DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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Quality Reimbursement Services, Inc.
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Lucie Greene
Quorum Health
1573 Mallory Lane, Suite 100
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RE: ***Board Decision***
McKenzie-Willamette Medical Center (Provider Number 38-0020)
FYE: 12/31/2017
Case Number: 21-0718

Dear Mr. Ravindran and Ms. Greene:

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the documentation in Case Number 21-0718 pursuant to a jurisdictional challenge filed by the Medicare Administrative Contractor ("MAC"). The Board's decision is set forth below.

Background

A. *Procedural History for Case No. 20-0718*

On August 18, 2020, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end December 31, 2017.

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

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

As the Provider is owned by Quorum Health and, thereby, subject to the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1), the Provider transferred Issue 2 to a Quorum Health group on September 23,2021. The DSH Payment/SSI Percentage (Provider Specific) and DSH Payment – Medicaid Eligible issues remain active on appeal.

On September 30, 2021, Quorum Health, the Provider representative at the time, filed its preliminary position paper.[2]

[1] On September 23, 2021, this issue was transferred to PRRB Case No. 20-1339GC.
[2] Quality Reimbursement Services was not made the representative until August 18, 2023.

On December 23, 2021, the Medicare Contractor filed a jurisdictional challenge, requesting the dismissal of Issue 1.

On January 20, 2022, the Medicare Contractor filed its preliminary position paper.

On April 28, 2021, and January 11, 2023, the Medicare Contractor filed requests for the Medicaid Eligible Days Listing in connection with Issue 3 and requested a response within 30 days. On March 2, 2023, the Medicare Contractor filed its Motion to Dismiss Issue 3 as the Provider had failed to file any response. To date, the Board has no record of the Provider having responded to any of the requests.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 20-1339GC

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

> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
> . . .
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.
> . . .
>
> The Provider also contends that CMS inconsistently interprets the term "entitled" as it is used in the statute. CMS requires SSI payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the denominator. CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days of care) as Medicare Part A days, yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment[3]

As the Provider is commonly owned by Quorum Health, the Provider transferred its Issue 2 – DSH – SSI Percentage to the CIRP group under 20-1339GC, Quorum Health CY 2017 DSH SSI

[3] Issue Statement at 1 (Feb. 9, 2021).

Percentage CIRP Group, on September 23, 2021. The Group Issue Statement in Case No. 20-1339GC reads, in part:

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

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $44,000.

On September 30, 2021, the Provider submitted its preliminary position paper to the MAC. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Provider Specific**
>
> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include

[4] Group Issue Statement, 20-1339GC, filed March 4, 2020.

> all patients that were entitled to SSI benefits in their calculation based on the Provider's Fiscal Year End (December 31).
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.
>
> Similar to *Loma Linda Community Hospital v. Dept of Health and Human Services*, No. CV-94-0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records. However, at this time, the Provider has been unable to analyze the Medicare Part A data because it has not yet received the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR"), HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000 from CMS. *See* 65 Fed. Reg. 50,548 (2000). Upon release of the complete MEDPAR data, the Provider will seek to reconcile its' records with that of CMS, and identify patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS based on the Federal Fiscal Year End (September 30) when it determined the Provider's SSI. *See Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).[5]

MAC's Contentions

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

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

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

[5] Provider's Preliminary Position Paper at 8-9 (Sept. 30, 2021).

Board dismiss this issue consistent with recent jurisdictional decisions.[6]

In addition, the MAC argues the DSH – SSI Percentage (Provider Specific) issue and the DSH – SSI Percentage (Systemic Errors) issue are considered the same issue by the Board.[7]

Issue 3 – DSH – Medicaid Eligible Days

The MAC requests that the Board find the Provider abandoned the DSH – Medicaid Eligible Days issue, arguing:

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

Provider's Jurisdictional Response

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

Analysis and Recommendation

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2018), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if

[6] Jurisdictional Challenge at 6-7 (Dec. 23, 2021).
[7] *Id*. at 4-5.
[8] MAC's Motion to Dismiss at 4-5 (Mar. 2, 2023).
[9] Board Rule 44.4.3, v. 2.0 (Aug. 2018).

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

A. DSH – SSI Percentage (Provider Specific)

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

1. *First Aspect of Issue 1*

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—concerns "[w]hether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation."[10] The Provider's legal basis for its DSH – SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[11] The Provider argues that "its SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[12]

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 20-1339GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds the DSH Payment/SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 20-1339GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[13], the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

In making this finding, the Board further notes that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, the Provider is pursuing that issue as part of the group under Case 20-1339GC. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[14] The Provider's

[10] Issue Statement at 1.
[11] *Id.*
[12] *Id.*
[13] PRRB Rules v. 2.0 (Aug. 2018).
[14] The types of systemic errors documented in the *Baystate* did not uniformly impact the SSI calculation for all providers but that does not make the errors any less systemic. *See Baystate Medical Ctr. v. Mutual of Omaha Ins.*

reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 20-1339GC.

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 20-1339GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with the Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" in its Preliminary Position Paper and include *all* exhibits.

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

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

The Board further notes that the Provider only cites to the 2000 Federal Register but additional issuances and developments on the availability of data underlying the SSI fraction, such MEDPAR data, have occurred. For example, as noted in the FY 2006 IPPS Final Rule, "[b]eginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108–173), we will arrange to furnish, consistent with the Privacy Act, MedPAR LDS data for a hospital's patients eligible for both SSI and Medicare at the hospital's request, regardless of whether there is a properly pending appeal relating to DSH payments. *We will make the information available for either the Federal fiscal year or, if the hospital's fiscal year differs from the Federal fiscal year, for the* ***months included in the 2***

Co., PRRB Dec. No. 2006-D20 (Mar. 17, 2006). *See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).

Federal fiscal years that encompass the hospital's cost reporting period. Under this provision, *the hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year*. The data set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year." Further highlighting the perfunctory nature of the briefing is the fact that providers *can* obtain certain data used to calculate their DSH SSI ratios directly from the Centers for Medicare and Medicaid Services ("CMS") and in some cases on a self-service basis as explained on the following webpage:

https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH.[15]

This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows: "DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[16]

Indeed, the D.C. Circuit affirmed in *Advocate Christ Med. Ctr. v. Becerra*, No. 22-5214, 2023WL5654312 (D.C. Cir., Sept. 1, 2023) that "What [MMA] section 951 cannot mean is that HHS must give hospitals data that it never received from SSA in the first place. And SSA does not provide HHS with the specific codes assigned to individual patients. See 75 Fed. Reg. at 50,276." Here, the Provider does not explain what information it needs or is waiting on or claims that it should have access to.

Accordingly, the Board finds that the remaining issue in the instant appeal and the group issue from Group Case 20-1339GC are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

2. *Second Aspect of Issue 1*

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

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

[15] Last accessed January 2, 2024.
[16] Emphasis added.

B. DSH – Medicaid Eligible Days

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

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

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

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

Board Rule 7.2 (B) states:

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

Moreover, the Provider neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2 (B).

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

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

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

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

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

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

Similarly, with regard to position papers,[21] Board Rule 25.2 (A) requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[22] This requirement is consistent with 42 C.F.R. § 405.1853(b)(3).

Similarly, consistent with that regulation, Board Rule 25.2 (B) provides the following instruction on the content of position papers as it relates to unavailable documentation/exhibits:

> *If documents necessary to support your position are still unavailable,* identify the missing documents, explain why the

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

[20] (Emphasis added).

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

[22] (Emphasis added).

> documents remain unavailable, state the efforts made to obtain the documents, and explain when the documents will be available. Once the documents become available, promptly forward them to the opposing party.[23]

When determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(iii) places the burden of production on the provider, stating:

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

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

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

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

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

The Board concurs with the Medicare Contractor that the Provider is required to identify and provide documentation to prove what additional Medicaid Eligible days are at issue and to which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rule 25. Further, pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[24] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. Based on the record before the Board, the Board finds that the Provider has failed to provide a listing or other supporting documentation for the Medicaid Eligible Days issue as required by the controlling regulations and Board Rules. Nor has the Provider provided any explanation as to why the documentation was absent or what is being done to obtain it consistent with Board Rule 25.2 (B). Indeed, without any days identified

[23] (Emphasis added).
[24] (Emphasis added).

in the position paper filing, the Board assumes that there are no days nor any amount in dispute for this issue.

The Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of Board Rules 25.2 (A) and 25.2 (B) related to identifying the days in dispute and the submission of documentary evidence required to support its claims or describe why said evidence is unavailable.[25]

Accordingly, the DSH Payment – Medicaid Eligible Days issue is dismissed.

Decision

The Board hereby dismisses the DSH Payment/SSI Percentage (Provider Specific) issue from appeal as it is duplicative of the issue in PRRB Case No. 20-1339GC and there is no final determination from which the Provider can appeal the SSI realignment portion of the issue.

The Board also dismisses the DSH – Medicaid Eligible Days issue as the Provider failed to meet the Board requirements for position papers for this issue and effectively abandoned the issue. As no issues remain in the appeal, the appeal is now closed.

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

Board Members Participating:

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

For the Board:

1/2/2024

X Kevin D. Smith, CPA

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

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

[25] Board Rule 25, of which 25.2 (A) and 25.2 (B) are a part, is applicable to final position papers via Board Rule 27.2.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Nicholas Putnam
Strategic Reimbursement Group, LLC
360 West Butterfield Road, Suite 310
Elmhurst, IL 60126

RE: ***Dismissal for Erroneous Filing Pursuant to Board Rules 20 and 20.1***

SRI Aurora FY 2010 Medicaid Eligible Medicare Unmatched Days CIRP Group
Case Number: 15-0256GC

Dear Mr. Putnam:

The Provider Reimbursement Review Board (the "Board") has completed its review of the subject common issue related party ("CIRP") group appeal in response to the Medicare Contractor's September 21, 2023 Motion to Dismiss the subject group and its November 17, 2023 follow-up request for dismissal. The Board notes that the CIRP group, which was filed on October 29, 2014, was filed prior to the implementation of the Office of Hearing Case & Document Management System ("OH CDMS"). As such, the electronic record for the CIRP group, which is considered a "Legacy" case, has not yet been populated in OH CDMS. A brief history of the facts and the Board's determination are set forth below.

For background, on November 1, 2021, the Board issued revised Board Rules which changed certain procedures for group appeals. Specifically, Rule 20 addresses the population of Issues/Providers in the Office of Hearings Case & Document Management System ("OH CDMS"). Rule 20 advises that, "***within (60) sixty days of the full formation of the group***, the group representative must file a statement certifying that the group is fully populated in OH CDMS with the relevant supporting jurisdictional documentation (i.e., all participants in the group are shown under the Issues/Providers Tab for the group in OH CDMS with the relevant supporting jurisdictional documentation."[1]

On November 7, 2022, the Board issued Alert 23, which gave notice that effective December 7, 2022, the Board was resuming its normal operations following the COVID- 19 Pandemic. The Alert 23 included a reminder to the Parties regarding the Rule 20 Certification requirement.

[1] Emphasis added.

Pertinent Facts with Regard to Case No. 15-0256GC:

On June 6, 2023, Strategic Reimbursement Group, LLC ("Strategic"/"Group Representative") designated the CIRP group fully formed. Pursuant to Board Rule 20, within 60 days of the group's full formation, the Group Representative was required to file a Schedule of Providers with supporting jurisdictional documentation which would have been due on February 4, 2023.[2]

On June 7, 2023, the Board issued a Group Completion Notice and Critical Due Dates notification setting preliminary position paper deadlines for the subject appeal. The Group's preliminary position paper deadline was set for August 6, 2023.

On August 3, 2023, Strategic filed its preliminary position paper. The preliminary position paper did not include a Rule 20 Certification, nor did it include a Schedule of Providers (which is required to be filed as a separate submission).

On September 11, 2023, the Medicare Contractor emailed Strategic advising them that it had not yet received the jurisdictional documentation or a "Rule 22" letter for the group.[3]

On October 4, 2023, the Medicare Contractor filed its Rule 22 Jurisdictional Review letter in which it advised the Board that it was unable to determine whether there were any impediments to jurisdiction for the group because jurisdictional documents had not been filed as required by Board Rule 20.1.

On November 3, 2023, the Board issued a Scheduling Order in which the Board ordered Strategic to file its Rule 20 Certification or a full SoP, with support, pursuant to Board Rule 20.1, as well as its response to the Medicare Contractor's Motion to Dismiss. Both submissions were due by Thursday, November 16, 2023.

On November 8, 2023, Strategic filed a Rule 20 Certification indicating that ". . . all applicable and available jurisdictional documentation has been populated in OH CDMS portal for the providers in the above-mentioned case."[4] The submission did not address the Medicare Contractor's motion to dismiss.

On November 17, 2023, the Medicare Contractor filed an updated request for dismissal because Strategic had failed to file a Schedule of Providers with supporting jurisdictional documents in OH CDMS as ordered by the Board and it did not respond to the Medicare Contractor's motion to dismiss.

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[2] Since the due date fell on a Sunday, the submission was due the following day, Monday, February 5, 2023.
[3] Although this email referred to a "Rule 22 letter," the Medicare Contractor clearly meant the Rule 20 Certification (i.e., the Rule 22 letter is the MAC's response to its review of the fully formed group). The email was not separately uploaded in OH CDMS, but a copy of the email was submitted as an exhibit (C-3) to the Medicare Contractor's September 21, 2023 Motion to Dismiss.
[4] Only one provider is populated in OH CDMS.

As set forth below, Strategic has failed to meet the requirements of Rules 20 and 20.1. Below is a discussion regarding Rule 20 and Rule 20.1 requirements and the information that was required in this case.

Rule 20/20.1 Background:

Rule 20 addresses the population of Issues/Providers in OH CDMS. Pursuant to Board Rule 20:

> If ***all*** the participants in a fully-formed group are ***populated*** under the Issues/Providers Tab in OH CDMS with supporting jurisdictional documentation (*see* Rule 21), then the representative is exempt from filing a ***hard copy*** of the schedule of providers with supporting jurisdictional documentation. In this instance, the Board uses the schedule of providers and supporting jurisdictional documentation that is created in OH CDMS using the information and documents included in each participating provider's request for transfer or direct add to the group.
>
> ***Prior to*** certifying that the group is fully formed or the date on which a group is fully formed, the group representative should review each participating provider's supporting jurisdictional documentation to ensure it is complete and, if not, file any additional documentation in OH CDMS.[5] If *all* of the participants in a fully-formed group are ***populated*** under the Issues/Providers Tab in OH CDMS, then ***within (60) sixty days of the full formation of the group***, the group representative must file a statement certifying that the group is *fully* populated in OH CDMS with the relevant supporting jurisdictional documentation (*i.e*., all participants in the group are shown under the Issues/Providers Tab for the group in OH CDMS with the relevant supporting jurisdictional documentation).[6]

Board Rule 20.1 applies to **"Group Cases that Are Not Fully Populated in OH CDMS."** Pursuant to Board Rule 20.1:

> If any participants in a fully-formed group are ***not*** populated under the Issues/Providers Tab in OH CDMS with supporting jurisdictional documentation (*see* Rule 21), then the Representative must prepare a traditional schedule of providers (*i.e.* Model Form G at Appendix G), for *all* participants in the group **following the instructions in this Rule and Rule 21, unless the Board instructs otherwise.** Specifically, *within sixty (60) days of the full formation of the group* (see Rule 19), the group representative must prepare and file a schedule of providers with the supporting jurisdictional

[5] If all participants are populated but jurisdictional support is not complete, the Rule 20 Certification must certify that all participants are populated, but should include an identification of the documents that are missing and then ***only*** file in OH CDMS those additional missing documents. See, https://www.cms.gov/files/document/oh-cdms-prrb-user-manual-supplement-supplemental-document-uploads-group-appeals.pdf.
[6] (Underline emphasis added.)

> documentation for all providers in the group that demonstrates that the Board has jurisdiction over each participant named in the group appeal (*see* Rule 21) . . . .

The Board recognizes that the Critical Due Dates notifications do not include a deadline for filing, as relevant, the Rule 20 Certification or the traditional SoP under Board Rule 20.1. However, making the applicable filing under Board Rules 20 and 20.1 *is* ***and*** *remains* a requirement under Board Rules and must be made ***within 60 days of full formation***.

The Board notes that in this group case, only one of the providers is populated behind the Participants tab and, therefore, Rule 20.1 applies.[7] As such, the Representative was required to separately file a PDF copy of the full SoP with **all relevant supporting jurisdictional documentation** within the 60-day period allotted under Board Rule 20.1.[8]

Board Determination:

Pursuant to 42 C.F.R. § 405.1868:

> (a) The Board has full power and authority to make rules and establish procedures, not inconsistent with the law, regulations, and CMS Rulings, that are necessary or appropriate to carry out the provisions of section 1878 of the Act and of the regulations in this subpart. *The Board's powers include the authority to take appropriate actions in response to the* ***failure of a party*** *to a Board appeal* ***to comply with Board*** rules and ***orders*** or for inappropriate conduct during proceedings in the appeal.
>
> (b) *If a provider fails to meet a filing deadline or other requirement established by the Board in a rule or order, the Board may—*
>
> *(1) Dismiss the appeal with prejudice***;**
>
> (2) Issue an order requiring the provider to show cause why the Board should not dismiss the appeal; or
>
> (3) Take any other remedial action it considers appropriate.[9]

[7] Based on the Model Form G filed with the group appeal request on October 29, 2014, there were five providers initially included in the group – so at a minimum there are at least six participants (of which, only one is currently populated in OH CDMS).
[8] Rule 20/20.1 Certifications must be stand-alone filings and never part of another filing *(e.g., never embedded within a preliminary position paper filing, group status response, etc.).*
[9] Emphasis added.

The Board is also cognizant of the fact that, on more than one occasion, it has explained the background and requirements of Board Rule 20 and Rule 20.1.[10] Numerous times, as a courtesy, the Board has extended Strategic additional time to correct such deficiencies, however Strategic continues to miss or make deficient filings related to this Board Rule. Specifically, regarding Case No. 15-0256GC, the Board admonishes Strategic for falsely filing a Rule 20 Certification in a case which has obviously not been fully populated.

Additionally, the Board notes that the Medicare Contractor made Strategic aware of the deficiencies in this group at least four times, via e-mail, in its Motion to Dismiss, in its Rule 22 Jurisdictional Review letter and in its November 17, 2023 follow-up request for dismissal. Strategic not only failed to respond to those notifications, but it also failed to respond to the Board's Scheduling Order by filing its comments regarding the Medicare Contractor's Motion to Dismiss, which suggests to the Board that Strategic has abandoned its appeal. Consequently, because the full SoP with supporting documentation was not timely filed in the subject group, as required under Board Rule 20.1, the Board hereby dismisses Case No. 15-0256GC, pursuant to its authority under 42 C.F.R. § 405.1868.

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

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

For the Board:

1/3/2024

X Kevin D. Smith, CPA

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

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services
Pam VanArsdale, National Government Services, Inc. (J-6)

[10] See 2/8/2023 Board Order to File Applicable Documents Required under Board Rules 20 & 20.1 issued in Case Nos. 20-0222GC, 21-1356GC, 21-1358GC, 22-0011GC. Also see 4/10/2023 Board Determination on Motion to Dismiss for Failure to (Timely) File Rule 20 Certification issued in Case No. 14-1402GC.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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Byron Lamprecht
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Omaha, NE 68114-2708

RE: ***Board Decision– SSI Percentage (Provider Specific)***
Jennersville Hospital (Provider Number 39-0220)
FYE: 06/30/2017
Case Number: 20-0470

Dear Messrs. Kramer and Lamprecht,

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the documentation in the above referenced appeal. The Board's analysis and determination is set forth below.

Background:

A. Procedural History for Case No. 20-0470

On May 22, 2019, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end June 30, 2017.

On November 15, 2019, the Provider's representative, Mr. Summar at Community Health Systems ("CHS"), filed the Provider's appeal request with the Board appealing the following five (5) issues:

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

After issue transfers and withdraws, the DSH Payment/SSI Percentage (Provider Specific) issue is the sole issue that remains pending in the appeal.

On July 1, 2020, CHS filed the Provider's preliminary position paper.

On October 15, 2020, the Medicare Contractor filed a Jurisdictional Challenge over Issue 1 requesting that it be dismissed as a prohibited duplicate of the Provider's pursuit of the same issue in Case No. 20-0997GC. CHS did not file a response.

On October 22, 2020, the Medicare Contractor filed its preliminary position paper.

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

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

> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> . . .
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[1]

On June 18, 2020, the Provider was directly added to PRRB Case No. 20-0997GC CHS CY 2017 DSH SSI Percentage CIRP Group, appealing from the same NPR as the instant appeal. This common issue related party ("CIRP") group issue statement reads:

> The Provider(s) contend(s) that the MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute at 42 U.S.C. § 1395ww (d)(5)(F)(vi)(I). The Provider(s) further contend(s) that the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") and used by the MAC to settle their Cost Reports incorporates a new methodology inconsistent with the Medicare statute.
>
> The Providers challenge their SSI percentages based on the following reasons:
>
> 1. Availability of MEDPAR and SSA Records;
> 2. Paid days vs. Eligible days;
> 3. Not in agreement with provider's records;
> 4. Fundamental problems in the SSI percentage calculation;
> 5. Covered days vs. Total days; and
> 6. Failure to adhere to required notice and comment rulemaking procedures.[2]

[1] Provider's Request for Hearing, Issue Statement (Nov. 15, 2019)
[2] See Group Issue Statement, PRRB Case No. 20-0997GC

On July 1, 2020, the Provider filed its preliminary position paper in 20-0470. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Calculation of the SSI Percentage**
>
> **Provider Specific**
>
> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation based on the Provider's Fiscal Year End (June 30).
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.
>
> Similar to L*oma Linda Community Hospital v. Dept of Health and Human Services*, No. CV-94- 0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records. However, at this time, the Provider has been unable to analyze the Medicare Part A data because it has not yet received the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR"), HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000 from CMS *See* 65 Fed. Reg. 50,548 (2000). Upon release of the complete MEDPAR data, the Provider will seek to reconcile its' records with that of CMS, and identify patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS based on the Federal Fiscal Year End (September 30) when it determined the Provider's SSI. *See Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).[3]

Medicare Contractor's Contentions

Issue 1 – DSH SSI Percentage (Provider Specific)

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

> The decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election. It is not a final contractor determination. A hospital must make a formal request to CMS in order to receive a realigned SSI

[3] Provider's Preliminary Position Paper at 8-9 (July 1, 2020).

> percentage. Once the hospital elects to use its own fiscal year end, it is bound by that decision, regardless of reimbursement impact.
>
> . . . .
>
> The Provider's appeal is premature. To date the Provider has not requested to have its SSI percentage realigned in accordance with 42 C.F.R. § 412.106(b)(3). Thus, the Provider has not exhausted all available remedies for this issue. The MAC requests that the Board dismiss this issue consistent with recent jurisdictional decisions.[4]

In addition, the MAC argues the DSH Payment/SSI Percentage (Provider Specific) issue and the DSH Payment/SSI (Systemic Errors) issue are considered the same issue by the Board, and the Provider is appealing this issue in PRRB Case No. 20-0997GC. The MAC requests that the Board dismiss the SSI data accuracy sub-issue as a duplicate filing in violation of Board Rule 4.6.1.[5]

Provider's Response

The Provider did not file a response to the Jurisdictional Challenge. Board Rule 44.4.3 specifies, "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

Board Analysis and Decision:

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

A. DSH Payment/SSI Percentage (Provider Specific)

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

[4] Jurisdictional Challenge at 6-7 (Oct. 15, 2020).
[5] *Id*.

1. First Aspect of Issue 1

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

The DSH Payment/SSI Percentage (Provider Specific) issue in the present appeal concerns "whether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation."[6] The Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[7] The Provider argues that "its SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[8]

The Provider's DSH Payment/SSI (Systemic Errors) issue in group Case No. 20-0997GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds the DSH Payment/SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH Payment/SSI (Systemic Errors) issue in Case No. 20-0997GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.5[9], the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

In making this finding, the Board further notes that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations, and to that end, the Provider is pursuing that issue as part of the group under Case 20-0997GC. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in Baystate, may impact the SSI percentage for each provider differently.[10] The Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) as to how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 20-0997GC.

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 20-0997GC, but instead refers to systemic Baystate data matching issues that are the subject of the issue in the group appeal. For example, the Provider asserts that "the SSI entitlement of

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[6] Issue Statement at 1.
[7] *Id.*
[8] *Id.*
[9] PRRB Rules v. 2.0 (August 2018).
[10] The types of systemic errors documented in the Baystate did not uniformly impact the SSI calculation for all providers but that does not make the errors any less systemic. See *Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). See also *Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).

individuals can be ascertained from State records"[11] but fails to explain what that means, what the basis for the alleged fact is,[12] or why that is even relevant to the issue. Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be fully developed and include all available documentation necessary to provide a thorough understanding of their opponent's positions." Here, it is clear that the Provider failed to fully develop the merits of its position on Issue 1 of its issue and explain the nature of any alleged "errors" in its Preliminary Position Paper and include all exhibits.

Moreover, the Provider has failed to comply with Board Rule 25.2(B) (2018) to explain why the MEDPAR data is unavailable. In this regard, Board Rule 25.2(B) (2018) specifies:

> 25.2 (B) Unavailable and Omitted Preliminary Documents: If documents necessary to support your position are still unavailable, identify the missing documents, explain why the documents remain unavailable, state the efforts made to obtain the documents and explain when the documents will be available. Once the documents become available, promptly forward them to the opposing party.

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

> https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH

This CMS webpage describes access to DSH data from 1998 to 2017 as follows: "DSH is now a self-service application. This new self-service process enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[13]

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[11] Provider's Preliminary Position Paper at 8.
[12] There are no exhibits or citations or examples of how SSI entitlement can be ascertained from state records.
[13] Last accessed January 4, 2024.

Indeed, the D.C. Circuit affirmed in *Advocate Christ Med. Ctr. v. Becerra*, No. 22-5214, 2023WL5654312 (D.C. Cir., Sept. 1, 2023) that "What [MMA] section 951 cannot mean is that HHS must give hospitals data that it never received from SSA in the first place. And SSA does not provide HHS with the specific codes assigned to individual patients. See 75 Fed. Reg. at 50,276." Here, the Provider does not explain what information it needs or is waiting on or claims that it should have access to.

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

2. Second Aspect of Issue 1

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

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

****

In summary, the Board hereby dismisses the DSH Payment/SSI Percentage (Provider Specific) issue from this appeal as it is duplicative of the issue in Case No. 20-0997GC and there is no final determination from which the Provider can appeal the SSI realignment portion of the issue.

As no issues remain pending, the Board hereby closes Case No. 20-0470 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:

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

For the Board:

1/4/2024

X Kevin D. Smith, CPA

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

cc:

Wilson C. Leong, Esq., Federal Specialized Services

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RE: ***Duplicative DSH SSI MMA 951 and SSI Accuracy Issues***

Sutter Delta Medical Center (Provider Number 05-0523)
FYE: 12/31/2018
Case Number: 23-1724

Sutter Health FFY 2018 DSH SSI Ratio – Inaccurate Data CIRP Group
Case Number: 22-1293GC

Dear Mr. Jaeger and Ms. Frewert:

The Provider Reimbursement Review Board (the Board) has reviewed the subject appeals in response to a December 13, 2023 request from Sutter Health ("Sutter") to transfer the "Medicare DSH SSI Ratio - MMA Sec 951" issue to Case No. 22-1293GC. The pertinent facts of the cases and the Board's determination are set forth below.

Pertinent Facts:

On September 21, 2023, Sutter filed the individual appeal for Sutter Delta Medical Center ("Sutter Delta"/Prov. No. 05-0523) for FYE 12/31/2018 under Case No. 23-1724. The appeal included 10 issues:

1) Medicare DSH SSI Ratio - Inaccurate Data
2) Medicare DSH SSI Ratio Part C Days
3) Medicare DSH SSI Ratio - Part A Days
4) Medicare DSH SSI Ratio - MMA Sec 951
5) Medicare DSH RAC 2 and 3 Days
6) Medicare DSH Medicaid Ratio - Part C Days
7) Medicare DSH Medicaid Ratio - Part A Days
8) Medicare DSH - Medicaid Eligible Days
9) Predicate Facts
10) Inpatient PPS Unrestored ATRA/MACRA Reduction

On December 13, 2023, Sutter requested the transfer of Issue #1 (Medicare DSH SSI Ratio -

Inaccurate Data) and Issue # 4 (Medicare DSH SSI Ratio - MMA Sec 951) to "the Sutter Health FFY 2018 DSH SSI Ratio - Inaccurate Data CIRP Group" under Case No. 22-1293GC. Sutter also transferred all other issues, except #3, #7 and #8, which were withdrawn from Case No. 23-1724. As these were the last remaining issues in the appeal, the appeal was closed on December 13, 2023.

Board Determination:

The Board finds that the SSI MMA § 951 issue is duplicative of the Medicare DSH SSI Ratio - Inaccurate Data issue, which has already been transferred to a DSH SSI Ratio - Inaccurate Data CIRP group.

Section 951 of the Medicare Modernization Act provides:

> Beginning not later than 1 year after the date of the enactment of this Act, the Secretary shall arrange to furnish to subsection (d) hospitals (as defined in section 1886(d)(1)(B) of the Social Security Act, 42 U.S.C. 1395ww(d)(1)(B)) the data necessary for such hospitals to compute the number of patient days used in computing the disproportionate patient percentage under such section for that hospital for the current cost reporting year. Such data shall also be furnished to other hospitals which would qualify for additional payments under Part A of title XVIII of the Social Security Act on the basis of such data.

In the Medicare DSH SSI Ratio - MMA Sec 951 issue (#4), the Provider argues that CMS has not complied with this provision in terms of both releasing the data to begin with, as well as releasing all of the data that the Providers believe should be released. The Provider made a very similar argument in the corresponding Medicare DSH SSI Ratio - Inaccurate Data issue (#1) which is now pending in Case No. 22-1293GC. Part of the issue statement in the SSI Accuracy group reads:

> The Provider contends that CMS did not use the best data available at the time of settlement to calculate the SSI fraction because of various reasons including but not limited to: not using updated current data, using data that excluded inactive claims, retroactive claims and what is sometimes referred to as forced or manual pay claims.

Both the SSI MMA § 951 issue and the SSI - Inaccurate Data issue raise the issue that CMS has failed to disclose the underlying patient data related to the SSI ratio. Therefore, having two issues that make the same argument related to the SSI ratio is duplicative in violation of PRRB Rule 4.6.[1]

[1] Board Rule 4.6.1 indicates "[a] provider may not appeal and pursue the same issue from a single determination in more than one appeal (individual or group).

There are several other indicators that the two issues are duplicative. First, Sutter Delta has plead the same amount in controversy in the respective SSI MMA § 951 and SSI - Inaccurate Data issue. Second, the Provider is ultimately seeking the same remedy from the two issues – it wants access to the underlying data so it can determine that its ratio is understated and can therefore receive a new SSI ratio. Finally, the Provider requested the transfer of both Issue #1 and Issue #4 to the same single-issue CIRP group.

Based on these factors, the Board finds that the SSI MMA § 951 issue and the SSI – Inaccurate Data issue are duplicative. Therefore, the Board hereby dismisses the SSI MMA § 951 issue (#4) and denies the transfer to the Sutter Health FFY 2018 DSH SSI Ratio - Inaccurate Data CIRP Group, Case No. 22-1293GC. Since there were no remaining issues in the individual appeal, after the transfers and withdrawals, the Board closed Case No. 23-1724 and removed it from the Board's docket on December 13, 2023. Case No. 23-1724 remains closed.

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

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

For the Board:

1/4/2024

X Kevin D. Smith, CPA

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

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

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RE: ***Board Decision*** **– SSI Percentage (Provider Specific) & Medicaid Eligible Days Issues**
Tennova Healthcare – Cleveland (Provider Number 44-0185)
FYE: 08/31/2018
Case Number: 22-0140

Dear Mr. Summar and Mr. Lamprecht,

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

Background:

A. ***Procedural History for Case No. 22-0140***

On June 3, 2021, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end August 31, 2018.

On November 16, 2021, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained three (3) issues:

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

As the Provider is owned by Community Health Systems, Inc. (hereinafter "Community Health") and, thereby, subject to the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1), the Provider transferred Issue 2 to a Community Health CIRP group on June 10, 2022. As a result, the remaining issues in this appeal are Issues 1 and 3.

On July 6, 2022, the Provider filed its preliminary position paper.

[1] On June 10, 2022, this issue was transferred to PRRB Case No. 21-1206GC.

On September 23, 2022, the Medicare Contractor filed a jurisdictional challenge, requesting the dismissal of Issues 1 and 3.

On October 21, 2022, the Medicare Contractor filed its preliminary position paper.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 21-1206GC

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

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

As the Provider is commonly owned by Community Health, the Provider transferred its Issue 2 – DSH/SSI Percentage to the CIRP group under 21-1206GC, CHS CY 2018 DSH SSI Percentage CIRP Group, on June 10, 2022. The Group Issue Statement in Case No. 21-1206GC reads, in part:

> **Statement of the Issue:**
>
> Whether the Secretary properly calculated the Provider's [DSH]/[SSI] percentage, and whether CMS should be required to recalculate the SSI percentages using a denominator based solely upon covered and paid for Medicare Part A days, or alternatively, expand the numerator of the SSI percentage to include paid/covered/entitled as well as unpaid/non-covered/eligible SSI days?
>
> **Statement of the Legal Basis**
>
> The Provider(s) contend(s) that the MAC's determination of Medicare Reimbursement for their DSH Payments are not in

[2] Issue Statement at 1 (Nov. 16, 2021).

> accordance with the Medicare statute 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). The Provider(s) further contend(s) that the SSI percentages calculated by [CMS] and used by the MAC to settle their Cost Reports incorporates a new methodology inconsistent with the Medicare statute.
>
> The Providers challenge their SSI percentages based on the following reasons:
>
> 1. Availability of MEDPAR and SSA records,
> 2. Paid days vs. Eligible days,
> 3. Not in agreement with provider's records,
> 4. Fundamental problems in the SSI percentage calculation,
> 5. Covered days vs. Total days and
> 6. Failure to adhere to required notice and comment rulemaking procedures.[3]

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $43,746.

On July 6, 2022, the Provider filed its preliminary position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Provider Specific**
>
> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation based on the Provider's Fiscal Year End (August 31).
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.
>
> Similar to *Loma Linda Community Hospital v. Dept of Health and Human Services*, No. CV-94-0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records. However, at this time, the Provider has been unable to analyze the Medicare Part A data because it has not yet received the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR"), HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000 from CMS. *See* 65 Fed. Reg. 50,548 (2000). Upon release of the complete MEDPAR

[3] Group Issue Statement, Case No. 21-1206GC.

> data, the Provider will seek to reconcile its' records with that of CMS, and identify patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS based on the Federal Fiscal Year End (September 30) when it determined the Provider's SSI. *See Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).[4]

MAC's Contentions

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

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

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

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

Finally, the MAC argues "the Provider did not file a **complete** preliminary position paper in accordance with 42 C.F.R. § 405.1853 and Board Rules 25.2 and 25.3."[7] The MAC posits that the Provider "failed to sufficiently develop and set forth the relevant facts and arguments regarding the merits of its claim in its Preliminary Position Paper."[8] In more detail:

---

[4] Provider's Preliminary Position Paper at 8-9 (Jul. 6, 2022).
[5] Jurisdictional Challenge at 6-7 (Sept. 23, 2022).
[6] *Id*. at 4-6.
[7] *Id*. at 7.
[8] *Id*. at 8.

> Within its Provider's Preliminary Position Paper, the Provider makes the broad allegation that "The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation based on the Provider's Fiscal Year End (August 31)," yet offers no evidence or analysis to demonstrate that CMS calculated its SSI percentage inaccurately. The Providers failed to include any evidence to establish the material facts in this case relating to inaccuracies in the SSI Percentage calculation at issue or any evidence pertaining to the alleged systemic SSI ratio data match errors like those referenced in the *Baystate* case. The Provider merely repeats their appeal request which itself is a verbatim recitation of the deficiencies that the Board found in the *Baystate* case.[9]

Issue 3 – DSH Payment – Medicaid Eligible Days

The MAC requests that the Board find the Provider abandoned the DSH – Medicaid Eligible Days issue, arguing:

> The MAC contends that the Provider was in violation of Board Rule 25.3 when it failed to sufficiently develop and set forth the relevant facts and arguments regarding the merits of its claim in its preliminary position paper. Moreover, the Provider neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2. Accordingly, the DSH – Medicaid Eligible Days issue should be dismissed.
>
> Within its Provider's preliminary position paper, the Provider makes the broad allegation, ". . . the Provider contends that the total number of days reflected in its' [sic] 2018 cost report does not reflect an accurate number of Medicaid eligible days. . ." The Provider has failed to include any evidence to establish the material facts in this case relating to inaccuracies in the Medicaid Percentage calculation at issue. The Provider merely repeats their appeal request.[10]

Provider's Jurisdictional Response

The Board Rules require that Provider Responses to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[11] The Provider has not

[9] *Id*. at 8-9.
[10] *Id*. at 10.
[11] Board Rule 44.4.3, v. 3.1 (Nov. 2021).

filed a response to the Jurisdictional Challenge and the time for doing so has elapsed. Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

Board Analysis and Decision:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2020), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

A. DSH Payment/SSI Percentage (Provider Specific)

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

1. First Aspect of Issue 1

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH/SSI Percentage (Systemic Errors) issue that was appealed in PRRB Case No. 21-1206GC.

The DSH Payment/SSI Percentage (Provider Specific) issue in the present appeal concerns "[w]hether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation."[12] The Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[13] The Provider argues that "its' SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[14]

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 21-1206GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds the

[12] Issue Statement at 1.
[13] *Id.*
[14] *Id.*

DSH Payment/SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 21-1206GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6,[15] the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

In making this finding, the Board further notes that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, the Provider is pursuing that issue as part of the group under Case No. 21-1206GC, which is required since it is subject to the CIRP group regulations under 42 C.F.R. § 405.1837(b)(1). Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[16] The Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) as to how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue, rather than being subsumed into the "systemic" issue appealed in Case No. 21-1206GC.

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 21-1206GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with the Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" in its Preliminary Position Paper and include *all* exhibits.

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

> **25.2.2 Unavailable and Omitted Documents**
>
> *If documents necessary to support your position are still unavailable,* then provide the following information in the position papers:
>
> 1. Identify the missing documents;

[15] PRRB Rules v. 3.1 (Nov. 2021).
[16] The types of systemic errors documented in the *Baystate* did not uniformly impact the SSI calculation for all providers but that does not make the errors any less systemic. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). *See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).

2. Explain why the documents remain unavailable;
3. State the efforts made to obtain the documents; and
4. Explain when the documents will be available.

Once the documents become available, promptly forward them to the Board and the opposing party.[17]

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

https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH.[18]

This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows: "DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[19]

Indeed, the D.C. Circuit affirmed in *Advocate Christ Med. Ctr. v. Becerra*, No. 22-5214, 2023WL5654312 (D.C. Cir., Sept. 1, 2023) that "What [MMA] section 951 cannot mean is that HHS must give hospitals data that it never received from SSA in the first place. And SSA does not provide HHS with the specific codes assigned to individual patients. See 75 Fed. Reg. at 50,276." Here, the Provider does not explain what information it needs or is waiting on or claims that it should have access to.

[17] (Emphasis added).
[18] Last accessed January 4, 2024.
[19] Emphasis added.

Accordingly, *based on the record before it*, the Board finds that the remaining issue in the instant appeal and the group issue from Group Case 21-1206GC are the same issue.[20] Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

2. Second Aspect of Issue 1

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

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

B. DSH Payment – Medicaid Eligible Days

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

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

[20] Moreover, even if it were not a prohibited duplicate, it was not properly in the individual appeal because it is a common issue that would be required to be in a Community Health CIRP group per 42 C.F.R. § 405.1837(b)(1).

> the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.[21]

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

The Provider's preliminary position paper indicated that it would be sending the eligibility listing under separate cover.[22]

Board Rule 7.3.1.2 states:

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

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

Notably, the Provider has not included a list of additional Medicaid eligible days with its preliminary position paper or submitted such list under separate cover, even after multiple requests by the Medicare Contractor. The Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it cannot produce those documents, as required by the regulations and the Board Rules.[23]

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

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.

---

[21] Individual Appeal Request, Issue 3.
[22] Provider's Preliminary Position Paper at 8.
[23] *See also* Board's jurisdictional decision in *Lakeland Regional Health* (Case No. 13-2953, 11/20/2019), in which the Board found a Provider essentially abandoned its appeal by filing a position paper that failed to set forth the merits of its claim, explain why the agency's calculation was wrong, and identifying missing documents to support its claim and to explain why those documents remained unavailable.

> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. *Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board through a schedule applicable to a specific case or through general instructions*.[24]

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

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

Similarly, with regard to position papers,[25] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[26] This requirement is consistent with 42 C.F.R. § 405.1853(b)(3).

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

> *If documents necessary to support your position are still unavailable,* then provide the following information in the position papers:
>
> 1. Identify the missing documents;
> 2. Explain why the documents remain unavailable;
> 3. State the efforts made to obtain the documents; and
> 4. Explain when the documents will be available.
>
> Once the documents become available, promptly forward them to the Board and the opposing party.[27]

When determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(4)(iii) places the burden of production on the provider, stating:

> The hospital has the burden of furnishing data adequate to prove eligibility for *each Medicaid patient day* claimed under this

[24] (Emphasis added).
[25] The minimum requirements for Final Position Paper narratives and exhibits are the same as those for Preliminary Position Papers. *See* Board Rule 27.2.
[26] (Emphasis added).
[27] (Emphasis added).

> paragraph, and of verifying with the State that a patient was eligible for Medicaid during *each claimed patient hospital day*.[28]

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

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

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

> • if it has a reasonable basis to believe that the issues have been fully settled or abandoned;
> • upon failure of the provider or group to comply with Board procedures or filing deadlines (*see* 42 C.F.R. § 405.1868);
> • if the Board is unable to contact the provider or representative at the last known address; or
> • upon failure to appear for a scheduled hearing.

The Board concurs with the Medicare Contractor that the Provider is required to identify and provide documentation to prove what additional Medicaid Eligible days are at issue and to which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rule 25. Further, pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[29] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. Based on the record before the Board, the Board finds that the Provider has failed to provide a listing or other supporting documentation for the Medicaid Eligible Days issue as required by the controlling regulations and Board Rules. Nor has the Provider provided any explanation as to why the documentation was absent or what is being done to obtain it, consistent with Board Rule 25.2.2. Indeed, without any days identified in the position paper filing, the Board assumes that there are no days nor any amount in dispute for this issue.

The Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of Board Rules 25.2.1 and 25.2.2 related to identifying the days in dispute and the submission of documentary evidence required to support its claims or describe why said evidence is unavailable.[30]

---

[28] (Emphasis added).
[29] (Emphasis added).
[30] Board Rule 25, of which 25.2 (A) and 25.2 (B) are a part, is applicable to final position papers via Board Rule 27.2.

Accordingly, the DSH Payment – Medicaid Eligible Days issue should be dismissed.

****

In summary, the Board hereby dismisses the DSH Payment/SSI Percentage (Provider Specific) issue from this appeal as it is duplicative of the issue in Case No. 21-1206GC and there is no final determination from which the Provider can appeal the SSI realignment portion of the issue. The Board also dismisses the DSH Payment - Medicaid Eligible Days issue as the Provider failed to meet the Board requirements for position papers for this issue in compliance with 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25. As no issues remain pending, the Board hereby closes Case No. 22-0140 and removes it from the Board's docket.

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

Board Members Participating:

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

For the Board:

1/4/2024

X Kevin D. Smith, CPA

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Board Decision*** **– SSI Percentage (Provider Specific) & Medicaid Eligible Days Issues**
Southern Virginia Regional Medical Center (Provider Number 49-0097)
FYE: 02/28/2018
Case Number: 22-0431

Dear Mr. Summar and Mr. Lamprecht,

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

Background:

A. ***Procedural History for Case No. 22-0431***

On July 29, 2021, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end February 28, 2018.

On January 14, 2022, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained five (5) issues:

1. DSH Payment/SSI Percentage (Provider Specific)
2. DSH/SSI Percentage (Systemic Errors)[1]
3. DSH Payment – Medicaid Eligible Days
4. DSH Payment – Medicare Managed Care Part C Days (SSI Fraction & Medicaid Fraction)[2]
5. DSH Payment – Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days) – (SSI Fraction & Medicaid Fraction)[3]

As the Provider is owned by Community Health Systems, Inc. (hereinafter "CHS") and, thereby, subject to the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1), the Provider

[1] On Aug. 15, 2022, this issue was transferred to PRRB Case No. 21-1206GC.
[2] On Aug. 15, 2022, this issue was transferred to PRRB Case No. 20-2149GC.
[3] On Aug. 15, 2022, this issue was transferred to PRRB Case No. 21-0066GC.

transferred Issues 2, 4, and 5 to Community Health groups on August 15, 2022. The remaining issues in this appeal are Issues 1 and 3.

On September 7, 2022, the Provider filed its preliminary position paper.

On November 28, 2022, the Medicare Contractor filed its preliminary position paper.

On December 12, 2022, the Medicare Contractor filed a jurisdictional challenge, requesting the dismissal of Issues 1 and 3.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 21-1206GC

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

> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> . . .
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[4]

As the Provider is commonly owned by CHS, the Provider transferred its Issue 2 – DSH/SSI Percentage to the CIRP group under 21-1206GC, CHS CY 2018 DSH SSI Percentage CIRP Group, on August 15, 2022. The Group Issue Statement in Case No. 21-1206GC reads, in part:

> **Statement of the Issue:**
>
> Whether the Secretary properly calculated the Provider's [DSH]/[SSI] percentage, and whether CMS should be required to recalculate the SSI percentages using a denominator based solely upon covered and paid for Medicare Part A days, or alternatively, expand the numerator of the SSI percentage to include paid/covered/entitled as well as unpaid/non-covered/eligible SSI days?

[4] Issue Statement at 1 (Jan. 14, 2022).

Statement of the Legal Basis

The Provider(s) contend(s) that the MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute at 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). The Provider(s) further contend(s) that the SSI percentages calculated by [CMS] and used by the MAC to settle their Cost Reports incorporates a new methodology inconsistent with the Medicare statute.

The Providers challenge their SSI percentages based on the following reasons:

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

The amount in controversy listed for both Issue 1 in the instant appeal and for the Provider as a participant in PRRB Case No. 21-1206GC is $5,297.

On September 7, 2022, the Provider filed its preliminary position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

Provider Specific

The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation based on the Provider's Fiscal Year End (February 28).

The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.

Similar to *Loma Linda Community Hospital v. Dept of Health and Human Services*, No. CV-94-0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records. However, at this time, the Provider has been unable to analyze the Medicare Part A data because it has not yet received

[5] Group Issue Statement, Case No. 21-1206GC.

> the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR"), HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000 from CMS. *See* 65 Fed. Reg. 50,548 (2000). Upon release of the complete MEDPAR data, the Provider will seek to reconcile its' records with that of CMS, and identify patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS based on the Federal Fiscal Year End (September 30) when it determined the Provider's SSI. *See Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).[6]

MAC's Contentions

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

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

> The decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election. It is not a final contractor determination. A hospital must make a formal request to CMS in order to receive a realigned SSI percentage. Once the hospital elects to use its own fiscal year end, it is bound by that decision, regardless of reimbursement impact.
>
> . . .
>
> The provider's appeal is premature. To date the Provider has not requested to have its SSI percentage realigned in accordance with 42 C.F.R. § 412.106(b)(3). Thus, the Provider has not exhausted all available remedies for this issue. The MAC requests that the Board dismiss this issue consistent with recent jurisdictional decisions.[7]

In addition, the MAC argues the DSH – SSI Percentage (Provider Specific) issue and the DSH/SSI Percentage (Systemic Errors) issue in PRRB Case No. 21-1206GC are considered the same issue by the Board.[8]

Finally, the MAC argues "the Provider did not file a **complete** preliminary position paper in accordance with 42 C.F.R. § 405.1853 and Board Rules 25.2 and 25.3."[9] The MAC posits that

[6] Provider's Preliminary Position Paper at 8-9 (Sept. 7, 2022).
[7] Jurisdictional Challenge at 6-7 (Dec. 12, 2022).
[8] *Id*. at 4-6.
[9] *Id*. at 7.

the Provider "failed to sufficiently develop and set forth the relevant facts and arguments regarding the merits of its claim in its Preliminary Position Paper."[10]

Issue 3 – DSH Payment – Medicaid Eligible Days

The MAC requests that the Board find the Provider abandoned the DSH – Medicaid Eligible Days issue, arguing:

> The MAC contends that the Provider was in violation of Board Rule 25.3 when it failed to sufficiently develop and set forth the relevant facts and arguments regarding the merits of its claim in its preliminary position paper. Moreover, the Provider neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2. Accordingly, the DSH – Medicaid Eligible Days issue should be dismissed.
>
> Within its Provider's preliminary position paper, the Provider makes the broad allegation, ". . . the Provider contends that the total number of days reflected in its' [sic] 2018 cost report does not reflect an accurate number of Medicaid eligible days. . ." The Provider has failed to include any evidence to establish the material facts in this case relating to inaccuracies in the Medicaid Percentage calculation at issue. The Provider merely repeats their appeal request.[11]

Provider's Jurisdictional Response

The Board Rules require that Provider Responses to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[12] The Provider has not filed a response to the Jurisdictional Challenge and the time for doing so has elapsed. Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

Board Analysis and Decision:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2020), 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

[10] *Id*. at 9.
[11] *Id*. at 11.
[12] Board Rule 44.4.3, v. 3.1 (Nov. 2021).

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

A. DSH Payment/SSI Percentage (Provider Specific)

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

1. First Aspect of Issue 1

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH/SSI Percentage (Systemic Errors) issue that was appealed in PRRB Case No. 21-1206GC.

The DSH Payment/SSI Percentage (Provider Specific) issue in the present appeal concerns "whether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation."[13] The Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[14] The Provider argues that "its' SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[15]

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 21-1206GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds the DSH Payment/SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 21-1206GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6,[16] the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

In making this finding, the Board further notes that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations, and to that end, the Provider is pursuing that issue as part of the group under Case No. 21-1206GC, which is required since it is subject to the CIRP group regulations under 42

[13] Issue Statement at 1.
[14] *Id.*
[15] *Id.*
[16] PRRB Rules v. 3.1 (Nov. 2021).

C.F.R. § 405.1837(b)(1). Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[17] The Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) as to how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 21-1206GC.

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 21-1206GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with the Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 and explain the nature of the any alleged "errors" in its Preliminary Position Paper and include *all* exhibits.

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

> **25.2.2 Unavailable and Omitted Documents**
>
> *If documents necessary to support your position are still unavailable,* then provide the following information in the position papers:
>
> 1. Identify the missing documents;
> 2. Explain why the documents remain unavailable;
> 3. State the efforts made to obtain the documents; and
> 4. Explain when the documents will be available.
>
> Once the documents become available, promptly forward them to the Board and the opposing party.[18]

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

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

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

https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH[19]

This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows: "DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[20]

Accordingly, the Board finds that the remaining issue in the instant appeal and the group issue from Group Case 21-1206GC are the same issue.[21] Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

2. Second Aspect of Issue 1

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

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

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[19] Last accessed January 4, 2024.
[20] Emphasis added.
[21] Moreover, even if it were not a prohibited duplicate, it was not properly in the individual appeal because it is a common issue that would be required to be in a Community Health CIRP group, per 42 C.F.R. § 405.1837(b)(1).

