reimbursement Analysis & Reporting
Ensign Service
29222 Ranch Viejo Road, Suite 127
San Juan Capistrano, CA 92675

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

Re: Downey Community Care LLC dba Brookfield Healthcare Center (05-6014)
FYE 12/31/2018, PRRB Case No. 21-0082

Dear Ms. Roche and Ms. Frewert:

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

Pertinent Facts:

Ensign Services (the "Representative") filed an appeal on October 8, 2020, on behalf of the Provider. The Representative submitted a single letter indicating that the Medicare Contractor would not accept the ". . . additional supporting documentation that became available while the auditor was finalizing their review." There was no support included with the appeal request.

Decision of the Board:

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

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

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

Attaching the actual determination being appealed to the appeal request is critical for a myriad of reasons, including to determine whether the Provider met the claim filing requirements specified in 42 C.F.R. § 405.1835. Because the Representative failed to submit the required copy of the final determination under appeal in the subject case, the Board finds that the Provider did not meet the regulatory requirements for filing an appeal before the Board. Accordingly, the Board finds dismissal is appropriate under § 405.1835(b) and Board Rules and hereby dismisses and closes Case No. 21-0082.

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

Board Members:
Clayton J. Nix, Esq.
Gregory H. Ziegler, CPA
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

For the Board:

10/20/2020

X Gregory H. Ziegler

Gregory H. Ziegler, CPA
Board Member
Signed by: Gregory H. Ziegler -S

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Chelsea Desrosiers
Chief Financial Officer
Cary Medical Center
163 Van Buren Road, Suite 1
Caribou, ME 04736

Pam VanArsdale
Appeals Lead (J-K)
National Government Services, Inc.
MP: INA 101-AF-42
P.O. Box 6474
Indianapolis, IN 46206-6474

Re: Cary Medical Center CY 2019 Sole Community Classification Group
PRRB Case No. 21-0102G
Participants: Cary Medical Center (20-0031) & Northern Light A.R. Gould (20-0018)

Dear Ms. Desrosiers and Ms. VanArsdale:

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

Pertinent Facts:

Cary Medical Center and Northern Light A.R. Gould (the "Providers") filed a "Joint Appeal for Sole Community Hospital Classification" on May 19, 2020. In the appeal request, the Providers indicate they are appealing the November 25, 2019 letter which indicates the request for Sole Community Hospital status, dated June 26, 2019, was denied based on the hospitals falling short of the 45 minute travel time between hospitals as required per 42 C.F.R. § 412.92(1)(3).

Although the group appeal included extensive support to document things like the mileage between hospitals, the environmental and climate conditions, transportation data, etc. to justify the failure to meet the 'travel time' requirement, the appeal request did not include copies of the Providers' final determinations. In addition, the appeal does not indicate the impact on the facilities by identifying a reimbursement impact.

Decision of the Board:

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

controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

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

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

Including the actual determinations being appealed with the appeal request is critical for a myriad of reasons, including to determine whether the Provider met the claim filing requirements specified in 42 C.F.R. § 405.1835. Because the Providers failed to submit the required copies of the final determinations under appeal in the subject group case, the Board finds that the Providers did not meet the regulatory requirements for filing an appeal before the Board. Further, the Providers did not provide support that the group appeal would meet the amount in controversy threshold as specified in 42 C.F.R. § 405.1837 and Board Rule 12. 2. Accordingly, the Board finds dismissal is appropriate under § 405.1835(b) and Board Rules and hereby dismisses and closes Case No. 21-0102G.

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

Board Members:
Clayton J. Nix, Esq.
Gregory H. Ziegler, CPA
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

For the Board:

10/27/2020

X Gregory H. Ziegler

Gregory H. Ziegler, CPA
Board Member
Signed by: Gregory H. Ziegler -S

cc: William Ford, Northern Light A.R. Gould
Wilson C. Leong, Esq., CPA, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Mail

E. Thomas Henefer, Esq.
Stevens & Lee
111 N. Sixth Street
P.O. Box 679
Reading, PA 19603

RE: ***EJR Determination***
George Washington University Hospital (Prov. No. 09-0001)
FYE 12/31/2016
Case No. 20-1129

Dear Mr. Henefer:

The Provider Reimbursement Review Board ("Board") has reviewed the Provider's June 12, 2020 request for expedited judicial review ("EJR") (received September 15, 2020[1]). On September 23, 2020, the Board requested the Representative determine if a common issue related party (CIRP) group was required for this Provider (42 C.F.R. § 405.1837(b)(1)(i)) as the Board had noted that the Provider was owned by Universal Health Services (UHS). This request for additional information affected the 30 day time period for responding to the EJR request.[2] The Provider responded on October 21, 2020 stating that UHS does not own any other hospitals that could file an appeal of the DGME issue. The decision of the Board with respect to EJR is set forth below.

Issue in Dispute:

The sole issue in the appeal is:

> . . . the validity of the formula contained in 42 C.F.R. § 413.79(c)(2)(iii) for calculating the number of full-time equivalents ("FTE") residents a hospital may count in a year for the purposes of direct graduate medical education ["DGME"] reimbursement. [The

[1] As explained in the Board's September 23, 2020 letter seeking additional information, although this EJR request was delivered to the Centers for Medicare & Medicaid Services mailroom on June 12, 2020, the Board did not receive the request in its office until September 15, 2020, because the Board and its staff have temporarily adjusted their operations as addressed in Board Alert 19. The Board was required to maximize telework and only recently gained very limited access to its office enabling the processing of mail. The Board has not resumed normal operations and is not able to process EJRs and associated jurisdictional documentation in the usual manner and establish jurisdiction. However, the Board is attempting to process EJR requests expeditiously and is still governed by the standards set forth in 42 C.F.R. § 405.1801(d)(2) when calculating the 30-day time period for issuing an EJR by excluding all days where the Board is not able to conduct its business in the usual manner.

[2] *See* 42 C.F.R. § 405.1842(b)(2), (e)(2)(ii) and (e)(3)(ii).

> Provider contends that the] formula is unlawful because it conflicts with the Medicare statute and is arbitrary and capricious because it penalizes hospital's that train "fellows" (*i.e.* residents who are not in their initial residency period) while operating in excess of the FYE caps.[3]

Background:

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

The Medicare statute prescribes a formula for computing annual DGME payments to hospitals. The statutory formula consists of three components:

1. The hospital's number of FTE residents, or "FTE count;"
2. The hospital's average cost per resident (*i.e.* the per resident amount or "PRA"); and
3. The hospital's patient load, which is the percentage of a hospital's inpatient treatment days attributable to Medicare Part A and Part C beneficiaries.[7]

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

The Medicare Statute

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

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

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

Pursuant to this statutory provision, FTEs attributable to residents who are training in their initial residency period[8] ("*IRP residents*") are weighted at 100 percent or 1.0 while FTEs attributable to residents who are not in their initial residency period (commonly referred to as "*fellows*") are weighted at 50 percent or 0.5. The sum of the weighted FTEs for IRP residents and fellows in a given year is known as a hospital's "weighted FTE count." For example, under this weighting assignment, a hospital that trained 10 IRPs and 10 fellows in a given year would have a weighted FTE count of 15.

On August 5, 1997, Congress enacted § 4623 of the Balanced Budget Act of 1997 ("BBA")[9] which added 42 U.S.C. § 1395ww(h)(4)(F) to establish a limit on the number of osteopathic and allopathic residents that a hospital can be included in its FTE count for DGME payments. For cost reporting periods beginning on or after October 1, 1997, a hospital's unweighted DGME FTE count could not exceed the hospital's unweighted FTE count for its most recent cost reporting period ending on or before December 31, 1996. In this regard, § 1395(h)(4)(F)(i) states:

> [F]or purposes of a cost reporting period beginning on or after October 1, 1997 . . . the total number of full-time equivalent residents before the application of the weighting factors (as determined under this paragraph) with respect to a hospital's approved medical residency training program in the fields of allopathic and osteopathic medicine *may not exceed* the number (or 130 percent of such number in the case of a hospital located in a rural area) of such full-time equivalent residents for the hospital's most recent cost reporting period ending on or before December 31, 1996.[10]

Further, 42 U.S.C. § 1395ww(h)(4)(G)(i) provides that residents are counted on a three year average. Finally, 42 U.S.C. § 1395ww(h)(4)(A) directs the Secretary to "establish rules consistent with [§ 1395ww(h)(4)] for the computation of the number of full-time equivalent residents in an approved medical residency training program."

CMS implemented BBA § 4623, in part, by promulgating regulations at 42 C.F.R. § 413.86(g)(4) to implement the unweighted FTE cap.[11] Specifically, in the FY 1998 inpatient prospective payment system ("IPPS") final rule published on August 20, 1997 ("FY 1998 IPPS Final Rule"), CMS promulgated revisions to 42 C.F.R. § 413.86(g)(4) and included the following explanation in the preamble to that rule:

> *To address situations in which a hospital increases the number of FTE residents* ***over*** *the cap*, notwithstanding the limit established

[8] "Initial residency period" is defined in the statute as the minimum number of years required for Board eligibility. 42 U.S.C. § 1395ww(h)(5)(F).
[9] Pub. L. 105–33, § 4623, 111 Stat. 251, 477 (1997).
[10] 42 U.S.C. § 1395ww(h)(4)(F)(i) (emphasis added). Further, 42 U.S.C. § 1395ww(h)(4)(H) directs the Secretary to establish rules for determining the caps of hospitals that establish new programs after December 31, 1996.
[11] 62 Fed. Reg. 45966, 45967, 46004 (Aug. 29, 1997).

> under section 1886(h)(4)(F), we are establishing the following policy for determining the hospital's weighted direct GME FTE count for cost reporting periods beginning on or after October 1, 1997.
>
> • *Determine the ratio of* the hospital's unweighted FTE count for residents in those specialties for the most recent cost reporting period ending on or before December 31, 1996, *to* the hospital's number of FTE residents without application of the cap for the cost reporting period at issue.
>
> •*Multiply the ratio determined above by* the weighted FTE count for those residents for the cost reporting period. Add the weighted count of residents in dentistry and podiatry to determine the weighted FTEs for the cost reporting period. This methodology should be used for purposes of determining payment for cost reporting periods beginning on or after October 1, 1997. . . .
>
> For example, if the hospital's FTE count of residents in its cost reporting period ending December 31, 1996 is 100 residents before application of the initial residency weighting factors and the hospital's number of residents for its December 31, 1990 cost reporting period is 110 FTE residents, the ratio of residents in the two cost reporting periods equals 100/110. If the hospital's weighted FTE count is 100 FTE residents in the December 31, 1998 cost reporting period (that is, of the 110 unweighted residents, 20 are beyond the initial residency period and are weighted as 0.5 FTE), the hospital's weighted FTE count for determining direct GME payment is equal to (100/110) [x] 100, or 90.9 FTE residents. . . .
>
> *****
>
> We believe this ***proportional*** *reduction* in the hospital's unweighted FTE count is an equitable mechanism for implementing the statutory provision.[12]

Section 413.86(g)(4) remained unchanged until the FY 2002 IPPS final rule published on August 1, 2001 ("FY 2002 IPPS Final Rule").[13] Therein, the Secretary modified the allowable FTEs formula so that the proportionate reduction to the weighted FTE count would be calculated separately for FTEs attributable to residents trained in primary care, obstetrics and gynecology programs and residents training in nonprimary care programs. In that final rule, the modified methodology, effective for cost report periods beginning on or after October 1, 2001 was:

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

> *Step 1.* Determine that the hospital's total unweighted FTE counts in the payment year cost reporting period and the prior two immediately preceding cost reporting periods for all residents in allopathic and osteopathic medicine do not exceed the hospital's FTE cap for these residents in accordance with § 413.86(g)(4). *If the hospital's total unweighted FTE count in a cost reporting period exceeds its cap,* the hospital's weighted FTE count, for primary care and obstetrics and gynecology residents and nonprimary care residents, respectively, will be reduced *in the same* ***proportion*** that the number of these FTE residents for that cost reporting period exceeds the unweighted FTE count in the cap. The ***proportional reduction*** is calculated *for primary care* ***and*** *obstetrics and gynecology residents and nonprimary care residents separately* in the following manner:
>
> > (FTE cap/unweighted total FTEs in the cost reporting period) × (weighted primary care and obstetrics and gynecology FTEs in the cost reporting period)
> >
> > plus
> >
> > (FTE cap/unweighted total FTEs in the cost reporting period) × (weighted nonprimary care FTEs in the cost reporting period).
>
> Add the two products to determine the hospital's reduced cap.[14]

To codify this change, the Secretary added clause (iii) to § 413.86(g)(4). In the final rule published on the August 11, 2004, CMS relocated 42 C.F.R. § 413.86(g)(4)(iii) to 42 C.F.R. § 413.79(c)(2)(iii).[15] This regulation is the focus of these appeals and this EJR request, and it states the following:

> If the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 2001 exceeds the limit described in this section [*i.e.*, the FTE cap or limit], the hospital's weighted FTE count (before application of the limit) for primary care and obstetrics and gynecology residents and nonresidents, respectively, will be reduced in the same proportion that the number of FTE residents for that cost reporting period exceeds the number of FTE

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

> residents for the most recent cost reporting period ending on or before December 31, 1996.[16]

As previously noted, this regulation addresses how to reduce a hospital's weighted FTE count for a fiscal year when the unweighted FTE count for that fiscal year exceeds the hospital's unweighted FTE cap.