B. DSH Payment – Medicaid Eligible Days

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

> **Statement of Issue**
>
> Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.
>
> **Statement of the Legal Basis**
>
> The Provider contends that the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.
>
> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.[22]

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

The Provider's preliminary position paper indicated that it would be sending the eligibility listing under separate cover.[23]

Board Rule 7.3.1.2 states:

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

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

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

Notably, the Provider has not included a list of additional Medicaid eligible days with its preliminary position paper or submitted such list under separate cover. The Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it cannot produce those documents, as required by the regulations and the Board Rules.[24]

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

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. *Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board through a schedule applicable to a specific case or through general instructions*.[25]

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

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

Similarly, with regard to position papers,[26] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[27] This requirement is consistent with 42 C.F.R. § 405.1853(b)(3).

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

[25] (Emphasis added).

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

[27] (Emphasis added).

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

> *If documents necessary to support your position are still unavailable,* then provide the following information in the position papers:
>
> 1. Identify the missing documents;
> 2. Explain why the documents remain unavailable;
> 3. State the efforts made to obtain the documents; and
> 4. Explain when the documents will be available.
>
> Once the documents become available, promptly forward them to the Board and the opposing party.[28]

When determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(4)(iii) places the burden of production on the provider, stating:

> The hospital has the burden of furnishing data adequate to prove eligibility for *each Medicaid patient day* claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during *each claimed patient hospital day*.[29]

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

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

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

> • if it has a reasonable basis to believe that the issues have been fully settled or abandoned;
> • upon failure of the provider or group to comply with Board procedures or filing deadlines (*see* 42 C.F.R. § 405.1868);
> • if the Board is unable to contact the provider or representative at the last known address; or
> • upon failure to appear for a scheduled hearing.

[28] (Emphasis added).
[29] (Emphasis added).

The Board concurs with the Medicare Contractor that the Provider is required to identify and provide documentation to prove what additional Medicaid Eligible days are at issue and to which it may be entitled, consistent with 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rule 25. Further, pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[30] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. Based on the record before the Board, the Board finds that the Provider has failed to provide a listing or other supporting documentation for the Medicaid Eligible Days issue, as required by the controlling regulations and Board Rules. Nor has the Provider provided any explanation as to why the documentation was absent or what is being done to obtain it consistent with Board Rule 25.2.2. Indeed, without any days identified in the position paper filing, the Board assumes that there are no days nor any amount in dispute for this issue.

The Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of Board Rules 25.2.1 and 25.2.2, related to identifying the days in dispute and the submission of documentary evidence required to support its claims or describe why said evidence is unavailable.[31]

Accordingly, the DSH Payment – Medicaid Eligible Days issue is dismissed.

****

In summary, the Board hereby dismisses the DSH Payment/SSI Percentage (Provider Specific) issue from this appeal as it is duplicative of the issue in Case No. 21-1206GC and there is no final determination from which the Provider can appeal the SSI realignment portion of the issue. The Board also dismisses the DSH Payment - Medicaid Eligible Days issue as the Provider failed to meet the Board requirements for position papers for this issue, in compliance with 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25. As no issues remain pending, the Board hereby closes Case No. 22-0431 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.

[30] (Emphasis added).
[31] Board Rule 25, of which 25.2 (A) and 25.2 (B) are a part, is applicable to final position papers via Board Rule 27.2.

Board Members Participating:

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

For the Board:

1/4/2024

X Kevin D. Smith, CPA

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Board Decision***
Berwick Hospital Center (Provider Number 39-0072)
FYE: 06/30/2017
Case Number: 20-0189

Dear Mr. Summar and Mr. Lamprecht,

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

Background:

A. ***Procedural History for Case No. 20-0189***

On April 16, 2019, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end June 30, 2017.

On October 9, 2019, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained five (5) issues:

1. DSH Payment/SSI Percentage (Provider Specific)
2. DSH/SSI Percentage (Systemic Errors)[1]
3. DSH Payment – Medicaid Eligible Days[2]
4. UCC Distribution Pool
5. 2 Midnight Census IPPS Payment Reduction[3]

As the Provider is owned by Community Health Systems, Inc. (hereinafter "CHS") and, thereby, subject to the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1), the Provider transferred Issue 2 to CHS groups on May 29, 2020. After the withdrawal of Issues 3 and 5, the remaining issues in this appeal are Issues 1 and 4.

[1] On May 29, 2020, this issue was transferred to PRRB Case No. 20-0997GC.
[2] This issue was withdrawn on March 2, 2023.
[3] This issue was withdrawn on May 20, 2020.

On January 7, 2020, the Medicare Contractor filed a jurisdictional challenge, requesting the dismissal of Issues 1 and 4.[4] The Provider filed a response to the jurisdictional challenge on February 3, 2020.

On June 2, 2020, the Provider submitted its preliminary position paper.

On September 11, 2020, the Medicare Contractor filed its preliminary position paper.

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

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

> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> . . .
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[5]

As the Provider is commonly owned by CHS, the Provider transferred its Issue 2 – DSH/SSI Percentage to the CIRP group under 20-0997GC, CHS CY 2017 DSH SSI Percentage CIRP Group, on May 29, 2020. The Group Issue Statement in Case No. 20-0997GC reads, in part:

> **Statement of the Issue:**
>
> Whether the Secretary properly calculated the Provider's [DSH]/[SSI] percentage, and whether CMS should be required to recalculate the SSI percentages using a denominator based solely upon covered and paid for Medicare Part A days, or alternatively, expand the numerator of the SSI percentage to include paid/covered/entitled as well as unpaid/non-covered/eligible SSI days?

[4] The Jurisdictional Challenge also challenged Issue 5. However, as noted previously, this issue was subsequently withdrawn.
[5] Issue Statement at 1 (Oct. 9, 2019).

Statement of the Legal Basis

The Provider(s) contend(s) that the MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). The Provider(s) further contend(s) that the SSI percentages calculated by [CMS] and used by the MAC to settle their Cost Reports incorporates a new methodology inconsistent with the Medicare statute.

The Providers challenge their SSI percentages based on the following reasons:

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

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $7,000.

On June 2, 2020, the Provider filed its preliminary position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

Provider Specific

The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation based on the Provider's Fiscal Year End (June 30).

The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.

Similar to *Loma Linda Community Hospital v. Dept of Health and Human Services*, No. CV-94-0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records. However, at this time, the Provider has been unable to analyze the Medicare Part A data because it has not yet received

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

> the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR"), HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000 from CMS. *See* 65 Fed. Reg. 50,548 (2000). Upon release of the complete MEDPAR data, the Provider will seek to reconcile its' records with that of CMS, and identify patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS based on the Federal Fiscal Year End (September 30) when it determined the Provider's SSI. *See Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).[7]

MAC's Contentions

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

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

> The decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election. It is not a final intermediary determination. A hospital must make a formal request to CMS in order to receive a realigned SSI percentage. Once the hospital elects to use its own fiscal year end, it is bound by that decision, regardless of the reimbursement impact.
>
> . . .
>
> The MAC contends that the Board does not have jurisdiction over the realignment portion of issue 1 and respectfully requests the Board to dismiss it from this appeal.[8]

In addition, the MAC argues the DSH – SSI Percentage (Provider Specific) issue and the DSH – SSI Percentage (Systemic Errors) issue are duplicates.[9]

Issue 4 – UCC Distribution Pool

The MAC argues that "[t]he Board does not have jurisdiction over the UCC DSH payment issue because jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2)."[10]

---

[7] Provider's Preliminary Position Paper at 8-9 (June 2, 2020).
[8] Jurisdictional Challenge at 7 (Jan. 7, 2020).
[9] *Id*. at 6.
[10] *Id*. at 10.

Provider's Jurisdictional Response

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

The Provider argues that the issues are not duplicative because "issues #1 and 2 represent different components of the SSI issue, which was specifically adjusted during the audit."[11] Additionally, the Provider argues that the issue is not duplicative because the Provider is "not addressing the errors which result from CMS' improper data matching process but is addressing the various errors of omission and commission that do not fit into the "systemic errors" category."[12]

Finally, the Provider contends the Provider Specific issue is appealable "because the MAC specifically adjusted the Provider's SSI percentage and the Provider is dissatisfied with the amount of DSH payments that it received for fiscal year 2017, as a result of its understated SSI percentage due to errors of omission and commission."[13]

Issue 4 – UCC Distribution Pool

In response to the MAC's position that the Provider is violating PRRB Rule 4.6.2 by appealing from the same issue from distinct determinations in multiple appeals, the Provider argues:

> Providers (sic) have appealed from the Federal Registers dated August 17, 2015, August 22, 2106 (sic) and from the NPR. In this instance, Provider's appeals in PRRB CN # 16-0769GC, 17-1042GC and #20-0189 are from two separate and distinct determinations, and appeal rights associated with Federal Register Publications vary from those of appeal rights based upon NPRs. Therefore, Provider contends there is no conflict with PRRB Rule 4.6.2, and Provider wishes to preserve their appeals for both types of appeals.[14]

Analysis and Recommendation

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2020), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

[11] Jurisdictional Response at 1 (Feb. 3, 2020).
[12] *Id*. at 2.
[13] *Id*.
[14] *Id*. at 3.

A. DSH Payment/SSI Percentage (Provider Specific)

The jurisdictional analysis for Issue 1 has two relevant aspects to consider: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, and 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period. As set forth below, the Board dismisses both aspects of Issue 1.

1. First Aspect of Issue 1

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

The DSH Payment/SSI Percentage (Provider Specific) issue in the present appeal concerns "[w]hether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation."[15] The Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[16] The Provider argues that "its' SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[17]

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 20-0997GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds the DSH Payment/SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 20-0997GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[18], the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

In making this finding, the Board further notes that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations, and to that end, the Provider is pursuing that issue as part of the group under Case No. 20-0997GC, which is required since it is subject to the CIRP group regulations under 42

[15] Issue Statement at 1.
[16] *Id.*
[17] *Id.*
[18] PRRB Rules v. 2.0 (Aug. 2018).

C.F.R. § 405.1837(b)(1). Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[19] The Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) as to how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 20-0997GC.

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

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

> **25.2.2 Unavailable and Omitted Documents**
>
> *If documents necessary to support your position are still unavailable,* identify the missing documents, explain why the documents remain unavailable, state the efforts made to obtain the documents, and explain when the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.[20]

The Board further notes that the Provider only cites to the 2000 Federal Register but additional issuances and developments on the availability of data underlying the SSI fraction, such MEDPAR data, have occurred. For example, as noted in the FY 2006 IPPS Final Rule, "[b]eginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108–173), we will arrange to furnish, consistent with the Privacy Act, MedPAR LDS data for a hospital's patients eligible for both SSI and Medicare at the hospital's request, regardless of whether there is a properly pending appeal relating to DSH payments. *We will make the information available for either the Federal fiscal year or, if the*

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

hospital's fiscal year differs from the Federal fiscal year, for the ***months included in the 2 Federal fiscal years that encompass the hospital's cost reporting period***. Under this provision, *the hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year*. The data set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year." Further highlighting the perfunctory nature of the briefing is the fact that providers *can* obtain certain data used to calculate their DSH SSI ratios directly from the Centers for Medicare and Medicaid Services ("CMS") and in some cases on a self-service basis as explained on the following webpage:

> https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH.[21]

This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows: "DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[22]

Accordingly, the Board finds that the remaining issue in the instant appeal and the group issue from Group Case 20-0997GC are the same issue.[23] Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

2. Second Aspect of Issue 1

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

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

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[21] Last accessed January 4, 2024.
[22] Emphasis added.
[23] Moreover, even if it were not a prohibited duplicate, it was not properly in the individual appeal because it is a common issue that would be required to be in a Community Health CIRP group per 42 C.F.R. § 405.1837(b)(1).

B. UCC Distribution Pool

The Board finds that it does not have jurisdiction over the DSH UCC payment issue in the above-referenced appeal because jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2).

1. Bar on Administrative Review

The Board does not generally have jurisdiction over Uncompensated Care DSH payment issues because 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2) preclude administrative and judicial review of certain aspects of the UCC payment calculation. Based on these provisions, judicial and administrative review is precluded 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).[24]
>
> (B) Any period selected by the Secretary for such purposes.

2. Interpretation of Bar on Administrative Review

a. Tampa General v. Sec'y of HHS

In *Florida Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Servs*. ("*Tampa General*"),[25] the U.S. Court of Appeals for the District of Columbia Circuit ("D.C. Circuit") upheld the D.C. District Court's decision[26] that there is no judicial or administrative review of uncompensated care DSH payments. In that case, 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 D.C. Circuit 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 hospital was seeking review of an "estimate" used by the Secretary to determine the factors used to calculate additional payments. The D.C. Circuit went on to hold that "the bar on judicial review of the Secretary's estimates precludes review of the underlying

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[24] Paragraph (2) is a reference to the three factors that make up the uncompensated care payment: (1) 75 percent of estimated DSH payments that would be paid in absence of § 1395ww(r); (2) 1 minus the percentage of individuals under age 65 who are uninsured in 2013 for the FY 2014 calculation; and (3) the hospital specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital with potential to receive DSH payments, to the amount of uncompensated care for all subsection (d) hospitals that receive payment under 42 U.S.C. § 1395ww(r)(2)(C). 78 Fed. Reg. 50496, 50627, 50631 and 50634.
[25] 830 F.3d 515 (D.C. Cir. 2016).
[26] 89 F. Supp. 3d 121 (D.D.C. 2015).

data as well."[27] 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.[28]

The D.C. Circuit went on to address the provider'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.[29]

b. DCH Regional Med. Ctr. v. Azar

The D.C. Circuit Court revisited the judicial and administrative bar on review of uncompensated care DSH payments again in *DCH Regional Med. Ctr. v. Azar* ("*DCH v. Azar*").[30] 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. Indeed, 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 estimation without reviewing the estimate itself."[31] 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 it 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, the D.C. Circuit found the same relationship existed with regard to the methodology used to generate the estimates.[32]

c. Scranton Quincy Hosp. Co. v. Azar

Recently, in *Scranton Quincy Hosp. Co. v. Azar* ("*Scranton*"),[33] the D.C. District Court considered a similar challenge and held that administrative review was precluded. In *Scranton*, the providers were challenging how the Secretary determined the amount of uncompensated care that would be used in calculating Factor 3 for their FY 2015 DSH adjustments.[34] For 2015 payments, the Secretary announced she would calculate DSH payments based on Medicaid and SSI patient days from 2012 cost reports, unless that cost report was unavailable or was for a period less than twelve months. In that scenario, the Secretary would calculate the FY 2015 DSH payments based on either the 2012 or 2011 cost report that was closest to a full twelve

[27] 830 F.3d 515, 517.
[28] *Id.* at 519.
[29] *Id.* at 521-22.
[30] 925 F.3d 503 (D.C. Cir. 2019) ("*DCH v. Azar*").
[31] *Id.* at 506.
[32] *Id.* at 507.
[33] 514 F. Supp. 249 (D.D.C. 2021).
[34] *Id.* at 255-56.

month cost report.[35] Since the providers in *Scranton* changed ownership in FY 2012, each had two cost reports that began in 2012: an initial cost report less than twelve months and a subsequent cost report that was a full twelve months.[36] Nevertheless, the Secretary used each hospital's shorter cost reporting period in calculating the Factor 3 values for their FY 2015 DSH payments.[37]

In *Scranton*, the providers argued that, unlike the providers in *Tampa General* and *DCH v. Azar* who were specifically attacking the methodology and policies adopted by the Secretary, they were simply trying to enforce those policies. The D.C. District Court was not persuaded, finding that the complaint was still about the method used and the particular data the Secretary chose to rely upon when estimating the amount of uncompensated care calculated. Just like in *Tampa General* and *DCH v. Azar*, the selection of one cost report for FY 2012 over another was "inextricably intertwined" with the Secretary's estimate in Factor 3 and not subject to administrative review. Similarly, the challenge to the decision to use one cost report over another was also a challenge to a "period selected by the Secretary," which is also barred from review.[38]

Finally, and perhaps most importantly, the D.C. District Court found that any allegations that the Secretary departed from her own policy and/or acted *ultra vires* did not alter its decision. The D.C. District Court found that, in the context of the bar on review of the Secretary's estimates used and periods chosen for calculating the factors in the UCC payment methodology, "saying that the Secretary wrongly departed from his own policies when he chose the data for the estimate or selected the period involved is fundamentally indistinguishable from a claim that he chose the wrong data or selected the wrong period."[39] While there is some case law to support that claims of *ultra vires* acts may be subject to review in narrow circumstances where such review is precluded by statute, the criteria in *Scranton* were not met.[40] For review to be available in these circumstances, the following criteria must satisfied:

> (i) the statutory preclusion of review is implied rather than express; (ii) there is no alternative procedure for review of the statutory claim; and (iii) the agency plainly acts in excess of its delegated powers and contrary to a specific prohibition in the statute that is clear and mandatory.[41]

The D.C. District Court found that the preclusion of review for this issue was express, not implied, which fails to satisfy the first prong of this test. Second, the departure from the period

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[35] *Id.* (quoting 79 Fed. Reg. 49854, 50018 (Aug. 22, 2014)).
[36] *Id.* One provider had a cost report for the six-month period from July 1, 2011 to December 31, 2011 and another for the twelve-month period from July 1, 2012 to June 30, 2013, while the second had a cost report for the nine-month period from October 1, 2011 to June 30, 2012 and another for the twelve-month period from July 1, 2012 to June 30, 2013.
[37] *Id.*
[38] *Id.* at 262-64.
[39] *Id.* at 265.
[40] *Id.* (discussing *Leedom v. Kyne*, 358 U.S. 184, 188 (1958)).
[41] *Id.* at 264 (quoting *DCH v. Azar*, 925 F.3d at 509-510).

to be used announced in the Secretary's rulemaking does not satisfy the third prong, which requires a violation of a clear statutory command.[42] The D.C. District Court ultimately upheld the Board's decision that it lacked jurisdiction to consider the providers' appeals.

d. Ascension Borgess Hospital v. Becerra

Even more recently, the D.C. Circuit revisited, once again, the judicial and administrative bar on review of uncompensated care DSH payments again in *Ascension Borgess Hospital v. Becerra* ("*Ascension*").[43] In *Ascension*, the providers sought an order declaring the Worksheet S-10 audit protocol was unlawful, vacating the payments based on the Worksheet S-10 audit, requiring the Secretary to recalculate those payments, and setting aside the Board decisions refusing to exercise jurisdiction over their appeals.[44] Ultimately, the D.C. Circuit found that 42 U.S.C. § 1395ww(r)(3) bars administrative and judicial review of the provider's claims. In making this finding, the D.C. Circuit pointed to its earlier decisions in *Tampa General* and *DCH v. Azar* where it "repeatedly applied a "functional approach" focused on whether the challenged action was " 'inextricably intertwined' with the unreviewable estimate itself" and eschewing "categorical distinction between inputs and outputs."[45] The D.C. Circuit further dismissed the applicability of the Supreme Court's 2019 decision in *Azar v. Allina Health Servs*.[46] noting that "[t]he scope of the Medicare Act's notice-and-comment requirement would be relevant in evaluating the merits of plaintiffs' claims—i.e., that the Worksheet S-10 audit protocol establishes or changes a substantive legal standard within the meaning of § 1395hh(a)(2)—***but has no bearing on whether these claims are barred by the Preclusion Provision***."[47]

The Board finds that the same findings are applicable to the Provider's challenge to their FFY 2017 UCC payments. The Providers here are challenging their uncompensated care DSH Payment amounts, as well as the general rules governing the methodology used in calculating those amounts, for FFY 2017. The challenge to CMS' notice and comment procedures focuses on a lack of information and underlying data used by the Secretary to determine the UCC payments, but *Tampa General* held that the underlying data cannot be reviewed or challenged. Likewise, the Provider's arguments centering on the *Allina* decision claim that certain data should be recalculated or revised. Again, a challenge to the underlying data used in calculating UCC DSH payments is not subject to administrative or judicial review. Likewise, any challenge to the methodology used to determine the payment amounts was rejected in *DSCH v. Azar*, finding that the methodology was just as "inextricably intertwined" with the actual estimates as the underlying data, and barred from review.

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[42] *Id.* at 264-6511 (quoting *DCH v. Azar*, 925 F.3d at 509).
[43] Civ. No. 20-139, 2021 WL 3856621 (D.D.C. August 30, 2021).
[44] *Id*. at *4.
[45] *Id.* at *9.
[46] 139 S. Ct. 1804 (2019).
[47] *Ascension* at *8 (bold italics emphasis added).

In summary, the Board hereby dismisses the DSH Payment/SSI Percentage (Provider Specific) issue from this appeal as it is duplicative of the issue in Case No. 20-0997GC and there is no final determination from which the Provider can appeal the SSI realignment portion of the issue. Finally, the Board dismisses the UCC Distribution Pool issue as the Board does not have jurisdiction because 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2) preclude administrative and judicial review of certain aspects of the UCC payment calculation. As no issues remain pending, the Board hereby closes Case No. 20-0189 and removes it from the Board's docket.

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

Board Members Participating:

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

For the Board:

1/5/2024

X Kevin D. Smith, CPA

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Board Dismissal of SSI Percentage (Provider Specific)***
Chester Regional Medical Center (Provider Number 42-0019)
FYE: 09/30/2017
Case Number: 21-0401

Dear Mr. Summar and Mr. Lamprecht,

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

Procedural History for Case No. 21-0401

On July 8, 2020, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end September 30, 2017.

On December 11, 2020, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained seven (7) issues:

1. Disproportionate Share Hospital (DSH) Supplemental Security Income (SSI) Percentage (Provider Specific)
2. DSH SSI Percentage[1]
3. DSH – SSI Fraction/Medicare Managed Care Part C Days[2]
4. DSH – SSI Fraction Dual Eligible Days[3]
5. DSH – Medicaid Eligible Days[4]
6. DSH – Medicaid Fraction Medicare Managed Care Part C Days[5]
7. DSH – Medicaid Fraction Dual Eligible Days[6]

The remaining issue in this appeal is Issue 1.

[1] On July 22, 2021, this issue was transferred to Case No. 20-1332GC.
[2] On July 22, 2021, this issue was transferred to Case No. 19-2620GC.
[3] On July 22, 2021, this issue was transferred to Case No. 20-1383GC.
[4] On March 2, 2023, this issue was withdrawn by the Provider.
[5] On July 22, 2021, this issue was transferred to Case No. 19-2620GC.
[6] On July 22, 2021, this issue was transferred to Case No. 20-1383GC.

On September 1, 2021, the Provider submitted its preliminary position paper.

On November 5, 2021, the Medicare Contractor filed a Jurisdictional Challenge.

On November 22, 2021, the Medicare Contractor submitted its preliminary position paper.

On January 6, 2023, the Medicare Contractor submitted a final request for DSH Medicaid Eligible Days support.

A. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 20-1332GC

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

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

As the Provider is commonly owned by Community Health Systems, the Provider transferred its Issue 2 – DSH/SSI Percentage to the CIRP group under 20-1332GC, CHS CY 2017 HMA DSH SSI Percentage CIRP Group, on July 22, 2021. The Group Issue Statement in Case No. 20-1332GC reads, in part:

> **Statement of the Issue:**
>
> Whether the Secretary properly calculated the Provider's [DSH]/[SSI] percentage, and whether CMS should be required to recalculate the SSI percentages using a denominator based solely upon covered and paid for Medicare Part A days, or alternatively, expand the numerator of the SSI percentage to include paid/covered/entitled as well as unpaid/non-covered/eligible SSI days?

[7] Issue Statement at 1 (Dec 11, 2020).

Statement of the Legal Basis

The Provider(s) contend(s) that the MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). The Provider(s) further contend(s) that the SSI percentages calculated by [CMS] and used by the MAC to settle their Cost Reports incorporates a new methodology inconsistent with the Medicare statute.

The Providers challenge their SSI percentages based on the following reasons:

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

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $4,000.

On September 1, 2021, the Provider filed its preliminary position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

Provider Specific

The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation. This is based on certain data from the State of South Carolina and the Provider that does not support the SSI percentage issued by CMS.

The Provider has worked with the State of South Carolina and has learned that similar to *Loma Linda Community Hospital v. Dept of Health and Human Services*, No. CV-94-0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records.

[8] Group Issue Statement, Case No. 20-1332GC.

> The Provider is seeking the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000 from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. *See* 65 Fed. Reg. 50,548 (2000). The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction.[9]

MAC's Contentions

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

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

> The decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election. It is not a final contractor determination. A hospital must make a formal request to CMS in order to receive a realigned SSI percentage. Once the hospital elects to use its own fiscal year end, it is bound by that decision, regardless of reimbursement impact.
>
> . . .
>
> The Provider's appeal is premature. To date the Provider has not requested to have its SSI percentage realigned in accordance with 42 C.F.R. § 412.106(b)(3). Thus, the Provider has not exhausted all available remedies for this issue. The MAC requests that the Board dismiss this issue consistent with recent jurisdictional decisions.[10]

In addition, the MAC argues the DSH – SSI Percentage (Provider Specific) issue and the DSH – SSI Percentage (Systemic Errors) issue are duplicates.[11]

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[9] Provider's Preliminary Position Paper at 8-9 (September 1, 2021).
[10] Jurisdictional Challenge at 6-7 (November 5, 2021).
[11] *Id*. at 4-6.

Provider's Jurisdictional Response

The Board Rules require that Provider Responses to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[12] The Provider has not filed a response to the Jurisdictional Challenge and the time for doing so has elapsed. Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

Board Analysis and Decision:

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

A. DSH Payment/SSI Percentage (Provider Specific)

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

1. First Aspect of Issue 1

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH/SSI Percentage (Systemic Errors) issue that was appealed in PRRB Case No. 20-1332GC.

The DSH Payment/SSI Percentage (Provider Specific) issue in the present appeal concerns "[w]hether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation."[13] The Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[14] The Provider argues that "its' SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ."

[12] Board Rule 44.4.3, v. 3.1 (Nov. 2021)
[13] Issue Statement at 1.
[14] *Id.*

and it ". . . disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[15]

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 20-1332GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds the DSH Payment/SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 20-1332GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[16], the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

In making this finding, the Board further notes that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, the Provider is pursuing that issue as part of the group under Case 20-1332GC, which is required since it is subject to the CIRP group regulations under 42 C.F.R. § 405.1837(b)(1). Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[17] The Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) as to how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 20-1332GC.

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 20-1332GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with the Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" in its Preliminary Position Paper and include *all* exhibits.

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

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[15] *Id.*

[16] PRRB Rules v. 3.1 (Nov. 2021).

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

25.2.2 Unavailable and Omitted Documents

If documents necessary to support your position are still unavailable, identify the missing documents, explain why the documents remain unavailable, state the efforts made to obtain the documents, and explain when the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.[18]

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

https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH.[19]

This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows: "DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[20]

Indeed, the D.C. Circuit affirmed in *Advocate Christ Med. Ctr. v. Becerra*, No. 22-5214, 2023WL5654312 (D.C. Cir., Sept. 1, 2023) that "What [MMA] section 951 cannot mean is that HHS must give hospitals data that it never received from SSA in the first place. And SSA does not provide HHS with the specific codes assigned to individual patients. See 75 Fed. Reg. at 50,276." Here, the Provider does not explain what information it needs or is waiting on or claims that it should have access to.

[18] (Emphasis added).
[19] Last accessed January 4, 2024.
[20] Emphasis added.

Accordingly, *based on the record before it*, the Board finds that the remaining issue in the instant appeal and the group issue from Group Case 20-1332GC are the same issue.[21] Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

2. Second Aspect of Issue 1

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

The Board finds that, under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." Without this written request, the Medicare Contractor cannot issue a final determination with which the Provider can be dissatisfied for appeal purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding DSH SSI Percentage realignment. Therefore, the Board finds that it lacks jurisdiction in this aspect of the appeal. Further, the Board takes note that the Provider's cost reporting period ends on 9/30, which is consistent with the Federal fiscal year end. Thus, any realignment of the SSI percentage would use the same data and have no effect on reimbursement.

****

In summary, the Board hereby dismisses the DSH Payment/SSI Percentage (Provider Specific) issue from this appeal as it is duplicative of the issue in Case No. 20-1332GC and there is no final determination from which the Provider can appeal the SSI realignment portion of the issue. The Board also dismisses the DSH Payment - Medicaid Eligible Days issue as the Provider failed to meet the Board requirements for position papers for this issue in compliance with 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25. As no issues remain pending, the Board hereby closes Case No. 21-0401 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.

[21] Moreover, even if it were not a prohibited duplicate, it was not properly in the individual appeal because it is a common issue that would be required to be in a Community Health Systems CIRP group per 42 C.F.R. § 405.1837(b)(1).

Board Members Participating:

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

For the Board:

1/5/2024

X Kevin D. Smith, CPA

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

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

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RE: ***Board Decision– SSI Percentage (Provider Specific)***
Merit Health Rankin, Prov. No. 25-0096, FYE 12/31/2017
Case No. 20-0471

Dear Messrs. Summar and Lamprecht,

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the documentation in the above-referenced appeal. The Board's analysis and determination is set forth below.

Background:

A. Procedural History for Case No. 20-0471

On **May 24, 2019**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end December 31, 2016. On **November 15, 2019**, the Provider's representative, Mr. Summar at Community Health Systems ("CHS"), filed the Provider's appeal request with the Board appealing that NPR for the following nine (9) issues where 7 involved the disproportionate share hospital ("DSH") payment:

Issue 1: DSH Payment Supplemental Security Income (SSI) Percentage- Provider Specific
Issue 2: DSH Payment SSI Percentage
Issue 3: SSI Fraction Medicare Managed Care Pt. C Days
Issue 4: SSI Fraction Dual Eligible Days
Issue 5: DSH- Medicaid Eligible Days
Issue 6: Medicaid Fraction Medicare Managed Care Pt. C Days
Issue 7: Medicaid Fraction Dual Eligible Days
Issue 8: Uncompensated Care Distribution Pool
Issue 9: 2 Midnight Census IPPS Payment Reduction

After all issues but the DSH Payment/SSI Percentage (Provider Specific) issue were either withdrawn or transferred, DSH SSI Provider specific is the sole issue that remains pending in the appeal.

On **July 1, 2020**, CHS filed the Provider's preliminary position paper.

On **October 16, 2020**, the Medicare Contractor filed a Jurisdictional Challenge over Issue 1 requesting that it be dismissed as a prohibited duplicate of the Provider's pursuit of the same issue in Case No. 19-0173GC. CHS did not filed a response. Significantly, the Provider did ***not*** file a response to the Jurisdictional Challenge within the 30 day period specified in Board Rule 44.4.3.

On **October 22, 2020**, the Medicare Contractor filed its preliminary position paper.

B. Description of Issue 1 in the Appeal Request & the Provider's Participation in Case No. 19-0173GC

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

> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> The Provider contends that the SSI percentage issued by CMS is flawed.
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include. in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395(d)(5)(F)(i).
>
> The Provider also contends that CMS inconsistently interprets the term "entitled" as it is used in the statistic. CMS requires SSI payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the denominator. CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days of care) as Medicare Part A days, yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment.[1]

On June 15, 2020, the Provider was directly added to Case No. 19-0173GC, appealing from the same NPR as the instant appeal. This common issue related party ("CIRP") group issue statement reads:

> The Provider(s) contend(s) that the MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute at 42 U.S.C. § 1395ww (d)(5)(F)(vi)(I). The Provider(s) further contend(s) that the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") and used by the MAC to settle their Cost Reports incorporates a new methodology inconsistent with the Medicare statute.
>
> The Providers challenge their SSI percentages based on the following reasons:
>
> 1. Availability of MEDPAR and SSA Records;
> 2. Paid days vs. eligible days;
> 3. Not in agreement with provider's records;
> 4. Fundamental problems in the SSI percentage calculation;
> 5. Covered days vs. Total days; and

[1] Provider's Request for Hearing, Issue Statement (Nov. 15, 2019)

6. Failure to adhere to required notice and comment rulemaking procedures.[2]

The appeal request lists the amount in controversy listed for both Issues 1 and 2 as $15,000.

On July 1, 2020, the Provider filed its preliminary position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Calculation of the SSI Percentage**
>
> **Provider Specific**
>
> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's Fiscal Year End (December 31).
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.
>
> Similar to L*oma Linda Community Hospital v. Dept of Health and Human Services*, No. CVT94- 0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records. However, at this time, the Provider has been unable to analyze the Medicare Part A data because it has not yet received the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR"), HHS/HCFAIOIS, 09-07-009, which was published in the Federal Register on August 18, 2000. Upon release of the complete MEDPAR data, the Provider will seek to reconcile its' records with that of CMS, and identify patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS based on the Federal Fiscal Year End (September 30) when it determined the Provider's SSI. *See Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).

Significantly, no exhibits were included with the position paper for this issue other than a copy of the *generic* 0.25 percent estimated impact of this issue that was included with the appeal request.[3]

Medicare Contractor's Contentions

Issue 1 – DSH SSI Percentage (Provider Specific)

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

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[2] *See* Group Issue Statement, Case No. 19-0173GC.
[33] Exhibit P-2 at1 states that "Estimated Impact of 0.25% [or $15,647] increase in SSI Percentage due to the Provider".

> The decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election. It is not a final contractor determination. A hospital must make a formal request to CMS in order to receive a realigned SSI percentage. Once the hospital elects to use its own fiscal year end, it is bound by that decision, regardless of reimbursement impact
>
> ****
>
> The Provider's appeal is premature. To date the Provider has not requested to have its SSI percentage realigned in accordance with 42 C.F.R. § 412.106(b)(3). Thus, the Provider has not exhausted all available remedies for this issue. The MAC requests that the Board dismiss this issue consistent with recent jurisdictional decisions.[4]

In addition, the MAC argues the DSH Payment/SSI Percentage (Provider Specific) issue and the DSH Payment/SSI (Systemic Errors) issue are considered the same issue by the Board, and the Provider is appealing this issue in PRRB Case No. 19-0173GC. The MAC requests the Board to dismiss the SSI data accuracy sub-issue as duplicate filing in violation of Board Rule 4.6.1.[5]

Provider's Response

The Provider did ***not*** file a response to the Jurisdictional Challenge. Board Rule 44.4.3 specifies, "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

Board Analysis and Decision

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

A. DSH Payment/SSI Percentage (Provider Specific)

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

[4] Jurisdictional Challenge (Oct. 16, 2020).
[5] *Id*.

1. First Aspect of Issue 1

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH SSI Percentage (Systemic Errors) issue transferred into Group Case No 19-0173GC.

The DSH Payment/SSI Percentage (Provider Specific) issue in the present appeal concerns "whether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation."[6] The Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[7] The Provider argues that "its SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[8]

The Provider's DSH Payment/SSI (Systemic Errors) issue in group Case No. 19-0173GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds the DSH Payment/SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH Payment/SSI (Systemic Errors) issue in Case No. 19-0173GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[9], the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

In making this finding, the Board further notes that CMS regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, is pursuing that issue as part of the group under Case 19-0173GC. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in Baystate, may impact the SSI percentage for each provider differently, including whether CMS has interpreted "entitled" consistently.[10] The Provider is misplaced in referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 19-0173GC.

To this end, the Board also reviewed the Provider's Preliminary Position Paper (as attached to the Motion to Dismiss) to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 19-0173GC, but instead refers to systemic Baystate data matching issues that are the subject of the issue in the group appeal. For example, the Provider asserts that

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[6] Issue Statement at 1.
[7] *Id.*
[8] *Id.*
[9] PRRB Rules v. 2.0 (August 2018).
[10] The types of systemic errors documented in the Baystate did not uniformly impact the SSI calculation for all providers but that does not make the errors any less systemic. See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co., PRRB Dec. No. 2006-D20 (Mar. 17, 2006). See also Baystate Med. Ctr. v. Leavitt, 545 F. Supp. 2d 20 (D.D.C. 2008).

"the SSI entitlement of individuals can be ascertained from State records" but fails to explain what that means, what the basis for the alleged fact is,[11] or why that it even relevant to the issue. Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with the Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be fully developed and include all available documentation necessary to provide a thorough understanding of their opponent's positions." Here, it is clear that the Provider failed to fully develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" in its Preliminary Position Paper and include all exhibits.

Moreover, the Provider has failed to comply with Board Rule 25.2.2 (2018) to explain why the MEDPAR data is unavailable. In this regard, Board Rule 25.2.2 (2018) specifies:

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

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

> https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH. This CMS webpage describes access to DSH data from 1998 to 2017 as follows: "DSH is now a self-service application. This new self-service process enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[12]

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

[11] There are no exhibits or citations or examples of how SSI entitlement can be ascertained from state records.
[12] Last accessed February 24, 2023.

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper must set forth the relevant facts and arguments regarding the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and the merits of the provider's Medicare payment claims for each remaining issue.

Accordingly, *based on the record before it*,[13] the Board finds that the remaining issue in the instant appeal and the group issue from Group Case 19-0173GC are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

2. Second Aspect of Issue 1

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

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

****

In summary, the Board hereby dismisses the DSH Payment/SSI Percentage (Provider Specific) issue from this appeal as it is duplicative of the issue in Case No. 19-0173GC and there is no final determination from which the Provider can appeal the SSI realignment portion of the issue.

As no issues remain pending, the Board hereby closes Case No. 20-0471 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:

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

For the Board:

1/8/2024

X Clayton J. Nix

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

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

[13] Again, CHS failed to respond to the Jurisdictional Challenge. The Board also takes administrative notice that it has made similar dismissals of duplicate SSI Provider Specific issues in numerous other CHS individual provider cases.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Dismissal of Duplicate Appeal***
18-0252GC Ascension Health 2009 Revised NPR DSH SSI Fraction Dual Eligible Days CIRP Group

Dear Ms. O'Brien Griffin and Mr. Redmond:

The above-referenced common issue related party ("CIRP") group appeal for Ascension Health ("Ascension") includes a challenge to the inclusion of dual eligible days in the Medicare fraction of the disproportionate share ("DSH") percentage and/or the exclusion of days for patients who are dually eligible for Medicaid from the Medicaid fraction of the DSH percentage, for patient discharges *before* October 1, 2013. The Provider Reimbursement Review Board ("PRRB" or "Board") has noted that the Common Owner of this group, Ascension, has already received a Hearing and a Board Decision for this specific Fiscal Year. As such, the above CIRP group appeal violates the CIRP regulation, is duplicative, and must be dismissed.

Background

The Board received the Group Representative's Request for Hearing dated November 21, 2017, to establish the above mentioned CIRP group.

In reviewing the documentation, the Board has noted that the common owner of this group had already received a hearing and a Board Decision issued for the Dual Eligible days issue for this specific fiscal year, in another group case. Specifically, the Board issued PRRB Dec. No. 2017-D11 on March 27, 2017, which included Case No. 13-2611GC, over whether "to include all supplementary security income ("SSI") eligible patient days in the numerator of the Medicare fraction of the Medicare DSH percentage . . ."[1]

Providence Health Center (Prov. No. 45-0042) is the only Provider included in the instant appeal. This Provider was also in Case No. 13-2611GC, the case that previously received a hearing and Board Decision on March 27, 2017, appealing from the same cost year. Given the inclusion of Case No. 13-2611GC in PRRB Dec. No. 2017-D11, these cases appear duplicative, and were reviewed for potential dismissal for violating the CIRP regulations.

[1] PRRB Dec. No. 2017-D11 at 2 (Mar. 27, 2017).

Board's Analysis and Decision

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

> Two or more providers under common ownership or control that wish to appeal to the Board a specific matter at issue that involves a question of fact or interpretation of law, regulations, or CMS Rulings that is common to the providers, and that arises in cost reporting periods that end in the same calendar year, and for which the amount in controversy is $50,000 or more in the aggregate, must bring the appeal as a group appeal.[2]

Subsection (e) requires that the group provider provide notice that the group is fully formed and complete.[3] Once the group is certified as complete, restrictions are placed on the ability for additional providers under common ownership:

> When the Board has determined that a group appeal brought under paragraph (b)(1) of this section is fully formed, absent an order from the Board modifying its determination, no other provider under common ownership or control may appeal to the Board the issue that is the subject of the group appeal with respect to a cost reporting period that falls within the calendar year(s) covered by the group appeal.[4]

PRRB Case No. 13-2611GC was fully formed as of October 24, 2014. Any additional providers outside of this group would be part of a duplicate case, violating those same CIRP regulations.[5] As PRRB Case No. 18-0252GC was part of the same common ownership, for the same issue, and for the same fiscal year, any providers within this case are in violation of 405.1837(b)(1) and (e), and thus must be dismissed.

As such, the Board dismisses the Dual Eligible Days issue from PRRB Case No. 18-0252GC because the issue was disposed of through PRRB Dec. No. 2017-D11, which included Case No. 13-2611GC, and thus, Case No. 18-0252GC violated the CIRP regulations at 42 C.F.R. § 405.1837(b)(1) and (e).

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

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[2] 42 C.F.R. § 405.1837(b)(1).
[3] 42 C.F.R. § 405.1837(e)(1).
[4] *Id*.
[5] *See* 42 C.F.R. § 405.1837(e).

Board Members Participating:

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

For the Board:

1/9/2024

X Kevin D. Smith, CPA

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

cc: Wilson C. Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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RE: ***Board Decision*** **– SSI Percentage (Provider Specific) and Medicaid Eligible Days**
Crossroads Community Hospital (Provider Number 14-0294)
FYE: 12/31/2015
Case Number: 19-0335

Dear Mr. Ravindran and Mr. Lamprecht,

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

Background:

A. ***Procedural History for Case No. 19-0335***

On May 7, 2018, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end December 31, 2015.

On October 29, 2018, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained six (6) issues:

1. DSH Payment/SSI Percentage (Provider Specific)
2. DSH/SSI Percentage[1]
3. DSH Payment – Medicaid Eligible Days[2]
4. Uncompensated Care ("UCC") Distribution Pool[3]
5. 2 Midnight Census IPPS Payment Reduction[4]
6. Standardized Payment Amount[5]

As the Provider is owned by Quorum Health and, thereby, subject to the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1), the Provider transferred Issues 2, 4, and 5 to Quorum

[1] On May 30, 2019, this issue was transferred to PRRB Case No. 18-1333GC.
[2] This issue was withdrawn on January 8, 2024. The MAC had previously filed a Motion to Dismiss on the issue, however since the issue was withdrawn, the Motion is moot and will not be addressed by the Board.
[3] On May 30, 2019, this issue was transferred to PRRB Case No. 18-0594GC.
[4] On May 30, 2019, this issue was transferred to PRRB Case No. 18-0595GC.
[5] This issue was withdrawn on June 13, 2019.

Health groups on May 30, 2019. After issues 3 and 6 were withdrawn, the remaining issue in the appeal is issue 1.

On February 22, 2019, the Medicare Contractor filed a Jurisdictional Challenge, requesting the dismissal of Issue 1.[6]

On June 13, 2019, the Provider filed its preliminary position paper.

On October 18, 2019, the Medicare Contractor filed its preliminary position paper.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 18-1333GC

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

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

As the Provider is commonly owned by Quorum Health, the Provider transferred its Issue 2 – DSH/SSI Percentage to the CIRP group under 18-1333GC, QRS Quorum 2015 DSH SSI Percentage CIRP Group, on May 30, 2019. The Group Issue Statement in Case No. 18-1333GC reads, in part:

> **Statement of the Issue:**
>
> Whether the Secretary properly calculated the Provider's [DSH]/[SSI] percentage, and whether CMS should be required to recalculate the SSI percentages using a denominator based solely upon covered and paid for Medicare Part A days, or alternatively, expand the numerator of the SSI percentage to include

[6] This motion also requested the dismissal of Issues 4, 5, and 6. However, those issues were subsequently transferred or withdrawn.
[7] Issue Statement at 1 (Oct. 29, 2018).

paid/covered/entitled as well as unpaid/non-covered/eligible SSI days?

Statement of the Legal Basis

The Provider(s) contend(s) that the MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). The Provider(s) further contend(s) that the SSI percentages calculated by [CMS] and used by the MAC to settle their Cost Report(s) incorporates a new methodology inconsistent with the Medicare statute.

The Providers challenge their SSI percentages based on the following reasons:

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

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $7,000.

On June 13, 2019, the Provider filed its preliminary position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

Provider Specific

The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation based on the Provider's Fiscal Year End (December 31).

The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.

Similar to *Loma Linda Community Hospital v. Dept of Health and Human Services*, No. CV-94-0055 (C.D. Cal. June 2, 1995), the

[8] Group Issue Statement, Case No. 18-1333GC.

> SSI entitlement of individuals can be ascertained from State records. However, at this time, the Provider has been unable to analyze the Medicare Part A data because it has not yet received the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR"), HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000 from CMS. *See* 65 Fed. Reg. 50,548 (2000). Upon release of the complete MEDPAR data, the Provider will seek to reconcile its' records with that of CMS, and identify patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS based on the Federal Fiscal Year End (September 30) when it determined the Provider's SSI. *See Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).[9]

MAC's Contentions

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

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

> The decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election. It is not a final intermediary determination. A hospital must make a formal request to CMS in order to receive a realigned SSI percentage. Once the hospital elects to use its own fiscal year end, it is bound by that decision, regardless of reimbursement impact.
>
> . . .
>
> The Provider's appeal is premature. To date the Provider has not requested to have its SSI percentage realigned in accordance with 42 C.F.R. § 412.106(b)(3). Thus, the Provider has not exhausted all available remedies for this issue. The MAC requests that the PRRB dismiss this issue consistent with recent jurisdictional decisions.[10]

In addition, the MAC argues the DSH Payment/SSI Percentage (Provider Specific) issue and the DSH/SSI Percentage issue are considered the same issue by the Board.[11]

---

[9] Provider's Preliminary Position Paper at 8-9 (June 13, 2019).
[10] Jurisdictional Challenge #1 at 4-5 (Feb. 22, 2019).
[11] *Id*. at 3-4.

Provider's Jurisdictional Response

The Board Rules require that Provider Responses to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[12] The Provider has not filed a response to the Jurisdictional Challenges and the time for doing so has elapsed. Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

Board Analysis and Decision:

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

DSH SSI Percentage (Provider Specific)

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

1. First Aspect of Issue 1

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH/SSI Percentage issue that was appealed in PRRB Case No. 18-1333GC.

The DSH Payment/SSI Percentage (Provider Specific) issue in the present appeal concerns "[w]hether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation."[13] The Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[14] The Provider argues that "its SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[15]

[12] Board Rule 44.4.3, v. 2.0 (Aug. 2018).
[13] Issue Statement at 1.
[14] *Id.*
[15] *Id.*

The Provider's DSH/SSI Percentage issue in group Case No. 18-1333GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). Thus, the Board finds the DSH Payment/SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH/SSI Percentage issue in Case No. 18-1333GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[16], the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

In making this finding, the Board further notes that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations, and to that end, the Provider is pursuing that issue as part of the group under Case 18-1333GC. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[17] The Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 18-1333GC.

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 18-1333GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with the Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." For example, the Provider asserts that "the SSI entitlement of individuals can be ascertained from State records"[18] but fails to explain what that means, what the basis for the alleged fact is,[19] or why that is even relevant to the issue. Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its appeal and explain the nature of the any alleged "errors" in its Preliminary Position Paper and include *all* exhibits.

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

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[16] PRRB Rules v. 2.0 (Aug. 2018).
[17] The types of systemic errors documented in the *Baystate* did not uniformly impact the SSI calculation for all providers but that does not make the errors any less systemic. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). *See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).
[18] Provider's Preliminary Position Paper at 8.
[19] There are no exhibit or citations to state records or example of how SSI entitlement can be ascertained from state records.

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

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

> https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH.[20]

This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows: "DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[21]

Indeed, the D.C. Circuit affirmed in *Advocate Christ Med. Ctr. v. Becerra*, No. 22-5214, 2023WL5654312 (D.C. Cir., Sept. 1, 2023) that "What [MMA] section 951 cannot mean is that HHS must give hospitals data that it never received from SSA in the first place. And SSA does not provide HHS with the specific codes assigned to individual patients. See 75 Fed. Reg. at 50,276." Here, the Provider does not explain what information it needs or is waiting on or claims that it should have access to.

Accordingly, *based on the record before it*, the Board finds that the remaining issue in the instant appeal and the group issue from Group Case 18-1333GC are the same issue. Because the issue is

[20] Last accessed January 4, 2024.
[21] Emphasis added.

duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

1. Second Aspect of Issue 1

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

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

****

In summary, the Board hereby dismisses the DSH Payment/SSI Percentage (Provider Specific) issue from this appeal as it is duplicative of the issue in Case No. 18-1333GC and there is no final determination from which the Provider can appeal the SSI realignment portion of the issue. As no issues remain pending, the Board hereby closes Case No. 19-0335 and removes it from the Board's docket.

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

Board Members Participating:

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

For the Board:

1/9/2024

X Kevin D. Smith, CPA

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

James Ravindran
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RE: ***Board Decision***
Poplar Bluff Regional Medical Center (Provider Number 26-0119)
FYE: 12/31/2015
Case Number: 19-1038

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the documentation in Case No. 19-1038 pursuant to a jurisdictional challenge filed by the Medicare Administrative Contractor ("MAC"). The Board's decision is set forth below.

Background

A. Procedural History for Case No. 19-1038

On July 19, 2018, the Provider, Poplar Bluff Regional Medical Center, was issued a Notice of Program Reimbursement ("NPR") for fiscal year end December 31, 2015.

On January 14, 2019, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained nine (9) issues:

1. DSH – SSI Percentage (Provider Specific)
2. DSH – SSI Percentage (Systemic Errors)[1]
3. DSH – SSI Fraction / Medicare Managed Care Part C Days[2]
4. DSH – SSI Fraction / Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payer Days, and No-Pay Part A Days[3]
5. DSH – Medicaid Eligible Days[4]
6. DSH – Medicaid Fraction / Medicare Managed Care Part C Days[5]

[1] On August 23, 2019, this issue was transferred to PRRB Case No. 18-0588GC.
[2] On August 23, 2019, this issue was transferred to PRRB Case No. 18-0589GC.
[3] On August 23, 2019, this issue was transferred to PRRB Case No. 18-0584GC.
[4] On January 2, 2024, the Provider withdrew this issue from the appeal.
[5] On August 23, 2019, this issue was transferred to PRRB Case No. 18-0591GC.

7. DSH – Medicaid Fraction / Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payer Days, and No-Pay Part A Days[6]
8. Uncompensated Care ("UCC") Distribution Pool[7]
9. 2 Midnight Census IPPS Payment Reduction[8]

As the Provider is commonly owned by Health Management Associates, Inc ("HMA"), and thereby, subject to the mandatory Common Issue Related Party ("CIRP") regulation at 42 C.F.R. § 405.1837(b)(1), the Provider transferred Issues 2, 3, 4, 6, 8, and 9 to QRS groups on August 23, 2019. The Provider withdrew Issue 5 from the appeal on January 2, 2024.

The only remaining issue in this appeal is Issue 1, DSH – SSI Percentage (Provider Specific).

On September 6, 2019, the Board received the Provider's preliminary position paper.

On December 16, 2019, the Medicare Contractor filed a jurisdictional challenge with the Board over Issue 1 and the Provider filed a jurisdictional response on January 13, 2020.[9]

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 18-0588GC

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

> The Provider contends that the MAC did not determine Medicare DSH Reimbursement in accordance with the statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i).
>
> . . .
>
> The Provider contends that its' SSI percentage published by the Centers for Medicare and Medicaid Services ("CMS") was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> . . .
>
> The Provider also contends that CMS inconsistently interprets the term "entitled" as it is used in the statute. CMS requires SSI payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the denominator. CMS interprets the term "entitled" broadly as it

[6] On August 23, 2019, this issue was transferred to PRRB Case No. 18-0585GC.
[7] On August 23, 2019, this issue was transferred to PRRB Case No. 18-0587GC.
[8] On August 23, 2019, this issue was transferred to PRRB Case No. 18-0592GC.
[9] The jurisdictional response was filed by Community Health Systems, who acquired HMA in 2014. CHS designated a new representative, QRS, as of November 22, 2023.

> applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days of care) as Medicare Part A days, yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment.[10]

The Group Issue Statement in Case No. 18-0588GC, to which the Provider transferred Issue 2 reads, in part:

> **Statement of the Legal Basis**
>
> The Provider contends that the Lead MAC's determination of Medicare Reimbursement for their DSH payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww(d)(5)(F)(vi). The Provider contends that the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") and used by the Lead MAC to settle their Cost Report were incorrectly computed.
>
> . . .
>
> The Provider also contends that CMS inconsistently interprets the term "entitled" as it is used in the statute. CMS requires SSI payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the denominator. CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days of care) as Medicare Part A days, yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment.
>
> The Provider(s) further contend(s) that the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") fail to address all the deficiencies as described in *Baystate Medical Center v. Michael O. Leavitt,* 545 F. Supp. 2d 20, *as amended,* 587 F. Supp. 2d 37, 44 (D.D.C. 2008) and incorporate a new methodology inconsistent with the Medicare Statute.
>
> Providers in this case are also seeking resolution of the following additional aspects of the Medicare fraction that were not addressed in the Baystate case:

[10] Provider's Appeal Request at 1 (Jan. 14, 2019).

1. Availability of MEDPAR and SSA Records
2. Failure to adhere to required notice and comment rulemaking procedures
3. Fundamental problems in the SSI percentage calculation
4. Not in agreement with provider's records
5. Paid days vs. Eligible days, and
6. Covered days vs. Total days[11]

On September 6, 2019, the Board received the Provider's preliminary position paper in 19-1038. The following is the Provider's ***complete*** position paper on Issue 1 set forth therein:

> **Provider Specific**
>
> The Provider contends that its' SSI percentage published by the Centers for Medicare and Medicaid Services ("CMS") was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation based on the Provider's Fiscal Year End (December 31).
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.
>
> Similar to *Loma Linda Community Hospital v. Dept. of Health and Human Services,* No. CV-94-0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from [s]tate records. However, at this time, the Provider has been unable to analyze the Medicare Part A data because it has not yet received the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR"), HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000[,] from CMS. *See* 65 Fed. Reg. 50,548 (2000). Upon release of the complete MEDPAR data, the Provider will seek to reconcile its' records with that of CMS, and identify patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS based on the Federal Fiscal Year End (September 30) when it determined the Provider's SSI. *See Baystate Medical Center v. Leavitt,* 545 F. Supp. 2d 20 (D.D.C. 2008).[12]

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $59,000.

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[11] Case No. 18-0588GC Group Appeal Issue Statement (Jan. 19, 2018).
[12] Provider's Preliminary Position Paper at 8-9 (Sept. 6, 2019).

MAC's Contentions

Issue 1 – DSH – SSI Percentage (Provider Specific)

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

> The MAC contends that Issue 1 has 3 sub-issues. Sub-issues 1 and 3 are duplicative of Issue 2. In sub-issues 1 and 3, the Provider states:
>
> > The Provider contends that the MAC did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations.
> >
> > The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
> >
> > . . .
> >
> > The Provider also contends that CMS inconsistently interprets the term "entitled" as it is used in the statute. CMS requires SSI payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the denominator. CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days of care) as Medicare Part A days yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment.
> >
> > . . .
>
> The Provider further argues in Issue 2:

> The Provider also contends that CMS inconsistently interprets the term "entitled" as it is used in the statute. CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days of care) as Medicare Part A days, yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment.
>
> The MAC contends that the above argument is duplicative of sub-issue 3 of Issue 1.
>
> The MAC requests that the Board dismiss sub-issues 1 and 3 of Issue 1 as they are duplicative of Issue 2.[13]

The MAC also argues that the appeal is premature because the Provider has not requested realignment, in accordance with 42 C.F.R. § 412.106(b)(3):

> The decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election. It is not a final MAC determination. The provider must make a formal request to the MAC and CMS in order to receive a realigned SSI percentage. Once the hospital elects to use its own fiscal year end, it is bound by that decision, regardless of the reimbursement impact.
> . . .
>
> The Provider's appeal of this item is premature. The Provider has not formally requested to have its SSI percentage realigned in accordance with 42 C.F.R. § 412.106(b)(3); therefore, the Provider has not exhausted all available remedies prior to requesting a PRRB appeal to resolve this issue. The MAC requests that the PRRB dismiss this issue consistent with recent jurisdictional decisions.[14]

Provider's Jurisdictional Response

The Provider filed a jurisdictional response, the Board which the Board received on January 13, 2020. The Provider made the following arguments in response to the Medicare Contractor's challenge:

> Provider contends that the Board has jurisdiction over the DSH/SSI issue, which includes both the "provider specific" and realignment sub-issues.

[13] Jurisdictional Challenge at 4-5 (Dec. 16, 2019).
[14] Jurisdictional Challenge at 5-6 (Dec. 16, 2019).

Duplicate SSI Issues:

The MAC argues issue 1 – SSI Provider Specific/Realignment is a duplicate issue to issue 2 – SSI Systemic issue that the Provider transferred to group appeal 18-0588GC QRS HMA 2015 DSH SSI Percentage CIRP Group, Provider contends each of the appeal SSI issues are separate and distinct issues, and that the Board should find jurisdiction over PRRB Case Number 19-1038.

Board Rule 8.1 states "Some issues may have multiple components. To comply with the [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…" Appeal issues #1 and 2 represent different components of the SSI issue, which was specifically adjusted during the audit. Since these specific appeal issues represent different aspects/components of the SSI issue, Provider contends that the Board should find jurisdiction over both the SSI Systemic and SSI Provider Specific/Realignment issues.[15]

The Provider further outlines their argument as follows:

SSI Systemic Issue:

The SSI Systemic issue addresses the various errors discussed in *Baystate Medical Center v. Leavitt,* 545 F. Supp 2d (D.D.C 2008) in CMS' calculation of the disproportionate payment percentage, which result in the MedPAR not reflecting all individuals who are eligible for SSI, including such errors as: not accounting for retroactive SSI eligibility determinations by the Social Security Administration (SSA); omitting days for individuals who were eligible for SSI at the time of their stay due to their records being considered inactive by SSA due to their death following their stay; omitting SSI eligibility records of payments that are typically used for SSI payments, and the exclusion of days from the numerator of the Medicare Fraction belonging to patients who are not eligible to receive SSI payments at the time of their stay, but who have a special status under Section 1619(b) of the Social Security Act, 42 U.S.C. § 1382h(b), which enables them to receive Medicaid assistance based on a past entitlement to SSI payments. These systemic errors are the result of CMS's improper policies and data matching process. The SSI Systemic Issue also covers CMS Ruling 1498-R.

[15] Provider's Jurisdictional Response at 1 (Jan. 13, 2020).

SSI Provider Specific Issue:

FSS, on behalf of the Medicare Administrative Contractor ("MAC") WPS Government Health Administrator, challenged the Board's jurisdiction, stating that the Provider does not have a right to a hearing before the Board on the DSH/SSI realignment issue because it is duplicative of the SSI systemic issue. However, Provider contends that FSS is incorrect. Provider is not addressing the errors which result from CMS' improper data matching process but is addressing the various errors of omission and commission that do not fit into the "systemic errors" category. In *Baystate*, the Board also considered whether, independent of these systemic errors, whether Baystate's SSI fractions were understated due to the number of days included in the SSI ratio. *See Baystate Medical Center v. Leavitt,* 545 F. Supp. 2d 20 (D.D.C. 2008). The Provider has analyzed Medicare Part A records and has been able to identify patients believed to be entitled to both Medicare Part A and SSI. The Provider has reason to believe that the SSI percentage determined by CMS is incorrect due to the understated days in the SSI ratio. Therefore, the Board should find jurisdiction over the SSI provider specific issue in the instant appeal.[16]

Analysis and Recommendation

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

A. DSH – SSI Percentage (Provider Specific)

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

1. *First Aspect of Issue 1*

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH – SSI Percentage (Systemic Errors) issue that was appealed in Case No. 18-0588GC.

The DSH – SSI Percentage (Provider Specific) issue in the present appeal concerns "[w]hether the Medicare Administrative Contractor ("MAC") used the correct Supplemental Security

[16] *Id.* at 2.

Income ("SSI") percentage in the Disproportionate Share Hospital ("DSH") calculation."[17] Per the appeal request, the Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[18] The Provider argues in its issue statement, which was included in the appeal request, that it "disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[19]

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 18-0588GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds that the DSH Payment/SSI Percentage (Provider Specific) issue in Case No. 19-1038 is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 18-0588GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[20], the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

In making this finding, the Board notes that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and the Provider has failed to explain how this argument is ***specific to this provider***. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[21] The Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors are specific to this provider.

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1 and finds that the Provider's Preliminary Position Paper failed to comply with Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" and include *all* exhibits.

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

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[17] Issue Statement at 1.
[18] *Id.*
[19] *Id.*
[20] PRRB Rules v. 2.0 (Aug. 2018).
[21] The types of systemic errors documented in the *Baystate* did not uniformly impact the SSI calculation for all providers but that does not make the errors any less systemic. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). *See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).

25.2.2 Unavailable and Omitted Documents (Aug. 29, 2018)

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

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

> https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH.[22]

This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows: "DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[23]

Indeed, the D.C. Circuit affirmed in *Advocate Christ Med. Ctr. v. Becerra*, No. 22-5214, 2023WL5654312 (D.C. Cir., Sept. 1, 2023) that "What [MMA] section 951 cannot mean is that HHS must give hospitals data that it never received from SSA in the first place. And SSA does not provide HHS with the specific codes assigned to individual patients. See 75 Fed. Reg. at 50,276." Here, the Provider does not explain what information it needs or is waiting on or claims that it should have access to. Nor does it document the alleged patients which it claims in the jurisdictional response are eligible for both Medicare Part A and SSI.

Accordingly, *based on the record before it*, the Board finds that the SSI Provider Specific issue in Case No. 19-1038 and the group issue from Group Case 18-0588GC are the same issue.

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[22] Last accessed January 4, 2024.
[23] Emphasis added.

Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

2. *Second Aspect of Issue 1*

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

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

****

In summary, the Board hereby dismisses the SSI Provider Specific issue as there is no final determination from which the Provider can appeal the SSI realignment portion of the issue, and the Provider failed to meet the Board requirements for position papers.

As no issues remain pending, the Board hereby closes Case No. 19-1038 and removes it from the Board's docket. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

1/10/2024

X Kevin D. Smith, CPA

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Board Decision*** **– DSH Payment/SSI Percentage (Provider Specific)**
Bluefield Regional Medical Center (Provider Number 51-0071)
FYE: 06/30/2014
Case Number: 18-0791

Dear Mr. Summar and Ms. Johnson,

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

Background:

A. ***Procedural History for Case No. 18-0791***

On August 10, 2017, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end June 30, 2014.

On February 6, 2018, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained five (5) issues:

1. DSH Payment/SSI Percentage (Provider Specific)
2. DSH/SSI Percentage (Systemic Errors)[1]
3. DSH Payment – Medicaid Eligible Days
4. Uncompensated Care ("UCC") Distribution Pool[2]
5. 2 Midnight Census IPPS Payment Reduction[3]

[1] On September 19, 2018, this issue was transferred to PRRB Case No. 18-0109GC.
[2] Per Provider's Final Position Paper, this issue was transferred to PRRB Case No. 16-1280GC. OHCDMS indicates that the issue was also transferred, but doesn't identify the specific case to which it was transferred. The Contractor's argument that it was not transferred and thereby abandoned (in the Contractor's Final Position Paper) is contradictory but does not affect the issue/situation addressed in this letter as both parties, and OHCDMS, agree that only Issues #1 & #3 remain in the instant case.
[3] On September 19, 2018, this issue was transferred to PRRB Case No. 18-0112GC.

As the Provider is owned by Community Health Systems, Inc. (hereinafter "Community Health") and, thereby, subject to the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1), the Provider transferred Issues 2, 4 and 5 to Community Health CIRP groups on September 19, 2018. As a result, the remaining issues in this appeal are Issues 1 and 3.

On September 25, 2018, the Provider filed its preliminary position paper.

On January 16, 2019, the Medicare Contractor filed a jurisdictional challenge, requesting the dismissal of Issue 1 and 3.[4]

On January 18, 2019, the Medicare Contractor filed its preliminary position paper.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 18-0109GC

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

> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> . . .
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395 (d)(5)(F)(i).
>
> The Provider also contends that CMS inconsistently interprets the term "entitled" as it is used in the statute. CMS requires SSI payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the denominator. CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days of care) as Medicare Part A days, yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment.[5]

[4] Per the Medicare Contractor's Final Position Paper, the jurisdictional challenge of issue 3 is no longer being pursued. Therefore, the Board will only review the challenge to Issue 1.
[5] Issue Statement at 1 (Feb. 6, 2018).

As the Provider is commonly owned by Community Health, the Provider transferred its Issue 2 – DSH/SSI Percentage to the CIRP group under 18-0109GC, QRS CHS 2014 DSH SSI Percentage CIRP Group, on September 19, 2018. The Group Issue Statement in Case No. 18-0109GC reads, in part:

> **Statement of the Issue:**
>
> Whether the Medicare/SSI fraction used in the Medicare Disproportionate Share Hospital and LIP payment calculations accurately and correctly counted the correct number of patient days to be included in the numerator and denominator of the Medicare/SSI fraction calculation per the Medicare Statute at 42 U.S.C. § 1395ww(d)(5)(F)(vi)?
>
> **Statement of the Legal Basis**
>
> The Provider(s) contend(s) that the Lead MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww(d)(5)(F)(vi). The Provider(s) contend(s) that the SSI percentages calculated by [CMS] and used by the Lead MAC to settle their Cost Report were incorrectly computed.
>
> The Provider(s) also contend(s) that CMS inconsistently interprets the term "entitled" as it is used in the statute. CMS requires SSI payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the denominator. CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days of care) as Medicare Part A days, yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment.
>
> The Provider(s) further contend(s) that the SSI percentages calculated by [CMS] fail to address all the deficiencies as described in *Baystate Medical Center v. Michael O. Leavitt*, 545 F. Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37, 44 (D.D.C. 2008) and incorporate a new methodology inconsistent with the Medicare Statute.

> Providers in this case are also seeking resolution of the following additional aspects of the Medicare fraction that were not addressed in the Baystate case:
>
> 1. Availability of MEDPAR and SSA records
> 2. Failure to adhere to required notice and comment rulemaking procedures
> 3. Fundamental problems in the SSI percentage calculation
> 4. Not in agreement with provider's records
> 5. Paid days vs. Eligible days, and
> 6. Covered days vs. Total days[6]

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $29,000.

On September 25, 2018, the Provider filed its preliminary position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Provider Specific**
>
> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation based on the Provider's Fiscal Year End (October 31).
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.
>
> Similar to *Loma Linda Community Hospital v. Dept of Health and Human Services*, No. CV-94-0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records. However, at this time, the Provider has been unable to analyze the Medicare Part A data because it has not yet received the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR"), HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000 from CMS. *See* 65 Fed. Reg. 50,548 (2000). Upon release of the complete MEDPAR data, the Provider will seek to reconcile its' records with that of CMS, and identify patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS based on the Federal Fiscal Year End (September 30) when it determined the Provider's SSI. *See*

[6] Group Issue Statement, Case No. 18-0109GC.

> *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).[7]

MAC's Contentions

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

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

> The appeal regulations do not allow Provider's to file an appeal to preserve future appeal rights. 42 CFR § 412.106(b)(3) allows a hospital to request that CMS calculate its SSI% based on its cost reporting period instead of the federal fiscal year end. Realignment can be performed once per hospital per cost reporting period and the resulting percentage becomes the hospital's official Medicare Part A/SSI percentage for that period, regardless of if the result is advantageous to the hospital or not. The decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election and not a final MAC determination.
>
> . . .
>
> The MAC has not made a determination on the realignment of the SSI% to the hospital fiscal year end as the Provider has not yet requested realignment. Since the Provider did not request SSI% realignment as required 42 CFR. § 412.106(b)(3), the MAC could not have made a final determination for this issue. The Provider's appeal is premature. The Provider has not exhausted all available remedies prior to requesting a PRRB appeal to resolve this issue. The MAC requests that the PRRB dismiss this subsidiary realignment issue consistent with its jurisdictional decisions.[8]

In addition, the MAC argues the DSH – SSI Percentage (Provider Specific) issue and the DSH/SSI Percentage (Systemic Errors) issue are considered the same issue by the Board.[9]

Provider's Jurisdictional Response

The Board Rules require that Provider Responses to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[10] The Provider has not

[7] Provider's Preliminary Position Paper at 8-9 (Sept. 25, 2018). The Board notes that the Provider's fiscal year end is actually June 30 but has quoted the issue statement as written.
[8] Jurisdictional Challenge at 4-5 (Jan. 16, 2019).
[9] *Id*. at 3-4.
[10] Board Rule 44.4, v. 1.3 (Jul. 2015).

filed a response to the Jurisdictional Challenge and the time for doing so has elapsed. Board Rule 44.4. specifies: "The responding party must file a response within 30 days of the Intermediary's jurisdictional challenge. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

Board Analysis and Decision:

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

The jurisdictional analysis for Issue 1 has two relevant aspects to consider: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, and 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period. As set forth below, the Board dismisses both aspects of Issue 1.

1. First Aspect of Issue 1

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH/SSI Percentage (Systemic Errors) issue that was appealed in PRRB Case No. 18-0109GC.

The DSH Payment/SSI Percentage (Provider Specific) issue in the present appeal concerns "[w]hether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation."[11] The Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[12] The Provider argues that "its' SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[13]

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 18-0109GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds the DSH Payment/SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 18-0109GC. Because the issue is

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

duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.5, the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

In making this finding, the Board further notes that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, the Provider is pursuing that issue as part of the group under Case No. 18-0109GC, which is required since it is subject to the CIRP group regulations under 42 C.F.R. § 405.1837(b)(1). Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[14] The Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 18-0109GC.

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 18-0109GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with the Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of their opponent's position." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" in its Preliminary Position Paper and include *all* exhibits.

Moreover, the Provider has failed to comply with Board Rule 25.2(B) to explain why the MEDPAR data is unavailable. In this regard, Board Rule 25.2(B) specifies:

> **B. Unavailable and Omitted Documents:** *If documents necessary to support your position are still unavailable,* identify the missing documents, explain why the documents remain unavailable, state the efforts made to obtain the documents, and explain when the documents will be available. Once the documents become available, promptly forward them to the opposing party.[15]

The Board further notes that the Provider only cites to the 2000 Federal Register but additional issuances and developments on the availability of data underlying the SSI fraction, such as

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

[15] (Emphasis added).

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

https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH.[16]

This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows: "DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[17]

Accordingly, the Board finds that the remaining issue in the instant appeal and the group issue from Group Case 18-0109GC are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

2. Second Aspect of Issue 1

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

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

[16] Last accessed January 4, 2024.
[17] Emphasis added.

****

In summary, the Board hereby dismisses the DSH Payment/SSI Percentage (Provider Specific) issue from this appeal as it is duplicative of the issue in Case No. 18-0109GC and there is no final determination from which the Provider can appeal the SSI realignment portion of the issue.

Since the Medicaid Eligible Days issue remains, the case will remain open. 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 this appeal.

Board Members Participating:

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

For the Board:

1/11/2024

X Kevin D. Smith, CPA

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
7500 Security Boulevard
Mail Stop: B1-01-31
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Via Electronic Delivery

James Ravindran
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150 N. Santa Anita Avenue, Suite 570A
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Byron Lamprecht
WPS Government Health Administrators
1000 N 90th Street, Suite 302
Omaha, NE 68114-2708

RE: ***Board Decision* – DSH Payment/SSI Percentage (Provider Specific)**
Northeast Regional Medical Center (Provider Number 26-0022)
FYE: 05/31/2016
Case Number: 19-1845

Dear Mr. Ravindran and Mr. Lamprecht,

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

Background:

A. *Procedural History for Case No. 19-1845*

On September 26, 2018, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end May 31, 2016.

On March 26, 2019, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained five (5) issues:

1. DSH Payment/SSI Percentage (Provider Specific)
2. DSH/SSI Percentage (Systemic Errors)[1]
3. DSH Payment – Medicaid Eligible Days[2]
4. Uncompensated Care ("UCC") Distribution Pool[3]
5. 2 Midnight Census IPPS Payment Reduction[4]

As the Provider is owned by Community Health Systems, Inc. (hereinafter "Community Health" or "CHS") and, thereby, subject to the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1), the Provider transferred Issues 2 and 5 to Community Health CIRP groups on

[1] On Oct. 22, 2019, this issue was transferred to PRRB Case No. 19-1409GC.
[2] This issue was withdrawn on Jan. 2, 2024.
[3] This issue was withdrawn on Apr. 28, 2020.
[4] On Oct. 22, 2019, this issue was transferred to PRRB Case No. 19-1410GC.

October 22, 2019. After the withdrawal of Issue 3 and 4, the remaining issue in this appeal is Issue 1.

On November 12, 2019, the Provider filed its preliminary position paper.

On March 17, 2020, the Medicare Contractor filed its preliminary position paper.

On April 8, 2020, the Medicare Contractor filed a jurisdictional challenge, requesting the dismissal of Issue 1.[5] CHS filed a response on April 27, 2020.[6]

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

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

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

As the Provider is commonly owned by Community Health, the Provider transferred its Issue 2 – DSH/SSI Percentage to the CIRP group under 19-1409GC, CHS CY 2016 DSH SSI Percentage CIRP Group, on October 22, 2019. The Group Issue Statement in Case No. 19-1409GC reads:

> **Statement of the Issue:**
>
> Whether the Secretary properly calculated the Provider's [DSH]/[SSI] percentage, and whether CMS should be required to recalculate the SSI percentages using a denominator based solely upon covered and paid for Medicare Part A days, or alternatively, expand the numerator of the SSI percentage to include paid/covered/entitled as well as unpaid/non-covered/eligible SSI days?

[5] The Jurisdictional Challenge also challenged jurisdiction over Issue 4, which was subsequently withdrawn.
[6] Quality Reimbursement Services was made the representative of this appeal on November 27, 2023.
[7] Issue Statement at 1 (Mar. 26, 2019).

Statement of the Legal Basis

The Provider(s) contend(s) that the MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). The Provider(s) further contend(s) that the SSI percentages calculated by [CMS] and used by the MAC to settle their Cost Reports incorporates a new methodology inconsistent with the Medicare statute.

The Providers challenge their SSI percentages based on the following reasons:

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

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $19,000.

On November 12, 2019, the Provider filed its preliminary position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

Provider Specific

The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation based on the Provider's Fiscal Year End (May 31).

The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.

Similar to *Loma Linda Community Hospital v. Dept of Health and Human Services*, No. CV-94-0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records. However, at this time, the Provider has been unable to analyze the Medicare Part A data because it has not yet received

[8] Group Issue Statement, Case No. 19-1409GC.

> the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR"), HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000 from CMS. *See* 65 Fed. Reg. 50,548 (2000). Upon release of the complete MEDPAR data, the Provider will seek to reconcile its' records with that of CMS, and identify patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS based on the Federal Fiscal Year End (September 30) when it determined the Provider's SSI. *See Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).[9]

MAC's Contentions

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

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

> The decision to realign a hospital's SSI percentage with its fiscal year end is a provider election. It is not a final MAC determination. The provider must make a formal request to the MAC and CMS in order to receive a realigned SSI percentage. Once the hospital elects to use its own fiscal year end, it is bound by that decision, regardless of the reimbursement impact.
>
> . . .
>
> The Provider's appeal of this item is premature. The Provider has not formally requested to have its SSI percentage realigned in accordance with 42 C.F.R. § 412.106(b)(3); therefore, the Provider has not exhausted all available remedies prior to requesting a PRRB appeal to resolve this issue. The MAC requests that the PRRB dismiss this issue consistent with recent jurisdictional decisions.[10]

In addition, the MAC argues the DSH – SSI Percentage (Provider Specific) issue and the DSH/SSI Percentage (Systemic Errors) issue are considered the same issue by the Board.[11]

[9] Provider's Preliminary Position Paper at 8-9 (Nov. 12, 2019).
[10] Jurisdictional Challenge at 4-5 (Apr. 8, 2020).
[11] *Id*. at 2-4.

Provider's Jurisdictional Response

The Provider argues that the issues are not duplicative because "issues #1 and 2 represent different components of the SSI issue, which was specifically adjusted during the audit."[12] Additionally, the Provider argues that the issue is not duplicative because the Provider is "not addressing the errors which result from CMS' improper data matching process but is addressing the various errors of omission and commission that do not fit into the "systemic errors" category."[13]

Finally, the Provider contends the Provider Specific issue is appealable "because the MAC specifically adjusted the Provider's SSI percentage and the Provider is dissatisfied with the amount of DSH payments that it received for fiscal year 2016, because of its understated SSI percentage due to errors of omission and commission."[14]

Board Analysis and Decision:

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

The jurisdictional analysis for Issue 1 has two relevant aspects to consider: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, and 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period. As set forth below, the Board is dismissing both aspects of Issue 1.

1. First Aspect of Issue 1

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH/SSI Percentage (Systemic Errors) issue that was appealed in PRRB Case No. 19-1409GC.

The DSH Payment/SSI Percentage (Provider Specific) issue in the present appeal concerns "[w]hether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation."[15] The Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory

[12] Jurisdictional Response at 1 (Apr. 27, 2020).
[13] *Id*. at 2.
[14] *Id*.
[15] Issue Statement at 1.

instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[16] The Provider argues that "its' SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[17]

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 19-1409GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds the DSH Payment/SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 19-1409GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6, the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

In making this finding, the Board further notes that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, the Provider is pursuing that issue as part of the group under Case No. 19-1409GC, which is required since it is subject to the CIRP group regulations under 42 C.F.R. § 405.1837(b)(1). Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[18] The Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 19-1409GC.

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

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[16] *Id.*

[17] *Id.*

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

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

> **25.2.2 Unavailable and Omitted Documents**
>
> *If documents necessary to support your position are still unavailable,* identify the missing documents, explain why the documents remain unavailable, state the efforts made to obtain the documents, and explain when the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.[19]

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

> https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH.[20]

This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows: "DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[21]

Indeed, the D.C. Circuit affirmed in *Advocate Christ Med. Ctr. v. Becerra*, No. 22-5214, 2023WL5654312 (D.C. Cir., Sept. 1, 2023) that "What [MMA] section 951 cannot mean is that HHS must give hospitals data that it never received from SSA in the first place. And SSA does not provide HHS with the specific codes assigned to individual patients. See 75 Fed. Reg. at

[19] (Emphasis added).
[20] Last accessed January 4, 2024.
[21] Emphasis added.

50,276." Here, the Provider does not explain what information it needs or is waiting on or claims that it should have access to.

Accordingly, *based on the record before it*, the Board finds that the remaining issue in the instant appeal and the group issue from Group Case 19-1409GC are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

2. Second Aspect of Issue 1

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

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

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In summary, the Board hereby dismisses the DSH Payment/SSI Percentage (Provider Specific) issue from this appeal as it is duplicative of the issue in Case No. 19-1409GC and there is no final determination from which the Provider can appeal the SSI realignment portion of the issue. As no issues remain pending, the Board hereby closes Case No. 19-1845 and removes it from the Board's docket.

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

Board Members Participating:

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

For the Board:

1/11/2024

X Kevin D. Smith, CPA

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Nicholas Putnam
Strategic Reimbursement Group, LLC
360 West Butterfield Road, Suite 310
Elmhurst, IL 60126

RE: ***Board Determination Regarding Deficient CIRP Group***
SRG Aurora Post 10/1/2013 DPP Medicare Part C Days CIRP Group
PRRB Case No. 17-1299GC

Dear Mr. Putnam:

The Provider Reimbursement Review Board (the "Board") has reviewed the subject common issue related party ("CIRP") group appeal in response to the Medicare Contractor's November 16, 2023 "Motion to Dismiss" and the Board's December 12, 2023 "Scheduling Order – Rule 20 Certification or Full SoP per Rule 20.1." The Board notes that Case No. 17-1299GC was filed prior to the implementation of the Office of Hearing Case & Document Management System ("OH CDMS").[1] The electronic record for the CIRP group, which is considered a "Legacy" case, has not yet been populated. Below is a discussion of the background and pertinent facts, the Regulations and Board Rules related to the specific deficiencies in this case, and the Board's determination.

Background:

On **November 1, 2021**, the Board issued revised Rules which changed certain procedures for group appeals. Specifically, Rule 20 addresses the population of Issues/Providers in the Office of Hearings Case & Document Management System ("OH CDMS"). Rule 20 advises that, "***within (60) sixty days of the full formation of the group***, the group representative must file a statement certifying that the group is fully populated in OH CDMS with the relevant supporting jurisdictional documentation (i.e., all participants in the group are shown under the Issues/Providers Tab for the group in OH CDMS with the relevant supporting jurisdictional documentation."[2] In contrast, Board Rule 20.1 specifies that if one or more participants are ***not*** listed behind the Participants tab, then the group representative must file a PDF copy of the traditional Schedule of Providers with supporting jurisdictional documentation. Here, there are no participants listed behind the Participants tab in OH CDMS. Accordingly, Rule 20.1 is applicable.

On **November 7, 2022**, the Board issued Alert 23, which gave notice that effective December 7, 2022, the Board was resuming its normal operations following the COVID- 19 Pandemic. The Alert 23 included a reminder to the Parties regarding the Rule 20 Certification requirement.

[1] The group was filed on March 29, 2017.
[2] Emphasis added.

Pertinent Facts:

On **November 13, 2020**, Strategic Reimbursement Group, LLC ("Strategic"/"Group Representative") designated the subject CIRP group to be fully formed. The group full formation was updated in relation to a request for expedited judicial review ("EJR") filed on the same date.[3]

On **April 5, 2021**, the Board remanded the group participants in Case No. 17-1299GC to the Medicare Contractor pursuant to CMS Ruling 1739-R. The group remained pending for Providers with Part C patient days *after* October 1, 2013 (and the group name was updated to the "SRG Aurora Post 10/1/2013 DPP Medicare Part C Days CIRP Group".)

On **May 11, 2023**, the Board issued a Critical Due Dates notification for the subject group case, setting new deadlines for the appeal. The Group's preliminary position paper deadline was set for September 22, 2023.

On **September 7, 2023**, Strategic timely filed the Group's preliminary position paper.

On **November 16, 2023**, the Medicare Contractor filed a Motion to Dismiss the group. In its Motion, the Medicare Contractor advised that the Group Representative failed to comply with Board Rule 20/20.1. The Medicare Contractor indicated that, on October 24, 2023, it had notified Strategic via email that it had not yet filed a Rule 20 letter and that the Office of Hearings Case & Document Management System ("OH CDMS") had not been populated.[4] Nevertheless, Strategic failed to file a Rule 20 Certification or Rule 20.1 SoP.

On **December 12, 2023**, the Board issued a "Scheduling Order – Rule 20 Certification or Full SoP per Rule 20.1" in which it ordered Strategic to file its Rule 20 letter or PDF SoP with full support, as well as its response to the Medicare Contractor's Motion to Dismiss by **Tuesday, December 19, 2023**. The Board warned that failure of the Group Representative to respond in a timely manner would result in remedial action, including but not limited to dismissal.

On **December 20, 2023**, one day after the Board's deadline, Strategic filed its response to the Board's Scheduling Order by filing the SoP with support. In the cover letter to the SoP, Strategic advised that the Rule 20 Certification was not filed because it was not a requirement at the time the group was marked fully formed. According to Strategic, the 60-day deadline set forth in Rule 20 for this group would have come due on January 12, 2021, which was 10 months prior to the November 1, 2021 Rule 20 requirement. Accordingly, Strategic requested the case not be dismissed.

Discussion of Regulations, Rules and Specific Deficiencies:

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

[3] On 11/24/2020 the Board denied the request for EJR because the Board found it no longer had jurisdiction over appeals of the Part C Days issue pursuant to CMS Ruling 1739-R.
[4] The email was not uploaded in OH CDMS, but a copy was provided as an exhibit to the Motion to Dismiss.

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

Further 42 C.F.R. § 405.1868 states that:

> (a) The Board has full power and authority to make rules and establish procedures, not inconsistent with the law, regulations, and CMS Rulings, that are necessary or appropriate to carry out the provisions of section 1878 of the Act and of the regulations in this subpart. *The Board's powers include the authority to take appropriate actions in response to the* ***failure of a party*** *to a Board appeal* ***to comply with Board*** rules and ***orders*** or for inappropriate conduct during proceedings in the appeal.
>
> (b) *If a provider fails to meet a filing deadline or other requirement established by the Board in a rule or order, the Board may—*
>
> *(1) Dismiss the appeal with prejudice***;**
>
> (2) Issue an order requiring the provider to show cause why the Board should not dismiss the appeal; or
>
> (3) Take any other remedial action it considers appropriate.[5]

The Board recognizes that its Critical Due Dates notifications do not include a deadline for filing, as relevant, the Rule 20 Certification or the traditional SoP under Board Rule 20.1. However, making the applicable filing under Board Rules 20 and 20.1 *is* ***and*** *remains* a requirement under Board Rules and must be made ***within 60 days of full formation,*** or in this case should have been made when the Medicare Contractor brought it to the Representative's attention.

The Board is also cognizant of the fact that, on numerous occasions, it has explained the background and requirements of Board Rule 20 and Rule 20.1. Many times, as a courtesy, the Board has extended Strategic additional time to correct such deficiencies, however Strategic continues to miss or make deficient filings related to this Board Rule.

Board Determination:

In this case, the Board notes that the Medicare Contractor made Strategic aware of the Rule 20/20.1 deficiency in this group by filing a Motion to Dismiss and that the Board issued a Scheduling Order requiring a response from Strategic ***and*** that Strategic file the requisite Rule 20 or 20.1 documentation as relevant. However, Strategic failed to timely file its response to the Motion to Dismiss with the requisite documentation necessary for the Medicare Contractor to perform its jurisdictional review by the Board deadline. Instead, Strategic belatedly filed the

[5] (Emphasis added.)

required documentation required by the Scheduling Order *one day beyond the Board's deadline* ***and*** failed to explain why the filing was made late.[6]

While Strategic's group was fully formed in 2020 such that Alert 19 was applicable, Strategic later timely filed its preliminary position paper in September 2023 without filing the required SoP with support. Because Strategic failed to respond when it was made aware of the deficiency in the Medicare Contractor's Motion to Dismiss, and because Strategic failed to **timely** respond to the Board's Scheduling Order by the deadline with the requisite Rule 20/20.1 documentation and response to the Motion to Dismiss, the Board finds it appropriate to dismiss Case No. 17-1299GC pursuant to its authority under 42 C.F.R. § 405.1868. The Board hereby dismisses Case No. 17-1299GC from its docket, and the appeal is now closed.

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

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

For the Board:

1/12/2024

X Clayton J. Nix

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

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services
Pam VanArsdale, National Government Services, Inc. (J-6)

[6] Indeed, the Board notes that, under Board Rule 44.3, a provider normally has only 30 days to respond to a Motion to Dismiss. Since the Medicare Contractor's Motion to Dismiss was filed on November 16, 2023, the response was due Saturday, December 16, 2023 which automatically was extended to Monday, December 18, 2023. However, the Board's Scheduling Order extended the filing deadline by one day to Tuesday, December 19, 2023. Notwithstanding the Board's Scheduling Order emphasizing the need to timely respond to the Motion to Dismiss, the group representative still failed to timely file its response.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

James Ravindran
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RE: ***Decision re: Motion for Reinstatement***
Case No. 10-1325GC – Univ. of Wash. 2007 SSI Covered vs. Total Days CIRP Grp.

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the Motion for Reinstatement[1] filed on November 22, 2023 in the above-referenced common issue related part ("CIRP") group appeal. Set forth below is the Board's decision denying the Motion for Reinstatement.

PROCEDURAL HISTORY:

A. Formation of Case 10-1325GC

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

> Whether the SSI percentages used in the Medicare DSH payment calculation under 42. C.F.R. § 412.l06(b)(2)(i), and the IRF LIP payment calculation under 42 C.F.R. § 412.624(e)(2), include all of the Provider's SSI entitled Medicare Part A patients and violates the applicable statutes and regulations because the denominator includes inpatient days Medicare classifies as not covered and/or not paid while the numerator is restricted to only paid days.
>
> **Legal Basis for Appeal:**
>
> In calculating the published SSI percentage used by the Intermediary in finalizing the Provider's cost report for FYE 6/30/07, the Provider

[1] Motion for Reinstatement, Request for Reconsideration of October 25, 2023 Board Dismissal and Denial of EJR, and Notice of Filing Renewed Request for EJR (Nov. 22, 2023) ("Motion for Reinstatement").

believes that CMS used a denominator that included both covered (paid for) and non-covered (not paid for) Medicare Part A inpatient days. By failing to limit the denominator to covered or paid for days, as it had in calculating the published SSI percentage for federal fiscal year 2004, CMS violated the Medicare statute, its own regulation, and its own policy articulated in the Federal Register.

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

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

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

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

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

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

As noted above, the Provider believes that the SSI percentages in question resulted from a denominator that included all Medicare days, both covered and non-covered, paid for and not paid for, in violation of CMS' long held policy. Additionally, while the denominator of the SSI fractions has been expanded by CMS, the Provider is not aware of anything that indicates that the numerator no longer excludes SSI-entitled patients that did not receive a payment in a particular month as testified by Ms. Cribbs at the Board's *Baystate* evidentiary bearing. This unlawful action by CMS reduced both the DSH and IRF LIP payments, and the Board should require a recalculation of the SSI percentage using a denominator based solely on covered and paid for Medicare days, or alternatively, an expansion of the numerator to include paid as well as unpaid and covered as well as non-covered days.

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

Payment and IRF LIP Adjustment." The issue statement for the "Covered vs. Total Days" Issue was identical to the one presented in Case No. 10-0767.

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

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

B. First EJR Request

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

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

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

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

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[2] *See* Board's Request for Additional Information (June 1, 2016) (citing EJR Request at 1).
[3] *Id.* at 3 (emphasis added).

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

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

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

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

On July 25, 2016, the Providers filed their response to this RFI, claiming that: (1) the instant "appeal challenges an entirely different aspect of the SSI percentage that is ***not*** *addressed by Ruling 1498-R*, namely, CMS's inconsistent policy of treating eligible but unpaid Part A days as days "entitled to [SSI] benefits'";[8] and (2) *a different CIRP group appeal* for the same providers under Case No. 09-1763GC concerned the 1498-R data matching issue and the Board remanded Case No. 09-1763GC pursuant to 1498-R on March 23, 2016.[9] The response also advised that the group participants had received revised NPRs which changed their SSI percentages, and also furnished copies of the revised NPRs to the Board.[10]

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[4] *Id.* at 1-2 (emphasis added).
[5] *See* Board's Request for Additional Information (July 8, 2016).
[6] (Footnotes omitted.)
[7] *Id.*
[8] Response to Board RFI, 1-2 (July 25, 2016) (footnote omitted and emphasis added).
[9] *Id.*
[10] *Id.*

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

C. District Court Proceedings and Administrator Remand

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

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

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

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

On August 31, 2017, the Providers filed a request for clarification of the Board's decision. They claimed that the issue they sought EJR for was the interpretation of the term "entitled," but that the Board's decision granting EJR was worded to imply the Providers were simply challenging 42

[11] EJR Request at 4 (Aug. 22, 2016).
[12] *Id.* at 3.
[13] The Administrator's Order was received by the Board on July 5, 2017.

C.F.R. § 412.106(b)(2)(i), and that regulation had been vacated at the time of judicial review.[14] The Providers concluded that they were:

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

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

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

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

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

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

> [O]n April 5, 2018, the Providers filed a new request for EJR. Specifically, the Providers asked the Board to determine whether it has authority to set aside the following policies of the Secretary, which the Providers contend are based upon inconsistent interpretations of the statutory term "entitled."

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

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

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

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

2. The treatment of other days for which the beneficiary did not receive Part A payments, such as exhausted benefit days and days for which Medicare was a secondary payer, as days entitled to benefits under Part A for purposes of the DSH calculation (which the Board dismissed from the appeal as duplicative of Case No. 15-0560GC); and

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

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

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

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

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

On September 29, 2023, QRS filed a new EJR Request on behalf of the Providers that was 3 pages long and did not include any exhibits or attachments.

D. Second EJR Request

On September 29, 2023, QRS filed *a very short* EJR request (3-page long *without* any exhibits) on behalf of the Providers. The Providers noted the Board found that the Provider's first EJR request cited to 75 Fed. Reg. 50042, 50280 (Aug. 16, 2010) ("FY 2011 Rule"), but that the NPRs in case 10-1325GC were issued prior to that Federal Register. In their second EJR Request, they claimed that the policy being challenged (*i.e.,* only including days where SSI benefits were actually paid, and the use of only three SSI codes as evidencing payment for SSI) predated that Federal Register.[20] They argued that CMS has stated the data match process described in the FY 2011 *proposed* Rule had existed since the inception of the DSH program. They also argued that the FY 2011 Rule made clear that it had already been CMS policy to use only three SSI codes to evidence SSI payment.

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

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[19] Board Letter re: Request to Reconsider or Clarify Denial of EJR (July 11, 2018).
[20] Request for Expedited Judicial Review, 2 (Sept. 29, 2023).
[21] Providers' EJR Request at 3 (Sept. 29, 2023).

E. Board Decision on EJR and Dismissal

On October 25, 2023, the Board issued a Decision on the Second Request for EJR. The Board reminded the Providers that in its July 11, 2018 letter it had Board confirmed that the ***sole*** issue remaining in this CIRP group is the treatment of days for individuals that have not received SSI payments as not entitled to SSI benefits for purposes of calculating the Medicare fraction of the DSH calculation. Notwithstanding this confirmation, the Providers presented their appeal challenges to two distinct[22] policies:

Challenge #1 "The Providers challenge . . . the policy that *only* ***paid*** [SSI] days can be included in the numerator of the Medicare Fraction as contrary to the statute . . . ."[23]

Challenge #2 "The Providers challenge . . . the policy that ***paid*** [SSI] days can be demonstrated only by SSI codes of C01, M01, and M02."[24]

First, the Board found that Challenge #1 failed to meet the *content* requirements for an EJR request as set forth in Board Rule 42.3 and therefore denied EJR. It also dismissed Challenge #1 from the appeal because the participants in Case No. 15-0560GC filed a Complaint in the U.S. District Court for the District of Columbia that encompasses the Challenge #1 that is being made in Case No. 10-1325GC.[25] The Board found that pursuing this issue in case 10-1325GC would be a prohibited duplicate in violation of the mandatory CIRP group rules at 42 C.F.R. §§ 405.1837(b)(1) and (e)(1) and Board Rules 4.6, and 19.2 which specify that any commonly owned providers pursuing a common issue for a particular year can only pursue that issue for that year in a single CIRP group.

Next, the Board denied EJR over Challenge #2 and dismissed that issue, as well. It denied EJR over this issue because the EJR Request failed to meet the content requirements specified in Board Rule 42.3 for an EJR request. The Board found that the Providers failed to identify the specific controlling authority being challenged as set forth in Board Rule 42.3 (and consistent with 42 C.F.R. § 405.1842(d)).

Finally, the Board dismissed the issue because: (1) it was otherwise a sub-issue of Challenge #1 that is thereby covered by the dismissal of Challenge #1; and (2) if not, it would be covered by CMS Ruling 1498-R and, on July 25, 2016, the Providers ***expressly*** confirmed Case No. 10-1325GC was not subject to CMS Ruling 1498-R and, to this end, recognized that the Providers had already appealed the data matching process issue in Case No. 09-1763GC which the Board remanded pursuant to 1498-R on March 23, 2016.[26] Additionally, the Board found that the

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[22] *Id.* (challenging "***both*** the policy that only paid days can *be* included in the numerator of the Medicare Fraction as contrary to the statute ***as well as*** the policy that paid days can be demonstrated only by SSI codes of C01, M01, and M02." (emphasis added)).
[23] *Id.* (emphasis added).
[24] *Id.* (emphasis added).
[25] 1:22-cv-01509-TNM (May 27, 2022).
[26] QRS Request for Reconsideration/Clarification at 1-2 (June 25, 2018) ("The Providers note that remand is not necessary pursuant to CMS Ruling 1498-R to correct the SSI matching errors litigated in Baystate because that issue has been separately appealed and the Board has previously remanded that appeal to the MAC.").

Complaint relating to Challenge #1 discussed *supra* ***also*** makes clear its argument for Challenge #2 that there while "the Secretary only uses C01, M01, and M02, to identify SSI entitled individuals . . . [t]he Secretary is aware of other payment codes . . . which could be used to determine the numerator of the SSI fraction . . . ."[27] Thus, similar to Challenge #1, since the Board's rules prohibit duplicate appeals, the Board dismissed Challenge #2 from the case since both participants are seeking the same relief in federal court for the same issue and fiscal years.

F. Motion for Reinstatement

On November 22, 2023, QRS filed a Motion for Reinstatement.[28] First, they ***allege*** (without providing any evidence) that, on November 2 and 7, 2023 (***after*** the Board's October 25, 2023 dismissal), the Providers' claims were withdrawn from the Complaint[29] in federal court and, thus, contend that this withdrawal "*ipso facto* eliminated the duplication discussed in the Board's October 25 2023 Decision."[30] They also contend that the "content" deficiencies noted by the Board have been cured in the Motion for Reinstatement, and all of the Board's other concerns have been addressed.

QRS notes that the Board previously granted EJR in this case and, therefore, at the time of the most recent EJR Request, there was no suggestion that the Board lacked jurisdiction or that any material facts remained in dispute.[31] Second, it acknowledged the Board's position that the Providers "fail[ed] to meet the deadline in the June 17, 2022 Scheduling Order' in Case No. 15-0560GC to identify any potential duplication between Case Nos. 15-0560GC and 10-1325GC." Notwithstanding, they ask the Board to reconsider the sanction imposed for this failure (*i.e.*, an alternate remedial action) and find the failure was harmless because: (1) QRS has "taken steps to ensure timely responses to Board requests in the future," and (2) it withdrew the Providers from the Complaint in federal court.[32]

The remainder of the Motion for Reinstatement expands on why the Board lacks the authority to grant the relief the Providers sought in their appeal, and notes disagreements with a number of the Board's conclusions and findings in its October 25, 2023 denial of EJR and dismissal of the appeal. They also note that their time period for filing for judicial review of the Board's October 25, 2023 decision was December 22, 2023, and that, if the Board did not issue a decision on this Request for Reconsideration before that date, they would file for judicial review and "will promptly notify the Board of the filing of any such action."[33]

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[27] Complaint at ¶ 29-30, 1:22-cv-01509-TNM (D.D.C. May 27, 2022).
[28] Motion for Reinstatement, Request for Reconsideration of October 25, 2023 Board Dismissal and Denial of EJR, and Notice of Filing Renewed Request for EJR (Nov. 22, 2023) ("Motion for Reinstatement").
[29] *Tarzana Providence Health System, et al., v. Becerra* ("*Tarzana*"), Civil Action No. 22-cv-01509-TNM (D.D.C).
[30] Motion for Reinstatement at 1, n.1.
[31] *Id.* at 2.
[32] *Id.* at 2-3, n.3.
[33] *Id.* at 11.

BOARD ANALYSIS AND DECISION:

The Board hereby denies the Motion for Reinstatement. The Board found multiple bases to deny the Second Request for EJR. QRS has attempted to cure the deficiencies identified in the Second EJR Request, but the Board has dismissed all of the claims in this CIRP group case for the Providers therein.

The case was dismissed, *inter alia*, because the same providers were pursuing the ***same*** claims for the ***same*** fiscal years in a duplicate case which has already proceeded on appeal to the District Court for the District of Columbia ("D.C. District Court") under No. 22-cv-01509. The Provider filed an ***Amended*** Complaint and *Errata* on November 2, 2023 and November 7, 2023, ***after*** the Board's October 25, 2023 dismissal of the instant case, which allegedly "confirm that the case no longer includes the Hospitals' claims." Significantly, the Providers' *fail* to explain how that Amended Complaint no longer includes the Hospitals' claims that are in this case.[34] Regardless, at the time the Board dismissed Case No. 10-1325GC, the pending federal litigation ***was*** a duplicate appeal concerning the same providers, claims, and fiscal years as the instant case. QRS' *subsequent* decisions regarding the case pending in federal court have no bearing on whether two duplicate appeals were pursued before the Board, which is prohibited, and only suggest that QRS may be attempting to *forum shop* due to the recent D.C. Circuit Court Appeals decision in *Advocate Christ Med. Ctr. v. Becerra*, 80 F.4th 346 (D.C. Cir. 2023).[35] Finally, the fact remains that the Representative failed to meet the filing deadline set forth in the Board's Scheduling Order to explain why Case No. 15-0560GC is not a prohibited of this case and the Board's remedial action to dismiss this case remains appropriate, *particularly in light of the circumstances surrounding the Board's closure of Case No. 15-0560GC as explained in detail in the Board's closure letter dated September 29, 2023 that is attached to the October 25, 2023 dismissal of this case*.[36]

Based on the foregoing, as well as the justifications laid out in its October 25, 2023 decision, the Board hereby ***declines*** to exercise its discretion to reopen the case and denies the relief requested in

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[34] Rather, in footnote 1, the Provider summarily allege that "Exhibit 1 hereto is the Amended Complaint and Errata filed in Tarzana on November 2, 2023 and November 7, 2023, respectively, which together confirm that the case no longer includes the Hospitals' claims and, thus, ipso facto eliminated the duplication discussed in the Board's October 25, 2023 Decision." They do not explain how the Errata and Amended Complaint resulted in the withdrawal of any claims that otherwise duplicate the issue(s) in this case that was dismissed on October 25, 2023.

[35] Indeed, under Board Rules 46 and 47.1, withdrawal of a case generally does not permit the provider to later file new appeals of the same issue. *It appears that the Providers are attempting to* ***forum shop*** because, rather than continuing to pursue the issue in this case in the D.C. District Court as part of No. 22-cv-01509 which they profess to (but fail to explain how they) have voluntarily withdrawn *subsequent to the Board's dismissal*, they have now filed in suit for the ***same*** issue for the ***same*** year in the U.S. District Court for the Western District of Washington on December 22, 2022 under Case No. 23-cv-01985.