On their cost reports, hospitals report the number of allopathic and osteopathic FTE residents (before applying the weighting factors mentioned above) that were actually trained at the facility that year.[17]

In addition, the statute sets the number of FTEs a hospital can claim for reimbursement as the hospital's average FTE count between the present, prior and penultimate years. The statute states:

> [T]he total number of full-time equivalent residents for determining a hospital's graduate medical education payment shall equal the average of the actual full-time equivalent resident counts for the cost reporting period and the preceding two cost reporting periods.[18]

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

The Provider's Position:

The Provider contends that the Secretary's regulation for calculating allowable FTEs in 42 C.F.R. § 413.79(c)(2)(iii) has no basis in the text of the statute that it purports to interpret. Moreover, the regulation produces absurd result. If a hospital is training residents in excess of its cap, and some of its residents are fellows, under the regulation each fellow that the hospital reports in excess of its cap will actually reduce its DGME reimbursement, otherwise known as "the fellow penalty." For these reasons, the Provider believes that the Secretary's regulation is arbitrary and capricious, in excess of statutory authority and should be held as unlawful by a reviewing court.

The Provider asserts that the regulation—as applied to hospitals that train fellows—conflicts with the Medicare statute which is designed to compensate hospitals based on their costs, including DGME costs. The regulation, the Provider argues, punishes hospitals which are above their cap and train fellows by ensuring that they do not receive reimbursement to which they are entitled under the statute.

---

[16] 42 C.F.R. §§ 413.79(c)(2)(iii) (2011). The Secretary has not made any changes to § 413.79(c)(2)(iii) since the FY 2005 IPPS final rule.
[17] 77 Fed. Reg. 53258, 53423 (Aug. 31, 2012) (stating that when a hospital trains residents in excess of its cap, "it should report those FTE residents on its cost report regardless of whether or not it is training over its caps.")
[18] 42 U.S.C. § 1395ww(h)(4)(G)(i).

The Provider believes that since the Board has jurisdiction over the appeal, but lacks the authority to grant the relief sought—(a) to find that the formula prescribed by 42 C.F.R. § 413.79(c)(2)(iii) is unlawful; and (b) to compel the Secretary to pay the Provider reimbursement that was withheld as a result of the regulation—EJR is appropriate.

Decision of the Board:

Pursuant to 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R.§ 405.1842(f)(1) (2017), the Board is required to grant an EJR request if it determines that: (i) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (ii) the Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute or to the substantive or procedural validity of a regulation or CMS Ruling.

The participant in this this EJR request has filed an appeal involving fiscal year 12/31/16.

A. Board review of compliance with the reimbursement requirement of an appropriate cost report claim pursuant to 42 C.F.R. § 405.1873

In Case No. 20-11129, the Provider appealed from the issuance of its NPR for the cost report period ending December 31, 2016. The appeal is subject to the regulations on the "substantive reimbursement requirement" for an appropriate cost report claim.[19] Specifically, effective January 1, 2016, the Secretary enacted both 42 C.F.R. §§ 413.24(j) and 405.1873. The regulation at § 413.24(j)(1) specifies that, in order to receive or potentially qualify for reimbursement for a specific item for its cost reporting period, a provider must include an appropriate claim on its cost report by either claiming the item in accordance with Medicare policy or self-disallow the specific item in the cost report if it believes it may not be allowable.[20]

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

The Board interprets the regulation at 42 C.F.R. § 405.1873 to only require the Board to review a provider's "compliance"[21] with the reimbursement requirement of an appropriate cost report

[19] 42 C.F.R. § 413.24(j) (entitled "Substantive reimbursement requirement of an appropriate cost report claim"). *See also* 42 C.F.R. § 405.1873 (entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim").
[20] 42 C.F.R. § 413.24(j)(2) sets forth the procedures for self-disallowing a specific item on the cost report.
[21] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."

claim for the specific item under appeal (and the supporting factual evidence and legal argument) ***if*** a party to the appeal questions whether there was an appropriate claim made.[22] As no party to the appeal has questioned, pursuant to § 405.1873(a), whether an appropriate claim was made,[23] the Board finds there was no regulatory obligation for the Board to affirmatively, on its own, review the appeal documents to determine whether an appropriate claim was made.[24] As a result, Board review under 42 C.F.R. § 405.1873(b) has not been triggered. Accordingly, the Board may proceed to rule on the EJR request pursuant to 42 C.F.R. § 405.1873(d).

B. Board Jurisdiction

The Board finds that the DGME reimbursement question is controlled by 42 C.F.R. § 413.79(c)(2)(iii) which is a regulation that left the Medicare Contractors without the authority to make the payment in the manner sought by the Provider in this case. Although, there has not been a challenge under 42 C.F.R. § 1873(b), the Board notes that the record contains evidence that the Provider protested its direct graduate medical education costs when it submitted its as-filed cost report to the Medicare Contractor. Consequently, the Board finds that it has jurisdiction over the Provider in this case. In addition, the participant's documentation shows that the estimated amount in controversy exceeds $10,000, as required for an individual appeal.[25] The appeal was timely filed. Based on the above, the Board finds that it has jurisdiction for the above-captioned appeal and the underlying provider. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount.

C. Board's Analysis of the Appealed Issue

The Provider asserts that the regulation at 42 C.F.R. § 413.79(c)(2)(iii) penalizes hospitals which exceed their FTE caps because of the perceived disparate treatment between residents in their initial training period and fellows. The Provider asserts that § 413.79(c)(2)(iii) states the following equation for calculating the weighted cap (*i.e.* "Allowable FTE Count") for a particular fiscal year ("FY") and that this formula results in the perceived disparate treatment between IRP residents and fellows. Specifically, the Provider presents the following equation in their request for EJR used to calculate the allowable count for primary care and obstetrics and gynecology residents and separately for nonprimary care residents:

$$\mathrm{WFTE}\left(\frac{\mathrm{UCap}}{\mathrm{UFTE}}\right) = \mathrm{WCap}\,[26]$$

[22] *See* 42 C.F.R. § 405.1873(a).
[23] The Board notes that Board Rule 10.2 states: "If the Medicare contractor opposes a provider's expedited judicial review request, . . . its response must be timely filed in accordance with Rules 42, 43, and 44."
[24] Although no question was raised in this appeal regarding whether an appropriate claim was made, the Board recognizes that the Provider's cost report included a claim for the disputed DGME payment as a protested amount on its as-filed cost reports as evidenced by the documentation in the record. This documentation included the Provider's description the DGME protested amount and workpapers demonstrating the DGME issue had been included as a protested amount.
[25] *See* 42 C.F.R. § 405.1835(a)(2).
[26] EJR Request at 4.