[36] A copy of the September 29, 2023 closure letter (where the lead case is Case No. 13-3814GC) is also available at: https://www.cms.gov/medicare/regulations-guidance/provider-reimbursement-review-board/list-prrb-jurisdictional/2023-09 at PDF pages 223-82 (last visited Jan. 12, 2024). *See also Saint Francis v. Becerra*, No. 22-cv-1960, 2023 WL 6294168 (D.D.C. Sept. 27, 2023) (affirming that the 30-day clock for considering an EJR request does not begin until the Board finds jurisdiction and stating, in particular, at *5: "The first sentence of § 405.1842(e)(1) fixes when the thirty-date period for determining authority defined in the second sentence becomes operative, specifically, after the Board determines it has jurisdiction." (citation omitted)).

the Motion for Reinstatement. Accordingly, the Board's October 25, 2023 denial of EJR and dismissal of Case No. 10-1325GC remains in effect and final.[37,38]

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

Board Members Participating:

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

For the Board:

1/12/2024

X Clayton J. Nix

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

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

[37] By letter dated December 22, 2023, the Board "dismisse[d]/denie[d] the 'renewed' request for EJR as ***void*** and improper in the first instance" (emphasis added) since: (1) "the case is ***closed*** and there is no live controversy or pending proceedings before the Board in which to consider any request for EJR" (emphasis in original) and (2) "the alleged 'renewed' 'formal' request for EJR is fatally flawed as it cannot be combined with any other filing or request but rather must be a *separate* filing."

[38] Note unlike Case No. 15-0560GC (*see* closure letter referenced in *supra* note 36), the Board's consideration of the Motion for Reinstatement is not governed by 42 C.F.R. § 405.1842(h)(3)(iii). Rather, it is governed by 42 C.F.R. § 405.1868(d)(2) which specifies that "[t]he Board may reopen and revise a ***final*** Board decision in accordance with §§ 405.1885 through 405.1889" where a Board decision does not become "final" *until* the 60-day period for review by the Administrator has lapsed without any action by the Administrator. (Emphasis added.) Here, the Board is declining to exercise its discretion to reopen pursuant to 42 C.F.R. § 405.1885 through 405.1889.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
7500 Security Blvd.
Baltimore, MD 21244
410-786-2671

Via Electronic Mail

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

RE: **Revised EJR Determination Hall Render DSH Dual Eligible SSI Patient Days Groups**
Case No. 17-1408G – Hall Render 2010 DSH Medicare Fraction Dual Elig. Days Grp III

Dear Ms. Griffin:

In furtherance of its Notice of Reopening for Case No. 17-1408G, and pursuant to 42 C.F.R. § 405.1885, the Provider Reimbursement Review Board ("Board") is hereby revising its EJR Determination dated December 21, 2021 in this case.

Background

This Revised EJR Determination involves a single provider, namely University of Wisconsin Hospitals and Clinics Authority (Prov. No 52-0988, hereinafter "Provider"), and concerns fiscal year ("FY") ending June 30, 2010. Board issued an EJR decision for Provider's appeal for FY 2010 in Case No. 17-1408G on December 21, 2021. The Provider filed a Request for Hearing ("RFH") for FY 2010 on March 11, 2015 and included an issue for "Disproportionate Share SSI Percent" in Case No. 15-1780.

The Board issued an EJR decision in Case No 17-1408G on December 21, 2021. The Board dismissed the Provider from this case in its EJR decision because the SSI issue that was appealed by the Provider in the RFH was not the issue in the group appeal for which EJR was requested. The Board found that the Provider appealed a vague, generic SSI Percentage issue that did not comply with the regulatory specificity requirements (or related Board Rules) mandated for a Board hearing. Specifically, the Board found that the Provider did not comply with the specificity requirements set forth in 42 C.F.R. § 405.1835(b)(2) and Board Rule 8.

Following the Board's EJR decision, the Provider appealed to the U.S. District Court for the Western District of Wisconsin ("District Court"). On September 12, 2022, the District Court granted a Joint Motion for Remand ("Joint Motion") in which both parties agreed that the Board's decision in Case No. 17-1408G should be vacated as to Provider's claims only. The Joint Motion requested the District Court remand these claims to the Secretary of the Department of Health and Human Services, who was to instruct the Board not to dismiss these claims on jurisdictional grounds and to either issue a decision pursuant to 42 C.F.R. § 405.1871 or grant EJR pursuant to 42 C.F.R. § 405.1842. The Joint Motion also specified that the Board's decision

on remand would be subject to judicial review pursuant to 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. §§ 405.1875, 405.1877.

On March 10, 2023, the Administrator issued an order pursuant to the District Court's remand order. Specifically, the Administrator ordered:

> That the Board's decisions in PRRB Case Nos. 18-0336G and 17-1408G with respect to this Provider only for the specified 2007, 2008 and 2010 cost years are vacated; and
>
> That the Provider's claims are remanded to the Provider Reimbursement Review Board (Board) for further proceedings consistent with the order of the district court and joint motion for remand; and
>
> That the Board is to consider the merits of the Providers' claims and either issue a decision pursuant to 42 C.F.R. § 405.1871 or grant expedited judicial review pursuant to 42 C.F.R. § 405.184; and
>
> That the Board is precluded from another dismissal decision on jurisdictional grounds; and
>
> THAT the Board's decision on remand is subject to review, pursuant to 42 C.F.R. §§ 405.1875 by the Secretary's delegate, the Administrator of the Centers for Medicare & Medicaid Services, and the final agency decision on remand is subject to judicial review under 405.1877. The Board's determination issued pursuant to this order will be subject to 42 CFR § 405.1877(g)(2)(iii)(A).

Pursuant to the Administrator's Order, the Board reopened Case No. 17-1408G on December 22, 2023. It ordered the parties to submit present any additional evidence or argument within fourteen days (*i.e.*, no later than Friday, January 5, 2024). The Provider filed a response on January 3, stating it believes no additional evidence or argument is necessary and renewing its request for EJR. On January 5, the Medicare Contractor filed a response stating that it believes the Board lacks jurisdiction over the University of Wisconsin Hospitals and Clinics Authority, but that it understands the Board cannot consider that argument.

Decision of the Board[1]

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.

[1] The disputed issue and arguments of the parties are outlined in the Board's December 21, 2021 EJR Determination, which is hereby incorporated in this Revised EJR Determination.

In its December 21, 2021 EJR Determination, the Board found jurisdiction was proper over the majority of the Providers in this case. The only Provider at issue in this Revised EJR Determination is University of Wisconsin Hospitals and Clinics Authority. The Administrator's March 10, 2023 Order remanding this case to the Board precludes the Board from issuing any dismissal based on jurisdictional grounds and, as a result, the Board need not make any findings with regard to its jurisdiction. Similarly, the Board has already determined that EJR is appropriate for the issue and for the calendar year under appeal and need not make any further determinations in this regard.

Board's Decision Regarding the EJR Request

The Board hereby revises its December 21, 2021 EJR Determination to incorporate the following:

1) In addition to the participants which were granted EJR on December 21, 2021, the Board finds that, as ordered on remand, it has jurisdiction over the matter for University of Wisconsin Hospitals and Clinics Authority for fiscal year ending June 30, 2010;[2]

2) Based upon the participants' assertions regarding FY 2011 Final IPPS Rule there are no findings of fact for resolution by the Board;

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

4) It is without authority to decide the legal question of whether the FY 2011 Final IPPS Rule is valid as set forth in the original EJR determination dated December 21, 2021.

Accordingly, the Board finds that the question of the validity of the 2011 Final IPPS Rule properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for EJR for the issue and the subject year. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute, the Board hereby closes this case.

Board Members Participating:

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

For the Board:

1/12/2024

X Clayton J. Nix

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

[22] Neither the Administrator's Remand Order nor the Joint Motion or Remand explain why the Board erred in original decision and the findings made therein. Nonetheless, while the Board continues to believe its original decision and findings therein were correct, the Board must comply with the Administrator's Remand Order.

Enclosure: Schedule of Providers

cc: Pam VanArsdale, National Government Services, Inc.
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Mail

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

RE: ***Revised EJR Determination***
Case No. 18-0336G – CY 2008 DSH SSI Fraction Dual Eligible Days Group III

Dear Ms. Griffin:

In furtherance of its Notice of Reopening for Case No. 18-0336G, and pursuant to 42 C.F.R. § 405.1885, the Provider Reimbursement Review Board ("Board") is hereby revising its EJR Determination dated September 23, 2021 in this case.

Background

This Revised EJR Determination involves a single provider, namely University of Wisconsin Hospitals and Clinics Authority (Prov. No. 52-0988, hereinafter "Provider"), and concerns fiscal years ending June 30, 2007 and June 30, 2008 ("FYs 2007 and 2008"). Board issued an EJR decision for Provider's appeal for FYs 2007 and 2008 in Case No. 18-0336G on September 23, 2021. The Provider filed Requests for Hearing ("RFHs") for FYs 2007 and 2008 in August 2013, and included an issue for "Disproportionate Share SSI Percent" in Case Nos. 13-3155 and 13-3156.

The Board issued an EJR decision in Case No. 18-0336G on September 23, 2021. The Board dismissed the Provider from this case in its EJR decision because the SSI issue that was appealed by the Provider in the RFH was not the issue in the group appeal for which EJR was requested. The Board found that the Provider appealed a vague, generic SSI Percentage issue that did not comply with the regulatory specificity requirements (or related Board Rules) mandated for a Board hearing. Specifically, the Board found that the Provider did not comply with the specificity requirements set forth in 42 C.F.R. § 405.1835(b)(2) and Board Rule 8.

Following the Board's EJR decision, the Provider appealed to the U.S. District Court for the Western District of Wisconsin ("District Court"). On September 12, 2022, the District Court granted a Joint Motion for Remand ("Joint Motion") in which both parties agreed that the Board's decision in Case No. 18-0336G should be vacated as to Provider's claims only. The Joint Motion requested the District Court remand these claims to the Secretary of the Department of Health and Human Services, who was to instruct the Board not to dismiss these claims on jurisdictional grounds and to either issue a decision pursuant to 42 C.F.R. § 405.1871 or grant EJR pursuant to 42 C.F.R. § 405.1842. The Joint Motion also specified that the Board's decision on remand would be subject to judicial review pursuant to 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. §§ 405.1875, 405.1877.

On March 10, 2023, the Administrator issued an order pursuant to the District Court's remand order. Specifically, the Administrator ordered:

> That the Board's decisions in PRRB Case Nos. 18-0336G and 17-1408G with respect to this Provider only for the specified 2007, 2008 and 2010 cost years are vacated; and
>
> That the Provider's claims are remanded to the Provider Reimbursement Review Board (Board) for further proceedings consistent with the order of the district court and joint motion for remand; and
>
> That the Board is to consider the merits of the Providers' claims and either issue a decision pursuant to 42 C.F.R. § 405.1871 or grant expedited judicial review pursuant to 42 C.F.R. § 405.184; and
>
> That the Board is precluded from another dismissal decision on jurisdictional grounds; and
>
> THAT the Board's decision on remand is subject to review, pursuant to 42 C.F.R. §§ 405.1875 by the Secretary's delegate, the Administrator of the Centers for Medicare & Medicaid Services, and the final agency decision on remand is subject to judicial review under 405.1877. The Board's determination issued pursuant to this order will be subject to 42 CFR § 405.1877(g)(2)(iii)(A).

Pursuant to the Administrator's Order, the Board reopened Case No. 18-0336G on December 22, 2023. It ordered the parties to submit present any additional evidence or argument within fourteen days (*i.e.*, no later than Friday, January 5, 2024). The Provider filed a response on January 3, stating it believes no additional evidence or argument is necessary and renewing its request for EJR. On January 5, the Medicare Contractor filed a response stating that it believes the Board lacks jurisdiction over the University of Wisconsin Hospitals and Clinics Authority, but that it understands the Board cannot consider that argument.

Decision of the Board[1]

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.

[1] The disputed issue and arguments of the parties are outlined in the Board's September 23, 2021 EJR Determination, which is hereby incorporated in this Revised EJR Determination.

In its September 23, 2021 EJR Determination, the Board found jurisdiction was proper over the majority of the Providers in this case. The only Provider at issue in this Revised EJR Determination is University of Wisconsin Hospitals and Clinics Authority. The Administrator's March 10, 2023 Order remanding this case to the Board precludes the Board from issuing any dismissal based on jurisdictional grounds and, as a result, the Board need not make any findings with regard to its jurisdiction. Similarly, the Board has already determined that EJR is appropriate for the issue and for the calendar year under appeal and need not make any further determinations in this regard.

Board's Decision Regarding the EJR Request

The Board hereby revises its September 23, 2021 EJR Determination to incorporate the following:

1) In addition to the participants which were granted EJR on September 23, 2021, the Board finds that, as ordered on remand, it has jurisdiction over the matter for University of Wisconsin Hospitals and Clinics Authority for fiscal years ending June 30, 2007 and 2008;[2]

2) Based upon the participants' assertions regarding FY 2011 Final IPPS Rule there are no findings of fact for resolution by the Board;

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

4) It is without authority to decide the legal question of whether the FY 2011 Final IPPS Rule is valid as set forth in the original EJR determination dated September 23, 2021.

Accordingly, the Board finds that the question of the validity of the 2011 Final IPPS Rule properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for EJR for the issue and the subject year. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute, the Board hereby closes this case.

Board Members Participating:

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

For the Board:

1/12/2024

X Clayton J. Nix

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

[22] Neither the Administrator's Remand Order nor the Joint Motion or Remand explain why the Board erred in original decision and the findings made therein. Nonetheless, while the Board continues to believe its original decision and findings therein were correct, the Board must comply with the Administrator's Remand Order.

Enclosures: Schedule of Providers

cc: Wilson Leong, Esq., CPA, FSS
Pam VanArsdale, National Government Services, Inc. (J-6)

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Via Electronic Delivery

Leslie Goldsmith, Esq.
Bass, Berry & Sims, PLC
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RE: ***Expedited Judicial Review Determination***
Case No. 22-1385GC – Kettering Health Network CY 2019 Capital DSH CIRP Group
Case No. 23-1118GC – Ardent Health CY 2018 Capital DSH CIRP Group
Case No. 23-1235GC – UPMC CY 2019 Capital DSH CIRP Group
Case No. 24-0026GC – UPMC CY 2021 Capital DSH CIRP Group

Dear Ms. Goldsmith:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' November 16, 2023 consolidated request for expedited judicial review ("EJR")[1] in the above-referenced group appeals.[2] The decision with respect to EJR is set forth below.

Issue

In these group cases, the EJR Request states that Providers are challenging:

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

[1] The consolidated EJR request also included three other group appeals, Case Nos. 23-1228GC (entitled "HonorHealth CY 2018 Capital DSH CIRP Group"), 24-0063GC (entitled "Mount Sinai Health System CY 2019 Capital DSH CIRP Group"), and 24-0088GC (entitled "Yale-New Haven CY 2020 Capital DSH CIRP Group"), for which the Board issued a decision under separate cover on December 1, 2023.

[2] Kettering Health Network, Ardent Health and UPMC (University of Pittsburgh Medical Center) are parent organizations with multiple hospitals and are subject to the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1) as it relates to the common issue in Case Nos. 22-1385GC, 23-1118GC, 23-1235GC and 24-0026GC for the years 2019, 2018, 2019 and 2021, respectively. As Kettering Health Network, Ardent Health and UPMC designated the CIRP groups fully formed, they are prohibited from pursuing this same issue for the same year in any other appeal (whether as part of an individual provider appeal or a group appeal) as explained in § 405.1837(e)(1): "When the Board has determined that a group appeal brought under paragraph (b)(1) . . . is fully formed, absent an order from the Board modifying its determination, no other provider under common ownership or control may appeal to the Board the issue that is the subject of the group appeal with respect to a cost reporting period that falls within the calendar year(s) covered by the group appeal."

Background

Under the inpatient prospective payment system ("IPPS"), Medicare pays hospitals predetermined rates for patient discharges and this system is comprised of two parts, one for operating costs ("operating IPPS") as set forth at § 1395ww(d); and one for capital costs ("capital IPPS") as set forth at 42 U.S.C. § 1395ww(g). The primary objective of IPPS is to create incentives for hospitals to operate efficiently, while providing adequate compensation to hospitals.[3] These cases focus on the capital IPPS.

A. Geographic Reclassification

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

B. Operating DSH Adjustment Under Operating IPPS

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

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

---

[3] Daniel R. Levinson, Department of Health and Human Services, Office of the Inspector General, *Significant Vulnerabilities Exist in the Hospital Wage Index System for Medicare Payments*, 1 (Nov. 2018), *available at* https://oig.hhs.gov/oas/reports/region1/11700500.pdf (last visited Nov. 29, 2023) ("*Significant Vulnerabilities*").
[4] *See* https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/wageindex.html (42 U.S.C. § 1395ww(d)(3)(E) requires that, as part of the methodology for determining prospective payments to hospitals, the Secretary must adjust the standardized amounts "for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level." This adjustment factor is the wage index. The Secretary currently defines hospital geographic areas (labor market areas) based on the definitions of Core-Based Statistical Areas ("CBSAs") established by the Office of Management and Budget and announced in December 2003. The wage index also reflects the geographic reclassification of hospitals to another labor market area, such as rural to urban or vice versa, in accordance with sections 1395ww(d)(8)(B) and 1395ww(d)(10).).
[5] Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, 103 Stat. 2106, 2154 (1989). *See also Significant Vulnerabilities* at 4-5.
[6] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[7] *Id.*
[8] *See* 42 U.S.C. § 1395ww(d)(5).
[9] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.

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

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

C. Capital DSH Adjustment Under Capital IPPS

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

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

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

> (iv) may provide for suitable adjustment to reflect hospital occupancy rate.
>
> (C) In this paragraph, the term ''capital-related costs'' has the meaning given such term by the Secretary under subsection (a)(4) as of September 30, 1987, and does not include a return on equity capital.[13]

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

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

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

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

[13] (Underline and italics emphasis added.)
[14] 42 C.F.R. § 412.320(a)(1). *See also* MedPAC, *Hospital Acute Inpatient Services Payment System: Payment Basics*, 2 (rev. Nov. 2021), *available at* https://www.medpac.gov/wp-content/uploads/2021/11/medpac_payment_basics_21_hospital_final_sec.pdf (last visited Nov. 29, 2023).
[15] 56 Fed. Reg. 43358 (Aug. 30, 1991).

> exceed the levels supported by empirical analysis. We believe the payment adjustments should be empirically supported and should reflect only the higher Medicare costs associated with teaching activity and treating low income patients.[16]

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

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

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

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

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

> 80 percent. Urban hospitals with 100 or more beds that receive disproportionate share payments under § 412.106(C)(2) would also be eligible for the higher minimum payment level. We are not extending the special protection to other hospitals that receive disproportionate share payments under the operating prospective payment system. In urban areas, we believe that our criteria properly focuses on those hospitals that serve a large disproportionate share population. Other urban hospitals receiving disproportionate share payments tend to serve fewer low income patients either because of their smaller size (i.e., under 100 beds) or lower disproportionate share patient percentage. **In rural areas, we believe the more relevant criteria for determining whether a hospital should receive special payment protection is whether the hospital represents the sole source of care reasonably available to Medicare beneficiaries**.[18]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

On November 29, 1999, Congress enacted the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 ("BBRA") and BBRA § 401 amended 42 U.S.C. § 1395ww(d)(8) to require that certain urban IPPS hospitals be reclassified as rural *for purposes of operating IPPS* if an application is submitted to the MGCRB and certain criteria are met.[25] IPPS hospitals are reclassified per BBRA § 401 are often referred to as "§ 401 hospitals."

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

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

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

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

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

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

****

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

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

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

> Congress clearly intended hospitals that become rural under section 1886(d)(8)(E) of the Act to receive some benefit as a result. For example, some hospitals currently located in very large urban counties are in fact fairly small, isolated hospitals. Some of these hospitals will now be able to be designated a rural hospital and become eligible to be designated a critical access hospital.
>
> ****
>
> We are not permitting hospitals redesignated as rural under section 1886(d)(8)(E) of the Act to be eligible for subsequent reclassification by the MGCRB, and are revising the regulations governing MGCRB reclassifications (§ 412.230) accordingly.
>
> ****
>
> *We wish to emphasize that urban to rural reclassification under section 1886(d)(8)(E) of the Act is entirely voluntary*. ***Each hospital anticipating that it may qualify under this provision should determine the impact of Medicare payment policies if it were to reclassify***. As discussed above, we believe that our policies here are consistent with the Secretary's broad authority under section 1886(d)(10) of the Act, the statutory language in section 1886(d)(8)(E) of the Act, as well as our understanding of the intent underlying the description of the House bill in the Conference Report.[27]

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

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

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

> Health and Human Services, Health Resources and Services Administration, Office of Rural Health Policy, 5600 Fishers Lane, Room 9–05, Rockville, MD 20857.
>
> (2) The hospital is located in an area designated by any law or regulation of the State in which it is located as a rural area, or the hospital is designated as a rural hospital by State law or regulation.
>
> (3) The hospital would qualify as a rural referral center as set forth in § 412.96, or as a sole community hospital as set forth in § 412.92, if the hospital were located in a rural area.[28]

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

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

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

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

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

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

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

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

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

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

(ii) The term *urban area* means—

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

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

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

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

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

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

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

> of redesignation of an MSA by the Executive Office of Management and Budget.[34]

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

The Secretary also amended 42 C.F.R. § 412.320(a). As previously noted, § 412.320(a) originally only referenced § 412.63: "A hospital is classified as a 'disproportionate share hospital' for the purposes of capital prospective payments if the hospital is located, *for purposes of receiving payment under § 412.63(a)*, in an urban area."[35] As a result of the FY 2005 IPPS Final Rule, § 412.320(a) was updated to reference § 412.64 as it relates to FYs 2005 forward:

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

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

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

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

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

> discharges on or after October 1, 2004, the payment adjustments under these sections, respectively, would be based on the geographic classifications at proposed new § 412.64.
>
> ****
>
> The commenter is correct that as a result of the implementation of the new MSA definitions, hospitals that had previously been located in a large urban area under the current MSA definitions, but will now be located in another urban or rural area under the new MSA definitions will no longer qualify for certain payment adjustments that they previously qualified for under the prior MSA definitions, including the 3-percent large urban add-on payment adjustment at § 412.312(b)(2)(ii) and § 412.316(b). As discussed previously, in the May 18, 2004 proposed rule, we solicited comments on the effect of the equalization of the operating IPPS standardized amount. Specifically, we discussed that rural and other urban hospitals that were previously eligible to receive the large urban add-on payment adjustment (and DSH payment adjustment) under the IPPS for capital-related costs if they reclassified to a large urban area for the purpose of the standardized amount under the operating IPPS, will no longer be reclassified and, therefore, will not be eligible to receive those additional payments under the IPPS for capital-related costs beginning in FY 2005. As we noted previously, we received no comments on that clarification.
>
> ****
>
> As previously discussed, we proposed and adopted as final our policy that, beginning in FY 2005 and thereafter, only those hospitals geographically located in a large urban area (as defined in revised § 412.63(c)(6)) will be eligible for the large urban add-on payment adjustment provided under § 412.312(b)(2)(ii) and § 412.316(b). *Similarly, beginning in FY 2005 and thereafter, to receive capital IPPS DSH payments under § 412.320, a hospital will need to be geographically located in an urban area (as defined in new § 412.64) and meet all other requirements of § 412.320.* Accordingly, we are adopting our proposed revisions as final without change.[37]

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

In the FY 2007 Proposed IPPS Rule, the Secretary[38] announced that he was proposing technical changes to 42 C.F.R. §§ 412.316(b) and 412.320(a)(1) to clarify that hospitals reclassified as rural under § 412.103 are not eligible for the large urban add-on payment or for the capital DSH

[37] 69 Fed. Reg. 48916, 49187-88 (Aug. 11, 2004).
[38] of the Department of Health and Human Services.

adjustment. These proposed changes reflected the historic policy that hospitals reclassified as rural under § 412.103 also would be considered rural under the capital IPPS. Since the genesis of the capital IPPS in FY 1992, the same geographic classifications used under the operating IPPS also have been used under the capital IPPS.[39]

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

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

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

[39] 71 Fed. Reg. 23995, 24122 (Apr. 25, 2006).
[40] *Id.*
[41] *Id.*

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

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

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

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

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

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

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

In *Toledo*, U.S. District Court for the District of Columbia ("D.C. District Court") outlined the legislative history surrounding the creation of the MGCRB in 1989 which, as noted above, can redesignate IPPS hospitals to different labor market areas in order to receive a different wage reimbursement rate.[46] The Court also noted how Congress enacted legislation in 1999[47] allowing IPPS hospitals to reclassify from an urban labor market area to a rural one for various reasons. Thus, a geographically urban hospital can be classified as rural, but then redesignate itself back into an urban labor market area for the purposes of fixing its wage index.[48] The Court also noted the separate IPPS payment for a hospital's *capital* costs at 42 U.S.C. § 1395ww(g) (compared to the IPPS payment for *operating* costs), as well as the capital IPPS adjustments found at 42 C.F.R. § 412.320 for large urban hospitals (the capital DSH payment).[49] The Court explained that, following the 2006 rulemaking, a geographically urban hospital which reclassifies as rural under § 401 loses its eligibility for the capital DSH adjustment.[50]

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

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

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

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

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

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

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

- "The Secretary also has not explained, even as a general matter, why classification uniformity outweighs the value of more accurate cost reimbursements. *Cf. Anna Jacques Hosp*., 797 F.3d at 1161 (upholding Secretary's regulation where the Secretary explained why 'added precision' 'would not justify the added complication') (quotation omitted)."[56]

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

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

Providers' Request for EJR

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

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

The Providers believe that the promulgation of 42 C.F.R. § 412.320(a)(1)(iii) is, therefore, beyond the authority granted under 42 U.S.C. §§ 1395ww(d)(8)(B) and 1395ww(g), and the

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[55] *Id.*
[56] *Id.*
[57] *Id.* at *11-12.
[58] *Id.* at *12.
[59] *Id.*
[60] Request for EJR at 7.
[61] *Id.* at 1, 7.

regulation must be found invalid.[62] The Providers assert that the Secretary has implicitly acknowledged that he cannot apply rural status for hospitals that have undergone a rural reclassification to payment provisions outside of subsection (d), and provides as an example, that the Secretary has stated with respect to direct graduate medical education ("GME") that no adjustment to the direct GME cap are available for urban hospitals that have reclassified as rural because subsection (d) reclassification "affects only payments under section 1886(d) of the Act . . . [and] payment for direct GME are made under section 1886(h) of the Act."[63] Further, the regulation fails to take into account any variation in cost based on location, as the capital PPS statute permits at 42 U.S.C. § 1395ww(g)(1)(B)(ii).[64]

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

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

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

Board Decision

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

[62] *See id.* at 7.
[63] *Id.* at 8, citing 70 Fed. Reg. 47278, 47437 (Aug. 12, 2005).
[64] *Id.*
[65] *Id.* at 8-9.
[66] *Id.* at 9-12.
[67] *Id.* at 9-10, *citing* Medicare Program: Hospital IPPS Fiscal Year 2024 Payment Rates & Policy Changes, 88 Fed. Reg. 58,640, 59,117, 59,334 (Aug. 28, 2023).
[68] *Id.* at 10, 11-12, *citing* 88 Fed. Reg. at 27,058-59.
[69] *See* 42 C.F.R. § 405.1867.
[70] Request for EJR at 10-12.

legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute or to the substantive or procedural validity of a regulation or CMS Ruling.

A. Jurisdiction

In the November 13, 2015 Final Outpatient Prospective Payment Rule,[71] the Secretary finalized new cost reporting regulations related to the substantive reimbursement requirement of an appropriate cost report claim.[72] The Secretary revised the Medicare cost reporting regulations in 42 C.F.R. part 413, subpart B, by requiring a provider to include an appropriate claim for a specific item in its Medicare cost report *beginning on or after January 1, 2016* in order to receive or potentially qualify for Medicare payment for the specific item. If the provider's cost report does not include an appropriate claim for a specific item, the Secretary stated that payment for the item will not be included in the Notice of Program Reimbursement ("NPR") issued by the Medicare Contractor or in any decision or order issued by a reviewing entity (as defined in 42 C.F.R. § 405.1801(a)) in an administrative appeal filed by a provider. In addition, the Secretary revised the appeals regulations in 42 C.F.R. part 405, subpart R, by eliminating the requirement that a provider must include an appropriate claim for a specific item in its cost report in order to meet the dissatisfaction requirement for jurisdiction before the Board (hereinafter the "claim-specific dissatisfaction requirement"), again, for cost reports beginning on or after January 1, 2016. As all of the participants in these group appeals have fiscal years that began after January 1, 2016, the claim-specific dissatisfaction requirement is not applicable.

The participants that comprise these group appeals have filed appeals involving fiscal years ending in 2018, 2019 and 2021. All of the participants have appealed from an original NPR or from the failure of the Medicare contractor to issue an NPR within twelve (12) months from the submission of the cost report or amended cost report.

On November 23, 2023, the Medicare Contractor filed a jurisdictional challenge to two of the providers in Case No. 24-0026GC (University of Pittsburgh Medical Center Hamot, Prov. No. 39-0063 and UPMC Presbyterian Shadyside, Prov. No. 39-0164), asserting that their appeals were untimely because the Medicare Contractor accepted amended cost reports for these two providers on October 11 and 19, 2023, respectively. These appeals were filed from the failure of the Medicare Contractor to issue an NPR within twelve (12) months from the submission of the cost report or amended cost report. As amended cost reports were accepted, the Medicare Contractor contends that the appeals filed by these two providers are not timely. Thereafter, on December 5, 2023, the two providers withdrew their appeals, and thus there are now only two remaining providers in this group appeal.[73]

Based on its review of the record, the Board finds that all of the providers remaining in the four group appeals filed their appeals within 180 days of the issuance of their respective final determinations as required by 42 C.F.R. § 405.1835, or more than 12 months after the submission of their amended cost report and a final determination has not yet been issued under

[71] 80 Fed. Reg. 70298, 70551-70580 (Nov. 13, 2015).
[72] *Id.* at 70555.
[73] *See* Schedule of Providers for Case No. 24-0026GC that is attached to this decision.

42 C.F.R. § 405.1835(c)(1). The providers each appealed the issue in the EJR request, and the Board is not precluded by regulation or statute from reviewing the issue. Finally, the amount in controversy meets the $50,000 amount in controversy requirement for a group appeal pursuant to 42 C.F.R. § 405.1837(a)(3) in the cases at issue. Therefore, the Board has jurisdiction over the providers.

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

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

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

> disallowed each specific item (instead of claiming full reimbursement in its cost report for the specific item) and describing how the provider calculated the estimated reimbursement amount for each specific self-disallowed item.

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

> (a) *General*. In order to receive or potentially receive reimbursement for a specific item, the provider must include in its cost report an appropriate claim for the specific item (as prescribed in § 413.24(j) of this chapter). **If** the provider files an appeal to the Board seeking reimbursement for the specific item and **any party** to such appeal **questions whether the provider's cost report included an appropriate claim for the specific item**, the Board must address such question in accordance with the procedures set forth in this section.[74]

These regulations are applicable to the cost reporting periods under appeal, which end after December 31, 2016. The regulation at § 405.1873(b) sets out certain procedures that must be followed in the event a party questions whether the cost report included an appropriate claim for a specific item under appeal. *In such situations where a party raises that question*, the regulation requires the Board to give the parties an adequate opportunity to submit factual evidence and legal arguments regarding whether the provider's cost report included an appropriate claim for the specific item under appeal, and upon receipt of the factual evidence or legal argument (if any), the Board must review the evidence and argument and prepare written specific findings of fact and conclusions of law on the question of whether the provider's cost report complied with the cost report claim requirements of § 413.24(j). The Board interprets the regulation at 42 C.F.R. § 405.1873 to only require the Board to review a provider's "compliance"[75] 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.[76]

On November 21 and 23, 2023, the Medicare Contractor filed substantive claim challenges in all four group appeals. These challenges were for all of the providers in the group appeals for Case Nos. 22-1385GC and 23-1118GC (the two providers in each of those cases), as well as two of the three providers in Case No. 23-1235GC (University of Pittsburgh Medical Center Hamot, Prov. No. 39-0063 and Williamsport Regional Medical Center, Prov. No. 39-0045).

In addition, in Case No. 24-0026GC, the Medicare Contractor acknowledged that all of the providers included capital DSH as part of their protested amounts. However, for one of the providers, Pinnacle Health Hospitals, Prov No. 39.-0067, the Medicare Contractor argued that the Pinnacle Health Hospitals failed to *properly* file its cost report under protest.

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[74] (Bold emphasis added.)
[75] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."
[76] *See* 42 C.F.R. § 405.1873(a).

1. Case Nos. 22-1385GC, 23-1118GC and 23-1235GC

All of the providers in the group appeals for Case Nos. 22-1385GC and 23-1118GC, as well as two of the three providers in Case No. 23-1235GC for which there was a substantive claim challenge (University of Pittsburgh Medical Center Hamot, Prov. No. 39-0063 and Williamsport Regional Medical Center, Prov. No. 39-0045), *have acknowledged/conceded* that they did ***not*** properly claim capital DSH as an allowable cost or as a protested item in compliance with 42 C.F.R. § 413.24(j), and instead, they self-disallowed the issue based on the Medicare Contractor being bound by 42 C.F.R. § 412.230(a)(1)(iii) (the regulation that is in dispute).

First, the Board notes that there was no substantive claim challenge to the third provider in Case No. 23-1235GC, Pinnacle Health Hospitals, Prov No. 39-0067. Since no party to the appeal has questioned, pursuant to § 405.1873(a), whether an appropriate claim was made for Pinnacle Health Hospitals (in Case No. 23-1235GC), the Board finds that there is no regulatory obligation for the Board to affirmatively, on its own, review the appeal documents to determine whether an appropriate claim was made by Pinnacle Health Hospitals *in Case No. 23-1235GC*. As a result, Board review under 42 C.F.R. § 405.1873(b) has not been triggered for Pinnacle Health Hospitals *in Case No. 23-1235GC*.

With respect to all of the other providers in these three group appeals, since a party to the appeal has questioned, pursuant to § 405.1873(a), whether an appropriate claim was made,[77] the Board finds that there is a regulatory obligation for the Board to affirmatively, on its own, review the appeal documents to determine whether an appropriate claim. However, all of the Providers *have conceded* that they failed to comply with 42 C.F.R. § 413.24(j) and, as such, this noncompliance is *undisputed*. Therefore, pursuant to 42 C.F.R. § 405.1873(d)(2), the Board finds in its specific findings of facts and conclusions of law that these Providers failed to make a substantive claim pursuant to 42 C.F.R. § 413.24(j)(1)-(2), and notes that this is undisputed as the Providers/Group Representative have acknowledged/conceded this fact.

2. Case No. 24-0026GC

As discussed above, there are two remaining providers in this group appeal, Pinnacle Health Hospitals, Prov. No. 39-0067 ("Pinnacle"), and Williamsport Regional Medical Center, Prov. No. 39-0045 ("Williamsport"). The Medicare Contractor acknowledges that each of the providers in this group appeal included capital DSH as part of their protested amounts. However, the Medicare Contractor contends that Pinnacle failed to ***properly*** file its cost report under protest in compliance with 42 C.F.R. § 413.24(j). Specifically, the Medicare Contractor asserts that Pinnacle's Worksheet E, Part A provides "0" for the capital DSH protested amount. The Medicare Contractor asserts that it is therefore unclear what that provider is appealing or how the Board has jurisdiction over the alleged dispute that falls significantly below the minimum amount threshold.

In response, Pinnacle (the Provider) asserts that the Medicare Contractor's assertions are factually inaccurate. The Provider explains that Pinnacle did in fact include capital DSH as a protest item

[77] 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."

on its applicable FY 2021 cost report, and that the total amount in controversy for Case No. 24-0026GC is well above the jurisdictional threshold of $50,000. The Provider attached as Exhibit P-1 supporting documentation to show Pinnacle's Protested Item Support that includes capital DSH as a protested amount. One of the items on the list of protested items is described as "Capital DSH § 412.103" and reflects an amount of $385,135. An accompanying calculation was also provided for the amount of $385,135. Therefore, the Provider asserts, that it did file its cost report under protest, and that not only does Pinnacle's FY 2021 appeal, by itself, satisfy the $50,000 amount in controversy requirement, the total amount at issue in this case is $565,150. Thus, the Providers contend that the Board has jurisdiction over this appeal.

First, the Board notes that, since no party to the appeal has questioned, pursuant to § 405.1873(a), whether an appropriate claim was made for Williamsport, the Board finds that there is no regulatory obligation for the Board to affirmatively, on its own, review the appeal documents to determine whether Williamsport made an appropriate claim on the relevant cost report in compliance with 42 C.F.R. § 413.24(j). As a result, Board review under 42 C.F.R. § 405.1873(b) has not been triggered for this Provider.

With respect to Pinnacle, the Medicare Contractor has contested whether Pinnacle is in compliance with the requirements of 42 C.F.R. § 413.24(j), asserting that it failed to ***properly*** file its cost report under protest. 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).

On review of Pinnacle's Worksheet E, Part A, the Board is not certain to which Line the Medicare Contractor is referring when it asserts that this Worksheet provides "0" for the capital DSH protested amount. There is a "0" amount on Line 51, the exception payment for inpatient program capital, however, that is not the Line to determine the protested amount. Instead, Line 75 is for protested amounts, and it has a value in the amount of $1,653,972. Further, the attachment to the cost report entitled "Summary of Protested Items-AMENDED" lists "Capital DSH § 412.103" as one of the protested items, and for Pinnacle, the amount listed for that item is $385,135. Thus, there is an amount greater than zero listed as the capital DSH protested amount.

The Board finds that Pinnacle has provided sufficient information to show that it reported the capital DSH protested amount in compliance with 42 C.F.R. § 413.24(j). Specifically, the Board must determine whether Pinnacle properly self-disallowed the capital DSH amount pursuant to 42 C.F.R. § 413.24(j)(2), which provides:

> *Self-disallowance procedures*. In order to properly self-disallow a specific item, the provider must—

> (i) Include an estimated reimbursement amount for each specific self-disallowed item in the protested amount line (or lines) of the provider's cost report; and
>
> (ii) Attach a separate work sheet to the provider's cost report for each specific self-disallowed item, explaining **why the provider self-disallowed each specific item (instead of claiming full reimbursement in its cost report for the specific item)** and describing how the provider calculated the estimated reimbursement amount for each specific self-disallowed item.[78]

As described above, Pinnacle included an estimated reimbursement amount for the capital DSH protested amount. Further, Pinnacle attached a separate worksheet describing how the provider calculated the estimated reimbursement amount for the capital DSH protested amount. While the explanation of "why" Pinnacle self-disallowed this item may not be an abundance of clarity, the Board concludes that, although a greater explanation may be preferable, the documentation when considered in its totality is sufficient in this case *for the issue appealed*. Moreover, the Medicare Contractor has *not* contested the sufficiency of Pinnacle's explanation. *In this respect, the Board urges the Provider (and the Provider's representative) to ensure a sufficient explanation of why the protested item is being made is included with the as-filed cost report in compliance with 42 C.F.R. § 413.24(j)(2)(ii).*

For these reasons, the Board finds that Pinnacle met the substantive claim regulation requirements, and denies the Medicare Contractor's substantive claim challenge for Pinnacle in this particular case (Case No. 24-0026).

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

As discussed above, it is *undisputed* that the following providers failed to claim the capital DSH costs at issue either as an allowable cost or a protested amount and, therefore, failed to comply with the requirements of 42 C.F.R. § 413.24(j):

- Case No. 22-1385GC: Grandview Hospital (Prov. No. 36-0133), and Kettering Medical Center (Prov. No. 36-0079).
- Case No. 23-1118GC: Portneuf Medical Center (Prov. No. 13-0028) and Hillcrest Medical Center (Prov. No. 37-0001).
- Case No. 23-1235GC: Williamsport Regional Medical Center (Prov. No. 39-0045) and University of Pittsburgh Medical Center (UPMC) Hamot (Prov. No. 39-0063).

However, these Providers also challenge the validity of 42 C.F.R. §§ 413.24(j) and 405.1873 insofar as these regulations limit the Board's authority to order payment to providers that have not claimed a particular cost on their cost report as an allowable cost or as a protested item. The

[78] (Emphasis added.)

Group Representative requested a second EJR in these cases over the validity of 42 C.F.R. §§ 413.24(j) and 405.1873 (in addition to the capital DSH issue discussed above).[79]

In the second EJR request, the Providers argue that the regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 contravene the Board's authority set forth in 42 U.S.C. § 1395oo. They note that nowhere in the statute is there a requirement that a provider must include a claim for a specific cost on its cost report before payment related to that cost can be addressed by the Board. The Providers recount how the 2008 self-disallowance regulation was held to conflict with the plain text of 42 U.S.C. § 1395oo in *Banner Heart Hosp. v. Burwell*, 201 F. Supp. 3d 131, 140 (2016). They argue that the 2016 self-disallowance regulation at 42 C.F.R. § 413.24(j) suffers from the same defects that led the *Banner* court to invalidate the 2008 self-disallowance regulation.[80]

With regard to the Board's jurisdiction, the Providers point to 42 U.S.C. § 1395oo(f)(1), which allows a provider to obtain judicial review "of any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines (on its own motion or at the request of a provider of services . . .) that it is without authority to decide the question." The Providers note that while the validity of these regulatory provisions was not at issue when the Providers filed their appeal, the Medicare Contractor raised this issue in its substantive claim challenge, and the Board's rules entitle the Providers to respond, including in the context of an EJR filing, citing Board Rule 44.5.2. Further, the Providers argue that because the Medicare Contractor argues that the substantive claim regulatory provisions prevent the Providers from receiving additional reimbursement for the capital DSH payment, the validity of these substantive claim regulatory provisions stems from the Providers' appeal of the capital DSH regulation and is integral to the resolution of the capital DSH issue.[81]

Per 42 C.F.R. § 405.1842(a)(1), "a provider [has] the right to seek EJR of a legal question relevant to a specific matter at issue in a Board appeal if there is Board jurisdiction to conduct a hearing on the matter." Here, the Providers' challenge to the validity of 42 C.F.R. §§ 413.24(j) and 405.1873 is relevant to the matter at issue in this group appeal. Since there is no factual dispute regarding these Providers' lack of compliance with 42 C.F.R. § 413.24(j), the Board is able to reach consideration of the Providers' challenge to the validity of 42 C.F.R. §§ 413.24(j) and 405.1873. Further, since 42 C.F.R. § 405.1867 requires that the Board comply with the requirements of the statute and regulations, the Board lacks the authority to eliminate the regulatory provisions that create the self-disallowance requirements in §§ 413.24(j) and 405.1873, which is the remedy the Providers are seeking. Consequently, EJR is appropriate on this issue and the Board grants the above-listed Providers' EJR request on this challenge.

D. Board's Analysis Regarding the Appealed Issue

The Providers in these cases are challenging the application of 42 C.F.R. § 412.320(a)(1)(iii), which states in effect that urban hospitals may qualify for Capital DSH payments unless, on or after October 1, 2006, the urban hospital is reclassified as rural. The Providers contend that this

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[79] Provider's Response and EJR Request at 1, 5-6, 9-13. The Medicare Contractors did not file a response to the second EJR request, and the time required to do so has now passed. *See* Board Rule 42.4.
[80] *Id.*
[81] *Id.* at 13-16.

regulation is inconsistent with the enabling statute, 42 U.S.C. § 1395ww(d)(8)(B), which concerns rural status. The Providers contend that §1395ww(d)(8)(B) specifically notes that the hospitals that have undergone a rural reclassification are rural only for "purposes of this subsection [1395ww(d)]."

Additionally, the Providers assert that the Capital DSH provisions are found at 42 U.S.C. § 1395ww(g), not § 1395ww(d), and, accordingly, the literal wording of the rural reclassification statutory provision identifies that rural status does not reach the Capital DSH calculation. Thus, the Providers maintain that the promulgation of 42 C.F.R. § 412.320(a)(1)(iii) is beyond the authority granted under 42 U.S.C. § 1395ww(d)(8)(B), and the regulation must be found invalid.

The Board finds that, pursuant to 42 C.F.R. § 405.1867, it must comply all the provisions of Title XVIII of the Act and regulations issued thereunder, including the challenged regulation, 42 C.F.R. § 412.320(a)(1)(iii). Moreover, pursuant to 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R. § 405.1842(f)(1), the Board is required to grant an EJR request if it determines that: (i) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (ii) the Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute or to the substantive or procedural validity of a regulation or CMS Ruling.

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

E. Board's Decision Regarding the EJR Requests

The Board finds that:

1) For the subject years, it has jurisdiction over both the capital DSH issue for all of the Providers, and the challenge to the validity of 42 C.F.R. §§ 413.24(j) and 405.1873 for the Providers raising that challenge,[82] and all of the Providers in these group appeals are entitled to a hearing before the Board;

2) As all of the Providers appealed cost reports with cost reporting periods beginning after January 1, 2016, they are all subject to the substantive claim cost reporting requirements at 42 C.F.R. § 413.24(j) and the Medicare Contractor timely raised a substantive claim challenge[83] under 42 C.F.R. § 405.1873(a) for the following Providers, resulting in the following findings of the Board:

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[82] Those Providers are: For Case No. 22-1385GC: Grandview Hospital (Prov. No. 36-0133), and Kettering Medical Center (Prov. No. 36-0079). For Case No. 23-1118GC: Portneuf Medical Center (Prov. No. 13-0028) and Hillcrest Medical Center (Prov. No. 37-0001). For Case No. 23-1235GC: Williamsport Regional Medical Center (Prov. No. 39-0045) and University of Pittsburgh Medical Center (UPMC) Hamot (Prov. No. 39-0063).

[83] As explained at Board Rule 44.5, "[t]he Board adoption of the term "Substantive Claim Challenge" simply refers to any question raised by a party concerning whether the cost report at issue included an appropriate claim for one or more of the specific items being appealed in order to receive or potentially qualify for reimbursement for those specific items."

a. It is undisputed that all of the providers in the group appeals for Case Nos. 22-1385GC and 23-1118GC, and two of the providers in Case No. 23-1235GC (University of Pittsburgh Medical Center Hamot, Prov. No. 39-0063 and Williamsport Regional Medical Center, Prov. No. 39-0045), ***did not meet*** the substantive claim cost reporting requirements in § 413.24(j) and, as such, may not receive reimbursement for the appealed item unless an exception is late met in 42 C.F.R. § 405.1873(f)(2)(ii);

b. The Board finds that Pinnacle Health Hospitals, Prov. No. 39-0067, in Case No. 24-0026GC, *did* ***meet*** the substantive claim reporting requirements in § 413.24(j).

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

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

5) It is without the authority to decide the following legal questions of:

a. As it relates to all providers in these 4 CIRP groups, whether 42 C.F.R. § 412.320(a)(1)(iii), as promulgated in the FY 2007 IPPS Final Rule, is substantively or procedurally valid; and

b. In connection with the following Providers not in compliance with § 413.24(j), whether the regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 are valid:

- Case No. 22-1385GC: Grandview Hospital (Prov. No. 36-0133), and Kettering Medical Center (Prov. No. 36-0079).
- Case No. 23-1118GC: Portneuf Medical Center (Prov. No. 13-0028) and Hillcrest Medical Center (Prov. No. 37-0001).
- Case No. 23-1235GC: Williamsport Regional Medical Center (Prov. No. 39-0045) and University of Pittsburgh Medical Center (UPMC) Hamot (Prov. No. 39-0063).

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

Board Members Participating:

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

For the Board:

1/12/2024

X Clayton J. Nix

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

Enclosures: Schedules of Providers

cc: Judith Cummings, CGS Administrators (J-15)
Michael Redmond, Novitas Solutions, Inc. (J-H)
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Adam Walker
Mercy Rehabilitation Hospital Northwest Arkansas
4313 S. Pleasant Crossing Boulevard
Rogers, AR 72758

Re: ***Notice of Dismissal***
Mercy Rehabilitation Hospital Northwest Arkansas (Prov. No. 04-3036, FFY 2023)
Case No. 24-0450

Dear Mr. Walker:

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

Pertinent Facts:

On **December 8, 2023**, Mercy Rehabilitation Hospital Northwest Arkansas (the "Provider") filed an individual appeal with the Board based on a "Notice of Quality Reporting Program Noncompliance Decision Upheld" dated October 13, 2023.[1] Upon review of the support documentation uploaded with the appeal, the Board noted that the document that had been labeled as the "issue statement" was actually an additional copy of the final determination under appeal. On the same date, the Provider filed an "Individual Supplementation Documentation" case action, in which it resubmitted five of the original nine documents that had been uploaded in the initial appeal request.[2] One of the uploads was another copy of an exhibit that was titled "MRH NWA Brief Letter." The letter included one paragraph explaining that the Provider is requesting a hearing regarding the Two Percent Reduction determination but did not give any further details.

On **December 14, 2023**, the Board issued the Acknowledgement and Notice of Critical Due Dates ("Notice") in which it included a request for an issue statement (which was due to the Board by December 29, 2023). Specifically, the Board advised that the issue statement ". . . should include the controlling authority (e.g., specific regulation, Federal Register issuance, manual provision, or Ruling); why the adjustment(s) is incorrect; how the payment should be determined differently; the reimbursement effect and the basis for jurisdiction before the Board."

Significantly, the Notice made clear that "[i]f the Provider misses any of its due days, the Board ***will dismiss*** the appeal."[3] Notwithstanding, to date, the Provider has not filed any response to the Board's request for an issue statement.

[1] The appeal was filed at 1:38 p.m.
[2] The Individual Supplementation Documentation was filed at 1:41 p.m.
[3] (Emphasis added.)

Decision of the Board:

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

42 C.F.R. § 405.1835(b) specifies that, if a Provider's appeal request does not meet the requirements of paragraph (b)(2) of the same section, the Board may dismiss the appeal with prejudice, or take any other remedial action it considers appropriate. Paragraph (b) states in pertinent part:

> (b) *Contents of request for a Board hearing on final contractor determination*. The provider's request for a Board hearing under paragraph (a) of this section must be submitted in writing in the manner prescribed by the Board, and the request must include the elements described in paragraphs (b)(1) through (4) of this section. If the provider submits a hearing request that does not meet the requirements of paragraph (b)(1), (2), or (3) of this section, **the Board may dismiss** with prejudice the appeal or take any other remedial action it considers appropriate.
>
> ****
>
> (2) For each specific item under appeal, **a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final contractor or Secretary determination under appeal**, **including** an account of all the following:
>
> (i) **Why the provider believes the Medicare payment is incorrect** for each disputed item (or, where applicable, why the provider is unable to determine whether Medicare payment is correct because it does not have access to underlying information concerning the calculation of its payment).
>
> (ii) **How and why the provider believes Medicare payment must be determined differently** for each disputed item . . . .

As noted above, pursuant to 42 C.F.R. § 405.1835(b), "[i]f the provider submits a hearing request that does not meet the requirements of paragraph (b)(1), (2) or (3) . . . , the Board may dismiss with prejudice the appeal or take other remedial action it considers appropriate. In this case, the Board finds that the Provider failed to submit the explanation of the specific item(s) or issue(s) under appeal in connection with the October 13, 2023 final determination at issue, as

required by 42 C.F.R. § 405.1835(b)(2) and Board Rules 6.1.1, 7.2, and 8, and then failed to cure this fatal defect by the December 29, 2023 deadline stated the Board's December 14, 2023 Notice. Significantly, this Notice also made clear that failure to filed by that deadline would result in dismissal. Accordingly, the Board finds that dismissal is appropriate under § 405.1835(b) and Board Rules and the Board hereby dismisses Case No. 24-0450 and removes it from the Board's docket.