Accordingly, the Board set out to confirm the Provider's assertion that § 413.79(c)(2)(iii) does in fact set forth the above equation.

At the outset, the Board notes that, pursuant to the introductory phrase in § 413.79(c)(2)(iii) (*i.e.*, "[i]f the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 2001 exceeds the limit described in this section [*i.e.*, the FTE cap or limit]"), the above equation is used ***only*** when the "Unweighted FTE Count" for a FY exceeds the "Unweighted FTE Cap" in order to determine what the Providers describe as the "Allowable [weighted] FTE count" for the FY.[27] As such, the equation would logically appear to be a method used to translate the "Unweighted FTE Cap" into a *weighted* context where the "Allowable FTE count" for a FY is really a "weighted FTE cap" for the FY because it is ***only*** used when the unweighted FTE count exceeds the unweighted FTE cap. Indeed, the Board's description of the product of the equation as a "cap" is consistent with the Secretary's description of it as a "reduced cap" in the preamble to the FY 2002 IPPS Final Rule.[28] Accordingly, the Board will refer to the variable "Allowable FTE count" for the FY as the "Weighted FTE Cap" to facilitate the Board's discussion below on how the equation is conceptually set forth in the text of § 413.79(c)(2)(iii).

Bearing this concept in mind, the Board reviewed the regulation closely and agrees with the Providers that § 413.79(c)(2)(iii) essentially states the above equation, albeit in a slightly different form where the difference is inconsequential and it gives the same results. In its entirety, § 413.79(c)(2)(iii) states:

> If the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 2001 exceeds the limit described in this section [*i.e.*, the FTE cap or limit], the hospital's weighted FTE count (before application of the limit) for primary care and obstetrics and gynecology residents and nonprimary care residents, respectively, *will be reduced* ***in the same proportion*** that the number of FTE residents for that cost reporting period exceeds the number of FTE residents for the most recent cost reporting period ending on or before December 31, 1996 [*i.e.*, the FTE cap or limit].[29]

At first blush, it would not appear that the equation is specifically stated in the regulation. However, once the regulation is unpacked around the words "in the same proportion," it is clear that the regulation is relying on ratios as the basis for the equation used to calculate the Weighted FTE Cap applicable for the fiscal year.[30] Indeed, CMS reiterates this in

---

[27] *See also* 62 Fed. Reg. at 46005 (describing the purpose of the regulation being adopted in the final rule as follows: "To address situations in which a hospital increases the number of FTE residents over the cap, notwithstanding the limit established under section 1886(h)(4)(F), we are establishing the following policy for determining the hospital's *weighted* direct GME FTE count for cost reporting periods beginning on or after October 1, 1997." (Emphasis added.)).

[28] 66 Fed. Reg. at 39894 (emphasis added).

[29] (Emphasis added.)

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

the preamble to the FY 1998 Final Rule by rationalizing § 413.79(c)(2)(iii) as follows: "We believe this ***proportional reduction*** in the hospital's unweighted FTE count is an equitable mechanism for implementing the statutory provision."[31] Essentially, the regulation is stating that the Weighted FTE Cap is to the FY's Weighted FTE Count as the Unweighted FTE Cap is to the FY's Unweighted FTE Count. The calculation of the Weighted FTE Cap is achieved through the operation of the following simple algebraic principle of equivalent fractions[32] (*i.e.*, ratios) using variables a, b, c, and d:

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

On first side of the initial algebraic equation (*i.e.*, the ratio of "a / b") is the following phrase: "the number of FTE residents for that cost reporting period exceeds [the FTE cap or limit]." This phrase (the ***Unweighted FTE Cap*** is to the ***FY's Unweighted FTE Count***) expressed as a ratio ("a/b") is the Unweighted FTE Cap over the FY's Unweighted FTE Count.[33]

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

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

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

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

---

[31] *Id.* (emphasis added). *See also* 66 Fed. Reg. at 3984 ("[F]or primary care and obstetrics and gynecology residents and nonprimary care residents, respectively, will be reduced *in the same* ***proportion*** that the number of these FTE residents for that cost reporting period exceeds the unweighted FTE count in the cap. The ***proportional reduction*** is calculated *for primary care* ***and*** *obstetrics and gynecology residents and nonprimary care residents separately…."* (Emphasis added.)).

[32] Two alternative ways to express the algebraic principle of equivalent functions include:
If a/b = c/d, then c = (a x d) / b ; and
If a/b = c/d, then c = (a/b) x d.

[33] Note that, in using equivalent ratios, the key is the relationship of the ratios. As such, the relation between the ratios does not change if they are flipped. For example, if these ratios are flipped, then the initial equation becomes the FY's Weighted FTE Count (variable d) over the Weighted FTE Cap (variable c) equals the FY's Unweighted FTE Count (variable b) over the Unweighted FTE Cap (variable a). The unknown variable is still "c" and you would get the same results where rule would then be: If b/a = d/c, then c = (a/b) x d.

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

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

D. Board's Decision Regarding the EJR Request

The Board finds that:

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

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

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

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

Accordingly, the Board finds that the question of the validity of 42 C.F.R. § 413.79(c)(2)(iii) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Provider's request for EJR for the issue and the subject year. The Provider has 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in this case, the Board hereby closes the case.

Board Members Participating:

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

For the Board:

10/29/2020

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: Clayton J. Nix -A

cc: Bruce Snyder, Novitas
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Byron Lamprecht
WPS Government Health Adm's (J-8)
2525 N 117th Avenue, Suite 200
Omaha, NE 68164

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

RE: ***Jurisdictional Decision***
Participant: Brooks Memorial Hospital (Prov. No. 33-0229; FYE 12/31/1999)
Case No. 13-0261G

Dear Mr. Lamprecht and Ms. Webster:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the documents in the above-referenced optional group appeal. The Board's jurisdictional decision is set forth below regarding one of the participants: Participant No. 6, Brooks Memorial Hospital.

BACKGROUND:

Brooks Memorial Hospital ("Provider") was issued a revised Notice of Program Reimbursement ("NPR") on May 11, 2004 for fiscal year end ("FYE") 12/31/1999. Via letter dated October 14, 2004, the Provider was added to Case No. 04-0728G entitled "National 1999 DSH Dual Eligible Group."