Based on the final determination date referenced in the Provider's appeal, the Provider is still within its appeal period (until Monday, April 15, 2024 if the relevant final determination to be appealed is dated October 13, 2023).[4] Therefore, the dismissal is without prejudice and, if the Provider elects, it may *refile* an individual appeal with the 180-day timeframe provided under 42 C.F.R. § 405.1835(a)(3). Please see 42 C.F.R. § 405.1835 and Board Rule 6, which both discuss individual appeal rights, and requirements. Additionally, since the Provider is appealing a Quality Reporting determination, it may be helpful to refer to the Frequently Asked Questions ("FAQs") for Quality Reporting Appeals located at https://www.cms.gov/files/document/faqs-quality-reporting-appeals.pdf.

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

For the Board:

1/16/2024

X Clayton J. Nix

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

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services
Michael Redmond, Novitas Solutions, Inc. (J-H)

[4] As an appeal must be filed within 180 days of receipt of the final determination and receipt is presumed to be 5 days from the date of the final determination, an appeal must be field within 185 days from the date of the final determination being appealed. *See* 42 C.F.R. §§ 405.1835(a)(3), 405.1801 (definition of date of receipt).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***EJR Determination***
King & Spalding FFY 2024 § 1115 Waiver Days Texas II Group
Case No. 24-0599G

Dear Mr. Kenny:

The Provider Reimbursement Review Board ("Board") has reviewed the request for expedited judicial review ("EJR") filed on December 22, 2023 for the above-referenced *optional* group case. Set forth below is the decision of the Board to deny the EJR request and to dismiss the group appeal in its entirety.

Background:

On December 22, 2023, the Providers' Representative, Christopher Kenny of King & Spalding, LLP ("King & Spalding"), filed a group appeal request to establish above-referenced *optional* group appeal and the 2 participants in this group were *directly* added to the group on the same day. The 2 participants in the optional group appeal are located in Texas, and the appeal itself is based on an appeal of the federal fiscal year ("FFY") 2024 IPPS Final Rule as it relates to the Secretary's policy to include inclusion only certain § 1115 waiver days in the Medicaid fraction of the disproportionate share hospital ("DSH") payment calculation.[1] The appeal ***only*** relates to FFY 2024[2] and the group appeal contains the following issue statement:

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

[1] 88 Fed. Reg. 58640, 59012-26 (Aug. 28, 2023) (excerpt from the preamble to the final rule addressing "Counting of Certain Days Associated With Section 1115 Demonstration in the Medicaid Fraction").
[2] FFY 2024 runs from October 1, 2023 through September 30, 2024. The 2 Providers in this optional group have fiscal years that coincide with the calendar year (i.e., have fiscal years ending annually on December 31). As a result, these 2 Providers appealed the 2 fiscal years that straddled FFY 2024. Specifically, since these Providers have fiscal years ending December 31st, these Providers appealed both its fiscal year ending December 31, 2023 (*i.e.*, its FY 2023 but only the last quarter of 2023 that began Oct. 1, 2023 when the policy at issue became effective) and its fiscal year ending December 31, 2024 (*i.e.*, its FY 2024 but only the first three quarters of FY 2024 as FFY 2024 ends September 2024). *In this example*, the provider's FY 2023 has not yet concluded and its FY 2024 has not yet begun.

> covered in whole or in part by an uncompensated care pool established under a waiver approved by CMS pursuant to Section 1115 of the Social Security Act. 88 Fed. Reg. 58640, 59016 (Aug. 28, 2023) (adopting 42 C.F.R. § 412.106(b)(4)(iii)). **Beginning on October 1, 2023, newly adopted 42 C.F.R. § 412.106(b)(4)(iii) bars hospitals from claiming in the Medicaid fraction of their Medicare DSH calculations all patient days attributable to such individuals**. This determination is unlawful because CMS is required to include in the Medicaid fraction all patients it has regarded as eligible for Medicaid under a Section 1115 waiver. 42 U.S.C. § 1395ww(d)(5)(F)(vi). Patients whose care is eligible for coverage under an uncompensated care pool that was established under a CMS approved Section 1115 waiver are regarded as eligible for Medicaid. *See Forrest General Hospital v. Azar*, 926 F.3d 221, 229 (5th Cir. 2019); *Bethesda Health, Inc. v. Azar*, 389 F. Supp. 3d 32, 47 (D.D.C. 2019) *aff'd*, 980 F.3d 121 (D.C. Cir. 2020).
>
> The Providers in this group appeal are hospitals located in the State of Texas. The Texas Medicaid program provides coverage to uninsured patients who receive some or all their hospital services free of charge under the hospital's charity care policy. Payments for this coverage are drawn from an uncompensated care (UC) pool authorized under the Texas Healthcare Transformation and Quality Improvement Program—a waiver approved by the Secretary of Health and Human Services (the Secretary) pursuant to section 1115(a)(2) of the Social Security Act (the Texas Section 1115 Waiver). Because the patients covered by the UC pool receive inpatient hospital benefits from a Section 1115 waiver, the Medicare statute regards them as eligible for Medicaid. Accordingly, the statute requires the Secretary to include the inpatient days attributable to these individuals in the Medicaid fraction of the Medicare DSH calculation. The Secretary's regulation defies this command.[3]

On the ***same*** day as the filing of the appeal request, King & Spalding certified that the groups were complete, filed its Rule 20 Certification, and then filed a Petition for Expedited Judicial Review ("EJR Request").

Statutory and Regulatory Background:

A. Medicare DSH Payment

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the

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

inpatient prospective payment system ("IPPS").[4] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[5]

The IPPS statute contains several provisions that adjust reimbursement based on hospital-specific factors.[6] This case involves the hospital-specific DSH adjustment, which requires the Secretary to provide increased IPPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[7]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[8] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.[9] The DPP is defined as the sum of two fractions expressed as percentages.[10] Those two fractions are referred to as the "Medicare/SSI fraction" and the "Medicaid fraction." Both of these fractions consider whether a patient was "entitled to benefits under part A."

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

> [T]he fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were entitled to benefits under part A of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were entitled to benefits under part A of this subchapter . . . .[11]

The Medicare/SSI fraction is computed annually by the Centers for Medicare and Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[12]

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

> The fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical

[4] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[5] *Id.*
[6] *See* 42 U.S.C. § 1395ww(d)(5).
[7] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[8] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I), (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[9] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv), (vii)-(xiii); 42 C.F.R. § 412.106(d).
[10] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[11] (Emphasis added.)
[12] 42 C.F.R. § 412.106(b)(2)-(3).

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

The Medicare contractor determines the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A and divides that number by the total number of patient days in the same period.[13]

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

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

[13] 42 C.F.R. § 412.106(b)(4).

> **this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day**.[14]

B. Background on Medicaid State Plans and § 1115 Waivers

Medicaid is a joint Federal and state program, established in Title XIX of the Social Security Act (the "Act").[15] To participate in the Medicaid program and receive federal matching funds (commonly referred to as federal financial participation or "FFP"),[16] a state must enter into an agreement ("State Plan") with the Federal government, describing the individuals covered, services provided, reimbursement methodologies for providers, and other administrative activities.[17]

Federal law provides states flexibility in operating Medicaid programs through multiple waivers of federal law and demonstration programs. To address the medical needs of its residents, a State may choose to apply for, and include in its State Plan, a demonstration program under § 1115 of the Act (42 U.S.C. § 1315) which allows CMS to waive various Federal Medicaid eligibility and benefits requirements. These projects expand Medicaid eligibility to populations who would ordinarily be disqualified from receiving benefits under the State Plan. The costs of such a demonstration project, including the costs of patient treatment, are regarded as expenditures under the State Plan and thus eligible for Federal matching funds.[18]

Prior to 2000, "hospitals were to include in the Medicare DSH calculation ***only*** those days for populations *under the section 1115 waiver* who were or could have been made eligible under a State plan."[19] As a result, patient days of *expanded* eligibility groups were *not* included in the Medicare DSH calculation.

In 2000, the Secretary published an interim rule to address the DSH adjustment calculation policy in reference to § 1115 waiver days and allow for certain *expanded* eligibility groups to be included in the Medicare DSH calculation.[20] Specifically, the interim rule revised this policy "to allow hospitals to include the patient days of all populations eligible for Title XIX matching payments in a State's section 1115 waiver in calculating the hospital's Medicare DSH adjustment."[21] This change in policy was effective for discharges occurring on or after January 20, 2000 and was codified in the regulations at 42 C.F.R. § 412.106(b)(4)(ii).[22]

In 2003, the Secretary amended the DSH regulation to specify that a patient shall be "deemed eligible for Medicaid on a given day only if the patient is *eligible for inpatient hospital services* under a [State

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[14] (Bold and underline emphasis added and italics in original.)
[15] 42 U.S.C. § 1396; 42 C.F.R. § 430.0.
[16] 42 U.S.C. § 1396b.
[17] 42 U.S.C. § 1396a.
[18] 42 U.S.C. § 1315(a)(2)(A).
[19] 65 Fed. Reg. 3136, 3136(Jan. 20, 2000) (emphasis added).
[20] *Id.* The interim rule was followed by a final rule, as well. 65 Fed. Reg. 47054, 47086-87 (Aug. 1, 2000).
[21] 65 Fed. Reg at 3136-3137. *See also* 65 Fed. Reg. at 47086-47087.
[22] 65 Fed. Reg. at 3139.

Plan] or under a waiver authorized under section 1115(a)(2)."[23] The rationale was that "certain section 1115 demonstration projects . . . serve expansion populations with benefit packages so limited that the benefits are not similar to the medical assistance available under a Medicaid State plan."[24] The purpose of the refinement was to include in the Medicaid Fraction only days of waiver populations where they were provided inpatient hospital benefits equivalent to the care provided to beneficiaries under a Medicaid State Plan.[25] To achieve this, the DSH regulation at 42 C.F.R. § 412.106(b)(4)(i) was amended to specify that "a patient is deemed eligible for Medicaid on a given day **only if the patient is eligible for inpatient hospital services** under an approved State Medicaid plan or under a waiver authorized under section 1115(a)(2) of the Act on that day . . . ."[26]

In 2006, Congress passed the Deficit Reduction Act of 2005 and this legislation amended 42 U.S.C. § 1395ww(d)(5)(F)(vi)[27] by adding the following language below subclause (II):

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

The Secretary has interpreted this amendment as confirming that waiver day groups' days are not automatically "eligible for Medicaid under a State plan," that she has the discretion to determine the extent to which patients are "not so eligible," and to what extent, if any, they may be "regarded as eligible" and thus included in the Medicaid fraction.[28]

On August 28, 2023 as part of the FFY 2024 IPPS Final Rule, the Secretary finalized further revisions to the regulations governing the inclusion of § 1115 expansion days in the Medicare DSH calculation.[29] In making these revisions, the Secretary has noted a rise in § 1115 waiver demonstrations which authorize funding a limited and narrowly circumscribed set of payments to hospitals, such as § 1115 demonstrations which include funding for uncompensated/ undercompensated care pools. These pools do not extend health insurance to individuals or benefits similar to Medicaid beneficiaries under a State plan. Instead, they provide funds directly to hospitals to offset treatment costs for uninsured and underinsured patients.[30] As such, these days have been typically excluded from the Medicaid fraction of the DSH calculation because the days associated with these § 1115 demonstrations do not create inpatient hospital eligibility.

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[23] 68 Fed. Reg. 45346, 45470 (Aug. 1, 2003).
[24] *Id.* at 45420.
[25] *See* 88 Fed. Reg. 58460, 59014 (Aug. 28, 2023).
[26] (2022) (emphasis added).
[27] Pub. L. 109-171, § 5002, 120 Stat. 4, 31 (2006).
[28] 88 Fed. Reg. at 59014.
[29] *Id.* at 59012-26.
[30] *Id.* at 59015.

The Secretary acknowledged that several court decisions have disagreed with this approach and ruled that 42 C.F.R. § 412.106(b)(4) requires the inclusion of days for which hospitals received payment from a uncompensated/undercompensated care pool authorized by a § 1115 waiver.[31] Thus, in the FY 2022 IPPS/LTCH PPS proposed rule,[32] the Secretary proposed to revise the regulation "to more clearly state that in order for an inpatient day to be counted in the DPP Medicaid fraction numerator, the section 1115 demonstration must provide inpatient hospital insurance benefits directly to the individual whose day is being considered for inclusion."[33] After reviewing comments on the proposal, the Secretary proposed different revisions to the regulations in the FY 2023 IPPS/LTCH PPS proposed rule,[34] but opted not to finalize them after reviewing comments on the proposal.[35]

Finally, in a proposed rule published on February 28, 2023,[36] the Secretary proposed revisions to the regulations "on the counting of days associated with individuals eligible for certain benefits provided by section 1115 demonstrations[.]"[37] Thereafter in the FFY 2024 IPPS Final Rule, he announced that "we are modifying our regulations to explicitly state our long-held view that only patients who receive health insurance through a section 1115 demonstration where State expenditures to provide the insurance may be matched with funds from title XIX can be 'regarded as' eligible for Medicaid."[38] He also finalized a proposed amendment "to state specifically that patients whose inpatient hospital costs are paid for with funds from an uncompensated/undercompensated care pool authorized by a section 1115 demonstration are not patients "regarded as" eligible for Medicaid, and the days of such patients may not be included in the DPP Medicaid fraction numerator."[39]

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

> (4) *Second computation*. The fiscal intermediary determines, for the same cost reporting period used for the first computation, the number of the hospital's patient days of service for patients who were not entitled to Medicare Part A, and who were either eligible for Medicaid on such days as described in paragraph (b)(4)(i) of this section or who were regarded as eligible for Medicaid on such days and the Secretary has determined to include those days in this computation as described in paragraph (b)(4)(ii)(A) or (B) of this section. The fiscal intermediary then divides that number by the total number of patient days in the same period. For purposes of this second computation, the following requirements apply:

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[31] *Id.* (citing *Bethesda Health, Inc.* v. *Azar*, 980 F.3d 121 (D.C. Cir. 2020); *Forrest General Hospital* v. *Azar*, 926 F.3d 221 (5th Cir. 2019); *HealthAlliance Hospitals, Inc.* v. *Azar*, 346 F. Supp. 3d 43 (D.D.C. 2018)).
[32] 86 Fed. Reg. 25070 (May 10, 2021).
[33] *Id.* at 25459.
[34] 87 Fed. Reg. 28108 (May 10, 2022).
[35] 87 Fed. Reg. 48780, 49051 (Aug. 10, 2022).
[36] 88 Fed. Reg. 12623 (Feb. 28, 2023).
[37] *Id.* at 12623.
[38] 88 Fed. Reg. at 59016.
[39] *Id.*

> (i) For purposes of this computation, a patient is eligible for Medicaid on a given day if the patient is eligible on that day for inpatient hospital services under a State Medicaid plan approved under title XIX of the Act, regardless of whether particular items or services were covered or paid for on that day under the State plan.
>
> (ii) For purposes of this computation, a patient is regarded as eligible for Medicaid on a given day if the patient receives health insurance authorized by a demonstration approved by the Secretary under section 1115(a)(2) of the Act for that day, where the cost of such health insurance may be counted as expenditures under section 1903 of the Act, or the patient has health insurance for that day purchased using premium assistance received through a demonstration approved by the Secretary under section 1115(a)(2) of the Act, where the cost of the premium assistance may be counted as expenditures under section 1903 of the Act, and in either case regardless of whether particular items or services were covered or paid for on that day by the health insurance. Of these patients regarded as eligible for Medicaid on a given day, only the days of patients meeting the following criteria on that day may be counted in this second computation:
>
> > (A) Patients who are provided by a demonstration authorized under section 1115(a)(2) of the Act health insurance that covers inpatient hospital services; or
> >
> > (B) Patients who purchase health insurance that covers inpatient hospital services using premium assistance provided by a demonstration authorized under section 1115(a)(2) of the Act and the premium assistance accounts for 100 percent of the premium cost to the patient.
>
> (iii) Patients whose health care costs, including inpatient hospital services costs, for a given day are claimed for payment by a provider from an uncompensated, undercompensated, or other type of funding pool authorized under section 1115(a) of the Act to fund providers' uncompensated care costs are not regarded as eligible for Medicaid for purposes of paragraph (b)(4)(ii) of this section on that day and the days of such patients may not be included in this second computation.[40]

Providers' Request for EJR:

The Providers have appealed from the Federal Register publishing these regulatory amendments. They argue the "determination is unlawful because the Medicare statute does not afford the

[40] *Id.* at 59332.

Secretary the discretion to exclude certain patients once he has conferred a benefit upon them by approving a section 1115 waiver."[41] They claim that the once a § 1115 waiver is approved, all such patient days must be included in the Medicaid fraction without any exceptions or qualifications.[42]

The Providers claim that the justifications set forth by the Secretary to "[c]arve out a sub-population of patients who receive inpatient benefits through an approved section 1115 uncompensated care pool" have been rejected by federal courts.[43] They argue the amended regulations "[flout] prior contrary and binding interpretations of the very statute [the Secretary] believes gives him the discretion to exclude certain categories of section 1115 beneficiaries from calculating the Medicaid fraction."[44] Since the Board is bound by these new regulations, it therefore cannot provide the relief sought by the Providers and, as a result, they are requesting EJR in order to challenge them.

The Providers argue that the challenged regulation will impact them specifically because they provide coverage to uninsured patients, whose payments are covered by an uncompensated care pool approved under a § 1115 waiver. Since these patients receive inpatient hospital benefits from a § 1115 waiver, they should be deemed as eligible for Medicaid and included in the Medicaid fraction of the DSH calculation.[45] They note that each provider in this group appeal has *historically* qualified for DSH and are all *projected to* qualify for DSH payments in FY 2023; but yet have no similarly "projected" information as it relates to their respective FY 2024.[46]

Medicare Contractor's Response to Request for EJR:

The Medicare Contractor has not filed a response to the request for EJR. Board Rule 42.4 requires a response be filed within five (5) business days of a request for EJR. The Provider filed its EJR Request on Friday, December 22, 2023 and the fifth business day following this filing was January 2, 2024.

Decision of the Board:

Pursuant to 42 C.F.R. § 405.1837(a)(1), a group of providers generally have the right to a hearing before the Board "with respect to a final contractor or Secretary determination ***for the provider's cost reporting period***"[47] if each provider satisfies individuals the requirements for a Board hearing under § 405.1835(a) and the group's amount in controversy is $50,000 or more. Pursuant to 42 C.F.R. § 405.1835(a)(1), an individual provider generally has a right to a hearing before the Board

[41] EJR Request at 7 (citing *Forrest General Hospital*, 926 F.3d at 224 ("Once the Secretary authorizes a demonstration project, no take-backs.")).
[42] *Id.* at 8 (citing *Forrest Gen. Hosp.*, 926 F.3d at 228-229).
[43] *Id.* at 9 (citing *Bethesda Health*, 389 F. Supp. 3d at 46-47; *Forrest Gen. Hosp.*, 926 F.3d at 229).
[44] *Id.* at 10.
[45] *Id.* at 7-8.
[46] *Id.* at 8.
[47] (Emphasis added).

"with respect to a final contractor or Secretary determination ***for the provider's cost reporting period***"[48] if:

- It "is dissatisfied *with the contractor's final determination of the total amount of reimbursement* ***due the provider***, as set forth in the contractor's written notice specified under § 405.1803"[49] In other words, providers must appeal from a "final determination" that impacts payment for the period under appeal.[50]

- The request for a hearing is filed within 180 days of the date of receipt of the final determination.[51]

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

> [W]ith respect to a final … determination ***for the provider's cost reporting period***, if – (1) The provider is dissatisfied with the contractor's final *determination* of total amount *of reimbursement* ***due the provider***, as set forth in the contractor's written notice specified under § 405.1803.[52]

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

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

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[48] 42 C.F.R. § 405.1835(a) (emphasis added).
[49] 42 C.F.R. § 405.1835(a)(1) (emphasis added).
[50] *See also* 42 U.S.C. § 1395oo(a)(1)(A); *Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 144-146 (D.C. Cir. 1986) (stating: "Viewing the amendments as a whole, we are inescapably drawn to the same conclusion as the District Court: § 1395oo (a) 'clearly contemplates two different kinds of appeal. One begins when the intermediary issues an NPR; the other, when the intermediary issues a notice of ***what will be paid*** *under the PPS system*.' . . . . Under PPS, in contrast, ***payment amounts*** are independent of current costs and *can be determined with finality* prior to the beginning of the cost year. Id. § 412.71(d). Thus a year-end cost report is not a report which is necessary ***in order for the Secretary to make PPS payments***, and the appeals provision applicable to PPS recipients cannot be read to require hospitals to file cost reports and await NPRs prior to filing a PRRB appeal." (emphasis added and citations omitted)).
[51] 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835 – 1840.
[52] (Emphasis added.)

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

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

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

42 C.F.R. § 405.1837(a)(3) also states that a group must demonstrate that the amount in controversy is $50,000 or more. Satisfying the criteria set out in 42 C.F.R. §§ 405.1835(a) and 1837(a) is required before the Board can exercise jurisdiction over an appeal.[53]

Pursuant to 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R.§ 405.1842(f)(1), the Board will grant an EJR request if it determines that: (i) it has jurisdiction to conduct a hearing on the specific matter at issue; and (ii) it lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute or to the substantive or procedural validity of a regulation or CMS Ruling. This regulation makes clear that a finding of jurisdiction is a prerequisite to consideration of an EJR request.[54]

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[53] 42 C.F.R. § 405.1840(a), (b). The Board notes that 42 C.F.R. § 405.1840 is entitled "Board Jurisdiction" but it also addresses certain claim filing requirements such as timelines or filing deadlines. However, whether an appeal was timely is not a jurisdictional requirement but rather is a claim filing requirement as the Supreme Court made clear in *Sebelius v. Auburn Reg. Med. Ctr.*, 568 U.S. 145 (2013). *See also* Board Rule 4.1 ("The Board will dismiss appeals that fail *to meet the timely filing requirements **and/or** jurisdictional requirements*. Similarly, the Board notes that 42 C.F.R. § 405.1835(b) addresses claim filing requirements.

[54] *See Saint Francis v. Becerra*, No. 22-cv-1960, 2023 WL 6294168 (D.D.C. Sept. 27, 2023) (for example stating at *5: "The first sentence of § 405.1842(e)(1) fixes when the thirty-date period for determining authority defined in the second sentence becomes operative, specifically, after the Board determines it has jurisdiction." (citation omitted)).

The Providers are appealing the Final Rule published on August 28, 2023 pursuant to 42 U.S.C. § 1395oo(a)(1)(A)(i),[55] which allows for a hearing before the Board if a provider:

> [I]s dissatisfied **with a final determination *of the organization serving as its fiscal intermediary*** pursuant to section 1395h of this title as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under this subchapter for the period covered by such report.[56]

The Board notes that the purported "final determination" being appealed in this case is a policy codified in regulation as part of a final rule published in the Federal Register. Significantly, the purported "final determination was not issued by the Providers' Medicare administrative contractor (formerly known as "fiscal intermediary") but rather was issued by the Secretary.

However, 42 U.S.C. § 1395oo(a)(1)(A)(ii) does allow for an appeal from a Secretary determination and the EJR Request suggests that this is the statutory provision upon which the Providers are relying for the appeal request.

The Board notes that the alleged "final determination" being appealed in this case is a change in policy adopted in a final rule published in the Federal Register, namely the FFY 2024 IPPS Final Rule. However, the adoption and codification of this policy in the FFY 2024 IPPS Final Rule is not a "final determination" directly appealable to the Board under 42 U.S.C. § 1395oo(a)(1)(A)(i) or (ii). Rather, the Providers' appeals of the group issue are premature.

Here, unlike DRG rates and other adjustments such as the wage index, a hospital's eligibility for a DSH payment (and, if eligible, the amount of that payment) is not *prospectively* set on an annual basis as part of the relevant IPPS final rule. Rather, 42 U.S.C. § 1395ww(d)(5)(F) refers to the DSH adjustment being calculated "with respect to a [hospital's] cost reporting period."[57] To this end, DSH eligibility and payment, if any, is determined, calculated, and finalized *annually* through the cost report audit/settlement process as made clear in 42 C.F.R. § 412.106(i) which sets forth the following instructions regarding the determination of a hospital's eligibility for a DSH payment for each fiscal year and, if so, how much:

> (i) *Manner and timing of [DSH] payments*. (1) Interim [DSH] payments are made **during the payment year to each hospital that is estimated to be eligible** for payments under this section at the time of the annual final rule for the hospital inpatient

[55] EJR Request at 11.
[56] (Emphasis added.)
[57] The Board notes that the Medicare DSH adjustment provision under 42 U.S.C. § 1395ww(d)(5)(F) was enacted by § 9105 of the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") and became effective for discharges occurring on or after May 1, 1986. Pub. L. 99-272, § 9105, 100 Stat. 82, 158-60. As such, it was enacted several years after the initial legislation that established the IPPS.

> prospective payment system, **subject to the final determination of eligibility at the time of cost report settlement for each hospital**.
>
> (2) **Final payment determinations are made at the time of cost report settlement**, based on the **final** determination of each hospital's eligibility for payment under this section.[58]

The Secretary makes clear that this regulation is based on "our ***longstanding*** *process* of making ***interim*** *eligibility* determinations for Medicare DSH payments *with* ***final*** *determination* ***at cost report settlement***."[59]

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[58] (Italics emphasis in original and bold and underline emphasis added.)

[59] 78 Fed. Reg. at 50627. *See also* Provider Reimbursement Manual, CMS Pub. 15-1 ("PRM 15-1"), § 2807.2(B)(5) (last revised Aug. 1993, Transmittal 371) (stating: "*At* ***final*** ***settlement*** *of the cost report*, the intermediary determines the final disproportionate share adjustment based on the actual bed size and disproportionate share patient percentage for the cost reporting period." (emphasis added)). In the preamble to the FY 2014 IPPS Final Rule, the Secretary discussed the DSH eligibility and payment process and the following are excerpts from that discussion:

> *Comment*: Several commenters requested that CMS undertake additional audits to verify the data used to compute the 25-percent empirically justified Medicare DSH payment adjustments. Other commenters requested that CMS grant additional time for hospitals to verify the data and adjust their cost reports to ensure that the data used to compute the adjustment are accurate and up to date. Some commenters requested that CMS establish procedures to allow a hospital initially determined not to be eligible for Medicare DSH payments to begin receiving empirically justified Medicare DSH payments if data become available that indicate that the hospital would be eligible.
>
> *Response*: As we have emphasized, we are maintaining the well-established methodology and payment processes used under the current Medicare DSH payment adjustment methodology for purposes of making the empirically justified Medicare DSH payment adjustments. Hospitals are quite familiar with the cost reporting requirements and auditing procedures employed under the current Medicare DSH payment adjustment methodology. Hospitals are also familiar with the current process of determining **interim eligibility** for Medicare DSH payments **with final determination at cost report settlement**. Therefore, we do not believe that it would be warranted to add additional complexity to these procedures by adopting any of these recommendations.
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> ****
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> **For the reasons discussed above regarding the empirically justified Medicare DSH payments** [*i.e.*, the DSH payment calculation made under 42 U.S.C. § 1395ww(d)(5)(F)], **we do not believe that it is necessary or advisable to depart from our longstanding process of making interim eligibility determinations for Medicare DSH payments with final determination at cost report settlement.** As we discuss in greater detail in section V.E.3.f. of the preamble to this final rule, we will make interim eligibility determinations based on data from the most recently available SSI ratios and Medicaid fractions prior to the beginning of the payment year. We will then make final determinations of eligibility at the time of settlement of each hospital's cost report. Therefore, we proposed that, at cost report settlement, the fiscal intermediary/MAC will issue a notice of program reimbursement that includes a determination concerning whether each hospital is eligible for empirically justified Medicare DSH payments and, therefore, eligible for uncompensated care payments in FY 2014 and each subsequent year. In the case where a hospital received interim payments for its empirically justified Medicare DSH payments and uncompensated care payments for FY 2014 or a subsequent year on the basis of estimates prior to the payment year, but is determined to be ineligible for the empirically justified Medicare DSH payment at cost report settlement, the hospital would no longer be eligible for either payment and CMS would recoup those monies. For a hospital that did not receive interim payments for its empirically justified Medicare DSH payments and uncompensated care payments for FY 2014 or a subsequent year, but at cost report settlement is

Indeed, a hospital that is potentially eligible for a DSH payment must "submit[] such [cost] report[] within such time as the Secretary may require *in order to make payment under such section* [*i.e.*, subsection (d)]" as confirmed in the above quote of 42 C.F.R. § 412.106(i). Examples of other adjustments to IPPS payment rates that are based, in whole or in part, on certain data/costs claimed on the as-filed cost report (where final payment is determined and reimbursed through the cost report audit and settlement process) include bad debts,[60] direct graduate medical education ("GME"),[61] and indirect GME.[62] This is what makes this case distinguishable from the facts presented in the D.C. Circuit's decisions in *Washington Hospital* where the determination that was appealed finalized the only hospital-specific variable used in setting the per-patient payment amount. Specifically, the hospitals in *Washington Hospital* appealed their "Final Notice of Base Period Cost and Target Amount Per Discharge" and the D.C. Circuit found: (a) "the ***only variable factor*** in the final determination as to the amount of payment under § 1395ww(d) is the hospital's target amount . . . .";[63] and (b) "The amount is the per-patient amount calculated under § 1395ww(d) and is final once the Secretary has published the DRG amounts (as has) and finally determined the hospital's target amount. Here each of the hospitals has received a 'Final Notice of Base Period Cost and Target Amount per Discharge.' The statute requires no more to trigger the hospital's right to appeal PPS Payments to the PRRB."[64]

To highlight what types of determinations are being made during the cost report audit/settlement process, the Board notes that any potential § 1115 waiver days for the fiscal years at issue would be included in the numerator of the Medicaid fraction used in each Provider's DSH adjustment calculation for each of the relevant fiscal years; however, in order for a day to be included in the numerator of the Medicaid fraction, 42 C.F.R. § 412.106(b)(4) (Oct. 1, 2023) specifies that the Medicare contractor (a/k/a fiscal intermediary[65]) "*determines*" the days to be included in the numerator of a hospital's Medicaid fraction based on the hospital's "burden" of "prov[ing]" Medicaid eligibility *on* ***each*** *day being claimed* ***on the cost report*** for the relevant fiscal year:

> (4) *Second computation*. **The fiscal intermediary determines**, for the same cost reporting period used for the first computation, **the number of the hospital's patient days** of service **for patients who were not**

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determined to be eligible for DSH payments, the uncompensated care payment for such a hospital is calculated based on the Factor 3 value determined prospectively for that fiscal year.

Id. at 50626-27 (emphasis added).

[60] 42 C.F.R. §§ 412.2(f)(4), 412.115(a) (stating: "An additional payment is made to each hospital in accordance with § 413.89 of this chapter for bad debts attributable to deductible and coinsurance amounts related to covered services received by beneficiaries.).

[61] 42 C.F.R. § 412.2(f)(7) (stating that hospitals receive an additional payment for "[t]he direct graduate medical education costs for approved residency programs in medicine, osteopathy, dentistry, and podiatry as described in §§ 413.75–413.83 of this chapter.").

[62] 42 C.F.R. §§ 412.2(f)(2), 412.105. *See also* PRM 15-1 § 2807.2(B)(6) (stating: "*At* ***final settlement*** *of the cost report*, the intermediary determines the indirect teaching adjustment based on the actual number of full time equivalent residents and average daily census for the cost reporting period. (emphasis added)).

[63] 795 F.2d at 143 (emphasis added).

[64] *Id.* at 147 (footnote omitted).

[65] CMS' payment and audit functions under the Medicare program were historically contracted to organizations known as fiscal intermediaries ("FIs") and these same functions are now contracted with organizations known as Medicare administrative contractors ("MACs"). The term "Medicare contractor" refers to both FIs and MACs.

> **entitled to Medicare Part A, and who were either eligible for Medicaid on such days** as described in paragraph (b)(4)(i) of this section **or who were regarded as eligible for Medicaid on such days** and the Secretary has determined to include those days in this computation as described in paragraph (b)(4)(ii)(A) or (B) of this section. The fiscal intermediary then divides that number by the total number of patient days in the same period. For purposes of this second computation, the following requirements apply:
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> (iv) **The hospital has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed** under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.[66]

Accordingly, unlike DRG rates and wage index rates, a hospital's eligibility for a DSH payment (and, if so, the amount) is determined through the following *italicized* phrase in 42 U.S.C. § 1395oo(a) and, as such, is a prerequisite to the Providers' appeal:

> (a) . . . any hospital which receives payments in amounts computed under subsection (b) or (d) of section 1395ww of this title *and which has submitted such [cost] reports* within such time as the Secretary

[66] 88 Fed. Reg. at 59332; 42 C.F.R. § 412.106 (Oct. 1, 2023). *See also id.* at 59023 (stating: "We are unsure why some commenters have significant concerns with verifying an individual's section 1115 eligibility and the amount of premium assistance when hospitals are already communicating with their state Medicaid office to verify an individual's eligibility. We do not understand why it is unclear who would furnish this data to hospitals or how hospitals would obtain the patient-specific data that they would need to prove eligibility for each patient under the proposed premium assistance rule. The states have this information as part of the section 1115 demonstration requirements. Finally, as a commenter recognizes, *it **remains the hospitals' burden** to furnish data adequate **to prove eligibility for each Medicaid patient day it claims** in the DPP Medicaid fraction numerator*, and we believe that the state will continue to be able to furnish hospitals with the eligibility data necessary for the hospitals to do so." (emphasis added)); 63 Fed. Reg. 40954, 40985 (Jul. 31, 1998) (revising 42 C.F.R. § 412.106 to codify HCFA Ruling 97-2); HCFA Ruling 97-2 at 4 (Feb. 1997) (stating: "Pursuant to this Ruling, Medicare fiscal *intermediaries will **determine*** the amounts due and make appropriate payments through normal procedures. Claims must, of course, meet all other applicable requirements. This includes the requirement for data that are adequate to document the claimed days. ***The hospitals bear the burden of proof** and must verify with the State that a patient was eligible for Medicaid* (for some covered services) *during **each** day of the patient's inpatient hospital stay*. As the intermediaries may require, hospitals are responsible for and must furnish appropriate documentation to substantiate the number of patient days claimed. *Days for patients that can**not** be verified by State records* to have fallen within a period wherein the patient was eligible for Medicaid *can**not** be counted*." (emphasis added)); 80 Fed. Reg. 70298, 70559 (Nov. 13, 2015) ("We have identified only *one circumstance where a provider may have difficulty obtaining sufficient information to make an appropriate cost report claim within the allotted time **for cost report submission***. This circumstance may occur if a hospital experiences difficulty obtaining sufficient information from State agencies *for the purpose of **claiming** DSH Medicaid-eligible patient days*. Therefore, as explained below in our response to the next comment, we will instruct contractors, in this limited circumstance, that they must accept one amended cost report submitted within a 12-month period after the hospital's cost report due date, solely for the specific purpose of revising a claim for DSH by using updated Medicaid-eligible patient days, after a hospital receives updated Medicaid eligibility information from the State." (emphasis added)).

> may require *in order to make payment under such section* may obtain a hearing with respect to such payment by the Board, if—
>
> (1) such provider—
>
> (A)(i) is dissatisfied with a final determination of the organization serving as its fiscal intermediary pursuant to section 1395h of this title as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under this subchapter for the period covered by such [cost] report, or
>
> (ii) is dissatisfied with a final determination of the Secretary as to the amount of the payment under subsection (b) or (d) of section 1395ww of this title, . . .

Specifically, a hospital that is eligible for a DSH payment must "submit[] such [cost] report[] within such time as the Secretary may require *in order to make payment under such section* [*i.e.*, subsection (d)]" as confirmed in the above quote of 42 C.F.R. § 412.106(i). This is what makes this case distinguishable from the facts presented in the D.C. Circuit's decision in *Washington Hospital*[67] and *Cape Cod Hospital v. Sebelius*.[68]

The Board recognizes that, in the 2022 *Memorial Hospital* and 2023 *Battle Creek* decision, the D.C. District Court addressed the Board's jurisdiction over appeals based on the publication of the SSI fractions[69] (another variable used in the DSH calculation) and reached different conclusions. In the

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[67] The type of situation presented in the above-captioned cases is unlike the type of situation addressed by the D.C. Circuit in *Washington Hosp.* where the determination that was appealed finalized the ***only*** hospital-specific variable used in setting the per-patient payment amount. *See Washington Hosp.*, 795 F.2d at 143, 147 (the hospitals appealed their "Final Notice of Base Period Cost and Target Amount Per Discharge" and the Court found: (a) "the ***only variable*** *factor* in the final determination as to the amount of payment under § 1395ww(d) is the hospital's target amount . . . ." (emphasis added); and (b) "The amount is the per-patient amount calculated under § 1395ww(d) and is final once the Secretary has published the DRG amounts (as has) and finally determined the hospital's target amount. Here each of the hospitals has received a 'Final Notice of Base Period Cost and Target Amount per Discharge.' The statute requires no more to trigger the hospital's right to appeal PPS Payments to the PRRB." (footnote omitted)).

[68] 630 F.3d 203, 209 (D.C. Cir. 2011).

[69] The Board also recognizes that the publication of the SSI ratios was at issue in *Allina Health Servs. v. Price*, 863 F.3d 937, 940–43 (D.C. Cir. 2017), *aff'd sub nom. Azar v. Allina Health Servs.*, 139 S. Ct. 1804 (2019) ("*Allina II*"). However, *Allina II* has no relevance to the ***jurisdictional*** issue being addressed here. First, the *Allina II* litigation does *not* address the Board's *jurisdiction* over the underlying appeals of the nine (9) Plaintiff hospitals in *Allina II* (*e.g.*, it does not address whether the publication of the SSI ratios was a "final determination" *for purposes of 42 U.S.C. § 1395oo(a)(1)(A)(ii)*). Further, the Board takes administrative notice that the Complaint filed to establish the *Allina II* litigation makes clear that ***none*** of the nine (9) Plaintiff hospitals based their right to appeal on the publication of the SSI fractions pursuant to 42 U.S.C. § 1395oo***(a)(1)(A)(ii)***. Rather, the Complaint makes clear that each of the nine (9) Plaintiff hospitals based their right to appeal *on the failure of the Medicare Contractor to timely issue an NPR as set forth in 42 U.S.C. § 1395oo**(a)(1)(B)***42 as implemented at 42 C.F.R. § 405.1835(c) (2014). *Allina Health Servs. v. Burwell*, No. 14-01415, Complaint at ¶¶ 38-39 (D.D.C. Aug. 19, 2014) (stating: "38. . . . None of the [9] plaintiff Hospitals has received an NPR reflecting final Medicare DSH payment determinations for their cost reporting periods beginning in federal fiscal years 2012. 39. As a result, *the [9] plaintiff Hospitals timely filed appeals to the Board*, ***pursuant to 42 U.S.C. §§ 1395oo(a)(1)(B)***, to challenge the agency's treatment of Medicare part C days as Medicare

instant case, the Board declines to follow D.C. District Court's 2023 decision in *Battle Creek* and instead finds the D.C. District Court's 2022 decision in *Memorial Hospital* to be instructive.[70] While the D.C. District Court's 2022 decision in *Memorial Hospital* also concerns the publication of SSI fractions, the Board finds it instructive based on its thoughtful application of the D.C. Circuit's decision in *Washington Hospital*. The providers in *Memorial Hospital* argued that there are certain instances where a provider can appeal prior to receiving an NPR and gave citations to certain D.C. Circuit cases in support. However, the Court distinguished these cases because "the secretarial determination at issue was either the only determination on which payment depended or clearly promulgated as a final rule."[71] The D.C. District Court ultimately agreed with the Board that this was not an appealable final determination. In its discussion, the Court agreed with the Secretary that the publication of the SSI ratios, *even if final*, could not be a final determination "as to the amount of payment" because they are "just one of the variables that determines whether hospitals receive a DSH payment ***and***, ***if so***, *for how much*."[72] The Court concluded:

> A challenge to *an* ***element*** *of payment* under 42 U.S.C. § 1395oo(a)(1)(A)(ii) is ***only*** *appropriate* ***if***, as the D.C. Circuit has explained, "*the Secretary ha[s] firmly established '****the only variable factor*** in the final determination as to the amount of payment under § 1395ww(d).'" *Monmouth Med. Ctr. v. Thompson*, 257 F.3d 807, 811 (D.C. Cir. 2001) (quoting *Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 147 (D.C. Cir. 1986)) (emphasis added); *see also Samaritan Health Serv. v. Sullivan*, 1990 WL 33141 at *3

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part A days for purposes of the part A/SSI fraction and the Medicaid fraction of the Medicare DSH calculation for their 2012 cost years." (footnote omitted and emphasis added)). Accordingly, it is clear that the *Allina II* litigation has no relevance to the ***jurisdictional*** question addressed by the Board in the instant case, namely whether the Providers have the right to appeal the policy at issue published in the FFY 2024 IPPS Final Rule pursuant to 42 U.S.C. § 1395oo***(a)(1)(A)(ii)***.

[70] The Board recognizes that, in *Battle Creek*, the D.C. District Court addressed a jurisdictional issue involving DSH SSI fractions ***similar to*** the jurisdictional issue that the *same* Court (different judge) issued in *Memorial Hospital* but reached a different conclusion. However, the Board disagrees with the *Battle Creek* decision and maintains that *Memorial Hospital* is a better-reasoned decision and, in particular, provides a more thoughtful analysis and application of the D.C. Circuit's decision in *Washington Hospital*. Indeed, the *Battle Creek* decision does not even discuss (much less reference) the *Memorial Hospital* decision that was issued 19 months earlier by a different judge in the ***same*** Court. Further, the Board notes that the Secretary's handling of the Part C days policy change announced in the June 9, 2023 Final Rule (88 Fed. Reg. 37772 (June 9, 2023)) supports the Board's findings here as that final rule *only* discussed hospital appeal rights from an NPR or RNPR to be issued following the publication of revised SSI fractions. Specifically, in finalizing that the recent Part C days policy adoption in the June 2023 Final Rule, the Secretary announced that "Providers who have pending appeals reflecting fractions calculated in the absence of a valid rule will receive NPRs or revised NPRs reflecting DSH fractions calculated pursuant to this new final action and *will have appeal rights with respect to the treatment of Part C days in the calculation of the DSH fractions* ***contained in the NPRs or revised NPRs***. Providers whose appeals of the Part C days issue have been remanded to the Secretary *will likewise receive NPRs or revised NPRs* reflecting fractions calculated pursuant to this new final action, *with attendant appeal rights*. Because NPRs and revised NPRs will reflect the application of a new DSH Part C days rule, CMS will have taken action under the new action, and *the new or revised* ***NPRs*** *will provide hospitals with a* ***vehicle to appeal*** *the new final action* even if the Medicare fraction or DSH payment does not change numerically." 88 Fed. Reg. at 37788 (emphasis added).

[71] 2022 WL 888190 at *8.

[72] *Id.* at *9 (emphasis added).

> (9th Cir. 1990) (unpublished table decision) ("We have held that if the Secretary's classification of a hospital effectively fixes the hospital's reimbursement rate, then that decision is a 'final determination' as referred to 42 U.S.C. § 1395oo(a)(1)(A)(ii).").[73]

Accordingly, the Court upheld the Board's decision to dismiss because the DSH SSI fraction was only one of the variables that determine whether a hospital receives a DSH payment (and, if so, for how much) and the publication of a hospital's SSI fraction is not a determination as to the amount of payment received.[74]

Similar to the D.C. District Court's decision in *Memorial Hospital*, while the policy at issue in this case was promulgated as part of the FFY 2024 IPPS Final Rule, it is ***not*** a final determination as to the amount of payment received by the Providers but rather is "just one of the variables that determines whether hospitals receive a DSH payment ***and***, ***if so***, *for how much*" and any "***final*** *payment* determination"[75] on whether a hospital receives a DSH payment for a particular fiscal year and, if so, for how much is made during the cost report audit/settlement process as explained at 42 C.F.R. § 412.106(i).[76] More specifically, here, each of the Providers are asserting that certain unspecified § 1115 waiver days[77] must be included in the numerator of the Medicaid fraction for their DSH adjustment calculation *yet-to-be calculated* for the fiscal years at issue. As such, the Providers' appeal is premature.

Indeed, while the August 28, 2023 Final Rule being appealed in the instant case was clearly promulgated as a final rule, it is ***not*** *the* ***only*** *determination or variable on which the Provider's DSH payment depends*. Just like the publication of SSI ratios, the policy at issue impacts one of many variables in calculating the Provider's DSH payment and is thus not an appealable final determination. More specifically, here, each of the Providers are asserting that certain § 1115 waiver days must be included in the Medicaid fraction for their DSH adjustment calculation for their 2024 fiscal year. However, consistent with 42 C.F.R. § 412.106(i) and the cost report audit/settlement process, the following factual gaps or flaws demonstrate that the promulgation of the policy at issue in the FFY 2024 IPPS Final rule was ***not*** an appealable reimbursement "determination":

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[73] *Id.* at *8.
[74] *Id.* at *9. While the Providers' did not reference the D.C. Circuit's decision in *Mercy Hospital, Inc. v. Azar*, 891 F.3d 1062, 1067 (D.C. Cir. 2018) ("*Mercy*"), the Board notes that the *Mercy* decision is not applicable for 2 separate reasons. First, it does not address the DSH payment calculation *under IPPS for short term acute care hospitals*, but rather addresses the low-income payment ("LIP") for inpatient rehabilitation hospitals ("IRFs"). Second, it does not address the scope of the provider's right to appeal *under 42 U.S.C. § 1395oo(a)* but rather concerns substantive jurisdiction, *i.e.*, whether a specific statute enacted by Congress precludes the Board from conducting administrative review of the LIP issue appealed by the IRF in *Mercy*, regardless of how the provider appealed (*i.e.*, regardless of whether the appeal was based on a cost report, NPR or final rule).
[75] 42 C.F.R. § 412.106(i)(2) (emphasis added).
[76] 2022 WL 888190 at *9 (emphasis added).
[77] Since the periods appealed, namely the last quarter of the Providers' FY 2023 (*i.e.*, October through December 2023) and the first three quarters of the Providers' FY 2024 (*i.e.*, January through September 2024)) (*see supra* note 2), had not fully transpired when this appeal was filed, the Providers had no ability to identify the specific § 1115 waiver days, if any, that would occur during those periods consistent with their burden of proof under 42 C.F.R. § 412.106(b)(4)(iii).

1. The FFY 2024 IPPS Final Rule does not apply the newly-promulgated § 1115 waiver day policy to ***specific*** existing State Medicaid programs which have § 1115 waiver programs that are otherwise covered by the "bar" described in the group issue statements. The Board recognizes that, at Exhibit 1 to its EJR Request, the Providers have identified the Texas § 1115 waiver program relevant to their appeal. However, the fact remains that the FFY 2024 IPPS Final Rule does not apply the new policy to this specific Texas § 1115 waiver program. How it may apply to this § 1115 waiver program is a factual dispute that would need to be determined by the Medicare Contractor as it relates to days yet-to-be identified and claimed on yet-to-be filed cost reports for the fiscal years at issue as part of the cost report audit and settlement process specified in 42 C.F.R. §§ 412.106(b)(4) and 412.106(i).[78]

2. It is unclear whether any of the Providers in these groups will, ***in fact***, qualify for a DSH payment during their fiscal year 2024 as that is not determined in the FFY 2024 Final Rule. Rather, that is a case-by-case determination made after the cost report is filed.[79]

3. Even if the Providers were to qualify for a DSH payment in their FYs 2023 and 2024,[80] it is not clear that *any* of the Providers would have patients during these fiscal years that are, in fact, covered under a § 1115 waiver program, much less "an uncompensated care pool" that would be barred from being counted in the DSH calculations under the new § 1115 waiver day policy. The Providers have included amounts in controversy but it is unclear what those estimates are based on since these are prospective estimates of anticipated § 1115 uncompensated care pool days occurring on or after October 1, 2024 that would be covered by the alleged "bar." Indeed, § 1115 waiver days are one type of Medicaid eligible day and 42 C.F.R. § 412.106(b)(4)(iii) specifies that "[t]he hospital has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day." None of the Providers has met this burden of proof *relative to the fiscal years at issue* because ***none*** of the days that could or would be at issue were known/provided when the alleged determination (*i.e.*, the FFY 2024 IPPS Final Rule) was issued.

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

5. The SSI percentage is a variable used in calculating a provider's DSH adjustment payment; however, CMS has not yet published the SSI ratios that would be used in either the

[78] Indeed, there is no case law applying 42 C.F.R. § 412.106(b)(4) to the current Texas § 1115 waiver program (as described at Exhibit 1 to the Providers' EJR Request).
[79] The fact that the Providers qualified in prior years does not mean that they will in fact qualify for future years where the future years are FY 2023 and 2024 (*see supra* note 2).
[80] *See supra* note 2.

Providers' FY 2023 or 2024[81] *if each of these Providers were to qualify for a DSH payment in those fiscal years*.

As discussed above, the Board finds that the August 28, 2023 Final Rule appealed in the instant cases is not an appealable "final determination" within the context of 42 U.S.C. § 1395oo(a)(1)(A)(ii) and 42 C.F.R. § 405.1835. Since satisfying the criteria set out in 42 C.F.R. § 405.1835 is required before the Board can exercise jurisdiction over an appeal,[82] and since the Providers have failed to demonstrate in their hearing requests that those criteria have been met for the fiscal years under appeal (*i.e.*, FYs 2023 and 2024 as it relates to FFY 2024[83]), the Board is permitted under § 405.1835(b) to "dismiss with prejudice the appeal or take any other remedial action it considers appropriate."[84] In this instance, the Board finds it is appropriate to deny the EJR request and dismiss the appeals as premature[85] and remove them from the Board's docket based on its findings that the promulgation of the § 1115 waiver day policy in the August 28, 2023 Final Rule is not an appealable final determination.

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

Board Members Participating:

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

For the Board:

1/19/2024

X Clayton J. Nix

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

cc: Michael Redmond, Novitas Solutions, Inc. (J-H), (J-L)
Wilson Leong, FSS
Jacqueline Vaughn, OAA

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[81] *See supra* note 2.
[82] 42 C.F.R. § 405.1840(a), (b).
[83] *See supra* note 2.
[84] 42 C.F.R. § 405.1835(b). *See also* 42 C.F.R. § 405.1837(a)(1), (c)(1), (c)(3). The Board's position is supported also by *Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 147 (D.C. Cir. 1986) ("*Washington Hospital*") because in that case the final rule contained "the only variable factor . . . as to the amount of payment under § 1395ww(d) . . . [,] the hospital's target amount, which the Secretary refers to as the hospital-specific rate." Unlike *Washington Hospital*, the policy on § 1115 waiver days is just one factor involved in determining the amount of a DSH payment for a particular year which is only calculated (i.e., relevant) if a hospital qualifies for DSH for that year. *See Memorial Hospital v. Becerra*, 2022 WL 888190 at *7-8 (D.D.C. 2022).
[85] The Providers are not prejudiced by the Board's dismissal because, to the extent the § 1115 waiver day policy promulgated in the FFY 2024 IPPS Final Rule is, in fact, applicable to them for their FY 2023 and/or FY 2024 (*see supra* note 2), the Providers will have an opportunity to appeal the NPR for those fiscal years once it is issued (or appeal the non-issuance of that NPR is if it is not timely issued per 42 C.F.R. § 405.1835(c)).