On March 11, 2013, the Board bifurcated the Medicare Part C Days issue in Case No. 04-0728G to a new group appeal. This was due to the issue statement in Case No. 04-0728G identifying Dual Eligible Days as well as Medicare Part C Days. This new group appeal was assigned Case No. 13-0261GC and entitled "National 1999 Medicare Part C Days CIRP Group."

BOARD'S DECISION:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2016), a provider has a right to a hearing before the Board with respect to specific items 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 Brooks Memorial Hospital and therefore dismisses this Provider from Case No. 13-0261G. The Provider appealed from a revised NPR that did not adjust Medicare Part C Days, nor did it adjust the Medicare Fraction of the Disproportionate Share Hospital payment adjustment.

The Code of Federal Regulations provides for an opportunity for a revised NPR. 42 C.F.R. § 405.1885 (2004) provides in relevant part:

> (a) A determination of an intermediary, . . . or a decision of the Secretary may be reopened with respect to findings on matters at issue in such determination or decision, by such intermediary officer . . . , or Secretary, as the case may be, either on motion of such intermediary officer . . . , or Secretary, or on the motion of the provider affected by such determination or decision to revise any matter in issue at any such proceedings. Any such request to reopen must be made within 3 years of the date of the notice of the intermediary. . . decision, or where there has been no such decision, any such request to reopen must be made within 3 years of the date of notice of the intermediary determination. No such determination or decision may be reopened after such 3-year period except as provided in paragraphs (d) and (e) of this section.

42 C.F.R. § 405.1889 (2004) explains the effect of a cost report revision:

> Where a revision is made in a determination or decision on the amount of program reimbursement after such determination or decision has been reopened as provided in §405.1885, such revision shall be considered *a separate and distinct determination* or decision to which the provisions of §§405.1811, 405.1835, 405.1875 and 405.1877 are applicable. (See §405.1801(c) for applicable effective dates.)

Thus, a revised NPR is "a separate and distinct determination" and the Board's jurisdiction over a revised NPR is limited to the specific issues revised on reopening.

In this case the Provider's NPR was issued in order to update Medicaid Eligible days, as well as DSH and capital payments due to a change in the DSH Medicaid ratio. There is nothing in the record to establish that Medicare Part C Days or the DSH Medicare fraction were revised. Accordingly, the Board finds that, pursuant to 42 C.F.R. § 405.1889 (2004), it does not have jurisdiction over the Medicare Part C Days issue for Brooks Memorial Hospital. In this regard, the Board notes that Courts have upheld the Board's application of provider's limited appeal rights under 42 C.F.R. § 405.1889.[1] Based on this finding, the Board hereby dismisses Provider No. 6, Brooks Memorial Hospital (Prov. No. 33-0229) from Case No. 13-0261G.

[1] *See, e.g., 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). *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).

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

Board Members Participating:

Clayton J. Nix, Esq.
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

For the Board:

10/29/2020

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: Clayton J. Nix -A

cc: Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Dylan Chinea
Toyon Associates, Inc.
1800 Sutter Street
Suite 600
Concord, CA 94520-2546

Lorraine Frewert
Noridian Healthcare Solutions
c/o Cahaba Safeguard Administrators
P.O. Box 6782
Fargo, ND 58108-6782

RE: ***Jurisdictional Determination***
Participant: Mission Hospital Reg'l Med. Center (Prov. No. 05-0567, FYE 06/30/09)
Toyon Assocs. CY 2008-2009 Inclusion of Medicare Part C Days in SSI Ratio #4 Grp.
Case No. 20-1262G

Dear Mr. Chinea and Ms. Frewert,

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Schedule of Providers and associated jurisdictional documents in the above-referenced optional group appeal. The Board finds that it lacks jurisdiction over Participant No. 1, Mission Hospital Regional Medical Center ("Mission") with Prov. No. 05-0567 and the fiscal year ending ("FYE") June 30, 2009 because Mission appealed from a revised Notice of Program Reimbursement ("NPR") that did not specifically adjust the Part C Days Supplemental Security Income ("SSI") Percentage issue.

Background

On February 12, 2019, the Medicare Contractor issued a revised NPR to Provider 1, Mission Hospital Regional Medical Center, Prov. No. 05-0567, for the cost reporting ending June 30, 2009. On August 8, 2019, Mission filed an appeal of the revised NPR challenging (among other issues) the Part C Days in the SSI Percentage issue. The Board assigned Case No. 19-2372 to the appeal. On February 25, 2020, Mission requested to transfer the Part C Days SSI Percentage issue from its individual appeal, Case No. 19-2372, to the current group appeal, Case No. 20-1262G.

Decision of the Board

The Code of Federal Regulations provides for an opportunity for a revised NPR. 42 C.F.R. § 405.1885(a)(1) (2019) 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)) 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 (as described in paragraph (c) of this section).

42 C.F.R. § 405.1889 (2019) 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. § 405.1887(d) (2019) provides additional guidance. It states:

> (d) A reopening by itself does not extend appeal rights. Any matter that is reconsidered during the course of a reopening, but is not revised, is not within the proper scope of an appeal of a revised determination or decision . . . .

Finally, Finally, 42 C.F.R. § 405.1835(a)(1) provides:

> 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)).

In the instant case, in a letter dated August 25, 2014 addressed to the Medicare Contractor, Mission requested to have CMS recalculate its SSI percentage based on its cost reporting year rather than the federal fiscal year pursuant to 42 C.F.R. §412.106(b)(3). On September 10, 2014, the Medicare Contractor forwarded Mission's request to CMS. In a Notice of Reopening of Cost Report dated December 8, 2016, the Medicare Contractor advised Mission:

> [i]n accordance with this regulation and your request of 8/25/14 we are hereby reopening the above referenced cost report.
>
> The cost report is 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 disproportionate share adjustment *based on 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[1]

On February 12, 2019,[2] the Medicare Contractor issued a revised NPR to Mission with the following relevant adjustments: Adj. No. 1, "[t]o include the SSI as calculated by CMS and to revise the DSH percentage for proper calculation of the DSH adjustment payment" on Worksheet E, Part A, Title XVIII, Line 4.00 and Line 4.03 and Adj. No. 4, "[t]o include the SSI as calculated by CMS and to revise the DSH percentage for proper calculation of the DSH adjustment payment" on Worksheet L, Part I, Title XVIII, Line 5.00.

The regulations at 42 C.F.R. §§ 405.1887 and 405.1889 makes it clear that only those matters that are specifically revised in a revised determination are within the scope of any appeal of the revised determination. Any matter that is not specifically revised may not be considered in any appeal of the revised determination. In the instant appeal, the Medicare Contractor made an adjustment to the SSI Percentage (Adj. Nos. 1, 4) in the revised NPR based on Mission's request to recalculate its SSI Percentage from the federal fiscal year to its cost reporting year (SSI Percentage realignment) and did not adjust any of the monthly data underlying the SSI percentages (*i.e.*, there is no change in or revision to Part C days since the underlying monthly data remains the same).[3] In other words, the determinations were only being reopened to include realigned SSI percentage.

---

[1] (Emphasis added.)
[2] The Provider's original NPR was issued on 05/13/13.
[3] CMS does not utilize a new or different data match process when it issues a realigned SSI percentage. CMS describes the matching process that it uses as part of the FY 2011 IPPS final rule published on August 16, 2010. *See*

Since the only matters specifically revised in the RNPRs were adjustments related to realigning the SSI percentage from the federal fiscal year to the provider fiscal year, the Board finds that, pursuant to 42 C.F.R. §§ 405.1835(a)(1) and 405.1889(b), Participant No. 1, , Mission Hospital Regional Medical Center, does not have the right to appeal the Part C Days issue from the revised NPR and, as such, the Board does not have jurisdiction over this participant. Accordingly, the Board hereby dismisses Provider 1, Mission Hospital Regional Medical Center (Prov. No. 05-0567, FYE 06/30/09) from Case No. 20-1262G.

It has also come to the Board's attention that Mission was also a participant in the common issue related party ("CIRP") group under Case No. 14-3483GC for the St. Joseph Health System ("SJHS") for the ***same*** Part C Days issue and the ***same*** fiscal year and that the Board granted expedited judicial review ("EJR") for Case No. 14-3483GC on October 18, 2018.[4] Thus, it is clear that the Board also has two alternative separate and distinct bases upon which to dismiss Mission from this optional group (*i.e.*, Case No. 20-1262G). First, as noted in Board Rule 4.6.2, "[a]ppeals of the ***same*** issue from distinct determinations must be pursued in a single appeal."[5] Second, it is clear that Mission's ability to pursue this issue for 2009 was extinguished when the Board closed Case No. 14-3483GC on October 18, 2018 because: (1) Mission was part of the SJHS health care chain during 2009 which had a CIRP group established for the Part C issue under Case No. 14-3493GC; and (2) the Group Representative certified that Case No. 14-3483GC was complete and requested EJR and the Board granted EJR on October 18, 2018.[6] ***Accordingly, the Board admonishes the Group Representative for its improper inclusion of Mission as part of this optional group appeal.***

75 Fed. Reg. 50042, 50275-85 (Aug. 16, 2010). All of the underlying data which is gathered on a month-by-month basis remains the same and the realigned SSI percentage simply reflects a different 12-month time period being used. *See* 42 C.F.R. § 412.106(b)(2) (noting that CMS gathers data on a month-by-month basis). The realignment solely takes the SSI data for each provider and the total Medicare days for each provider (previously accumulated on a month-by-month basis and used in the original CMS published SSI percentages) and reports it on the provider's cost reporting period instead of the September 30 FFY. *See also* 75 Fed. Reg. 50042, 50279 (Aug. 16, 2010) (stating: "The SSI fractions are generally based on the Federal fiscal year; however, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived from the data match process for the two Federal fiscal years that spanned the hospital's cost reporting period.); 70 Fed. Reg. 47278, 47439 (Aug. 12, 2005) (stating: "Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period, and *the hospital **must accept** the resulting DSH percentage for that year, whether or not it is a more favorable number than the DSH percentage based on the Federal fiscal year*." (emphasis added)).

[4] Specifically, Mission appealed the same issue from its May 13, 2013 original NPR (Case No. 14-0524, issue 6) for the same FYE and transferred the issue to Case No. 14-3483GC which was granted expedited judicial review on October 18, 2018.

[5] (Emphasis added.)

[6] The Board further notes that these actions all occurred prior to CMS Ruling CMS-1739-R.

The case will remain open as there are two other Providers in the appeal. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877 upon final disposition of the appeal.

Board Members

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

FOR THE BOARD

10/30/2020

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: Clayton J. Nix -A

Enclosure: Case No. 20-1262G Schedule of Providers

cc: Wilson Leong, Federal Specialized Services

Schedule of Providers

Case Number: 20-1262G
Case Name: Toyon Associates CY 2008 - 2009 Inclusion of Medicare Part C Days in SSI Ratio #4 Group
Appealed Period: CY
Period End: 12/31/2009

Organization #	Organization Name	Cost Reporting Period Affected	Addnl. Cost Reporting Period Affected	MAC Code	Determination Type	Final Determination Date	Issue Submission Date	# of Days	Audit Adjustment Number	Controversy Amount	Provider Status	Fiscal Year End	Provider Source	Transfer From - Case Number	Date GCP Added/ Transferred
[redacted]	Mission Hospital Regional Medical Center (05-0567)			J-E	Revised NPR	02/12/2019	08/08/2019	177	1, 4	5203	Active	06/30/2009	Transferred	19-2372	02/25/2020
05-0334	Salinas Valley Memorial Hospital (05-0334)			J-E	Notice of Program Reimbursement (NPR)	03/11/2013	01/17/2020	2503	32	601000	Active	06/30/2009	Transferred	13-3480	02/25/2020
05-0334	Salinas Valley Memorial Hospital (05-0334)			J-E	Notice of Program Reimbursement (NPR)	10/12/2012	01/21/2020	2657	14, 17, 24	25768	Active	06/30/2008	Transferred	13-1047	02/25/2020

Provider 1, Mission Hospital Regional Medical Center, Dismissed

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

Lorraine Frewert, Appeals Coordinator
Noridian Healthcare Solutions
c/o Cahaba Safeguard Administrators (J-E)
P.O. Box 6782
Fargo, ND 58108-6782

RE: ***Jurisdictional Decision***
Rideout Memorial Hospital (05-0133)
FYE 06/30/2010
Case No. 18-1272

Dear Ms. Giberti and Ms. Frewert,

The Provider Reimbursement Review Board ("Board") has reviewed the above-captioned appeal in response to the Representative's September 14, 2020 request for the transfer of the Medicare Part C- SSI Ratio issue to an optional group, Case No. 20-1262G. The pertinent facts and the Board's jurisdictional determination are set forth below.

Background

On March 15, 2013, the Provider requested ". . . a recalculation of its Hospital SSI ratio for purposes of aligning it with the Hospital's fiscal year ended FYE 6/30/2010." The request for recalculation was forwarded to CMS on April 10, 2013.

The Medicare Contractor issued a Notice of Reopening on June 2, 2017. The cost report was reopened:

- 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 the SSI ratio used to calculate the Provider's Disproportionate Share Adjustment based on 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 the SSI ratio.