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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

RE: ***Notice of Dismissal of Untimely Appeals***
Case Nos. 24-0643GC, *et al.* (*see* attached listing of 46 cases)

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("PRRB") is in receipt of the above-captioned 46 individual and common issue related party ("CIRP") group appeals that were filed between January 10, 2024 to January 18, 2024 by the Providers' designated representative, James Ravindran of Quality Reimbursement Services, Inc. ("QRS") based on an appeal of the final rule published in the Federal Register on June 9, 2023 ("June 9, 2023 Final Rule") involving Part C days as used in the disproportionate share calculation ("DSH") by the Centers for Medicare and Medicaid Services ("CMS").[1] Set forth below is the Board's decision dismissing the above-captioned 46 individual and CIRP group cases for failure of the Providers' to *timely* file their appeals of the June 9, 2023 Final Rule by the Wednesday, December 6, 2023 filing deadline consistent with 42 U.S.C. § 1395oo(a)(1)(3), 42 C.F.R. §§ 405.1835(a)(3) and 405.1837(a)(1) and Board Rules 4.3.2 and 7.1.1.

Background

Between January 10, 2024 and January 18, 2024, QRS filed appeal requests in the Office of Hearings Case and Document Management System ("OH CDMS") to establish the above-captioned 46 individual and CIRP group cases. The appeal request filed for each case identifies the final determination being appealed as the June 9, 2023, Final Rule and describe the statement of issue as follows:

> **ISSUE TITLE**
>
> [DSH] – Inclusion of Part C Days in Denominator of the Medicare Fraction- Challenge to Part C Days retroactive final rule.
>
> **STATEMENT OF ISSUE**
>
> The issue is whether Part C days are properly included in the denominator of the Medicare Fraction per a July 8, 2023, retroactive

[1] 88 Fed. Reg. 37772 (June 9, 2023).

> final rule issued by [CMS], which is binding on the [Medicare contractor], or whether such final rule is illegal and cannot be enforced.
>
> The Provider appeals [Providers appeal] the Secretary's determination, which it calls a "final action," embodied in a July 8, 2023, retroactive final rule, that requires Part C Days to be included in the Medicare Fraction of the disproportionate payment percentage for discharges occurring prior to October 1, 2013 ("the Part C Days Final Rule"). The Part C Days Final Rule ***became effective on August 8, 2023***. The Providers challenge the procedural and substantive validity of the Part C Days Final Rule. Specifically, the Providers assert that the Part C Days Final Rule is procedurally invalid the retroactive nature of the rule violates the rulemaking provisions of the Social Security Act and the Administrative Procedure Act, and is contrary to the D.C. Circuit's opinion in *Northeast Hospital v. Sebelius*, and established precedent regarding the applicability of a pre-existing rule when a later rule is vacated (as was the 2004 final rule on Part C days). The Part C Days Final Rule is substantively invalid because it is arbitrary and capricious. Specifically, the Part C Days Final Rule is arbitrary and capricious because CMS did acknowledge that putting Part C Days in the Medicare Fraction was a departure from its policy or practice prior to the vacated 2004 rule. The Part C Days Final Rule also failed to account for hospitals' reliable interest on the pre-2004 final rule practice or policy, and also failed to recognize the enormous adverse financial impact on hospitals due to the change from the pre-2004 final rule practice or policy.[2]

However, each of these 46 individual and group appeal was filed more than ***180 days*** after the publication of the June 9, 2023 Final Rule provision that implemented the Final Rule for "Treatment of Medicare Part C Days in the Calculation of a Hospital's Medicare Disproportionate Patient Percentage."[3] Notwithstanding, each of these appeal requests identified, *in error*, that the "final determination date" from which they are appealing is August 8, 2023 – the ***effective date*** of the provision, rather than the date of ***notice***, *i.e.*, the publication date, of June 9, 2023.

Decision of the Board

The Board finds that the above-captioned 46 appeals were ***not*** timely filed as required by the Board's enabling statute at 42 U.S.C. § 1395oo(a)(3), which specifies that appeals of Federal Register Notices (i.e., appeals under 42 U.S.C. § 1395(a)(1)(ii)) must be filed "*within . . . 180 days*

[2] Providers' Group Appeals Issue Statement

[3] 88 Fed. Reg. 37772 (June 9, 2023). *See also Wash. Hosp. Ctr. v. Bowen*, 795 F.2d 139, 146 (D.C. Cir. 1986) ("[A] year end cost report is *not* a report which is necessary in order for the Secretary to make PPS payments, and the appeals provision applicable to PPS recipients cannot be read to require hospitals to file cost reports and await NPRs prior to filing a PRRB appeal") and *Dist. of Columbia Hosp. Ass'n Wage Index Group Appeal*, HCFA Adm'r Dec., Medicare & Medicaid Guide (CCH) ¶ 41,025 (Jan. 15, 1993) (publication of the wage index in the Federal Register is a final determination which can be appealed to the Board).

*after **notice** of the Secretary's final determination.*"[4] These appeals were filed in OH CDMS more than a month past the filing deadline of 180 days after the issuance of the June 9, 2023 Federal Register provision that implemented the Final Rule for "Treatment of Medicare Part C Days in the Calculation of a Hospital's Medicare Disproportionate Patient Percentage."

Consistent with 42 U.S.C. § 1395oo(a)(3), 42 C.F.R. § 405.1835(a)(3) specifies that a provider's appeal request must be filed no later than 180 days after the "date of receipt" of the final determination being appealed:

> (3) Unless the provider qualifies for a good cause extension under § 405.1836, the date of receipt by the Board of the provider's hearing request must be no later than 180 days after the date of receipt by the provider of the final contractor or Secretary determination.

The regulation at 42 C.F.R. § 405.1837(a)(1) makes clear that this requirement applies to provider's participating in a group appeal whether by transfer or direct add.[5] To this end, Board Rule 7.1.1 specifies that the appeal request must "[i]dentify the date the final determination ***was issued***"[6] and Board Rule 4.3.2 specifies in connection with appeals based on a Federal Register Notice that: (1) "[t]he date of receipt of a Federal Register Notice is the date the Federal Register is published"; and (2) "[t]he appeal period begins on the date of publication and ends 180 days from that date."

The Board is bound by all of the provisions of Title XVIII of the Act (the Social Security Act, as amended) and the regulations issued thereunder.[7] The Board cannot apply a regulation or instruction which is contrary to a statute and other regulations that deal specifically with the matter at hand: the date a provider is deemed to have notice of the contents of the Federal Register. In this case, the laws and regulations governing the publication of Federal Register notices specifically define the time of notice as that of publication. These laws and regulations have been incorporated into Title XVIII.

The Secretary[8] has enacted Part 401 of Title 42 of the Code of Federal Regulations which is entitled "General Administrative Requirements." Subpart B, §§ 401.101(a)(1) and (2) of this Part states that "[t]he regulations in this subpart: (1) Implement section 1106(a)[9] of the Social Security Act [relating to disclosure of information] as it applies to [CMS] . . . [and] (2) Relate to the

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[4] (Emphasis added.)
[5] 42 C.F.R. § 405.1837(a)(1) specifies that a provider's right to participate in a group is dependent, in part, on the "[t]he provider satisfy[ying] individually the requirements for a Board hearing under § 405.1835(a) or § 405.1835(c), except for the $10,000 amount in controversy requirement in § 405.1835(a)(2) or § 405.1835(c)(3)." NOTE – none of the providers in these 46 appeals have alleged that they are appealing from the nonissuance of an NPR or revised NPR consistent with § 405.1835(c) and, to that end, there is no information in the records for these cases to support such an allegation consistent with Board Rule 7.5.
[6] (Emphasis added.)
[7] *See* 42 C.F.R. § 405.1867.
[8] of the Department of Health and Human Services.
[9] 42 U.S.C. § 1306(a).

availability to the public, under 5 U.S.C. § 552,[10] of records of CMS." These laws and regulations set out which records are available and how they may be obtained, and they supplement the regulations of CMS relating to the availability of information. Section 401.106 of this subpart, which deals with publication of materials under 5 U.S.C. § 552, requires publication to serve as notice and identifies the Federal Register as the vehicle to be used to give notice. Section 552(a) states in part that:

> (1) Each agency shall separately state and currently publish in the Federal Register for the guidance of the public-
>
> * * * *
>
> (D) substantive rules of general applicability adopted as authorized by law, and statements of general policy or interpretations of general applicability formulated and adopted by the agency; and
>
> (E) each amendment, revision, or repeal of the foregoing.

In order to comply with the statutes and regulations requiring that public notice be given, the Secretary annually publishes the schedules of the Inpatient Prospective Payment System ("IPPS") rates as well as other IPPS policies in the Federal Register pursuant to the requirements of 42 C.F.R. § 412.8(b)(2). The Secretary may issue other changes as Federal Register Notices outside of this annual ratesetting process as was done here with the issuance of the Part C days policy published in the June 9, 2023 Final Rule. These processes were created to comply with 5 U.S.C. § 552 of the Freedom of Information Act which requires that agencies publish regulations and notices in the Federal Register.[11]

With regard to the Notices published in the Federal Register, 44 U.S.C. § 1507 states in part that:

> A document required. . .to be published in the Federal Register is not valid as against a person who has not had actual knowledge of it until the duplicate originals or certified copies of the document have been filed with the Office of the Federal Register and a copy made available for public inspection as provided by section 1503. . . . *[F]iling of a document, required or authorized to be published [in the Federal Register] by section 1505. . .is sufficient to give notice* of the contents of the document to a person subject to or affected by it.[12]

Reflecting new technology and the ability to transmit information immediately upon publication, the Government Printing Office ("GPO") promulgated 1 C.F.R. § 5.10 which authorizes publication of the Federal Register on the internet at the GPO website.[13] The GPO website

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[10] 5 U.S.C. § 550 *et seq.* contains the Administrative Procedures Act; 5 U.S.C. § 552 deals with the availability of government information and is known as the Freedom of Information Act ("FOIA").
[11] *See also* 42 C.F.R. Part 401, Subpart B.
[12] (Emphasis added).
[13] *See also* 44 U.S.C. § 4101 (the Superintendent of Documents is to maintain an electronic director and system of online access to the Federal Register).

containing the Federal Register is updated daily at 6 a.m. Monday through Friday, except holidays.[14] Consequently, the Provider is deemed to have notice of the Part C days policy at issue on the date the Federal Register was published and made available online. Indeed, the Board notes that Notices are often available for public inspection several days ***prior to*** the official publication date and, here, the June 9, 2023 Final Rule was posted to the public at 4:15 pm on June 7, 2023, 2 days in advance of the June, 9, 2023 publication date.[15]

With respect to statutes and regulations dealing with the Federal Register, the Supreme Court has found that:

> Congress has provided that the appearance of rules and regulations in the Federal Register give legal notice of their contents . . . .
>
> . . . Regulations [are] binding on all who sought to come within the [Act], regardless of actual knowledge of what is in the Regulations or of the hardship resulting from innocent ignorance.[16]

The statutes governing the Board (44 U.S.C. § 1507 as applied through the requirements of 42 C.F.R. § 401.101 and the Administrative Procedures Act ("APA")) are clear on their face: ***the date of publication*** of the Federal Register is the date the Providers are deemed to have notice of the June 9, 2023 Final Rule. The Board is bound by all of the provisions of Title XVIII which includes, by reference, the provisions of the Administrative Procedures Act and the Public Printing and Documents law which require that CMS publish its notices and regulations in the Federal Register. In publishing materials in the Federal Register, CMS must comply with the statutes and regulations governing the Superintendent of Documents and the Governing Printing Office.

Pursuant 42 U.S.C. § 1395oo(a)(3), the Board's enabling statute, providers have 180 days "after *notice* of the Secretary's final determination" to file an appeal. To this end, Board Rule 4.3.2 confirms that the appeal period for a final rule published in the Federal Register appeal ends 180 days from the date of ***publication***, not the effective date that may be listed in a provision:

> The date of receipt of a Federal Register Notice is the date the Federal Register is ***published***. The appeal period begins on the date of publication and ends 180 days from that date.[17]

In this case, the notice of the Secretary's determination is, by law, the date the Federal Register is issued by the Superintendent of Documents, or June 9, 2023. Here, the 180th day for appealing was ***Wednesday, December 6, 2023***. The above-captioned appeals were not filed with the Board

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[14] *See* http://www.gpo.gov/help/index.html#about_federal_register.htm.
[15] https://www.federalregister.gov/public-inspection/2023/06/07 (last accessed Jan. 19, 2024).
[16] *Fed. Crop Ins. Corp. v. Merrill*, 332 U.S. 380, 385 (1947).
[17] Emphasis added.

until ***more than a month after this deadline*** (specifically between January 10, 2024 and January 18, 2024) and, thus, were not timely filed.[18]

Based on the above findings, the Board concludes that it does not have jurisdiction over the above-captioned 46 appeals for failure of the Providers' to *timely* file these appeals of the June 9, 2023 Final Rule by the Wednesday, December 6, 2023 filing deadline consistent with 42 U.S.C. § 1395oo(a)(1)(3), 42 C.F.R. §§ 405.1835(a)(3) and 405.1837(a)(1) and Board Rules 4.3.2 and 7.1.1 and, as such, hereby dismisses them. Accordingly, the Board closes the above-captioned 46 cases and removes them from the Board's docket.[19] Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

1/19/2024

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services
Byron Lamprecht, WPS Government Health Administrators
Dana Johnson, Palmetto GBA c/o National Government Services, Inc.
Michael Redmond, Novitas Solutions, Inc.
Danelle Decker, National Government Services
John Bloom, Noridian Healthcare Solutions

[18] The Providers in these 46 appeals have not requested good cause exception under 42 C.F.R. § 405.1836 and have not presented any evidence suggesting that they would qualify under the criteria specified in that regulation.

[19] Regardless, even if the Board had not dismissed these appeals as being untimely filed (more than a month late), the Board would find that the Providers appeals were premature as they failed to appeal from a "final determination" consistent with the jurisdictional dismissal decisions issued in: (1) Case No. 23-1498 on Nov. 27, 2023 which similarly appealed the June 9, 2023 Final Rule (available at: https://www.cms.gov/files/document/prrb-jurisdictional-decisions-11-1-2023-through-11-30-2023.pdf (last accessed Jan. 19, 2023)); (2) Case Nos. 23-1796GC, *et al*. on Oct. 25, 2023 which appealed the § 1115 waiver day policy finalized in the August 28, 2023 FY 2024 IPPS Final Rule (available at: https://www.cms.gov/files/document/prrb-jurisdictional-decisions-10-1-2023-through-10-31-2023.pdf (last accessed Jan. 19, 2023)). Moreover, even if it were a final determination, the Board would also need to conduct further review to confirm, *based on the information/documentation included in the relevant appeal request*, whether the Providers have established (consistent with 42 C.F.R. §§ 405.1835(b)(1) and 405.1837(c)(1), (3)) that the June 9, 2023 Final Rule is, ***in fact***, applicable to them (*i.e.*, confirm for the fiscal years at issue that either: (a) no NPR has been issued; or (b) they had a Board appeal of the Part C issue that was subsequently remanded per CMS Ruling 1739-R).

Listing of 46 Cases
(3 Individual Provider Appeals and 43 CIRP Group Appeals)

24-0643GC	CHS CY 2005 Treatment of Part C Days Final Rule CIRP Group
24-0639GC	Hartford Health CY 2006 Treatment of Part C Days Final Rule CIRP Group
24-0645GC	Hartford Health CY 2008 Treatment of Part C Days Final Rule CIRP Group
24-0646GC	Hartford Health CY 2009 Treatment of Part C Days Final Rule CIRP Group
24-0647GC	Hartford Health CY 2010 Treatment of Part C Days Final Rule CIRP Group
24-0648GC	Hartford Health CY 2011 Treatment of Part C Days Final Rule CIRP Group
24-0649GC	Hartford Health CY 2012 Treatment of Part C Days Final Rule CIRP Group
24-0644	The Hospital of Central Connecticut (07-0035), FFY 2007
24-0650	The Hospital of Central Connecticut (07-0035), FFY 2013
24-0652GC	BS&W Health CY 2005 Treatment of Part C Days Final Rule CIRP Group
24-0654GC	BS&W Health CY 2007 Treatment of Part C Days Final Rule CIRP Group
24-0655GC	BS&W Health CY 2008 Treatment of Part C Days Final Rule CIRP Group
24-0656GC	BS&W Health CY 2009 Treatment of Part C Days Final Rule CIRP Group
24-0657GC	BS&W Health CY 2010 Treatment of Part C Days Final Rule CIRP Group
24-0658GC	BS&W Health CY 2011 Treatment of Part C Days Final Rule CIRP Group
24-0659GC	BS&W Health CY 2012 Treatment of Part C Days Final Rule CIRP Group
24-0660GC	Houston Methodist CY 2005 Treatment of Part C Days Final Rule CIRP Group
24-0661GC	Houston Methodist CY 2008 Treatment of Part C Days Final Rule CIRP Group
24-0662GC	Houston Methodist CY 2009 Treatment of Part C Days Final Rule CIRP Group
24-0663GC	Houston Methodist CY 2010 Treatment of Part C Days Final Rule CIRP Group
24-0664GC	Houston Methodist CY 2011 Treatment of Part C Days Final Rule CIRP Group
24-0665GC	Houston Methodist CY 2012 Treatment of Part C Days Final Rule CIRP Group
24-0666GC	WVU Medicine CY 2007 Treatment of Part C Days Final Rule CIRP Group
24-0667GC	WVU Medicine CY 2008 Treatment of Part C Days Final Rule CIRP Group
24-0673GC	WVU Medicine CY 2012 Treatment of Part C Days Final Rule CIRP Group
24-0674GC	WVU Medicine CY 2013 Treatment of Part C Days Final Rule CIRP Group
24-0675GC	CHS CY 2007 Treatment of Part C Days Final Rule CIRP Group
24-0677GC	Univ of Washington Med CY 2006 Treatment of Part C Days Final Rule CIRP Group
24-0678GC	Univ of Washington Med CY 2007 Treatment of Part C Days Final Rule CIRP Group
24-0676	Harborview Medical Center (50-0064), FFY 2005
24-0679GC	Univ of Washington Med CY 2008 Treatment of Part C Days Final Rule CIRP Group
24-0680GC	Univ of Washington Med CY 2009 Treatment of Part C Days Final Rule CIRP Group
24-0681GC	Univ of Washington Med CY 2010 Treatment of Part C Days Final Rule CIRP Group

24-0682GC	Univ of Washington Med CY 2011 Treatment of Part C Days Final Rule CIRP Group
24-0683GC	Univ of Washington Med CY 2012 Treatment of Part C Days Final Rule CIRP Group
24-0684GC	Univ of Washington Med CY 2013 Treatment of Part C Days Final Rule CIRP Group
24-0686GC	Providence Health CY 2004 Treatment of Part C Days Final Rule CIRP Group
24-0687GC	Providence Health CY 2005 Treatment of Part C Days Final Rule CIRP Group
24-0691GC	Providence Health CY 2006 Treatment of Part C Days Final Rule CIRP Group
24-0692GC	Providence Health CY 2007 Treatment of Part C Days Final Rule CIRP Group
24-0693GC	Providence Health CY 2008 Treatment of Part C Days Final Rule CIRP Group
24-0694GC	Providence Health CY 2009 Treatment of Part C Days Final Rule CIRP Group
24-0697GC	Providence Health CY 2010 Treatment of Part C Days Final Rule CIRP Group
24-0698GC	Providence Health CY 2011 Treatment of Part C Days Final Rule CIRP Group
24-0700GC	Providence Health CY 2012 Treatment of Part C Days Final Rule CIRP Group
24-0701GC	Providence Health CY 2013 Treatment of Part C Days Final Rule CIRP Group

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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RE: ***EJR Determination***
Huntsville Memorial Hospital (Provider No. 45-0347)
FFY 2024
Case No. 24-0629

Dear Mr. Kenny:

The Provider Reimbursement Review Board ("Board") has reviewed the request for expedited judicial review ("EJR") filed on January 5, 2024 for the above referenced individual appeal case relating to federal fiscal year ("FFY") 2024. Set forth below is the decision of the Board to deny the EJR request and to dismiss the group appeal.

Background:

On January 5, 2024, the Provider's Representative, King & Spalding, LLP ("King & Spalding"), filed an individual appeal request. The Provider is located in Texas and the appeal is based on an appeal of the FY 2024 IPPS Final Rule as it relates to the inclusion of § 1115 waiver days in the Medicaid fraction of the disproportionate share hospital ("DSH") payment calculation.[1] Specifically, the appeal ***only*** relate to FFY 2024 (*i.e.*, only those portions of the Provider's fiscal years ending June 30, 2024 and June 30, 2025 that overlap with FFY 2024[2]), and contains the following issue statement:

> This appeal challenges CMS's final determination set forth in the Inpatient Prospective Payment System Final Rule for fiscal year 2024 to deny hospitals Medicare DSH payments attributable to the inpatient days of individuals whose inpatient hospital services were eligible to be covered in whole or in part by an uncompensated care pool established under a waiver approved by CMS pursuant to Section 1115 of the Social Security Act. 88 Fed. Reg. 58640, 59016 (Aug. 28, 2023)

[1] 88 Fed. Reg. 58640, 59012-26 (Aug. 28, 2023) (excerpt from the preamble to the final rule addressing "Counting of Certain Days Associated With Section 1115 Demonstration in the Medicaid Fraction").
[2] As FFY 2024 runs from October 1, 2023 through September 30, 2024, only the 2nd through 4th quarters of the Provider's FY 2024 (*i.e.*, October 1, 2023 through June 30, 2024) overlap with FFY 2024 and only the 1st quarter of the Provider's FY 2025 (*i.e.*, July 1, 2024 through September 2024) overlaps with FFY 2024.

> (adopting 42 C.F.R. § 412.106(b)(4)(iii)). **Beginning on October 1, 2023, newly adopted 42 C.F.R. § 412.106(b)(4)(iii) bars hospitals from claiming in the Medicaid fraction of their Medicare DSH calculations all patient days attributable to such individuals.** This determination is unlawful because CMS is required to include in the Medicaid fraction all patients it has regarded as eligible for Medicaid under a Section 1115 waiver. 42 U.S.C. § 1395ww(d)(5)(F)(vi). Patients whose care is eligible for coverage under an uncompensated care pool that was established under a CMS-approved Section 1115 waiver are regarded as eligible for Medicaid. *See Forrest General Hospital v. Azar*, 926 F.3d 221, 229 (5th Cir. 2019); *Bethesda Health, Inc. v. Azar*, 389 F. Supp. 3d 32, 47 (D.D.C. 2019) *aff'd*, 980 F.3d 121 (D.C. Cir. 2020).
>
> The Provider in this appeal is located in the State of Texas. The Texas Medicaid program provides coverage to uninsured patients who receive some or all their hospital services free of charge under the hospital's charity care policy. Payments for this coverage are drawn from an uncompensated care (UC) pool authorized under the Texas Healthcare Transformation and Quality Improvement Program—a waiver approved by the Secretary of Health and Human Services (the Secretary) pursuant to section 1115(a)(2) of the Social Security Act (the Texas Section 1115 Waiver). Because the patients covered by the UC pool receive inpatient hospital benefits from a Section 1115 waiver, the Medicare statute regards them as eligible for Medicaid. Accordingly, the statute requires the Secretary to include the inpatient days attributable to these individuals in the Medicaid fraction of the Medicare DSH calculation. The Secretary's regulation defies this command.[3]

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

Statutory and Regulatory Background:

A. Medicare DSH Payment

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the inpatient prospective payment system ("IPPS").[4] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[5] The IPPS statute

[3] (Bold emphasis added and italics emphasis in original.)
[4] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[5] *Id.*

contains several provisions that adjust reimbursement based on hospital-specific factors.[6] This case involves the hospital-specific DSH adjustment, which requires the Secretary to provide increased IPPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[7]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[8] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.[9] The DPP is defined as the sum of two fractions expressed as percentages.[10] Those two fractions are referred to as the "Medicare/SSI fraction" and the "Medicaid fraction." Both of these fractions consider whether a patient was "entitled to benefits under part A" relative to each day of the patient's hospital stay.[11]

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

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

The Medicare/SSI fraction is computed annually by the Centers for Medicare and Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[12]

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

> The fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX [the Medicaid program], but who were not entitled to benefits under

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[6] *See* 42 U.S.C. § 1395ww(d)(5).
[7] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[8] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I), (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[9] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv), (vii)-(xiii); 42 C.F.R. § 412.106(d).
[10] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[11] *See, e.g.,* 42 C.F.R. § 412.106(b)(3), (4).
[12] 42 C.F.R. § 412.106(b)(2)-(3).

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

The Medicare contractor determines the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A and divides that number by the total number of patient days in the same period.[13]

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

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

[13] 42 C.F.R. § 412.106(b)(4).

> **this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day**.[14]

B. Background on Medicaid State Plans and § 1115 Waivers

Medicaid is a joint Federal and state program, established in Title XIX of the Social Security Act (the "Act").[15] To participate in the Medicaid program and receive federal matching funds (commonly referred to as federal financial participation or "FFP"),[16] a state must enter into an agreement ("State Plan") with the Federal government, describing the individuals covered, services provided, reimbursement methodologies for providers, and other administrative activities.[17]

Federal law provides states flexibility in operating Medicaid programs through multiple waivers of federal law and demonstration programs. To address the medical needs of its residents, a State may choose to apply for, and include in its State Plan, a demonstration program under § 1115 of the Act (42 U.S.C. § 1315) which allows CMS to waive various Federal Medicaid eligibility and benefits requirements. These projects expand Medicaid eligibility to populations who would ordinarily be disqualified from receiving benefits under the State Plan. The costs of such a demonstration project, including the costs of patient treatment, are regarded as expenditures under the State Plan and thus eligible for Federal matching funds.[18]

Prior to 2000, "hospitals were to include in the Medicare DSH calculation ***only*** those days for populations *under the section 1115 waiver* who were or could have been made eligible under a State plan."[19] As a result, patient days of *expanded* eligibility groups were *not* included in the Medicare DSH calculation.

In 2000, the Secretary published an interim rule to address the DSH adjustment calculation policy in reference to § 1115 waiver days and allow for certain *expanded* eligibility groups to be included in the Medicare DSH calculation.[20] Specifically, the interim rule revised this policy "to allow hospitals to include the patient days of all populations eligible for Title XIX matching payments in a State's section 1115 waiver in calculating the hospital's Medicare DSH adjustment."[21] This change in policy was effective for discharges occurring on or after January 20, 2000 and was codified in the regulations at 42 C.F.R. § 412.106(b)(4)(ii).[22]

In 2003, the Secretary amended the DSH regulation to specify that a patient shall be "deemed eligible for Medicaid on a given day only if the patient is *eligible for inpatient hospital services*

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[14] (Bold and underline emphasis added and italics in original.)
[15] 42 U.S.C. § 1396; 42 C.F.R. § 430.0.
[16] 42 U.S.C. § 1396b.
[17] 42 U.S.C. § 1396a.
[18] 42 U.S.C. § 1315(a)(2)(A).
[19] 65 Fed. Reg. 3136, 3136 (Jan. 20, 2000) (emphasis added).
[20] *Id.* The interim rule was followed by a final rule, as well. 65 Fed. Reg. 47054, 47086-87 (Aug. 1, 2000).
[21] 65 Fed. Reg at 3136-3137. *See also* 65 Fed. Reg. at 47086-47087.
[22] 65 Fed. Reg. at 3139.

under a [State Plan] or under a waiver authorized under section 1115(a)(2)."[23] The rationale was that "certain section 1115 demonstration projects . . . serve expansion populations with benefit packages so limited that the benefits are not similar to the medical assistance available under a Medicaid State plan."[24] The purpose of the refinement was to include in the Medicaid Fraction only days of waiver populations where they were provided inpatient hospital benefits equivalent to the care provided to beneficiaries under a Medicaid State Plan.[25] To achieve this, the DSH regulation at 42 C.F.R. § 412.106(b)(4)(i) was amended to specify that "a patient is deemed eligible for Medicaid on a given day **only if the patient is eligible for inpatient hospital services** under an approved State Medicaid plan or under a waiver authorized under section 1115(a)(2) of the Act on that day . . . ."[26]

In 2006, Congress passed the Deficit Reduction Act of 2005 and this legislation amended 42 U.S.C. § 1395ww(d)(5)(F)(vi)[27] by adding the following language below subclause (II):

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

The Secretary has interpreted this amendment as confirming that waiver day groups' days are not automatically "eligible for Medicaid under a State plan," that she has the discretion to determine the extent to which patients are "not so eligible," and to what extent, if any, they may be "regarded as eligible" and thus included in the Medicaid fraction.[28]

On August 28, 2023 as part of the FY 2024 IPPS Final Rule, the Secretary finalized further revisions to the regulations governing the inclusion of § 1115 expansion days in the Medicare DSH calculation.[29] In making these revisions, the Secretary has noted a rise in § 1115 waiver demonstrations which authorize funding a limited and narrowly circumscribed set of payments to hospitals, such as § 1115 demonstrations which include funding for uncompensated/ undercompensated care pools. These pools do not extend health insurance to individuals or benefits similar to Medicaid beneficiaries under a State plan. Instead, they provide funds directly to hospitals to offset treatment costs for uninsured and underinsured patients.[30] As such, these days have been typically excluded from the Medicaid fraction of the DSH calculation because the days associated with these § 1115 demonstrations do not create inpatient hospital eligibility.

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[23] 68 Fed. Reg. 45346, 45470 (Aug. 1, 2003).
[24] *Id.* at 45420.
[25] *See* 88 Fed. Reg. 58460, 59014 (Aug. 28, 2023).
[26] (2022) (emphasis added).
[27] Pub. L. 109-171, § 5002, 120 Stat. 4, 31 (2006).
[28] 88 Fed. Reg. at 59014.
[29] *Id.* at 59012-26.
[30] *Id.* at 59015.

The Secretary acknowledged that several court decisions have disagreed with this approach and ruled that 42 C.F.R. § 412.106(b)(4) requires the inclusion of days for which hospitals received payment from a uncompensated/undercompensated care pool authorized by a § 1115 waiver.[31] Thus, in the FY 2022 IPPS/LTCH PPS proposed rule,[32] the Secretary proposed to revise the regulation "to more clearly state that in order for an inpatient day to be counted in the DPP Medicaid fraction numerator, the section 1115 demonstration must provide inpatient hospital insurance benefits directly to the individual whose day is being considered for inclusion."[33] After reviewing comments on the proposal, the Secretary proposed different revisions to the regulations in the FY 2023 IPPS/LTCH PPS proposed rule,[34] but opted not to finalize them after reviewing comments on the proposal.[35]

Finally, in a proposed rule published on February 28, 2023,[36] the Secretary proposed revisions to the regulations "on the counting of days associated with individuals eligible for certain benefits provided by section 1115 demonstrations[.]"[37] Thereafter in the FY 2024 IPPS Final Rule, he announced that "we are modifying our regulations to explicitly state our long-held view that only patients who receive health insurance through a section 1115 demonstration where State expenditures to provide the insurance may be matched with funds from title XIX can be 'regarded as' eligible for Medicaid."[38] He also finalized a proposed amendment "to state specifically that patients whose inpatient hospital costs are paid for with funds from an uncompensated/undercompensated care pool authorized by a section 1115 demonstration are not patients "regarded as" eligible for Medicaid, and the days of such patients may not be included in the DPP Medicaid fraction numerator."[39]

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

> (4) *Second computation*. The fiscal intermediary determines, for the same cost reporting period used for the first computation, the number of the hospital's patient days of service for patients who were not entitled to Medicare Part A, and who were either eligible for Medicaid on such days as described in paragraph (b)(4)(i) of this section or who were regarded as eligible for Medicaid on such days and the Secretary has determined to include those days in this computation as described in paragraph (b)(4)(ii)(A) or (B) of this section. The fiscal intermediary then divides that number by the

[31] *Id.* (citing *Bethesda Health, Inc.* v. *Azar*, 980 F.3d 121 (D.C. Cir. 2020); *Forrest General Hospital* v. *Azar*, 926 F.3d 221 (5th Cir. 2019); *HealthAlliance Hospitals, Inc.* v. *Azar*, 346 F. Supp. 3d 43 (D.D.C. 2018)).
[32] 86 Fed. Reg. 25070 (May 10, 2021).
[33] *Id.* at 25459.
[34] 87 Fed. Reg. 28108 (May 10, 2022).
[35] 87 Fed. Reg. 48780, 49051 (Aug. 10, 2022).
[36] 88 Fed. Reg. 12623 (Feb. 28, 2023).
[37] *Id.* at 12623.
[38] 88 Fed. Reg. at 59016.
[39] *Id.*

> total number of patient days in the same period. For purposes of this second computation, the following requirements apply:
>
> (i) For purposes of this computation, a patient is eligible for Medicaid on a given day if the patient is eligible on that day for inpatient hospital services under a State Medicaid plan approved under title XIX of the Act, regardless of whether particular items or services were covered or paid for on that day under the State plan.
>
> (ii) For purposes of this computation, a patient is regarded as eligible for Medicaid on a given day if the patient receives health insurance authorized by a demonstration approved by the Secretary under section 1115(a)(2) of the Act for that day, where the cost of such health insurance may be counted as expenditures under section 1903 of the Act, or the patient has health insurance for that day purchased using premium assistance received through a demonstration approved by the Secretary under section 1115(a)(2) of the Act, where the cost of the premium assistance may be counted as expenditures under section 1903 of the Act, and in either case regardless of whether particular items or services were covered or paid for on that day by the health insurance. Of these patients regarded as eligible for Medicaid on a given day, only the days of patients meeting the following criteria on that day may be counted in this second computation:
>
> > (A) Patients who are provided by a demonstration authorized under section 1115(a)(2) of the Act health insurance that covers inpatient hospital services; or
> >
> > (B) Patients who purchase health insurance that covers inpatient hospital services using premium assistance provided by a demonstration authorized under section 1115(a)(2) of the Act and the premium assistance accounts for 100 percent of the premium cost to the patient.
>
> (iii) Patients whose health care costs, including inpatient hospital services costs, for a given day are claimed for payment by a provider from an uncompensated, undercompensated, or other type of funding pool authorized under section 1115(a) of the Act to fund providers' uncompensated care costs are not regarded as eligible for Medicaid for purposes of paragraph (b)(4)(ii) of this section on that day and the days of such patients may not be included in this second computation.[40]

[40] *Id.* at 59332.

Provider's Request for EJR:

The Provider has appealed from the Federal Register publishing these regulatory amendments. The Provider argues the "determination is unlawful because the Medicare statute does not afford the Secretary the discretion to exclude certain patients once he has conferred a benefit upon them by approving a section 1115 waiver."[41] The Provider claims that the once a section 1115 waiver is approved, all such patient days must be included in the Medicaid fraction without any exceptions or qualifications.[42]

The Provider claims that the justifications set forth by the Secretary to "[c]arve out a sub-population of patients who receive inpatient benefits through an approved section 1115 uncompensated care pool" have been rejected by federal courts.[43] It argues the amended regulations "[flout] prior contrary and binding interpretations of the very statute [the Secretary] believes gives him the discretion to exclude certain categories of section 1115 beneficiaries from calculating the Medicaid fraction."[44] Since the Board is bound by these new regulations, it therefore cannot provide the relief sought by the Provider and, as a result, it is requesting EJR in order to challenge them.

The Provider argues that the challenged regulation will impact them specifically because they provide coverage to uninsured patients, whose payments are covered by an uncompensated care pool approved under a section 1115 waiver. Since these patients receive inpatient hospital benefits from a section 1115 waiver, they should be deemed as eligible for Medicaid and included in the Medicaid fraction of the DSH calculation.[45] The Provider notes that it has *historically* qualified for DSH and are *projected to* qualify for DSH payments in FY 2024.[46]

Medicare Contractor's Response to Request for EJR:

The Medicare Contractor argues that the Provider's Request for Expedited Judicial Review is "Facially Deficient" because Huntsville filed the instant appeal for its 2024 fiscal year – a year that has not yet closed.[47] Additionally, the Provider cannot establish dissatisfaction:

> Huntsville claims that it was dissatisfied with the final rule being challenged (Provider Request at 11) (interestingly, the request refers to "each provider" though only a single provider is seeking EJR), but it cannot demonstrate how or why it was dissatisfied. Section 1115 waivers impact one part of a multi-part equation; an equation whose variables cannot be populated until after the cost report is finalized.

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[41] EJR Request at 7 (citing *Forrest General Hospital*, 926 F.3d at 224 ("Once the Secretary authorizes a demonstration project, no take-backs.")) (Jan. 5, 2024).
[42] *Id.* at 8-9 (citing *Forrest Gen. Hosp.*, 926 F.3d at 228-229).
[43] *Id.* at 9 (citing *Bethesda Health*, 389 F. Supp. 3d at 46-47; *Forrest Gen. Hosp.*, 926 F.3d at 229).
[44] *Id.* at 10.
[45] *Id.* at 7-8.
[46] *Id.* at 8.
[47] Medicare Contractor's Response to EJR Request at 1 (Jan. 10, 2024).

> The impact of the final rule on this particular provider, likewise, cannot be determined until the cost report is finalized. Provider's reliance on *Washington Hosp. Ctr. v. Bowen*, *District of Columbia Hosp. Ass'n Wage Index Group Appeal*; and *Cape Cod Hosp. v. Sebelius* is misplaced. Each of those cases involved final rules that had immediate, specific and quantifiable impacts on providers – the present challenge does not involve such a rule.[48]

Just as Huntsville cannot demonstrate that it is dissatisfied with the amount of payment, it cannot demonstrate that its challenge satisfies the $50,000 threshold, as its request for EJR is tellingly silent as to the financial impact of the challenged rule because it cannot articulate what that impact is:

> Provider's claim that it "will receive smaller DSH payments in FY 2024 because of the regulation" (Provider Request at 13) does not establish the Board's jurisdiction. Likewise, Provider's projections for the impact in 2024 and 2025 does not establish the Board's jurisdiction. It is unclear what data Provider is relying on as it has not yet treated the Section 1115 waiver patients on which its appeal relies.[49]

Because Huntsville cannot demonstrate either its dissatisfaction or the Board's jurisdiction, because it cannot even articulate the fiscal impact of the final rule, EJR is inappropriate.

Decision of the Board:

Pursuant to 42 C.F.R. § 405.1835(a)(1), a provider generally have the right to a hearing before the Board "with respect to a final contractor or Secretary determination ***for the provider's cost reporting period***"[50] if the provider satisfies the requirements for a Board hearing under § 405.1835(a) and the amount in controversy is $10,000 or more. Pursuant to 42 C.F.R. § 405.1835(a)(1), an individual provider generally has a right to a hearing before the Board "with respect to a final contractor or Secretary determination ***for the provider's cost reporting period***"[51] if:

- It "is dissatisfied *with the contractor's final determination of the total amount of reimbursement* ***due the provider***, as set forth in the contractor's written notice specified under § 405.1803"[52] In other words, providers must appeal from a "final determination" that impacts payment for the period under appeal.[53]

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[48] *Id.* at 2.
[49] *Id.*
[50] (Emphasis added).
[51] 42 C.F.R. § 405.1835(a) (emphasis added).
[52] 42 C.F.R. § 405.1835(a)(1) (emphasis added).
[53] *See also* 42 U.S.C. § 1395oo(a)(1)(A); *Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 144-146 (D.C. Cir. 1986) (stating: "Viewing the amendments as a whole, we are inescapably drawn to the same conclusion as the District Court: § 1395oo (a) 'clearly contemplates two different kinds of appeal. One begins when the intermediary issues an NPR; the

- The request for a hearing is filed within 180 days of the date of receipt of the final determination.[54]

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

> (2) With respect to a hospital that receives payments for inpatient hospital services under the prospective payment system (part 412 of this chapter), the term means a final determination of the total amount of payment due the hospital, pursuant to § 405.1803 following the close of the hospital's cost reporting period, under that system for the period covered by the final determination.
>
> (3) For purposes of appeal to the Provider Reimbursement Review Board, the term is synonymous with the phrases "intermediary's final determination," "final determination of the organization serving as its fiscal intermediary," "Secretary's final determination" and "final determination of the Secretary," as those phrases are used in section 1878(a) of the Act, and with the phrases "final contractor determination" and "final Secretary determination" as those phrases are used in this subpart.

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

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

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other, when the intermediary issues a notice of ***what will be paid*** *under the PPS system*.' . . . . Under PPS, in contrast, ***payment amounts*** are independent of current costs and *can be determined with finality* prior to the beginning of the cost year. Id. § 412.71(d). Thus a year-end cost report is not a report which is necessary ***in order for the Secretary to make PPS payments***, and the appeals provision applicable to PPS recipients cannot be read to require hospitals to file cost reports and await NPRs prior to filing a PRRB appeal." (emphasis added and citations omitted)).

[54] 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835 – 1840.

> the item, and why the provider self-disallowed the item instead of claiming reimbursement for the item.

42 C.F.R. § 405.1839(a)(1) also states that a provider must demonstrate that the amount in controversy is $10,000 or more. Satisfying the criteria set out in 42 C.F.R. § 405.1835(a) is required before the Board can exercise jurisdiction over an appeal.[55]

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

The Provider is appealing the Final Rule published on August 28, 2023 pursuant to 42 U.S.C. § 1395oo(a)(1)(A)(i),[56] which allows for a hearing before the Board if a provider:

> [I]s dissatisfied **with a final determination *of the organization serving as its fiscal intermediary*** pursuant to section 1395h of this title as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under this subchapter for the period covered by such report.[57]

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

However, 42 U.S.C. § 1395oo(a)(1)(A)(ii) does allow for an appeal from a Secretary determination and the EJR Request suggests that this is the statutory provision upon which the Provider is relying for the appeal request:

> (ii) is dissatisfied with a final determination of the Secretary **as to the amount of the payment** under subsection (b) or (d) of section 1395ww of this title[58]

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[55] 42 C.F.R. § 405.1840(a), (b). The Board notes that 42 C.F.R. § 405.1840 is entitled "Board Jurisdiction" but it also addresses certain claim filing requirements such as timelines or filing deadlines. However, whether an appeal was timely is not a jurisdictional requirement but rather is a claim filing requirement as the Supreme Court made clear in *Sebelius v. Auburn Reg. Med. Ctr.*, 568 U.S. 145 (2013). *See also* Board Rule 4.1 ("The Board will dismiss appeals that fail *to meet the timely filing requirements **and/or** jurisdictional requirements*. Similarly, the Board notes that 42 C.F.R. § 405.1835(b) addresses claim filing requirements.

[56] EJR Request at 11.

[57] (Emphasis added.)

[58] (Emphasis added).

The Board finds that this provision has not been met. The alleged "final determination" being appealed in this case is a change in policy adopted in a final rule published in the Federal Register, namely the FFY 2024 IPPS Final Rule. However, the adoption and codification of this policy in the FFY 2024 IPPS Final Rule is not a "final determination" directly appealable to the Board under 42 U.S.C. § 1395oo(a)(1)(A)(i) or (ii). Rather, the Provider's appeal is premature.

Here, unlike DRG rates and other adjustments such as the wage index, a hospital's eligibility for a DSH payment (and, if eligible, the amount of that payment) is not *prospectively* set on an annual basis as part of the relevant IPPS final rule. Rather, 42 U.S.C. § 1395ww(d)(5)(F) refers to the DSH adjustment being calculated "with respect to a [hospital's] cost reporting period."[59] To this end, DSH eligibility and payment, if any, is determined, calculated, and finalized *annually* through the cost report audit/settlement process as made clear in 42 C.F.R. § 412.106(i) which sets forth the following instructions regarding the determination of a hospital's eligibility for a DSH payment for each fiscal year and, if so, how much:

> (i) *Manner and timing of [DSH] payments*. (1) Interim [DSH] payments are made **during the payment year to each hospital that is estimated to be eligible** for payments under this section at the time of the annual final rule for the hospital inpatient prospective payment system, **subject to the final determination of eligibility at the time of cost report settlement for each hospital**.
>
> (2) **Final payment determinations are made at the time of cost report settlement**, based on the **final** determination of each hospital's eligibility for payment under this section.[60]

The Secretary makes clear that this regulation is based on "our ***longstanding*** *process* of making ***interim*** *eligibility* determinations for Medicare DSH payments *with* ***final*** *determination* ***at cost report settlement***."[61]

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[59] The Board notes that the Medicare DSH adjustment provision under 42 U.S.C. § 1395ww(d)(5)(F) was enacted by § 9105 of the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") and became effective for discharges occurring on or after May 1, 1986. Pub. L. 99-272, § 9105, 100 Stat. 82, 158-60. As such, it was enacted several years after the initial legislation that established the IPPS.

[60] (Italics emphasis in original and bold and underline emphasis added.)

[61] 78 Fed. Reg. at 50627. *See also* Provider Reimbursement Manual, CMS Pub. 15-1 ("PRM 15-1"), § 2807.2(B)(5) (last revised Aug. 1993, Transmittal 371) (stating: "*At* ***final*** ***settlement*** *of the cost report*, the intermediary determines the final disproportionate share adjustment based on the actual bed size and disproportionate share patient percentage for the cost reporting period." (emphasis added)). In the preamble to the FY 2014 IPPS Final Rule, the Secretary discussed the DSH eligibility and payment process and the following are excerpts from that discussion:

> *Comment*: Several commenters requested that CMS undertake additional audits to verify the data used to compute the 25-percent empirically justified Medicare DSH payment adjustments. Other commenters requested that CMS grant additional time for hospitals to verify the data and adjust their cost reports to ensure that the data used to compute the adjustment are accurate and up to date. Some

Indeed, a hospital that is potentially eligible for a DSH payment must "submit[] such [cost] report[] within such time as the Secretary may require *in order to make payment under such section* [*i.e.*, subsection (d)]" as confirmed in the above quote of 42 C.F.R. § 412.106(i). Examples of other adjustments to IPPS payment rates that are based, in whole or in part, on certain data/costs claimed on the as-filed cost report (where final payment is determined and reimbursed through the cost report audit and settlement process) include bad debts,[62] direct graduate medical education ("GME"),[63] and indirect GME.[64] This is what makes this case distinguishable from the facts presented in the D.C. Circuit's decisions in *Washington Hospital* where the determination that was appealed finalized the only hospital-specific variable used in setting the per-patient payment

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> commenters requested that CMS establish procedures to allow a hospital initially determined not to be eligible for Medicare DSH payments to begin receiving empirically justified Medicare DSH payments if data become available that indicate that the hospital would be eligible.
> *Response*: As we have emphasized, we are maintaining the well-established methodology and payment processes used under the current Medicare DSH payment adjustment methodology for purposes of making the empirically justified Medicare DSH payment adjustments. Hospitals are quite familiar with the cost reporting requirements and auditing procedures employed under the current Medicare DSH payment adjustment methodology. Hospitals are also familiar with the current process of determining **interim eligibility** for Medicare DSH payments **with final determination at cost report settlement**. Therefore, we do not believe that it would be warranted to add additional complexity to these procedures by adopting any of these recommendations.
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> **For the reasons discussed above regarding the empirically justified Medicare DSH payments** [*i.e.*, the DSH payment calculation made under 42 U.S.C. § 1395ww(d)(5)(F)], **we do not believe that it is necessary or advisable to depart from our longstanding process of making interim eligibility determinations for Medicare DSH payments with final determination at cost report settlement.** As we discuss in greater detail in section V.E.3.f. of the preamble to this final rule, we will make interim eligibility determinations based on data from the most recently available SSI ratios and Medicaid fractions prior to the beginning of the payment year. We will then make final determinations of eligibility at the time of settlement of each hospital's cost report. Therefore, we proposed that, at cost report settlement, the fiscal intermediary/MAC will issue a notice of program reimbursement that includes a determination concerning whether each hospital is eligible for empirically justified Medicare DSH payments and, therefore, eligible for uncompensated care payments in FY 2014 and each subsequent year. In the case where a hospital received interim payments for its empirically justified Medicare DSH payments and uncompensated care payments for FY 2014 or a subsequent year on the basis of estimates prior to the payment year, but is determined to be ineligible for the empirically justified Medicare DSH payment at cost report settlement, the hospital would no longer be eligible for either payment and CMS would recoup those monies. For a hospital that did not receive interim payments for its empirically justified Medicare DSH payments and uncompensated care payments for FY 2014 or a subsequent year, but at cost report settlement is determined to be eligible for DSH payments, the uncompensated care payment for such a hospital is calculated based on the Factor 3 value determined prospectively for that fiscal year.

Id. at 50626-27 (emphasis added).

[62] 42 C.F.R. §§ 412.2(f)(4), 412.115(a) (stating: "An additional payment is made to each hospital in accordance with § 413.89 of this chapter for bad debts attributable to deductible and coinsurance amounts related to covered services received by beneficiaries.).

[63] 42 C.F.R. § 412.2(f)(7) (stating that hospitals receive an additional payment for "[t]he direct graduate medical education costs for approved residency programs in medicine, osteopathy, dentistry, and podiatry as described in §§ 413.75–413.83 of this chapter.").

[64] 42 C.F.R. §§ 412.2(f)(2), 412.105. *See also* PRM 15-1 § 2807.2(B)(6) (stating: "*At **final settlement** of the cost report*, the intermediary determines the indirect teaching adjustment based on the actual number of full time equivalent residents and average daily census for the cost reporting period. (emphasis added)).

amount. Specifically, the hospitals in *Washington Hospital* appealed their "Final Notice of Base Period Cost and Target Amount Per Discharge" and the D.C. Circuit found: (a) "the ***only variable*** *factor* in the final determination as to the amount of payment under § 1395ww(d) is the hospital's target amount . . . ."[65] and (b) "The amount is the per-patient amount calculated under § 1395ww(d) and is final once the Secretary has published the DRG amounts (as has) and finally determined the hospital's target amount. Here each of the hospitals has received a 'Final Notice of Base Period Cost and Target Amount per Discharge.' The statute requires no more to trigger the hospital's right to appeal PPS Payments to the PRRB."[66]

To highlight what types of determinations are being made during the cost report audit/settlement process, the Board notes that any potential § 1115 waiver days for the fiscal years at issue would be included in the numerator of the Medicaid fraction used in each Provider's DSH adjustment calculation for each of the relevant fiscal years; however, in order for a day to be included in the numerator of the Medicaid fraction, 42 C.F.R. § 412.106(b)(4) (Oct. 1, 2023) specifies that the Medicare contractor (a/k/a fiscal intermediary[67]) "*determines*" the days to be included in the numerator of a hospital's Medicaid fraction based on the hospital's "burden" of "prov[ing]" Medicaid eligibility *on* ***each*** *day being claimed* ***on the cost report*** for the relevant fiscal year:

> (4) *Second computation*. **The fiscal intermediary determines**, for the same cost reporting period used for the first computation, **the number of the hospital's patient days** of service **for patients who were not entitled to Medicare Part A, and who were either eligible for Medicaid on such days** as described in paragraph (b)(4)(i) of this section **or who were regarded as eligible for Medicaid on such days** and the Secretary has determined to include those days in this computation as described in paragraph (b)(4)(ii)(A) or (B) of this section. The fiscal intermediary then divides that number by the total number of patient days in the same period. For purposes of this second computation, the following requirements apply:
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> (iv) **The hospital has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed** under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.[68]

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[65] 795 F.2d at 143 (emphasis added).
[66] *Id.* at 147 (footnote omitted).
[67] CMS' payment and audit functions under the Medicare program were historically contracted to organizations known as fiscal intermediaries ("FIs") and these same functions are now contracted with organizations known as Medicare administrative contractors ("MACs"). The term "Medicare contractor" refers to both FIs and MACs.
[68] 88 Fed. Reg. at 59332; 42 C.F.R. § 412.106 (Oct. 1, 2023). *See also id.* at 59023 (stating: "We are unsure why some commenters have significant concerns with verifying an individual's section 1115 eligibility and the amount of premium assistance when hospitals are already communicating with their state Medicaid office to verify an individual's eligibility. We do not understand why it is unclear who would furnish this data to hospitals or how hospitals would obtain the patient-specific data that they would need to prove eligibility for each patient under the

Accordingly, unlike DRG rates and wage index rates, a hospital's eligibility for a DSH payment (and, if so, the amount of such payment[69]) is determined through the following *italicized* phrase in 42 U.S.C. § 1395oo(a) and, as such, is a prerequisite to the Provider's appeal:

> (a) . . . any hospital which receives payments in amounts computed under subsection (b) or (d) of section 1395ww of this title *and which has submitted such [cost] reports* within such time as the Secretary may require *in order to make payment under such section* may obtain a hearing with respect to such payment by the Board, if—
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> (1) such provider—
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> (A)(i) is dissatisfied with a final determination of the organization serving as its fiscal intermediary pursuant to section 1395h of this title as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under this subchapter for the period covered by such [cost] report, or
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> (ii) is dissatisfied with a final determination of the Secretary as to the amount of the payment under subsection (b) or (d) of section 1395ww of this title, . . .