On November 8, 2017, the Medicare Contractor issued a Proposed Adjustment Report based on the reopening and issued the revised Notice of Program Reimbursement ("RNPR") on November 15, 2017.

Toyon Associates, Inc. ("Toyon") filed an individual appeal of the RNPR with the Board on May 14, 2018. The appeal included two issues: Medicare Disproportionate Share (DSH) Payments – Accuracy of CMS Developed SSI Ratio (SSI Ratio) **and** Medicare Disproportionate Share (DSH) Payments – Inclusion of Medicare Part C Days in the SSI Ratio (Part C Days).

According to the Board's records, the SSI Ratio issue (which addressed data accuracy and Section 951 of the MMA) was previously transferred to the "Toyon 2010 Accuracy of CMS Developed SSI Ratio Group," Case No. 17-1639G, on August 7, 2018. The Medicare Contractor challenged jurisdiction of Rideout Memorial Hospital as a participant in Case No. 17-1639G on July 29, 2019, because it contends the issue was not adjusted in the Realignment RNPR.

On September 14, 2020, Toyon requested the transfer of the sole remaining issue in the individual appeal (Part C days) to the "Toyon Associates CY 2008 - 2009 Inclusion of Medicare Part C Days in SSI Ratio #4 Group," Case No. 20-1262G. The transfer of Rideout Memorial Hospital would require the optional group to be expanded to include FYE 2010.

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.

Relevant Regulations – RNPRs

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

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

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

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

Finally, 42 C.F.R. § 405.1835(a)(1) provides:

> 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)).

The Board finds that it does not have jurisdiction over either the SSI Ratio Accuracy issue **or** the Part C Days issue in this individual appeal which was filed from an RNPR.

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[.]"[1] 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 adjustments associated with 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 and did not adjust any of the monthly data underlying the SSI percentages (*i.e.*, there is no change in or revision to Part C days or other aspects of the monthly data since the underlying monthly data remains the same).[2] The Notice of

[1] 42 C.F.R. § 405.1889(b)(1).

[2] CMS does not utilize a new or different data match process when it issues a realigned SSI percentage. CMS describes the matching process that it uses as part of the FY 2011 IPPS final rule published on August 16, 2010. *See* 75 Fed. Reg. 50042, 50275-85 (Aug. 16, 2010). All of the underlying data which is gathered on a month-by-month basis remains the same and the realigned SSI percentage simply reflects a different 12-month time period being used. *See* 42 C.F.R. § 412.106(b)(2) (noting that CMS gathers data on a month-by-month basis). The realignment solely takes the SSI data for each provider and the total Medicare days for each provider (previously accumulated on a month-by-month basis and used in the original CMS published SSI percentages) and reports it on the provider's cost reporting period instead of the September 30 FFY. *See also* 75 Fed. Reg. 50042, 50279 (Aug. 16, 2010) (stating: "The SSI fractions are generally based on the Federal fiscal year; however, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived from the data match process for the two Federal fiscal years that spanned the hospital's cost reporting period.); 70 Fed. Reg. 47278, 47439 (Aug. 12,

Reopening explicitly stated that the purpose of the reopening was "[t]o adjust the SSI ratio used to calculate the Provider's Disproportionate Share Adjustment based on 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 the SSI ratio." In other words, the determination was only being reopened to include the realigned SSI percentage. Since the only matters specifically revised in the RNPR were adjustments related to realigning the SSI percentage from the federal fiscal year to the provider fiscal year, the Board does not have jurisdiction over either issue in the subject individual appeal pursuant to 42 C.F.R. §§ 405.1835(a)(1) and 405.1889(b). The Board notes that Courts have upheld the Board's application of provider's limited appeal rights under 42 C.F.R. § 405.1889(b).[3]

Conclusion

In conclusion, the Board dismisses both the SSI Ratio Accuracy ***and*** Part C Days issues from Case No. 18-1272 because, pursuant to 42 C.F.R. §§ 405.1835(a)(1) and 405.1889(b), the Provider does not have the right to appeal the RNPR at issue for these issues. Further, the Board denies the Provider's previous transfer of the SSI Ratio Accuracy issue to Case No. 17-1639G and denies the current request to transfer (and expand) the Part C Days issue to Case No. 20-1262G. The Board notes that Toyon serves as Representative in this case and Case No. 17-1639G and, due to the transfer denial, the Board instructs Toyon to not to include Rideout on the Schedule of Providers for Case No. 17-1639G. As there are no remaining issues in the individual appeal, the Board hereby closes Case No. 18-1272 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.
Susan A. Turner, Esq.

For the Board:

10/30/2020

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: Clayton J. Nix -A

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

2005) (stating: "Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period, and *the hospital **must accept** the resulting DSH percentage for that year, whether or not it is a more favorable number than the DSH percentage based on the Federal fiscal year*." (emphasis added)).

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Wade H. Jaeger
Sutter Health
P.O. Box 619092
Roseville, CA 95661

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

RE: ***Jurisdictional Decision***
15-0420GC Sutter Health 2008 DSH – SSI Ratio Realignment CIRP Group
16-2310GC Sutter Health 2009 DSH – SSI Realignment Ratio CIRP Group
18-0141GC Sutter Health 2012 DSH SSI Ratio Realignment CIRP Group
18-0733GC Sutter Health 2013 DSH SSI Ratio Realignment CIRP Group
18-0883GC Sutter Health 2014 DSH – SSI Realignment CIRP Group
19-2047GC Sutter Health CY 2015 DHS SSI Ratio Realignment

Dear Mr. Jaeger and Ms. Frewert:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above referenced common issue related party ("CIRP") group appeals on its own motion. The Board's decision is set forth below.

Background:

Sutter Health has filed numerous CIRP group appeals relating to the SSI Realignment issue. Many of these CIRP groups have a related CIRP group appeal of the SSI Accuracy Ratio issue for the same Providers and fiscal year ends ("FYEs"). There are six (6) CIRP group appeals for the SSI Realignment issue which are the subject of the Board's decision.

All six CIRP group cases were filed with matching SSI Accuracy CIRP group appeals that were filed at the same time as the SSI Realignment appeals:

15-0420GC	**Sutter Health 2008 DSH – SSI Ratio Realignment CIRP Group**
15-0327GC	Sutter Health 2008 DSH – SSI Ratio Inaccurate Data CIRP Group
16-2310GC	**Sutter Health 2009 DSH – SSI Realignment Ratio CIRP Group**
16-2038GC	Sutter 2009 DSH – SSI Ratio Inaccurate Data CIRP Group
18-0141GC	**Sutter Health 2012 DSH SSI Ratio Realignment CIRP Group**
18-0294GC	Sutter 2012 DSH SSI Ratio Accurate Data CIRP Group
18-0290GC	Sutter Health 2012 DSH SSI ratio Part A Data CIRP Group

18-0733GC	**Sutter Health 2013 DSH SSI Ratio Realignment CIRP Group**
18-0719GC	Sutter Health 2013 DSH SSI Ratio Part A Data CIRP Group
18-0735GC	Sutter Health 2013 DSH SSI Ratio Accurate Data CIRP Group
18-0883GC	**Sutter Health 2014 DSH – SSI Realignment CIRP Group**
18-0891GC	Sutter Health 2014 DSH – SSI Ratio Part
19-2047GC	**Sutter Health CY 2015 DSH SSI Ratio Realignment CIRP Group**
19-2051GC	Sutter Health CY 2015 DSH SSI Accurate Data CIRP Group

The issue statements for each of the six SSI Realignment CIRP groups make similar arguments, for example:

> **19-2047GC (SSI Realignment Appeal)**:
>
> The Provider disputes the SSI percentage developed by CMS and utilized by the MAC in their updated calculation of Medicare DSH payment and low income patient (LIP) payment for Inpatient Rehabilitation Facilities, if applicable. On May 3, 2010 CMS published CMS Ruling 1498-R pertaining to three Medicare DSH issues, one of which requires the inclusion of Medicare Part A non-covered days (such as exhausted benefit days and Medicare secondary payer days) in the SSI ratio of the Medicare DSH and LIP payment calculations.
>
> The Provider specifically contends that the SSI percentage as generated by the Social Security Administration (SSA) and put forth by CMS is understated. The Intermediary Manual Part 3 (CMS Pub. 13-3), section 3610.15, instructs the Intermediaries to only accept the SSI Percentage supplied to them by CMS in the DSH calculation. This policy precludes the Provider from using its own internally generated SSI percentage and the Provider maintains that it validly self-disallowed such an internally generated percentage in favor of that promulgated by CMS.

Similarly, the issue statements for the corresponding SSI Accuracy Group appeals make similar arguments, for example:

> **19-2051GC issue statement reads, in part (SSI Accuracy Appeal):**
>
> The Provider disputes the SSI percentage developed by CMS and utilized by the MAC in their updated calculation of Medicare DSH payment and low income patient (LIP) payment for Inpatient Rehabilitation Facilities, if applicable. On May 3, 2010 CMS published CMS Ruling 1498-R pertaining to three Medicare DSH issues, one of which requires the inclusion of Medicare Part A non-

covered days (such as exhausted benefit days and Medicare secondary payer days) in the SSI ratio of the Medicare DSH and LIP payment calculations.

The Provider specifically contends that the SSI percentage as generated by the Social Security Administration (SSA) and put forth by CMS is understated because the best data available was not used. It is critical this data be accurate but the inaccuracies and inconsistencies are having a critical negative impact on Medicare DSH reimbursement. Numerous errors have been identified including:

- Unidentified Medicare beneficiaries who have exhausted their Part-A coverage
- Varied treatment of Medicare beneficiaries who are covered under Medicare Part-C
- Medicare Part-A beneficiaries in the SSI Percentage who are not included on the Medicare PS&R
- Medicare beneficiaries who are receiving SSI benefits but are not treat as such in the SSI percentage
- The use of incorrect health insurance claim numbers for matching SSI recipients
- The total Medicare days reported in the denominator of the SSI ratio are often under reported

Jurisdictional Challenge:

A Jurisdictional Challenge dated July 17, 2019 was filed for Case No. 19-2047GC. The Medicare Contractor challenged the Board's jurisdiction over the SSI Realignment issue arguing it is premature as none of the Providers in the group have requested their SSI percentages be recalculated from the federal fiscal year end to their own cost reporting period/fiscal year ends. The Medicare Contractor's position is that it made no adjustment to the cost report related to SSI percentage realignment, and therefore it has not made a final determination with respect to the providers for the issue appealed as required under 42 C.F.R. § 405.1835.

Board Analysis and Decision:

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

The Board finds that it does not have jurisdiction over the SSI Realignment issue in Case Nos. 19-2047GC, 18-0883GC, 18-0733GC, 18-0141GC, 16-2310GC, and 15-0420GC because there

is no final determination from which the Providers are appealing and the underlying issue that would give rise to a potential future request for realignment is duplicative of the issue being pursued in the SSI Accuracy groups. Under 42 C.F.R. § 412.106(b)(3) a hospital can, if it prefers, use its cost reporting period (fiscal year end) data instead of the federal fiscal year end data in determining the DSH Medicare fraction. The decision to use its own cost reporting period is the hospitals alone, which then must submit a written request to the Medicare Contractor. Without these requests it is not possible for the Medicare Contractor to have issued a final determination from which any of the Providers could appeal. Furthermore, even if a Provider had requested a realignment from the Federal Fiscal Year to its cost reporting year, 42 C.F.R. § 412.106(b)(3) makes clear that the Provider must use the data from its cost reporting year; there is no appeal right that stems from a realignment.[1]

Additionally, the Board finds that the SSI Realignment is otherwise duplicative of the SSI Accuracy Group appeals.[2] This is a violation of PRRB Rules which provide, "A Provider may not appeal an issue from a final determination in more than one appeal."[3]

All six of the SSI Realignment groups and the corresponding SSI Accuracy groups raise the issue that the SSI percentage as generated by the SSA and put forth by CMS is understated. Therefore, having two group appeals that make the same argument related to the SSI ratio is duplicative in violation of Board Rule 4.5 (Mar. 1, 2013 and July 1, 2015) and Board Rule 4.6 (Aug. 29, 2018). The Providers are ultimately seeking the same remedy from the two types of appeals – they want access to the underlying data so that they can determine that their ratios are understated and can therefore receive a new SSI ratio and, in the six cases at issue in this determination, potentially request a realignment.

---

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

[2] Although the SSI Accuracy group appeal issue statements offer additional arguments, the SSI Realignment group appeal issue statements include, in part, the same exact arguments.

[3] PRRB Rule 4.5 (March 1, 2013 and July 1, 2015 Versions); and PRRB Rule 4.6 (August 29, 2018).

Conclusion:

The Board finds that it does not have jurisdiction over the group issue in the SSI Realignment Groups because there is no final determination from which the Providers can appeal and the remaining underlying issue that would give rise to a potential realignment request is duplicative of those issues in the SSI Accuracy Groups. Accordingly, the Board closes Case Nos. 19-2047GC, 18-0883GC, 18-0733GC, 18-0141GC, 16-2310GC, and 15-0420GC and removes them from the Board's docket.

Board Members Participating:

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

For the Board:

10/30/2020

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: Clayton J. Nix -A

cc: Wilson Leong, FSS