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proposed premium assistance rule. The states have this information as part of the section 1115 demonstration requirements. Finally, as a commenter recognizes, *it **remains the hospitals' burden** to furnish data adequate **to prove eligibility for each Medicaid patient day it claims** in the DPP Medicaid fraction numerator*, and we believe that the state will continue to be able to furnish hospitals with the eligibility data necessary for the hospitals to do so." (emphasis added)); 63 Fed. Reg. 40954, 40985 (Jul. 31, 1998) (revising 42 C.F.R. § 412.106 to codify HCFA Ruling 97-2); HCFA Ruling 97-2 at 4 (Feb. 1997) (stating: "Pursuant to this Ruling, Medicare fiscal *intermediaries will **determine*** the amounts due and make appropriate payments through normal procedures. Claims must, of course, meet all other applicable requirements. This includes the requirement for data that are adequate to document the claimed days. ***The hospitals bear the burden of proof** and must verify with the State that a patient was eligible for Medicaid* (for some covered services) *during **each** day of the patient's inpatient hospital stay*. As the intermediaries may require, hospitals are responsible for and must furnish appropriate documentation to substantiate the number of patient days claimed. *Days for patients that can**not** be verified by State records* to have fallen within a period wherein the patient was eligible for Medicaid *can**not** be counted*." (emphasis added)); 80 Fed. Reg. 70298, 70559 (Nov. 13, 2015) ("We have identified only *one circumstance where a provider may have difficulty obtaining sufficient information to make an appropriate cost report claim within the allotted time **for cost report submission***. This circumstance may occur if a hospital experiences difficulty obtaining sufficient information from State agencies *for the purpose of **claiming** DSH Medicaid-eligible patient days*. Therefore, as explained below in our response to the next comment, we will instruct contractors, in this limited circumstance, that they must accept one amended cost report submitted within a 12-month period after the hospital's cost report due date, solely for the specific purpose of revising a claim for DSH by using updated Medicaid-eligible patient days, after a hospital receives updated Medicaid eligibility information from the State." (emphasis added)).

[69] Unlike DSH payments, DRG rates are published in the IPPS Final Rule for the relevant federal fiscal year *in advance of that federal fiscal year.* In contrast, the DSH payment is an add-on payment and, as such, the DSH payment rate (*i.e*., the DSH adjustment rate per discharge) is not determined until the cost report audit and settlement process is completed.

Specifically, a hospital that is eligible for a DSH payment must "submit[] such [cost] report[] within such time as the Secretary may require *in order to make payment under such section* [*i.e.*, subsection (d)]" as confirmed in the above quote of 42 C.F.R. § 412.106(i). This is what makes this case distinguishable from the facts presented in the D.C. Circuit's decision in *Washington Hospital*[70] and *Cape Cod Hospital v. Sebelius*.[71]

The Board recognizes that, in the 2022 *Memorial Hospital* and 2023 *Battle Creek* decision, the D.C. District Court addressed the Board's jurisdiction over appeals based on the publication of the SSI fractions[72] (another variable used in the DSH calculation) and reached different conclusions. In the instant case, the Board declines to follow D.C. District Court's 2023 decision in *Battle Creek* and instead finds the D.C. District Court's 2022 decision in *Memorial Hospital* to be instructive.[73]

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[70] The type of situation presented in the above-captioned cases is unlike the type of situation addressed by the D.C. Circuit in *Washington Hosp.* where the determination that was appealed finalized the ***only*** hospital-specific variable used in setting the per-patient payment amount. *See Washington Hosp.*, 795 F.2d at 143, 147 (the hospitals appealed their "Final Notice of Base Period Cost and Target Amount Per Discharge" and the Court found: (a) "the ***only variable*** *factor* in the final determination as to the amount of payment under § 1395ww(d) is the hospital's target amount . . . ." (emphasis added); and (b) "The amount is the per-patient amount calculated under § 1395ww(d) and is final once the Secretary has published the DRG amounts (as has) and finally determined the hospital's target amount. Here each of the hospitals has received a 'Final Notice of Base Period Cost and Target Amount per Discharge.' The statute requires no more to trigger the hospital's right to appeal PPS Payments to the PRRB." (footnote omitted)).

[71] 630 F.3d 203, 209 (D.C. Cir. 2011).

[72] The Board also recognizes that the publication of the SSI ratios was at issue in *Allina Health Servs. v. Price*, 863 F.3d 937, 940–43 (D.C. Cir. 2017), *aff'd sub nom. Azar v. Allina Health Servs.*, 139 S. Ct. 1804 (2019) ("*Allina II*"). However, *Allina II* has no relevance to the ***jurisdictional*** issue being addressed here. First, the *Allina II* litigation does *not* address the Board's *jurisdiction* over the underlying appeals of the nine (9) Plaintiff hospitals in *Allina II* (*e.g.*, it does not address whether the publication of the SSI ratios was a "final determination" *for purposes of 42 U.S.C. § 1395oo(a)(1)(A)(ii)*). Further, the Board takes administrative notice that the Complaint filed to establish the *Allina II* litigation makes clear that ***none*** of the nine (9) Plaintiff hospitals based their right to appeal on the publication of the SSI fractions pursuant to 42 U.S.C. § 1395oo***(a)(1)(A)(ii)***. Rather, the Complaint makes clear that each of the nine (9) Plaintiff hospitals based their right to appeal *on the failure of the Medicare Contractor to timely issue an NPR as set forth in 42 U.S.C. § 1395oo****(a)(1)(B)***42 as implemented at 42 C.F.R. § 405.1835(c) (2014). *Allina Health Servs. v. Burwell*, No. 14-01415, Complaint at ¶¶ 38-39 (D.D.C. Aug. 19, 2014) (stating: "38. . . . None of the [9] plaintiff Hospitals has received an NPR reflecting final Medicare DSH payment determinations for their cost reporting periods beginning in federal fiscal years 2012. 39. As a result, *the [9] plaintiff Hospitals timely filed appeals to the Board*, ***pursuant to 42 U.S.C. §§ 1395oo(a)(1)(B)***, to challenge the agency's treatment of Medicare part C days as Medicare part A days for purposes of the part A/SSI fraction and the Medicaid fraction of the Medicare DSH calculation for their 2012 cost years." (footnote omitted and emphasis added)). Accordingly, it is clear that the *Allina II* litigation has no relevance to the ***jurisdictional*** question addressed by the Board in the instant case, namely whether the Provider has the right to appeal the policy at issue published in the FFY 2024 IPPS Final Rule pursuant to 42 U.S.C. § 1395oo***(a)(1)(A)(ii)***.

[73] The Board recognizes that, in *Battle Creek*, the D.C. District Court addressed a jurisdictional issue involving DSH SSI fractions ***similar to*** the jurisdictional issue that the *same* Court (different judge) issued in *Memorial Hospital* but reached a different conclusion. However, the Board disagrees with the *Battle Creek* decision and maintains that *Memorial Hospital* is a better-reasoned decision and, in particular, provides a more thoughtful analysis and application of the D.C. Circuit's decision in *Washington Hospital*. Indeed, the *Battle Creek* decision does not even discuss (much less reference) the *Memorial Hospital* decision that was issued 19 months earlier by a different judge in the ***same*** Court. Further, the Board notes that the Secretary's handling of the Part C days policy change announced in the June 9, 2023 Final Rule (88 Fed. Reg. 37772 (June 9, 2023)) supports the Board's findings here as that final rule *only* discussed hospital appeal rights from an NPR or RNPR to be issued following the publication of revised SSI fractions. Specifically, in finalizing that the recent Part C days policy adoption in the June 2023 Final Rule, the Secretary

While the D.C. District Court's 2022 decision in *Memorial Hospital* also concerns the publication of SSI fractions, the Board finds it instructive based on its thoughtful application of the D.C. Circuit's decision in *Washington Hospital*. The providers in *Memorial Hospital* argued that there are certain instances where a provider can appeal prior to receiving an NPR and gave citations to certain D.C. Circuit cases in support. However, the Court distinguished these cases because "the secretarial determination at issue was either the only determination on which payment depended or clearly promulgated as a final rule."[74] The D.C. District Court ultimately agreed with the Board that this was not an appealable final determination. In its discussion, the Court agreed with the Secretary that the publication of the SSI ratios, *even if final*, could not be a final determination "as to the amount of payment" because they are "just one of the variables that determines whether hospitals receive a DSH payment ***and***, ***if so***, *for how much*."[75] The Court concluded:

> A challenge to *an* ***element*** *of payment* under 42 U.S.C. § 1395oo(a)(1)(A)(ii) is ***only*** *appropriate* ***if***, as the D.C. Circuit has explained, "*the Secretary ha[s] firmly established '****the only variable factor*** in the final determination as to the amount of payment under § 1395ww(d).'" *Monmouth Med. Ctr. v. Thompson*, 257 F.3d 807, 811 (D.C. Cir. 2001) (quoting *Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 147 (D.C. Cir. 1986)) (emphasis added); *see also Samaritan Health Serv. v. Sullivan*, 1990 WL 33141 at *3 (9th Cir. 1990) (unpublished table decision) ("We have held that if the Secretary's classification of a hospital effectively fixes the hospital's reimbursement rate, then that decision is a 'final determination' as referred to 42 U.S.C. § 1395oo(a)(1)(A)(ii).").[76]

Accordingly, the Court upheld the Board's decision to dismiss because the DSH SSI fraction was only one of the variables that determine whether a hospital receives a DSH payment (and, if so, for how much) and the publication of a hospital's SSI fraction is not a determination as to the amount of payment received.[77]

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announced that "Providers who have pending appeals reflecting fractions calculated in the absence of a valid rule will receive NPRs or revised NPRs reflecting DSH fractions calculated pursuant to this new final action and *will have appeal rights with respect to the treatment of Part C days in the calculation of the DSH fractions* ***contained in the NPRs or revised NPRs***. Providers whose appeals of the Part C days issue have been remanded to the Secretary *will likewise receive NPRs or revised NPRs* reflecting fractions calculated pursuant to this new final action, *with attendant appeal rights*. Because NPRs and revised NPRs will reflect the application of a new DSH Part C days rule, CMS will have taken action under the new action, and *the new or revised* ***NPRs*** *will provide hospitals with a* ***vehicle to appeal*** *the new final action* even if the Medicare fraction or DSH payment does not change numerically." 88 Fed. Reg. at 37788 (emphasis added).

[74] 2022 WL 888190 at *8.

[75] *Id.* at *9 (emphasis added).

[76] *Id.* at *8.

[77] *Id.* at *9. While the Provider did not reference the D.C. Circuit's decision in *Mercy Hospital, Inc. v. Azar*, 891 F.3d 1062, 1067 (D.C. Cir. 2018) ("*Mercy*"), the Board notes that the *Mercy* decision is not applicable for 2 separate reasons. First, it does not address the DSH payment calculation *under IPPS for short term acute care hospitals*, but rather addresses the low-income payment ("LIP") for inpatient rehabilitation hospitals ("IRFs"). Second, it does not address the scope of the provider's right to appeal *under 42 U.S.C. § 1395oo(a)* but rather concerns substantive jurisdiction, *i.e.*, whether a specific statute enacted by Congress precludes the Board from conducting administrative review of the LIP

Similar to the D.C. District Court's decision in *Memorial Hospital*, while the policy at issue in this case was promulgated as part of the FFY 2024 IPPS Final Rule, it is ***not*** a final determination as to the amount of payment received by the Provider but rather is "just one of the variables that determines whether hospitals receive a DSH payment ***and***, ***if so***, *for how much*" and any "***final*** *payment* determination"[78] on whether a hospital receives a DSH payment for a particular fiscal year and, if so, for how much is made during the cost report audit/settlement process as explained at 42 C.F.R. § 412.106(i).[79] More specifically, here, the Provider is asserting that certain unspecified § 1115 waiver days[80] must be included in the numerator of the Medicaid fraction for their DSH adjustment calculation *yet-to-be calculated* for the fiscal years at issue. As such, the Provider's appeal is premature.

Indeed, while the August 28, 2023 Final Rule being appealed in the instant case was clearly promulgated as a final rule, it is ***not*** *the* ***only*** *determination or variable on which the Provider's DSH payment depends*. Just like the publication of SSI ratios, the policy at issue impacts one of many variables in calculating the Provider's DSH payment and is thus not an appealable final determination. More specifically, here, the Provider is asserting that certain § 1115 waiver days must be included in the Medicaid fraction for their DSH adjustment calculation for their 2024 fiscal year. However, the following factual gaps or flaws demonstrate that the final rule was not an appealable reimbursement "determination":

1. The FFY 2024 IPPS Final Rule does not apply the newly-promulgated § 1115 waiver day policy to ***specific*** existing State Medicaid programs which have § 1115 waiver programs that are otherwise covered by the "bar" described in the group issue statements. The Board recognizes that, at Exhibit 1 to its EJR Request, the Provider has identified the Texas § 1115 waiver program relevant to their appeal. However, the fact remains that the FFY 2024 IPPS Final Rule does not apply the new policy to this specific Texas § 1115 waiver program. How it may apply to this § 1115 waiver program is a factual dispute that would need to be determined by the Medicare Contractor as it relates to days yet-to-be identified and claimed on yet-to-be filed cost reports for the fiscal years at issue as part of the cost report audit and settlement process specified in 42 C.F.R. §§ 412.106(b)(4) and 412.106(i).[81]

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issue appealed by the IRF in *Mercy*, regardless of how the provider appealed (*i.e.*, regardless of whether the appeal was based on a cost report, NPR or final rule).

[78] 42 C.F.R. § 412.106(i)(2) (emphasis added).

[79] 2022 WL 888190 at *9 (emphasis added).

[80] Since the periods appealed, namely the 2nd through 4th quarters of the Provider's FY 2024 (*i.e.*, October 2023 through June 2024) and the 4th quarters of the Provider's FY 2025 (*i.e.*, July through September 2025)) (*see supra* note 2), had not fully transpired when this appeal was filed, the Provider had no ability to identify the specific § 1115 waiver days, if any, that would occur during those periods consistent with their burden of proof under 42 C.F.R. § 412.106(b)(4)(iii).

[81] Indeed, there is no case law applying 42 C.F.R. § 412.106(b)(4) to the current Texas § 1115 waiver program (as described at Exhibit 1 to the Provider's EJR Request).

2. It is unclear whether the Provider will qualify for a DSH payment during their fiscal years 2024 and 2025 as that is not determined in the FFY 2024 IPPS Final Rule. Rather, that is a case-by-case determination made when the cost report is filed.[82]

3. Even if the Provider were to qualify for a DSH payment in its FYs 2024 and 2025,[83] it is not clear that the Provider would have patients during the relevant quarters of these fiscal years that are, in fact, covered under a § 1115 waiver program, much less "an uncompensated care pool" that would be barred from being counted in the DSH calculations under the new § 1115 waiver day policy. The Provider has included an amount in controversy but it is unclear what those estimates are based on since these are prospective estimates of anticipated § 1115 uncompensated care pool days occurring on or after October 1, 2024 that would be covered by the alleged "bar." Indeed, § 1115 waiver days are one type of Medicaid eligible day and 42 C.F.R. § 412.106(b)(4)(iii) specifies that "[t]he hospital has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day." The Provider has not met this burden of proof *relative to the fiscal years at issue* because ***none*** of the days that could or would be at issue were known/provided when the alleged determination (*i.e.*, the FY 2024 IPPS Final Rule) was issued.

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

5. The SSI percentage is a variable used in calculating a provider's DSH adjustment payment; however, CMS has not yet published the SSI ratios that would be used in either the Provider's FY 2024 or 2025[84] *if the Provider were to qualify for a DSH payment in those fiscal years*.

As discussed above, the Board finds that policy at issue as finalized in the August 28, 2023 FFY 2024 IPPS Final Rule is not an appealable "final determination" within the context of 42 U.S.C. § 1395oo(a)(1)(A)(ii) and 42 C.F.R. § 405.1835. Since satisfying the criteria set out in 42 C.F.R.

[82] The fact that the Provider qualified in prior years does not mean that they will in fact qualify for future years where the future years are FY 2024 and 2025 (*see supra* note 2). Similarly, the fact that a provider is predicted to be eligible and may receive interim DSH payments during a fiscal year does not mean the provider will in fact be eligible for a DSH payment and then to have a DSH payment calculated based on the audit and settlement of the relevant cost report.
[83] *See supra* note 2.
[84] *See supra* note 2.

§ 405.1835 is required before the Board can exercise jurisdiction over an appeal,[85] and since the Provider has failed to demonstrate in their hearing requests that those criteria have been met for the year under appeal (*i.e.*, FY 2024), the Board is permitted under § 405.1835(b) to "dismiss with prejudice the appeal or take any other remedial action it considers appropriate."[86] In this instance, the Board finds it is appropriate to deny the Provider's EJR request and dismiss the Provider's appeal as premature[87] and remove it from the Board's docket based on its findings that the promulgation of the § 1115 waiver day policy in the August 28, 2023 FFY 2024 IPPS Final Rule is not an appealable final determination.

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

Board Members Participating:

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

For the Board:

1/22/2024

X Clayton J. Nix

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

cc: Michael Redmond, Novitas Solutions, Inc. (J-H)
Wilson Leong, FSS

[85] 42 C.F.R. § 405.1840(a), (b).
[86] 42 C.F.R. § 405.1835(b). *See also* 42 C.F.R. § 405.1837(a)(1), (c)(1), (c)(3). The Board's position is supported also by *Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 147 (D.C. Cir. 1986) ("*Washington Hospital*") because in that case the final rule contained "the only variable factor . . . as to the amount of payment under § 1395ww(d) . . . [,] the hospital's target amount, which the Secretary refers to as the hospital-specific rate." Unlike *Washington Hospital*, the policy on § 1115 waiver days is just one factor involved in determining the amount of a DSH payment for a particular year which is only calculated (i.e., relevant) if a hospital qualifies for DSH for that year. *See Memorial Hospital v. Becerra*, 2022 WL 888190 at *7-8 (D.D.C. 2022).
[87] The Provider is not prejudiced by the Board's dismissal because, to the extent the § 1115 waiver day policy promulgated in the FFY 2024 IPPS Final Rule is, in fact, applicable to them for their FY 2024 and/or FY 2025 (*see supra* note 2), the Provider will have an opportunity to appeal the NPR for those fiscal years once it is issued (or appeal the non-issuance of that NPR is if it is not timely issued per 42 C.F.R. § 405.1835(c)).

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Christopher Kenny, Esq.
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RE: ***Decision re: Motion for Reinstatement***
24-0075GC Texas Health Resources FFY 2024 Section 1115 Waiver Days Texas CIRP Group
24-0076GC Houston Methodist FFY 2024 Section 1115 Waiver Days Texas CIRP Group
24-0077GC Ascension Health FFY 2024 Section 1115 Waiver Days Texas CIRP Group

Dear Mr. Kenny:

On November 16, 2023, Christopher Kenny of King & Spalding, LLP ("K&S") filed the Motion for Reinstatement Motion for Reinstatement in the above-captioned three (3) common issue related party ("CIRP") group cases on behalf of the Providers in these group cases as their designated representative. The Provider Reimbursement Review Board ("Board") has reviewed the Motion for Reinstatement and set forth below is the decision of the Board to deny it.

Background:

On **October 18, 2023**, K&S filed group appeal requests to establish the three (3) above-referenced CIRP group appeals. Each participant in the groups is a hospital located in Texas and was *directly added* to the relevant group appeal ***based on*** an appeal of the federal fiscal year 2024 inpatient prospective payment system final rule ("FFY 2024 IPPS Final Rule")[1] as it relates to the inclusion of § 1115 waiver days in the Medicaid fraction of the disproportionate share hospital ("DSH") payment calculation[2] for their fiscal year(s) impacted by FFY 2024 (which in some cases is their FYs 2023 and 2024 and in other cases their FYs 2024 and 2025).[3] Specifically, each of the three (3) group appeals relates to the FFY 2024 period and contains the following issue statement:

[1] 88 Fed. Reg. 58640 (Aug. 28, 2023).
[2] *Id.* at 59012-26 (excerpt from the preamble to the final rule addressing "Counting of Certain Days Associated With Section 1115 Demonstration in the Medicaid Fraction").
[3] FFY 2024 runs from October 1, 2023 through September 30, 2024. Some of the Providers in these three group cases have a fiscal year for 2024 that coincides with FFY 2024 (i.e., have a fiscal year 2024 ending September 30, 2024) and, as such, the appealed period has only just begun for these participants. However, the remaining Providers in these group cases appealed fiscal years that did not coincide with FFY 2024 and, as a result, appealed the 2 fiscal years that straddled FFY 2024. *For example*, if a provider's fiscal year ended December 31st, the provider appealed both its fiscal year ending December 31, 2023 (*i.e.*, its FY 2023 but only the last quarter of 2023 that began Oct. 1, 2023 when the policy at issue became effective) and its fiscal year ending December 31, 2024 (*i.e.*, its FY 2024 but only the first three quarters that began January 1, 2024 and ended September 30, 2024). *In this example*, the provider's FY 2023 has not yet concluded and its FY 2024 has not yet begun. Other participants have fiscal years that end June 30, and as

> This appeal challenges **CMS's final determination** set forth in the [IPPS] Final Rule for fiscal year 2024 to deny hospitals Medicare DSH payments attributable to the inpatient days of individuals whose inpatient hospital services were eligible to be covered in whole or in part by an uncompensated care pool established under a waiver approved by CMS pursuant to Section 1115 of the Social Security Act. 88 Fed. Reg. 58640, 59016 (Aug. 28, 2023) (adopting 42 C.F.R. § 412.106(b)(4)(iii)). **Beginning on October 1, 2023, newly adopted 42 C.F.R. § 412.106(b)(4)(iii) bars hospitals from claiming in the Medicaid fraction of their Medicare DSH calculations all patient days attributable to such individuals**. This determination is unlawful because CMS is required to include in the Medicaid fraction all patients it has regarded as eligible for Medicaid under a Section 1115 waiver. 42 U.S.C. § 1395ww(d)(5)(F)(vi). Patients whose care is eligible for coverage under an uncompensated care pool that was established under a CMS approved Section 1115 waiver are regarded as eligible for Medicaid. *See Forrest General Hospital v. Azar*, 926 F.3d 221, 229 (5th Cir. 2019); *Bethesda Health, Inc. v. Azar*, 389 F. Supp. 3d 32, 47 (D.D.C. 2019) *aff'd*, 980 F.3d 121 (D.C. Cir. 2020).[4]

Significantly, the group appeal request that established of these group appeals does ***not*** *discuss the basis for the Board's jurisdiction* over the group appeal and, similarly, the direct add requests for *each* of the participants in these groups does ***not*** *discuss or explain the Board's jurisdiction or the basis for their right to appeal* the FFY 2024 IPPS Final Rule other than asserting that the final rule serves as a "CMS's final determination" for the above issue.

On the same day as the filing of the appeal requests, K&S filed a Consolidated Petition for Expedited Judicial Review ("EJR Request") for the three (3) group cases. *Significantly, the EJR request asserts that "[t]he Board has* ***jurisdiction*** *over these appeals pursuant to [42 U.S.C. § 1395oo(a)]" because* ***"[a]ll*** the Providers ***filed their appeals under [§ 1395oo(a)(1)(A)(i)]***."[5] The EJR Request then asserts that "[i]t is well-settled that the publication in the Federal Register of a final rule that effectively fixes the amount of Medicare payment is a final determination that is appealable to the Board pursuant to section 1878(a)"[6] and that principle is true of the Secretary's codification of the § 1115 waiver days policy as part of the FFY 2024 IPPS Final Rule. They explain that, "[b]y announcing in the Federal Register that he is excluding section 1115 uncompensated care pool patients from the numerator of the Medicaid fraction, the Secretary has

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such appealed those portions of their FYs 2024 and 2025 impacted by this FY 2024 IPPS Final Rule, namely the second quarter through fourth quarters of their FY 2024 and the first quarter of their FY 2025.

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

[5] Providers' EJR Request at 11 (Dec. 22, 2023) (emphasis added). Significantly, the EJR request does *not* reference the right to appeal under 42 U.S.C. § 1395oo(a)(1)***(A)(ii)*** as the Providers ***now*** assert in their Request for Reinstatement.

[6] *Id. at 12* (citing: "*See Washington Hosp. Ctr. v. Bowen*, 795 F.2d at 144-48 (D.C. Cir. 1986); *District of Columbia Hosp. Ass'n Wage Index Group Appeal*, HCFA Adm'r Dec., Medicare & Medicaid Guide (CCH) ¶ 41,025 (Jan. 15, 1993); *Cape Cod Hospital v. Sebelius*, 630 F.3d 203, 209 (D.C. Cir. 2011)").

made a final determination to deny Medicare DSH reimbursement attributable to those individuals (fixing payment at zero)."[7]

On **October 23, 2023**, the Medicare Contractor filed its "Response to Providers' EJR Request" opposing the EJR request stating that: (1) "Though providers are challenging the legality of the final rule, because their DSH payment has not yet been computed – and won't be computed until final settlement of the cost reports that are not yet due – Providers cannot point to a final determination by either the MACs or the Secretary as to the amounts due"; and (2) " Likewise, they cannot demonstrate that they are dissatisfied with a final determination by the fiscal intermediary or the Secretary as required by 42 U.S.C. § 1395oo [and, a]s a result, they cannot demonstrate that the Board has jurisdiction to hear the appeal or grant the request for EJR." The Medicare Contractor's filing was 5 paragraphs long just over a page long (with a reference to the Board's decision in #8 below involving Tampa General Hospital) and had no exhibits.

On **October 25, 2023**, the K&S filed the Providers' "Response to MAC's Opposition to EJR and Jurisdictional Challenge" that was 5 ½ pages long with one exhibit. In opposing the Medicare Contractor's Response, K&S cites to at least 11 different Board, Administrator, and court decisions:

1. *District of Columbia Hosp. Ass'n Wage Index Group Appeal*, HCFA Adm'r Dec., Medicare & Medicaid Guide (CCH) ¶ 41,025 (Jan. 15, 1993);
2. *Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 146 (D.C. Cir. 1986);
3. *Cape Cod Hosp. v. Sebelius*, 630 F.3d 203, 205 (D.C. Cir. 2011);
4. *Shands Jacksonville Med. Ctr. v. Burwell*, 139 F. Supp. 3d 240, 250 (D.D.C. 2015);
5. *Samaritan Health Serv. v. Sullivan*, 898 F.2d 156 (9th Cir. 1990);
6. *Georgetown Univ. Hosp. v. Sullivan*, 934 F.2d 1280, 1282 (D.C. Cir. 1991);
7. *Memorial Hosp. of South Bend v. Becerra*, No. 20-3461, 2022 WL 888190 (D.D.C. Mar. 25, 2022);
8. *PRRB EJR Determination, Tampa Gen. Hosp.*, PRRB Case No. 23-1498 (Aug. 9, 2023) (available at: https://www.cms.gov/files/document/prrb-jurisdictional-decisions-8-1-2023-through-8-31-2023.pdf (last accessed Jan. 22, 2024));
9. *Abbott-Nw. Hosp. v. Leavitt*, 377 F. Supp. 2d 119, 127 (D.D.C. 2005);
10. *Mercy Hospital, Inc. v. Azar*, 891 F.3d 1062, 1067 (D.C. Cir. 2018);
11. *PRRB Jurisdictional Determination, McLaren Health CY 2015 LIP SSI Fraction Dual Eligible Days CIRP Group*, PRRB Case No. 18-1741GC (Jan. 1, 2019) (available at: https://www.cms.gov/regulations-and-guidance/review-boards/prrbreview/downloads/jd-2019-01.pdf (last accessed Jan. 22, 2024)).

Notwithstanding the fact that it filed a response, K&S stated that it understood that the Board would issue a scheduling order to give it "the opportunity to provide it the Board with a more full and formal response to the MAC's jurisdictional challenge."

On **November 14, 2023**, the Board issued an EJR Determination which denied the EJR Request and dismissed the cases because FFY 2024 IPPS Final Rule appealed in the instant cases "is not an

[7] *Id.*

appealable 'final determination' within the context of 42 U.S.C. § 1395oo(a)(1)(A)(ii) and 42 C.F.R. § 405.1835."[8]

On **November 16, 2023**, K&S filed the Providers' "Motion for Reinstatement" consisting of 6 ½ pages and 5 exhibits. K&S argues that the Board's November 14, 2023 dismissal decision was "premature" because, even though they filed a response to the Medicare Contractor's Response to the EJR Request, they maintain they should have had an opportunity to respond certain "factual gaps" identified by the Board in its November 14, 2023 dismissal decision prior to the Board issuing that decision.

Providers' Motion for Reinstatement:

K&S filed a Motion for Reinstatement on November 16, 2023. It notes that all of the Providers are in Texas and asserts that Texas has an approved § 1115 wavier impacted by the regulatory amendments published in the FFY 2024 IPPS Final Rule under appeal.[9] K&S insists that the new regulation is "unquestionably a final payment determination because it ***will reduce*** the amount of Medicare DSH payment the Providers receive in FY 2024"[10] and that "[t]he impact is not hypothetical or speculative" based on the following:

1. "According to the Hospital Cost Report Information System (HCRIS), each Provider has ***historically*** qualified for and received Medicare DSH payments."[11]

2. All of the Providers in these appeals "is ***projected*** [by the Secretary] to qualify" as a DSH hospital in FY 2024, the year under appeal.[12]

3. The historical HCRIS data "also shows that each Provider has ***historically*** treated uninsured patients who qualified for and received charity discounts under the hospitals' financial assistance policies—the very population of patients covered by the Texas Section 1115 waiver. Exhibit P-4."[13]

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[8] Board's Dismissal Letter at 21 (Nov. 14, 2023). The Statutory and Regulatory Background related to DSH payments and Section 1115 Waiver Days was set forth in the Board's November 14, 2023 decision.
[9] Motion for Reinstatement at 1-2.
[10] *Id.* at 2 (emphasis added).
[11] *Id.* (emphasis added). K&S does not provide any of this "historical" data but rather includes as Exhibit P-2 to its Motion for Reinstatement a table that purports to list the empirical DSH payments each provider received over the *past* 10 years. A footer on the exhibit asserts that the source is "Hospital Cost Report Information System [HCRIS], Worksheet E, Part A, Line 34 ("Disproportionate Share Adjustment")." However, the HCRIS is a CMS database based on uploads by CMS and/or the relevant Medicare contractor and, in connection with a particular hospital for a prior year (dependent on when uploads by the Medicare contractor/CMS occur), HCRIS will contain the as-filed cost report, any amended cost report if one has been accepted, the Notice of Program reimbursement ("NPR") if it has been issued, and any revised NPR if one has been issued. As a result, it is unclear where the information originates from within HCRIS (*e.g.*, as filed cost report vs. amended cost report vs. NPR vs. revised NPR) and whether it reflects the "final determination" of DSH payment as described at 42 C.F.R. § 412.106(i).
[12] *Id.* at 2.
[13] *Id.* (footnote omitted) (emphasis added).

4. "The payment impact of the Secretary's new regulation is further corroborated by data from the Texas Department of Health and Human Services indicating that *each of the Providers has* ***historically*** *received* coverage payments from the Section 1115 UC pool authorized by the Texas Section 1115 Waiver for treating uninsured charity patients. Exhibit P-5."[14]

K&S claims that the Board's November 14, 2023 decision was "premature" and they object to the Board's dismissal based on any factual gaps in the record.[15] K&S references the Board's discussion of certain "factual gaps" and essentially characterizes that discussion as the Board stating that the filling of "the 'factual gaps' in the record [is] necessary for the Board to exercise jurisdiction" (*e.g.*, whether Texas even had an applicable § 1115 waiver program or whether the Providers in these appeals would ultimately be eligible for a DSH payment *for the FY 2024 and 2025 years at issue*). K&S then objects to the Board's dismissal based on those "factual gaps" and contends that dismissal was not an appropriate remedy for these "factual gaps" or deficiencies and implies that the Board could have simply resolved these factual disputes, and that it would have been appropriate to allow the Providers to supplement the record to fill these gaps. Similarly, with respect to the EJR Request, K&S maintains that, if the Board found the request to be incomplete, the Board "must notify the provider that it is incomplete and provide instructions to supplement the request with the missing information or documents" per 42 C.F.R. § 405.1842(e)(3)(ii).[16] Even though the Providers disagree that the Board-identified "factual gaps" are barriers to jurisdiction, K&S submitted with the Motion for Reinstatement five (5) Exhibits "to address the Board's concerns" and "to demonstrate" that no such "factual gaps" exist.[17] These exhibits are described, in part above, and also included at Exhibit P-1 a copy of the CMS approval letter for the Texas § 1115 waiver program that the Providers contend is an uncompensated care pool and that the § 1115 waiver day policy codified in the FY 2024 IPPS Final Rule would otherwise exclude any patient care days covered by that program (in whole or in part) from being counted in the numerator of the Medicaid fraction.

K&S then moves to more substantive arguments as to why the regulatory amendments published in the FFY 2024 IPPS Final Rule qualify as an appealable "final determination of the amount of payment under subsection (d)."[18] More specifically, K&S asserts that the final rule "constitutes a final determination [the Secretary] will make no Medicare DSH payments to Providers attributable to Section 1115 UC pool days" and that, as a result, "[w]aiting for a MAC to settle a future cost report will not alter that result because the MACs are bound by this regulation."[19] Accordingly, K&S argues that any rule or regulation that fixes an aspect of IPPS payments is, as such, a final determination,[20] and that the new regulation fixes the Providers' reimbursement for the § 1115 Waiver days at issue at "zero."[21] K&S claims that the appeals here are distinguishable from those underlying the D.C. District

[14] *Id.* (emphasis added).
[15] *Id.* a 3.
[16] *Id.*
[17] *Id.* at 2, 4.
[18] *Id.* at 4.
[19] *Id.*
[20] *Id.* at 5 (citing *Cape Cod Hosp. v. Sebelius*, 630 F.3d 203, 205 (D.C. Cir. 2011); *Shands Jacksonville Med. Ctr. v. Burwell*, 139 F. Supp. 3d 240, 250 (D.D.C. 2015)).
[21] *Id.* at 4.

Court's decision in *Memorial Hospital of South Bend v. Becerra* ("*Memorial Hospital*")[22] and the D.C. Circuit's decision in *Washington Hosp. Ctr. v. Bowen* ("*Washington Hospital*").[23] The Providers state that *Memorial Hospital* held jurisdiction is proper over a Secretarial determination when it is ***either*** the only determination on which payment depended ***or*** clearly promulgated as a final rule.[24] They posit that the final determination here was a clearly promulgated final rule, while the determinations in *Memorial Hospital* and *Washington Hospital* were not.[25] In essence, K&S asserts that, because the policy change was issued as part of a final rule, it must *ipso facto* be a "final determination" appealable under 42 U.S.C. § 1395oo(a)(1)(A)(ii).

Finally, the Providers argue that the inability to predict an *exact* amount in controversy does not preclude the Board's jurisdiction, and that a good faith estimate is sufficient. They claim the new regulation will have a "non-zero impact on the hospital's DSH payment in FY 2024" and that this is sufficient o satisfy the jurisdictional amount in controversy requirement.[26]

Medicare Contractor's Response to Motion for Reinstatement:

Board Rule 44.3 generally allows thirty (30) days for a party to respond to a motion filed by the opposing party. The Medicare Contractor has not filed a response since the Motion for Reinstatement was filed on November 16, 2023.

Decision of the Board:

The Providers filed their Motion for Reconsideration requesting that the Board reconsider its jurisdictional dismissal and reinstate the Provider's appeal under Board Rule 47.1 which reflects the reopening process in 42 C.F.R. §§ 405.1885 and 405.1889. As set forth below, the Board denies the Motion.

A. Board Rules and Regulations Reviewed in Considering the Request:

In considering the request, the Board reviewed the following regulations and Board Rules of which relevant excerpts are included in Appendix A:

1. *42 C.F.R. § 405.1840* addressing "Board jurisdiction."

2. *Board Rule 4.1* addressing the general requirements for Board Jurisdiction and specifies that the Board may review jurisdiction at any time.

[22] No. 20-3461, 2022 WL 888190 (D.D.C. Mar. 25, 2022).
[23] 795 F.2d 139, 148 (D.C. Cir. 1986).
[24] Motion for Reinstatement at 6 (citing *Memorial Hospital*, 2022 WL 888190 at *8).
[25] *Id.* at 6-7.
[26] *Id.* at 5-6 (quoting *Georgetown University Hosp. v. Sullivan*, 934 F.2d 1280, 1284, n.6 (D.C. Cir. 1991)).

3. *Board Rule 16.2* confirming that participants in a group directly added to a group must meet the requirements for filing an individual appeal request under Board Rules 6 to 8 (which implement 42 C.F.R. § 405.1835).

4. *Board Rule 7* addressing the support required for an individual appeal request consistent with 42 C.F.R. § 405.1835(b) or (d) as applicable.

5. *42 C.F.R. § 405.1835(b)* addressing the minimum content requirements that an appeal request meet.

6. *42 C.F.R. §§ 405.1837(c), (e)(2)* confirming the minimum content requirements for a group appeal request and that the Board may make jurisdictional findings **at any time** (regardless of whether requested by the group representative).

7. *Board Rules 8 and 14* confirming that an acknowledgement of an appeal request (individual or group) does not limit the Board's ability to later dismiss an appeal for being jurisdictionally deficient.

8. *Board Rule 20* specifying that, in situations where OH CDMS lists all participants behind the Participants tab, then the group representative must file a statement within 60 days following full formation of the group "certifying" that OH CDMS lists all participants in the group behind the participants tab and includes **all** relevant supporting jurisdictional documentation for each participant in the group.

9. *Board Rule 42* addressing, in part, the content requirements for an EJR request.

10. *42 C.F.R. § 405.1842* governing EJR requests.

11. *Board Rule 47.1* addressing motions for reinstatement.

B. Board Analysis and Findings:

1. The Board's November 14, 2023 decision to dismiss and deny EJR was not premature and the Board was not required to give the Providers an opportunity to address certain "factual gaps" identified in that decision.

In the cover letter to its motion for reinstatement, K&S contends that the Board's November 14, 2023 dismissal decision was "premature" because, even though they filed a response to the Medicare Contractor's Response to the EJR Request, they maintain they should have had an opportunity to respond certain "factual gaps" identified by the Board in its November 14, 2023 dismissal decision prior to the Board issuing that decision. K&S contends that the Board determined that the EJR request is incomplete due to "factual gaps" regarding jurisdiction and that, as a result, "the Board ***must*** *notify* the provider that the [EJR] request is incomplete and

provide instructions to supplement the request with the missing information or documents" pursuant to 42 C.F.R. § 405.1842(e)(3)(ii).[27]

The Board disagrees with K&S' contentions. In reviewing the Motion for Reconsideration, the Appeal requests for the three (3) group cases, and the above regulations and Board Rules, the Board makes the following comments on the procedural history of these three (3) group cases:

a. The Providers' group appeal requests for these three (3) group cases were all filed virtually simultaneously on the ***same*** day[28] and did not address the Board's jurisdiction over the cases and the participants therein, *notwithstanding* instruction in Board Rule 7.2 and 42 C.F.R. §§ 405.1835(b)(1) that they do so, *and notwithstanding* the facts that: (a) 42 C.F.R. § 405.1840 specifies that the Board "***must*** determine" its jurisdiction over an appeal "***[a]fter*** a request for a Board hearing [individual or group] is filed"[29]; and (b) 42 C.F.R. § 405.1835(b) specifies that "the Board ***may dismiss*** with prejudice ***the appeal*** or take any other remedial action it considers appropriate" "if the provider submits a hearing request that does not meet the requirements of paragraph (b)(1)."

b. In ***each*** of these group cases, ***less than*** *1 hour after the group appeal request was filed*, K&S made the following filings: (a) designated the relevant group fully formed; ***and*** (b) filed "Certification that Group is Complete and Fully Populated on OH CDMS" with "the Providers in the [] group appeal certify[ing] that ***all*** *the relevant* ***supporting jurisdictional documentation*** for this group has been fully populated in OH CDMS"[30]

c. 42 C.F.R. § 405.1837(e)(2) specifies that "The Board *may make* ***jurisdictional findings*** *under § 405.1840* ***at any time***, including, but not limited to, following a request by the providers for the jurisdictional findings." Similarly, Board Rule 4.1 confirms that "[t]he Board may review jurisdiction on its own motion ***at any time***."[31] The D.C. District Court recently confirmed this fact in its 2022 decision in *Memorial Hosp. of South Bend v. Becerra*, No. 20-3461, 2022 WL 888190 at *10 (D.D.C. Mar. 25, 2022).[32]

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[27] EJR Request at 3 (emphasis added).

[28] All 3 of the cases were filed between 2:48 pm and 2:49 pm EDT on October 18, 2023.

[29] (Emphasis added.) The group issue statement for these appeals only contains references to certain Medicare regulatory provisions and certain case law addressing the inclusion of § 1115 waiver days in the DSH adjustment under the IPPS.

[30] (Emphasis added.)

[31] (Emphasis added.)

[32] Specifically, the Court in *Memorial Hospital* states the following at 2022 WL 888190 at *10:

> Plaintiffs also contend that the PRRB's delay stymied them from pursuing relief in other ways. The hospitals were no doubt exceedingly frustrated by waiting eleven years for a resolution of their appeal, only to have it *sua sponte* dismissed by the PRRB. The Board could certainly have acted with greater alacrity, but *no matter its pace,* ***the PRRB was still obligated to determine if it had jurisdiction*** *and, if not, to "dismiss[ ] the appeal," as it did here.* See 42 C.F.R. § 405.1840(c)(2); id. at § 405.1840(a)(4). Plaintiffs argue that jurisdictional issues could have been raised earlier—such as when the PRRB acknowledged receipt of the appeal in 2009 . . . —and that they could have been allowed to brief the jurisdictional issue prior to dismissal. . . . They also note that the MAC told the PRRB when the case was initially filed that "no jurisdictional impediments exist for these providers." . . . *While the hospitals may feel sandbagged, the PRRB's rules explicitly state that "[a]n acknowledgement does not limit the*

d. Notwithstanding Board Rule 42.3 which requires an EJR Request to contain "a ***fully developed*** narrative" that, among other things, "[d]emonstrates that the Board has jurisdiction."[33] the Providers' EJR Request only *briefly* addresses their alleged right to appeal the codification of the § 1115 waiver day policy in FFY 2024 IPPS Final Rule by asserting that *"*[t]he Board has ***jurisdiction*** over these appeals pursuant to [42 U.S.C. § 1395oo(a)]" *because* "***[a]ll*** the Providers *filed their appeals* ***under [§ 1395oo(a)(1)(A)(i)]***"[34] (as opposed to § 1395oo(a)(1)***(A)(ii)*** which they are now asserting the Motion for Reinstatement). The EJR Request then asserts that "[i]t is well-settled that the publication in the Federal Register of a final rule that effectively fixes the amount of Medicare payment is a final determination that is appealable to the Board pursuant to section 1878(a)"[35] and that principle is true of the Secretary's codification of the § 1115 waiver days policy as part of the FFY 2024 IPPS Final Rule. They then conclude that, "[b]y announcing in the Federal Register that he is excluding section 1115 uncompensated care pool patients from the numerator of the Medicaid fraction, the Secretary has made a final determination to deny Medicare DSH reimbursement attributable to those individuals (fixing payment at zero)."[36]

e. The Medicare Contractor filed its Response to the EJR Request ("Response") within five (5) business days of the EJR request. The filing was not styled as a "Jurisdictional Challenge" but rather as a "Response to Providers' EJR Request." Similar to the Provider's discussion of jurisdiction in the EJR Request, the Response is brief at 5 paragraphs (barely over a page) and without any specific citations outside of generic citations to the final rule at issue, 42 U.S.C. § 1395oo, and an oblique reference (*i.e*., without citation) to a previous Board decision "den[ying] a request for expedited judicial review for an appeal of the 2023 post-Alina Part C days final rule because the providers seeking EJR could not demonstrate the financial impact, on them, of the final rule and because the rule itself was not a determination as to the amount of payment received. Like the determination in that case." Merely 2 days later, K&S ***substantively*** responded to Medicare Contractor's filing with a 5 ½ page response that included one exhibit and citations to 11 different Board, Administrator and court decisions (as listed *supra*). K&S did not supplement that filing even though the

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Board's authority . . . to dismiss the appeal if it is later found to be jurisdictionally deficient." CMS, PRRB Rule 9 (Aug. 29, 2018), https://go.cms.gov/3vEW0LW. And the Board's acknowledgement of receipt was purely procedural and did not address the merits of the appeal. ***The Board, moreover, is allowed to "review jurisdiction on its own motion at any time."*** CMS, PRRB Rule 4.1 (Aug. 29, 2018), https://go.cms.gov/3vEW0LW. There was thus nothing improper about its dismissing the hospitals' claims on its own motion, although it admittedly could have done so sooner.

(Underline emphasis in original and bold and italics emphasis added.)

[33] (Emphasis added.)

[34] Providers' EJR Request at 10 (emphasis added). The EJR request does ***not*** reference the right to appeal under 42 U.S.C. § 1395oo(a)(1)(A)(ii) as the Providers are ***now*** asserting in their Request for Reinstatement.

[35] *Id.* at 11 (citing: "*See Washington Hosp. Ctr. v. Bowen*, 795 F.2d at 144-48 (D.C. Cir. 1986); *District of Columbia Hosp. Ass'n Wage Index Group Appeal*, HCFA Adm'r Dec., Medicare & Medicaid Guide (CCH) ¶ 41,025 (Jan. 15, 1993); *Cape Cod Hospital v. Sebelius*, 630 F.3d 203, 209 (D.C. Cir. 2011)").

[36] *Id.*

Board did not issue its dismissal until 20 days later (13 business and 7 nonbuisness days) on Tuesday, November 14, 2023.[37]

f. The "Decision" section of the Board's November 14, 2023 Dismissal Determination does ***not*** discuss or rely on the Medicare Contractor's Response to the EJR Request (much less "grant" any request made by the Medicare Contractor therein).[38] Rather, the focus of the "Decision" section is on whether the FFY 2024 IPPS Final Rule is an appealable "final determination" within the context of 42 U.S.C. § 1395oo(a)(1)(A)(ii) and 42 C.F.R. § 405.1835 *as directed by 42 C.F.R. § 405.1840(a)*.

Further, based on its review of the Board's Rules and governing regulations and the above comments, the Board makes the findings set forth below. First, the Board disagrees with the Providers' suggestion that the Board violated its own Rules by dismissing these appeals and denying its EJR Request before it had an opportunity to address certain "factual gaps" identified by the Board in its Dismissal Determination. Consistent with 42 C.F.R. §§ 405.1840 and 405.1837(e)(2), Board Rule 4.1 (Nov. 2021) clearly explains that the "Board may review jurisdiction on its own motion at any time." Rule 42.3 (Content of the EJR Request) clearly states that any EJR Request must contain "a ***fully developed*** narrative" that, among other things, "[d]emonstrates that the Board has jurisdiction."[39] If a request for EJR does not clearly demonstrate that the Board has jurisdiction, the request is deficient and it may be denied by the Board.[40] The Board is permitted to review jurisdiction over any appeal *without input from any party* as confirmed by the decision of the D.C. District Court in *Memorial Hospital*.[41] In further support of its position, the Board notes that: (1) under Board Rules and regulations cited above, the Providers had an obligation to demonstrate the Board's jurisdiction over these appeals both in their appeal request ***and*** in their EJR request; and (2) concurrent its filing of the EJR request, K&S filed certification *in*

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[37] While business days are noted, electronic filings may be made in OH CDMS on any nonbusiness day at any hour unless there is scheduled maintenance (which occurs after normal business hours or on weekends as noted in Board Rule 2.1.1). Accordingly, there were 7 additional nonbusiness days occurring between the Providers' Response to the Medicare Contractor's filing (3 weekends and 1 holiday) and the Board Dismissal Determination, *resulting in a total of 19 days between the Providers' filing and the Dismissal Determination* (*i.e.,*12 business days + 7 nonbusiness days).

[38] The Board notes that the Medicare Contractor referenced another recent dismissal that the Board made in another case but did not give a citation. The citation is as follows: Board EJR Determination in Case No. 23-1438, Tampa Gen. Hosp. (July 9, 2023) (dismissing Case No. 23-14**3**8 without prejudice) (copy available at: https://www.cms.gov/ regulations-and-guidance/review-boards/prrbreview/listprrb-jurisdictional-decisions/ 1657096125/2023-07 (last visited Nov. 14, 2023)); Board EJR determination in 23-1498, Tampa Gen. Hosp. (Aug. 8, 2023) (Tampa Gen. Hosp. filed a new appeal under Case No. 23-14**9**8 attempting to cure the defects of its original appeal; however, the Board again dismissed for lack of jurisdiction) (copy available at: https://www.cms.gov/ regulations-and-guidance/review-boards/prrbreview/list-prrb-jurisdictional-decisions/2023-08 (last visited Nov. 14, 2023)). Significantly, the Providers' October 25, 2023 filing does reference the Board's August 2023 dismissal of the Tampa General Hospital case.

[39] (Emphasis added.)

[40] *See* 42 C.F.R. § 405.1868(b) (permitting dismissal or other remedial action for failure to meet requirements established by the Board); Board Rule 41.2 (permitting dismissal of a case or issue for failure to comply with Board procedures).

[41] *See supra* note 32 and accompanying text.

each group that the OH CDMS record contains "***all*** *the relevant* ***supporting jurisdictional documentation*** for this group." However, it failed to do so.

Indeed, the Board's dismissal was made within 27 days of the appeal request (as well as the EJR request) and dismissed the appeal consistent with 42 C.F.R. § 405.1840(a)(1) which specifies "*[a]fter a request for hearing is filed* under § 405.1835 or § 405.1837 of this part, the Board ***must*** *determine* in accordance with paragraph (b) of this section, whether or not it has jurisdiction to grant a hearing on each of the specific matters at issue in the hearing request." The criteria in § 405.1840(b) specifies that "[t]he Board has jurisdiction to grant a hearing over a specific matter at issue in an appeal ***only if*** *the provider has a right to a Board hearing* as a single provider appeal under § 405.1835 of this subpart or as part of a group appeal under § 405.1837 of this subpart, as applicable." Here, the Board determined that, shortly after the appeal request was filed, the Providers did not have the right under 42 U.S.C. § 1395oo(a)(1)(A)(ii) to appeal codification of the § 1115 waiver day policy from the FFY 2024 IPPS Final Rule. Consistent with § 405.1840(a)(1), the Board would have issued the Dismissal Determination for these cases (*irrespective of whether the Providers had filed their EJR request concurrent with their appeal requests*). Unfortunately, the Providers conflated the appeal request with the EJR Request by filing them at the same time. Regardless of whether the Board is correct in finding no procedural deficiency or error, the Providers have had an opportunity to present those additional arguments (plus others) to the Board in their Motion for Reinstatement. Notwithstanding, the Providers did not present any new arguments or provide any meaningful expansion on their original October 25, 2023 filing.

Second, the Providers mischaracterize the Board's discussion on "factual gaps." Contrary to the Providers' assertion, these "factual gaps" did ***not*** "prevent[] [the Board] from determining whether it had jurisdiction over the appeals." The Dismissal Determination discusses four (4) "factual gaps or flaws" that "demonstrate that the final rule was not an appealable final determination" because this information must be determined before any "final determination" of DSH payment can be made. The Providers' attempts to supplement the record to try to fill these gaps/flaws does not and cannot change the fact that, *for purposes of 42 U.S.C. § 1395oo(a)(1)(A)(ii)*, the FFY 2024 IPPS Final Rule itself does not address these gaps/flaw and, as such, the issuance of the policy change as part of that final rule for FFY 2024 cannot be a "final determination" of the Providers' eligibility for a DSH payment *for FY 2024 (and FY 2023 or FY 2025 as relevant*[42]) and, if so, how much.

Indeed, K&S' ***belated*** attempt to supplement the record through its Motion for Reinstatement demonstrates the extent to which the EJR Request was *fatally flawed*, notwithstanding the requirement in Board Rule 42.3 that an EJR Request contain "a ***fully developed*** narrative" that, among other things, "[d]emonstrates that the Board has jurisdiction."[43] Even if the Board were to have jurisdiction (which it does not), the fact that *neither* the FFY 2024 IPPS Final Rule, the appeal request, *nor* the EJR Request identify the *specific* § 1115 waiver program(s) at issue highlights how the Providers failed to develop the record for this case prior to filing the EJR Request. In situations where the Board has jurisdiction in a case and the Board proceeds with processing and ruling on an EJR request, the Board has no obligation to give the provider an

[42] *See supra* note 3.
[43] (Emphasis added.)

opportunity to cure a *fatally flawed* EJR request (such as the one here), but rather may deny the EJR request pursuant to 42 C.F.R. § 405.1842(f)(2)(iii).[44] In this regard, the Board notes that Rule 42.3 also requires that any EJR must "[d]emonstrate[] that there are ***no*** *factual issues* in dispute."[45] As such, even if the Board were to have jurisdiction (which it does not), the "factual gaps" identified by the Board in the EJR Request at issue independently made the EJR Request deficient and were a sufficient basis for the Board to deny the EJR Request itself.[46] Regardless of whether the EJR request itself was fatally flawed, the fact remains that the codification of the § 1115 waver day policy at issue as part of the FY 2024 IPPS Final Rule is not a "final determination" under 42 U.S.C. § 1395oo(a)(1)(A)(ii) as confirmed in the November 14, 2023 Dismissal Determination.

2. The Board's November 14, 2023 Dismissal of the Three (3) Cases and Denial of the EJR Request Was Correct.

The Board notes that the alleged "final determination" being appealed in this case is a change in policy adopted in a final rule published in the Federal Register, namely the FY 2024 IPPS Final Rule. As the Board explained in its November 14, 2023 Dismissal Determination, the adoption and codification of this policy in the FY 2024 IPPS Final Rule is not a "final determination" directly appealable to the Board under 42 U.S.C. § 1395oo(a)(1)(A)(i) or (ii). Rather, the Providers' appeals of the group issue are premature.

Here, unlike DRG rates and other adjustments such as the wage index, a hospital's eligibility for a DSH payment (and, if eligible, the amount of that payment) is not *prospectively* set on an annual basis as part of the relevant IPPS final rule. Rather, 42 U.S.C. § 1395ww(d)(5)(F) refers to the DSH adjustment being calculated "with respect to a [hospital's] cost reporting period."[47] To this end, DSH eligibility and payment, if any, is determined, calculated, and finalized *annually* through the cost report audit/settlement process as made clear in 42 C.F.R. § 412.106(i) which sets forth the following instructions regarding the determination of a hospital's eligibility for a DSH payment for each fiscal year and, if so, how much:

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[44] In situations where the Board has jurisdiction but denies an EJR request, the provider has an opportunity to refile the EJR request and cure any defects or flaws or missing information. Here, the Board never reaches the sufficiency of the EJR request because it lacks jurisdiction over the appeal requests in the first instance. As such, the Board declines to accept K&S ***belated*** supplementation of the record through the Exhibits attached to its Motion for Reinstatement.

[45] (Emphasis added.)

[46] The factual disputes would need to be addressed and resolved *prior to* Board consideration of an EJR request. For example, if the Board were to find jurisdiction and were to accept the Providers' *belated* supplementation of the record (neither of which it has), the Board would need to make a finding on whether the alleged Texas § 1115 waiver day program identified in Exhibit P-1 is in fact covered by the regulatory provision as alleged by the Providers since this finding is not made in the FFY 2024 IPPS Final Rule that the Providers have appealed. As K&S filed the EJR Request simultaneously with the appeal requests being filed, the parties have not had an opportunity to either confer regarding any factual issues (which could result in stipulations) or file position papers for this case. *See* 42 C.F.R. § 405.1853(a)-(b); Board Rules 23, 25, 35.1.

[47] The Board notes that the Medicare DSH adjustment provision under 42 U.S.C. § 1395ww(d)(5)(F) was enacted by § 9105 of the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") and became effective for discharges occurring on or after May 1, 1986. Pub. L. 99-272, § 9105, 100 Stat. 82, 158-60. As such, it was enacted several years after the initial legislation that established the IPPS.

> (i) *Manner and timing of [DSH] payments*. (1) Interim [DSH] payments are made **during the payment year to each hospital that is estimated to be eligible** for payments under this section at the time of the annual final rule for the hospital inpatient prospective payment system, **subject to the final determination of eligibility at the time of cost report settlement for each hospital**.
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> (2) **Final payment determinations are made at the time of cost report settlement**, based on the **final** determination of each hospital's eligibility for payment under this section.[48]

The Secretary makes clear that this regulation is based on "our ***longstanding*** *process* of making ***interim*** *eligibility* determinations for Medicare DSH payments *with* ***final*** *determination* ***at cost report settlement***."[49]

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[48] (Italics emphasis in original and bold and underline emphasis added.)

[49] 78 Fed. Reg. at 50627. *See also* Provider Reimbursement Manual, CMS Pub. 15-1 ("PRM 15-1"), § 2807.2(B)(5) (last revised Aug. 1993, Transmittal 371) (stating: "*At* ***final*** ***settlement*** *of the cost report*, the intermediary determines the final disproportionate share adjustment based on the actual bed size and disproportionate share patient percentage for the cost reporting period." (emphasis added)). In the preamble to the FY 2014 IPPS Final Rule, the Secretary discussed the DSH eligibility and payment process and the following are excerpts from that discussion:

> *Comment*: Several commenters requested that CMS undertake additional audits to verify the data used to compute the 25-percent empirically justified Medicare DSH payment adjustments. Other commenters requested that CMS grant additional time for hospitals to verify the data and adjust their cost reports to ensure that the data used to compute the adjustment are accurate and up to date. Some commenters requested that CMS establish procedures to allow a hospital initially determined not to be eligible for Medicare DSH payments to begin receiving empirically justified Medicare DSH payments if data become available that indicate that the hospital would be eligible.
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> *Response*: As we have emphasized, we are maintaining the well-established methodology and payment processes used under the current Medicare DSH payment adjustment methodology for purposes of making the empirically justified Medicare DSH payment adjustments. Hospitals are quite familiar with the cost reporting requirements and auditing procedures employed under the current Medicare DSH payment adjustment methodology. Hospitals are also familiar with the current process of determining **interim eligibility** for Medicare DSH payments **with final determination at cost report settlement**. Therefore, we do not believe that it would be warranted to add additional complexity to these procedures by adopting any of these recommendations.
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> **For the reasons discussed above regarding the empirically justified Medicare DSH payments** [*i.e.*, the DSH payment calculation made under 42 U.S.C. § 1395ww(d)(5)(F)], **we do not believe that it is necessary or advisable to depart from our longstanding process of making interim eligibility determinations for Medicare DSH payments with final determination at cost report settlement.** As we discuss in greater detail in section V.E.3.f. of the preamble to this final rule, we will make interim eligibility determinations based on data from the most recently available SSI ratios and Medicaid fractions prior to the beginning of the payment year. We will then make final determinations of eligibility at the time of settlement of each hospital's cost report. Therefore, we proposed that, at cost report settlement, the fiscal intermediary/MAC will issue a notice of program reimbursement that includes a determination concerning whether each hospital is eligible for empirically justified Medicare DSH payments and, therefore, eligible for uncompensated care payments in FY 2014 and each subsequent year. In the case where a hospital received interim

Indeed, a hospital that is potentially eligible for a DSH payment must "submit[] such [cost] report[] within such time as the Secretary may require *in order to make payment under such section* [*i.e*., subsection (d)]" as confirmed in the above quote of 42 C.F.R. § 412.106(i). Examples of other adjustments to IPPS payment rates that are based, in whole or in part, on certain data/costs claimed on the as-filed cost report (where final payment is determined and reimbursed through the cost report audit and settlement process) include bad debts,[50] direct graduate medical education ("GME"),[51] and indirect GME.[52] This is what makes this case distinguishable from the facts presented in the D.C. Circuit's decisions in *Washington Hospital* where the determination that was appealed finalized the only hospital-specific variable used in setting the per-patient payment amount. Specifically, the hospitals in *Washington Hospital* appealed their "Final Notice of Base Period Cost and Target Amount Per Discharge" and the D.C. Circuit found: (a) "the ***only variable*** *factor* in the final determination as to the amount of payment under § 1395ww(d) is the hospital's target amount . . . .";[53] and (b) "The amount is the per-patient amount calculated under § 1395ww(d) and is final once the Secretary has published the DRG amounts (as has) and finally determined the hospital's target amount. Here each of the hospitals has received a 'Final Notice of Base Period Cost and Target Amount per Discharge.' The statute requires no more to trigger the hospital's right to appeal PPS Payments to the PRRB."[54]

To highlight what types of determinations are being made during the cost report audit/settlement process, the Board notes that any potential § 1115 waiver days for the fiscal years at issue would be included in the numerator of the Medicaid fraction used in each Provider's DSH adjustment calculation for each of the relevant fiscal years; however, in order for a day to be included in the numerator of the Medicaid fraction, 42 C.F.R. § 412.106(b)(4) (Oct. 1, 2023) specifies that the Medicare contractor (a/k/a fiscal intermediary[55]) "*determines*" the days to be included in the

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> payments for its empirically justified Medicare DSH payments and uncompensated care payments for FY 2014 or a subsequent year on the basis of estimates prior to the payment year, but is determined to be ineligible for the empirically justified Medicare DSH payment at cost report settlement, the hospital would no longer be eligible for either payment and CMS would recoup those monies. For a hospital that did not receive interim payments for its empirically justified Medicare DSH payments and uncompensated care payments for FY 2014 or a subsequent year, but at cost report settlement is determined to be eligible for DSH payments, the uncompensated care payment for such a hospital is calculated based on the Factor 3 value determined prospectively for that fiscal year.

Id. at 50626-27 (emphasis added).

[50] 42 C.F.R. §§ 412.2(f)(4), 412.115(a) (stating: "An additional payment is made to each hospital in accordance with § 413.89 of this chapter for bad debts attributable to deductible and coinsurance amounts related to covered services received by beneficiaries.).

[51] 42 C.F.R. § 412.2(f)(7) (stating that hospitals receive an additional payment for "[t]he direct graduate medical education costs for approved residency programs in medicine, osteopathy, dentistry, and podiatry as described in §§ 413.75–413.83 of this chapter.").

[52] 42 C.F.R. §§ 412.2(f)(2), 412.105. *See also* PRM 15-1 § 2807.2(B)(6) (stating: "*At* ***final settlement*** *of the cost report*, the intermediary determines the indirect teaching adjustment based on the actual number of full time equivalent residents and average daily census for the cost reporting period. (emphasis added)).

[53] 795 F.2d at 143 (emphasis added).

[54] *Id.* at 147 (footnote omitted).

[55] CMS' payment and audit functions under the Medicare program were historically contracted to organizations known as fiscal intermediaries ("FIs") and these same functions are now contracted with organizations known as Medicare administrative contractors ("MACs"). The term "Medicare contractor" refers to both FIs and MACs.

numerator of a hospital's Medicaid fraction based on the hospital's "burden" of "prov[ing]" Medicaid eligibility *on **each** day being claimed **on the cost report*** for the relevant cost reporting period:

> (4) *Second computation*. **The fiscal intermediary <u>determines</u>**, for the same cost reporting period used for the first computation, **the number of the hospital's patient days** of service **for patients who were not entitled to Medicare Part A, and who were either eligible for Medicaid on such days** as described in paragraph (b)(4)(i) of this section **<u>or</u> who were regarded as eligible for Medicaid on such days** and the Secretary has determined to include those days in this computation as described in paragraph (b)(4)(ii)(A) or (B) of this section. The fiscal intermediary then divides that number by the total number of patient days in the same period. For purposes of this second computation, the following requirements apply:
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> (iv) **The hospital has the <u>burden</u> of furnishing data adequate to <u>prove</u> eligibility for <u>each</u> Medicaid patient day <u>claimed</u>** under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.[56]

[56] 88 Fed. Reg. at 59332; 42 C.F.R. § 412.106 (Oct. 1, 2023). *See also id.* at 59023 (stating: "We are unsure why some commenters have significant concerns with verifying an individual's section 1115 eligibility and the amount of premium assistance when hospitals are already communicating with their state Medicaid office to verify an individual's eligibility. We do not understand why it is unclear who would furnish this data to hospitals or how hospitals would obtain the patient-specific data that they would need to prove eligibility for each patient under the proposed premium assistance rule. The states have this information as part of the section 1115 demonstration requirements. Finally, as a commenter recognizes, *it **remains the hospitals' <u>burden</u>** to furnish data adequate **to <u>prove</u> eligibility for <u>each</u> Medicaid patient day it <u>claims</u>** in the DPP Medicaid fraction numerator*, and we believe that the state will continue to be able to furnish hospitals with the eligibility data necessary for the hospitals to do so." (emphasis added)); 63 Fed. Reg. 40954, 40985 (Jul. 31, 1998) (revising 42 C.F.R. § 412.106 to codify HCFA Ruling 97-2); HCFA Ruling 97-2 at 4 (Feb. 1997) (stating: "Pursuant to this Ruling, Medicare fiscal *intermediaries will **determine*** the amounts due and make appropriate payments through normal procedures. Claims must, of course, meet all other applicable requirements. This includes the requirement for data that are adequate to document the claimed days. ***The hospitals bear the <u>burden of proof</u>** and must verify with the State that a patient was eligible for Medicaid* (for some covered services) *during **<u>each</u** day of the patient's inpatient hospital stay*. As the intermediaries may require, hospitals are responsible for and must furnish appropriate documentation to substantiate the number of patient days claimed. *Days for patients that can**<u>not</u>** be verified by State records* to have fallen within a period wherein the patient was eligible for Medicaid *can**<u>not</u>** be counted*." (emphasis added)); 80 Fed. Reg. 70298, 70559 (Nov. 13, 2015) ("We have identified only *one circumstance where a provider may have difficulty obtaining sufficient information to make an appropriate cost report claim within the allotted time **for cost report submission***. This circumstance may occur if a hospital experiences difficulty obtaining sufficient information from State agencies *for the purpose of **claiming** DSH Medicaid-eligible patient days*. Therefore, as explained below in our response to the next comment, we will instruct contractors, in this limited circumstance, that they must accept one amended cost report submitted within a 12-month period after the hospital's cost report due date, solely for the specific purpose of revising a claim for DSH by using updated Medicaid-eligible patient days, after a hospital receives updated Medicaid eligibility information from the State." (emphasis added)).

Accordingly, unlike DRG rates and wage index rates, a hospital's eligibility for a DSH payment (and, if so, the amount) is determined through the following *italicized* phrase in 42 U.S.C. § 1395oo(a) and, as such, is a prerequisite to the Providers' appeal:

> (a) . . . any hospital which receives payments in amounts computed under subsection (b) or (d) of section 1395ww of this title *and* *which has submitted such [cost] reports* within such time as the Secretary may require *in order to make payment under such section* may obtain a hearing with respect to such payment by the Board, if—
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> (1) such provider—
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> (A)(i) is dissatisfied with a final determination of the organization serving as its fiscal intermediary pursuant to section 1395h of this title as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under this subchapter for the period covered by such [cost] report, or
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> (ii) is dissatisfied with a final determination of the Secretary as to the amount of the payment under subsection (b) or (d) of section 1395ww of this title, . . .

Specifically, a hospital that is eligible for a DSH payment must "submit[] such [cost] report[] within such time as the Secretary may require *in order to make payment under such section* [*i.e*., subsection (d)]" as confirmed in the above quote of 42 C.F.R. § 412.106(i). This is what makes this case distinguishable from the facts presented in the D.C. Circuit's decision in *Washington Hospital*[57] and *Cape Cod*.

The Board recognizes that, in the 2022 *Memorial Hospital* and 2023 *Battle Creek* decision, the D.C. District Court addressed the Board's jurisdiction over appeals based on the publication of the SSI fractions[58] (another variable used in the DSH calculation) and reached different

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[57] The type of situation presented in the above-captioned cases is unlike the type of situation addressed by the D.C. Circuit in *Washington Hosp.* where the determination that was appealed finalized the only hospital-specific variable used in setting the per-patient payment amount. *See Washington Hosp.*, 795 F.2d at 143, 147 (the hospitals appealed their "Final Notice of Base Period Cost and Target Amount Per Discharge" and the Court found: (a) "the ***only variable*** *factor* in the final determination as to the amount of payment under § 1395ww(d) is the hospital's target amount . . . ." (emphasis added); and (b) "The amount is the per-patient amount calculated under § 1395ww(d) and is final once the Secretary has published the DRG amounts (as has) and finally determined the hospital's target amount. Here each of the hospitals has received a 'Final Notice of Base Period Cost and Target Amount per Discharge.' The statute requires no more to trigger the hospital's right to appeal PPS Payments to the PRRB." (footnote omitted)).

[58] The Board also recognizes that the publication of the SSI ratios was at issue in *Allina Health Servs. v. Price*, 863 F.3d 937, 940–43 (D.C. Cir. 2017), *aff'd sub nom. Azar v. Allina Health Servs.*, 139 S. Ct. 1804 (2019) ("*Allina II*"). However, *Allina II* has no relevance to the ***jurisdictional*** issue being addressed here. First, the *Allina II* litigation does *not* address the Board's *jurisdiction* over the underlying appeals of the nine (9) Plaintiff hospitals in *Allina II* (*e.g*., it does not address whether the publication of the SSI ratios was a "final determination" *for purposes of 42 U.S.C. § 1395oo(a)(1)(A)(ii)*). Further, the Board takes administrative notice that the Complaint filed to establish

conclusions. In the instant case, the Board declines to follow D.C. District Court's 2023 decision in *Battle Creek* and instead finds the D.C. District Court's 2022 decision in *Memorial Hospital* to be instructive.[59] While the D.C. District Court's 2022 decision in *Memorial Hospital* also concerns the publication of SSI fractions, the Board finds it instructive based on its thoughtful application of the D.C. Circuit's decision in *Washington Hospital*. The providers in *Memorial Hospital* argued that there are certain instances where a provider can appeal prior to receiving an NPR and gave citations to certain D.C. Circuit cases in support. However, the Court distinguished these cases because "the secretarial determination at issue was either the only determination on which payment depended or clearly promulgated as a final rule."[60] The D.C. District Court ultimately agreed with the Board that this was not an appealable final determination. In its discussion, the Court agreed with the Secretary that the publication of the SSI ratios, *even if final*, could not be a final determination "as to the amount of payment" because they are "just one of the variables that determines whether hospitals receive a DSH payment ***and***, ***if so***, *for how much*."[61] The Court concluded:

> A challenge to *an* ***element*** *of payment* under 42 U.S.C. § 1395oo(a)(1)(A)(ii) is ***only*** *appropriate* ***if***, as the D.C. Circuit has explained, "*the Secretary ha[s] firmly established '****the only variable factor*** in the final determination as to the amount of payment under § 1395ww(d).'" *Monmouth Med. Ctr. v. Thompson*, 257 F.3d 807, 811 (D.C. Cir. 2001) (quoting *Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 147 (D.C. Cir. 1986)) (emphasis added); *see also Samaritan Health Serv. v. Sullivan*, 1990 WL 33141 at *3 (9th Cir. 1990) (unpublished table decision) ("We have held that if the Secretary's classification of a hospital effectively fixes the

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the *Allina II* litigation makes clear that ***none*** of the nine (9) Plaintiff hospitals based their right to appeal on the publication of the SSI fractions pursuant to 42 U.S.C. § 1395oo***(a)(1)(A)(ii)***. Rather, the Complaint makes clear that each of the nine (9) Plaintiff hospitals based their right to appeal *on the failure of the Medicare Contractor to timely issue an NPR as set forth in 42 U.S.C. § 1395oo****(a)(1)(B)***42 as implemented at 42 C.F.R. § 405.1835(c) (2014). *Allina Health Servs. v. Burwell*, No. 14-01415, Complaint at ¶¶ 38-39 (D.D.C. Aug. 19, 2014) (stating: "38. . . . None of the [9] plaintiff Hospitals has received an NPR reflecting final Medicare DSH payment determinations for their cost reporting periods beginning in federal fiscal years 2012. 39. As a result, *the [9] plaintiff Hospitals timely filed appeals to the Board*, ***pursuant to 42 U.S.C. §§ 1395oo(a)(1)(B)***, to challenge the agency's treatment of Medicare part C days as Medicare part A days for purposes of the part A/SSI fraction and the Medicaid fraction of the Medicare DSH calculation for their 2012 cost years." (footnote omitted and emphasis added)). Accordingly, it is clear that the *Allina II* litigation has no relevance to the ***jurisdictional*** question addressed by the Board in the instant case, namely whether the Providers have the right to appeal the policy at issue published in the FFY 2024 IPPS Final Rule pursuant to 42 U.S.C. § 1395oo***(a)(1)(A)(ii)***.

[59] The Board recognizes that, in *Battle Creek*, the D.C. District Court addressed a jurisdictional issue involving DSH SSI fractions ***similar to*** the jurisdictional issue that the *same* Court (different judge) issued in *Memorial Hospital* but reached a different conclusion. However, the Board disagrees with the *Battle Creek* decision and maintains that *Memorial Hospital* is a better-reasoned decision and, in particular, provides a more thoughtful analysis and application of the D.C. Circuit's decision in *Washington Hospital*. Indeed, the *Battle Creek* decision does not even discuss (much less reference) the *Memorial Hospital* decision that was issued 19 months earlier by a different judge in the ***same*** Court.

[60] 2022 WL 888190 at *8.

[61] *Id.* at *9 (emphasis added).

> hospital's reimbursement rate, then that decision is a 'final determination' as referred to 42 U.S.C. § 1395oo(a)(1)(A)(ii).").[62]

Accordingly, the Court upheld the Board's decision to dismiss because the DSH SSI fraction was only one of the variables that determine whether a hospital receives a DSH payment (and, if so, for how much) and the publication of a hospital's SSI fraction is not a determination as to the amount of payment received.[63]

Similar to the D.C. District Court's decision in *Memorial Hospital*, while the policy at issue in this case was promulgated as part of the FFY 2024 IPPS Final Rule, it is ***not*** a final determination as to the amount of payment received by the Providers but rather is "just one of the variables that determines whether hospitals receive a DSH payment ***and***, ***if so***, *for how much*" and any "***final*** *payment* determination"[64] on whether a hospital receives a DSH payment for a particular fiscal year and, if so, for how much is made during the cost report audit/settlement process as explained at 42 C.F.R. § 412.106(i).[65] More specifically, here, each of the Providers are asserting that certain unspecified § 1115 waiver days[66] must be included in the numerator of the Medicaid fraction for their DSH adjustment calculation yet to be calculated for the fiscal years at issue. In its November 14, 2023 Dismissal Determination, the Board listed certain factual gaps or flaws *to demonstrate that the promulgation of the policy at issue in the FFY 2024 IPPS Final Rule* was not an appealable reimbursement "determination" which will not occur until a "***final*** *[DSH] payment* determination"[67] is made consistent with 42 C.F.R. § 412.106(i) as part of the cost report audit/settlement process. K&S subsequent (and belated) attempts in its Motion for Reconsideration to address these gaps/flaws cannot change the fact that the codification of the new § 1115 waiver day policy in the FY 2024 IPPS Final Rule is not an appealable "final determination" for purposes of 42 U.S.C. § 1395oo(a)(1)(A)(ii) or 42 C.F.R. § 405.1835(a).[68]

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In summary, the Board is not persuaded by the arguments presented in the Motion for Reconsideration and hereby affirms its November 14, 2023 finding that the FFY 2024 IPPS Final

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[62] *Id.* at *8.
[63] *Id.* at *9. The Board also recognizes that, in their Motion at 6-7, the Providers reference the D.C. Circuit's decision in *Mercy Hospital, Inc. v. Azar*, 891 F.3d 1062, 1067 (D.C. Cir. 2018) ("*Mercy*"). However, the *Mercy* decision is not applicable for 2 separate reasons. First, it does not address the DSH payment calculation *under IPPS for short term acute care hospitals*, but rather addresses the low-income payment ("LIP") for inpatient rehabilitation hospitals ("IRFs"). Second, it does not address the scope of the provider's right to appeal *under 42 U.S.C. § 1395oo(a)* but rather concerns substantive jurisdiction, *i.e.*, whether a specific statute enacted by Congress precludes the Board from conducting administrative review of the LIP issue appealed by the IRF in *Mercy*, regardless of how the provider appealed (*i.e.*, regardless of whether the appeal was based on a cost report, NPR or final rule).
[64] 42 C.F.R. § 412.106(i)(2) (emphasis added).
[65] 2022 WL 888190 at *9 (emphasis added).
[66] *See* Board's October 25, 2023 Dismissal Determination at 19-20 (describing how the class of § 1115 waiver days alleged to be issue in the case are unspecified and undefined *for the fiscal years at issue* not only from the four corners of the FY 2024 IPPS Final Rule being appealed but also from the four corners of the appeal request and EJR request).
[67] 42 C.F.R. § 412.106(i)(2) (emphasis added).
[68] To the extent this information was relevant (which the Board finds it is not), it should have been included with the appeal request or, at a minimum, with the EJR request as discussed *supra*.

Rule appealed in these three (3) group cases is not an appealable "final determination" within the context of 42 U.S.C. § 1395oo(a)(1)(A)(ii) and 42 C.F.R. § 405.1835. Based on the foregoing, the Board ***denies*** the Providers' Motion for Reinstatement filed on November 16, 2023.

Board Members Participating:

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

For the Board:

1/22/2024

X Clayton J. Nix

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

cc: Michael Redmond, Novitas Solutions, Inc. (J-H), (J-L)
Wilson Leong, FSS

APPENDIX A

Excerpts from Relevant Board Rules & Regulations

1. *42 C.F.R. § 405.1840*—This regulation addresses "Board jurisdiction" and states, in pertinent part:

> (a) *General rules*. (1) **After a request for a Board hearing is filed** under § 405.1835 or § 405.1837 of this part, the Board **must determine in accordance with paragraph (b)** of this section, **whether or not it has jurisdiction to grant a hearing** on each of the specific matters at issue in the hearing request. . . .
>
> (b) *Criteria*. Except with respect to the amount in controversy requirement, **the jurisdiction of the Board to grant a hearing** must be determined separately for each specific matter at issue in each contractor or Secretary determination for each cost reporting period under appeal. The Board has **jurisdiction to grant a hearing** over a specific matter at issue in an appeal **only if the provider has a right to a Board hearing** as a single provider appeal under § 405.1835 of this subpart or as part of a group appeal under § 405.1837 of this subpart, as applicable. . . .
>
> (c) *Board's jurisdictional findings and jurisdictional dismissal decisions*. (1) In issuing an EJR decision under § 405.1842 of this subpart or a hearing decision under § 405.1871 of this subpart, as applicable, the Board must make a separate determination of whether it has jurisdiction for each specific matter at issue in each contractor or Secretary determination under appeal. A decision by the Board must include specific findings of fact and conclusions of law as to whether the Board has jurisdiction to grant a hearing on each matter at issue in the appeal.
>
> (2) Except as provided in §§ 405.1836(e)(1) and 405.1842(f)(2)(i), where the Board determines it lacks jurisdiction to grant a hearing for every specific matter at issue in an appeal, it must issue a dismissal decision dismissing the appeal for lack of Board jurisdiction. The decision by the Board must include specific findings of fact and conclusions of law explaining the Board's determination that it lacks jurisdiction to grant a hearing on each matter at issue in the appeal. A copy of the Board's decision must be sent promptly to each party to the appeal (as described in § 405.1843).
>
> (3) A dismissal decision by the Board under paragraph (c)(2) of this section is final and binding on the parties unless the decision is

> reversed, affirmed, modified or remanded by the Administrator under § 405.1875(a)(2)(ii) and § 405.1875(e) or § 405.1875(f) of this subpart, no later than 60 days after the date of receipt by the provider of the Board's decision. **The Board decision is inoperative during the 60-day period for review of the decision by the Administrator**, or in the event the Administrator reverses, affirms, modifies or remands that decision within that period. **A final Board decision under paragraphs (c)(2) and (c)(3) of this section may be reopened and revised by the Board in accordance with §§ 405.1885 through 405.1889 of this subpart**.[69]

2. *Board Rule 4.1*—This Board Rule addresses the general requirements for Board Jurisdiction and specifies that the Board may review jurisdiction *at any time*:

> **4.1 General Requirements**
>
> *See* 42 C.F.R. §§ 405.1835 - 405.1840.
> The Board **will dismiss appeals that fail to meet** the timely filing requirements and/or **jurisdictional requirements**. A jurisdictional challenge (see Rule 44.4) may be raised at any time during the appeal; however, for judicial economy, the Board strongly encourages filing any challenges as soon as possible. **The Board may review jurisdiction on its own motion at any time**. The parties cannot waive jurisdictional requirements.

3. *Board Rule 16.2*—This Board Rule confirms that participants in a group directly added to a group must meet the requirements for filing an individual appeal request under Board Rules 6 to 8 (which implement 42 C.F.R. § 405.1835).

> **16.2 Filing Requirements for Requests to Join a Group Directly from a Final Determination**
>
> *A direct add request must include the same information required for a provider filing an individual appeal* (see Rules 6 through 8), including the determination and issue-specific information addressed in Rule 7, plus a copy of the representative letter associated with the group appeal. *This information must be provided* in order for the Board *to*

[69] (Bold and underline emphasis added.) *See also* 42 C.F.R. § 405.1845(e) (stating "(e) *Hearings*. The Board may conduct **a hearing** and issue a hearing decision (as described in §405.1871 of this subpart) on a specific matter at issue in an appeal, **provided it finds jurisdiction over the matter at issue in accordance with § 405.1840 of this part** and determines it has the legal authority to fully resolve the issue (as described in §405.1867 of this subpart)." (bold emphasis added)); Board Rule 4.1 (stating "*The Board **will dismiss** appeals that fail to meet* the timely filing requirements and/or *jurisdictional requirements*. . . . The Board may review jurisdiction on its own motion at any time." (emphasis added)).

> *confirm that the direct add request meets the requirements for a Board hearing*. See 42 C.F.R. §§ 405.1835(a), 405.1835(c), 405.1840(a).[70]

4. *Board Rule 7*—Board Rule 7 addresses the support required for an individual appeal request consistent with 42 C.F.R. § 405.1835(b) or (d) as applicable:

> **Rule 7 Support for Appealed Final Determination, Availability of Issue-Related Information and Basis for Dissatisfaction**
>
> *The provider must support the determination being appealed and the basis for its dissatisfaction* for each issue under appeal *consistent with 42 C.F.R. § 405.1835(b)* or (d) as applicable. . . .
>
> ****
>
> **7.2 Issue Related Information**
>
> **7.2.1 General Information**
> The following information and supporting documentation *must be submitted for each issue raised in the appeal request*.
>
> • An issue title and a concise issue statement describing:
> o the adjustment, including the adjustment number,
> o the controlling authority,
> o why the adjustment is incorrect,
> o how the payment should be determined differently,
> o the reimbursement effect, and
> o *the basis for jurisdiction before the PRRB*.
>
> • A copy of the applicable audit adjustment report page(s) or a statement addressing why an adjustment report is not applicable or available.
>
> • A calculation or other support for the reimbursement effect noted in the issue statement.
>
> • Support for protested items or claim of dissatisfaction as noted in Rules 7.3 and 7.4.
>
> **7.2.2. Additional Information**
> Providers *must* submit additional information not specifically addressed above *in order to support jurisdiction* or appropriate claim for the appealed issue(s).

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

> Example: Revised NPR workpapers and applicable cost report worksheets to document that the issue under appeal was specifically adjusted.[71]

5. *42 C.F.R. § 405.1835(b)*—This regulation addresses the minimum content requirements that an appeal request meet:

> (b) *Contents of request for a Board hearing on final contractor determination*. The provider's request for a Board hearing under paragraph (a) of this section must be submitted in writing in the manner prescribed by the Board, and the request **must include** the elements described in paragraphs (b)(1) through (4) of this section. If the provider submits a hearing request that does not meet the requirements of paragraph (b)(1), (2), or (3) of this section, the Board **may dismiss with prejudice** the appeal or take any other remedial action it considers appropriate.
>
> (1) **A demonstration that the provider satisfies the requirements for a Board hearing as specified in paragraph (a) of this section**, including a specific identification of the final contractor or Secretary determination under appeal.
>
> (2) For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final contractor or Secretary determination under appeal, including an account of all of the following:
>
> (i) Why the provider believes Medicare payment is incorrect for each disputed item (or, where applicable, why the provider is unable to determine whether Medicare payment is correct because it does not have access to underlying information concerning the calculation of its payment).
>
> (ii) How and why the provider believes Medicare payment must be determined differently for each disputed item.
>
> (iii) If the provider self-disallows a specific item (as specified in § 413.24(j) of this chapter), an explanation of the nature and amount of each self-disallowed item, the reimbursement sought

[71] (Bold emphasis in original and underline and italics emphasis added.) This Rule is based on 42 C.F.R. § 405.1835(a)-(b) and, in this regard, the Board notes that subsection (b)(1) states that an appeal request ***must*** include "*[a] demonstration that the provider* ***satisfies the requirements*** *for a Board hearing* as specified in paragraph (a) of this section, including a specific identification of the final contractor or Secretary determination under appeal." This necessarily includes whether the Board has substantive jurisdiction over the matter being appealed. *See* 42 C.F.R. § 405.1840(b) (emphasis added).

> for the item, and why the provider self-disallowed the item instead of claiming reimbursement for the item.
>
> (3) **A copy of the final contractor or Secretary determination under appeal and any other documentary evidence the provider considers necessary to satisfy the hearing request requirements of paragraphs (b)(1) and (b)(2) of this section**.[72]

6. *42 C.F.R. §§ 405.1837(c), (e)(2)*—Subsection (c) of this regulation specifies the minimum content requirements for a group appeal request and subsection (e)(2) confirms that the Board may make jurisdictional findings ***at any time*** (regardless of whether requested by the group representative).

> (c) *Contents of request for a group appeal*. The request for a Board hearing as a group appeal must be submitted in writing to the Board, and the request **must include** all of the following:
>
> (1) A demonstration that the request satisfies the requirements for a Board hearing as a group appeal, as specified in paragraph (a) of this section.
>
> (2) An explanation (for each specific item at issue) of each provider's dissatisfaction with the final contractor or Secretary determination under appeal, including an account of—
>
> (i) Why the provider believes Medicare payment is incorrect for each disputed item;
>
> (ii) How and why the provider believes Medicare payment must be determined differently for each disputed item; and
>
> (iii) If the provider self-disallows a specific item (as specified in § 413.24(j) of this chapter), an explanation of the nature and amount of each self-disallowed item, the reimbursement sought for the item, and why the provider self-disallowed the item instead of claiming reimbursement for the item.
>
> (3) A copy of each final contractor or Secretary determination under appeal, and any other documentary evidence the providers consider to satisfy the hearing request requirements of paragraphs (c)(1) and (c)(2) of this section, and a precise description of the one question

[72] (Italics emphasis in original and bold and underline emphasis added.)

> of fact or interpretation of law, regulations, or CMS Rulings that is common to the particular matter at issue in the group appeal.
>
> (4) **A statement that**—
>
> (i) The providers believe **they have satisfied <u>all</u> of the requirements for a group appeal hearing request** under paragraph (a) of this section **<u>and</u> requesting the Board to proceed to make jurisdictional findings <u>in accordance with § 405.1840</u>**; or
>
> (ii) The Board is requested to defer making jurisdictional findings until the providers request the findings in accordance with paragraph (e)(2) of this section.[73]
>
> ****
>
> (2) **The Board <u>may make jurisdictional findings</u> under § 405.1840 <u>at any time</u>, including, but not limited to, following a request by the providers for the jurisdictional findings**. The providers may request jurisdictional findings by notifying the Board in writing that the group appeal is fully formed, or that the providers believe they have satisfied all of the requirements for a group appeal hearing request, and the Board may proceed to make jurisdictional findings. The providers must include with the notice any additional information or documentary evidence that is required for group appeal hearing requests. The Board does not dismiss a group appeal hearing request for failure to meet the $50,000 amount in controversy requirement until the Board has determined, in accordance with paragraph (e)(1) of this section, that the group is fully formed.[74]

7. *<u>Board Rules 8 and 14</u>*—These Board Rules confirm that acknowledgement of an appeal request (individual or group) does not limit the Board's ability to later dismiss an appeal for being jurisdictionally deficient:

> **Rule 9 Board Acknowledgement of Appeals**
>
> The Board will send an acknowledgement notice via email to the designated representative confirming receipt of the appeal request and identifying the case number assigned. *Such an acknowledgement notice does <u>not limit the Board's authority</u>* to require more information or *<u>to dismiss the appeal</u>* if it is later found to be jurisdictionally deficient. *If the appeal request does not*

[73] (Italics emphasis in original and bold and underline emphasis added.)
[74] (Italics emphasis in original and bold and underline emphasis added.)

> *comply with the filing requirements, the Board may dismiss the appeal or take other remedial action*.
>
> ****
>
> **Rule 14 Acknowledgement of Group Appeal**
>
> The Board will send an Acknowledgement and Critical Due Dates Notice via email to the group representative and the lead Medicare contractor confirming receipt of the group appeal and the case number assigned. *Such an acknowledgement notice does not limit the Board's authority* to require more information or *to dismiss the appeal* if it is later found to be jurisdictionally deficient. *If the provider's appeal does not comply with the filing requirements, the Board may dismiss the appeal or take other remedial action*.[75]

8. *Board Rule 20*—This Board Rule specifies that, in situations where OH CDMS lists all participants behind the Participants tab, then the group representative must file a statement within 60 days following full formation of the group "*certifying*" that OH CDMS lists all participants in the group behind the participants tab and includes ***all*** *relevant supporting jurisdictional documentation* for each participant in the group:

> **Rule 20 Group Schedule of Providers and Supporting Documentation – Procedure**
>
> If ***all*** the participants in a fully-formed group are ***populated*** under the Issues/Providers Tab in OH CDMS with supporting jurisdictional documentation (*see* Rule 21), then the representative is exempt from filing a ***hard copy*** of the schedule of providers with supporting jurisdictional documentation. In this instance, the Board uses the schedule of providers and supporting jurisdictional documentation that is created in OH CDMS using the information and documents included in each participating provider's request for transfer or direct add to the group.
>
> ***Prior to*** *certifying that the group is fully formed or the date on which a group is fully formed*, the group representative should review each participating provider's supporting jurisdictional documentation to ensure it is complete and, if not, file any additional documentation in OH CDMS. If ***all*** of the participants in a fully-formed group are ***populated*** under the Issues/Providers Tab in OH CDMS, then ***within (60) sixty days of the full formation of the group***, the group representative must file a statement certifying that the group is *fully populated* in OH CDMS with the relevant supporting jurisdictional

[75] (Bold emphasis added and italics and underline emphasis added.)

documentation (*i.e*., all participants in the group are shown under the Issues/Providers Tab for the group in OH CDMS with the relevant supporting jurisdictional documentation).[76]

9. *Board Rule 42*—This Rule addresses, in part, the content requirements for an EJR request:

> **Rule 42 Expedited Judicial Review**
>
> **42.1 General**
> A provider or group of providers may bypass the Board's hearing process and obtain expedited judicial review ("EJR") for a final determination of reimbursement that involves a challenge to the validity of a statute, regulation, or CMS ruling. Board jurisdiction must be established prior to granting an EJR request. Similarly, the Board must process and rule on any substantive claim challenges pertaining to the cost report at issue prior to granting an EJR request (*see* Rule 44.5). In an appeal containing multiple issues, EJR may be granted for fewer than all the issues, in which case the Board will conduct a hearing on the remaining issues. The Board will make an EJR determination within 30 days *after it determines whether it has jurisdiction and the request for EJR is complete*. *See* 42 C.F.R. § 405.1842.
>
> **42.2 Requests for EJR**
> Because an EJR request is time sensitive, the request for EJR is to be filed separately and clearly labeled. . . .
>
> **42.3 Content of the EJR Request**
> A provider or a group of providers must file a written request for EJR with a fully developed narrative that:
>
> - Identifies the issue for which EJR is requested;
> - *Demonstrates that there are no factual issues in dispute*;
> - *Demonstrates that the Board has jurisdiction*;
> - Identifies the controlling law, regulation, Federal Register notice, or CMS ruling that is being challenged; and
> - Explains why the Board does not have authority to decide the legal question posted by the appeal.

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

10. *42 C.F.R. § 405.1842*—This regulation governs EJR requests and states, in pertinent part:

> (d) *Provider requests*. A provider (or, in the case of a group appeal, a group of providers) may request a determination by the Board that it lacks the authority to decide a legal question relevant to a specific matter at issue in an appeal. A provider must submit a request in writing to the Board and to each party to the appeal (as described in § 405.1843 of this subpart), and the request must include—
>
> (1) For each specific matter and question included in the request, **an explanation of why the provider believes the Board has jurisdiction under § 405.1840 of this subpart over each matter at issue** and no authority to decide each relevant legal question; and
>
> (2) **Any documentary evidence the provider believes supports the request**.
>
> (e) *Board action on provider requests*. (1) **If the Board makes a finding that it has jurisdiction to conduct a hearing on a specific matter at issue in accordance with § 405.1840(a) of this part**, then (and only then) it must consider whether it lacks the authority to decide a legal question relevant to the matter at issue. The Board is required to make a determination of its authority to decide the legal question raised in a review request under paragraph (d)(1) of this section by issuing an EJR decision no later than 30 days after receiving a complete provider request as defined in paragraph (e)(2) of this section.
>
> (2) Requirements of a complete provider request. A complete provider request for EJR consists of the following:
>
> (i) A request for an EJR decision by the provider(s).
>
> (ii) All of the information and documents found necessary by the Board for issuing a decision in accordance with paragraph (f) of this section.
>
> (3) Board's response to provider requests. After receiving a provider request for an EJR decision, the Board must review the request, along with any responses to the request submitted by other parties to the appeal (as described in § 405.1843 of this subpart). The Board must respond to the provider(s) as follows:

(i) Upon receiving a complete provider request, issue an EJR decision in accordance with paragraph (f) of this section no later than 30 days after receipt of the complete provider request. If the Board does not issue a decision within that 30-day period, the provider has a right to file a complaint in Federal district court in order to obtain EJR over the specific matter(s) at issue.

(ii) If the provider has not submitted a complete request, issue no later than 30 days after receipt of the incomplete request a written notice to the provider describing in detail the further information that the provider must submit in order to complete the request.

(f) *Board's decision on EJR: Criteria for granting EJR*. Subject to paragraph (h)(3) of this section, the Board is required to issue an EJR decision following either the completion of the Board's own motion consideration under paragraph (c) of this section, or a notice issued by the Board in accordance with paragraph (e)(3)(i) of this section.

(1) The Board's decision must grant EJR for a legal question relevant to a specific matter at issue in a Board appeal if the Board determines the following conditions are satisfied:

(i) The Board has jurisdiction to conduct a hearing on the specific matter at issue in accordance with § 405.1840 of this subpart.

(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.

(2) **The Board's decision must deny EJR** for a legal question relevant to a specific matter at issue in a Board appeal **if <u>any</u> of the following conditions are satisfied**:

(i) **The Board determines that it does <u>not have jurisdiction</u> to conduct a hearing** on the specific matter at issue **in accordance with § 405.1840 of this subpart**.

(ii) The Board determines it has the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is neither a challenge to the constitutionality of a provision of a statute, nor a challenge to the substantive or procedural validity of a regulation or CMS Ruling.

> (iii) **The Board does <u>not</u> have sufficient information to determine whether the criteria specified in paragraph (f)(1)(i) or (f)(1)(ii) of this section are met**.

11. *<u>Board Rule 47.1</u>*—This Rule addresses motions for reinstatement:

> **47.1 Motion for Reinstatement**:
> A provider may request reinstatement of an issue(s) or case within three years of the date of the Board' decision to dismiss the issue(s)/case, or if no dismissal was issued, within three years of the Board's receipt of the provider's withdrawal of the issue(s) (see *42 C.F.R. § 405.1885 addressing reopening of Board decisions*). *The request for reinstatement is a motion and must be in writing <u>setting out the reasons for reinstatement</u>* (see Rule 44 governing motions). The Board will not reinstate an issue(s)/case if the provider was at fault.[77]

[77] (Underline and italics emphasis added.) *See also* 42 C.F.R. § 405.1885 (entitled, in pertinent part, "Reopening a . . . reviewing entity decision" and stating in subsection (a) that "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 the reviewing entity that made the decision (as described in paragraph (c) of this section).")

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Gary Rosenberg, Esq.
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RE: ***Notice of Dismissal***
Verrill Dana Standardized Amount CIRP Group Cases
Case Nos. 19-1094GC, *et al.* (*see* **Appendix A** listing 31 group cases)

Dear Mr. Rosenberg:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal requests filed by the Providers in the thirty-one (31) above-referenced common issue related party ("CIRP") *and* optional group cases. The Medicare Contractor has filed Jurisdictional Challenges in all of those group cases. The Providers' Representative filed responses to these challenges. As set forth below, the Board has determined that, consistent with 42 U.S.C. § 1395ww(d)(7) and 42 C.F.R. § 405.1840(b), it lacks *substantive* jurisdiction over the appealed issue and is therefore dismissing all thirty-one (31) CIRP and optional group cases in their entirety.

In summary, the Board finds that it lacks substantive jurisdiction over the issue raised in these appeals. The standardized amounts used for IPPS rates for FFYs 1984 and FFY 1985 are each based on the budget neutrality adjustment made for that FFY and the 1984 and 1985 budget neutrality adjustments are presumably designed to be corrective of the initial base rate that was set *using 1981 data*.[1] Therefore, the *final* FFY 1984 and 1985 standardized amounts are *inextricably intertwined* with those applicable budget neutrality adjustments.[2] Indeed, the standardized amounts were too high for FFYs 1984 and 1985 and the budget neutrality adjustments applied to those years reduced the standardized amounts (reduced by factors of approximately 0.03 for FFY 1984 and 0.05 for FFY 1985) and, thus, these budget neutrality adjustments appear to have already automatically accounted for any such alleged errors in setting the initial base rate (which again was based on 1981 data).[3] Because 42 U.S.C. 1395ww(d)(7) prohibits administrative or

[1] The Board has included at **Appendix B** examples of other adjustments to the standardized amounts that have occurred outside of the FFY 1984 and 1985 budget neutrality adjustments. These intervening adjustments for FFYs 1986 and 2018 include both mandatory and discretionary revisions ***to the standardized amounts*** (as well as the Congress' decisions to revise or not revise the "applicable percentage increases" for FFYs 1986 and forward as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i)) and highlight the complexity of the issue before the Board, particularly where such adjustments were made in a budget neutral manner or were based on factoring in certain other estimated impacts
[2] *See infra* note 51 (citing to decisions that discuss similar circumstances involving Medicare provisions found to be inextricably tied to certain other provisions for which Congress precluded administrative and judicial review).
[3] *See infra* note 38 (discussing how the removal of nurse anesthetists costs were removed from IPPS and how that removal was *automatically* accounted for as part of the 1985 budget neutrality adjustment).

judicial review of those adjustments and the resulting *final* standardized amounts for those years were carried/flowed forward, the Board may not review the standardized amount used for the FFYs being appealed as they relate to the issue in these appeals, *i.e.*, the alleged inaccuracies in the standardized amounts used for FFY 1984 as carried/flowed forward for all years following FFY 1984 to the FFYs being appealed. In this regard, the Board notes that the Providers may not simply pass through, or over, the budget neutrality adjustments for FFYs 1984 and 1985 because those adjustments are tied to an absolute *external* event (the Secretary's estimate, based on the best available data, of what would have been paid for those years if there were no IPPS) ***and*** were ***fixed*** (no greater *and* no less than what would have been paid had there been no IPPS). To do otherwise, would impact the very integrity of IPPS.

Background:

Verrill Dana, LLP ("Providers' Representative") represents a number of providers in common issue related party ("CIRP") and optional groups which are challenging the IPPS standardized amount. The Medicare Contractor filed three (3) Jurisdictional Challenges covering thirty-one (31) group cases.[4] The Providers' Representative filed responses to these challenges. The group issue statements, jurisdictional challenges, and responses thereto for all thirty-one (31) cases are materially identical and can be considered together.

The statement of the issue presented is:

> Was the IPPS standardized amount that was calculated in 1983 and continually used in subsequent fiscal years, including the year under appeal, incorrect because CMS failed to distinguish between transfers and discharges in the 1981 data that was used to calculate the initial standardized amount[?][5]

Procedural Background:

A. Appealed Issue

In the Providers' group issue statements, they explain that the IPPS requires the categorization of different types of discharges (diagnostic related groups, or "DRGs"), and payment rates applicable to each discharge category. Their appeals challenge the latter, arguing that the data used to establish the initial "flat rate" payable per discharge resulted in an understated payment rate. CMS opted to use 1983 as a "base year" to calculate these rates, and thus data was collected from hospitals' 1981 cost reports to determine average costs for each discharge category. The data was adjusted for inflation and standardized, but the Providers argue that the initial calculation of this standardized amount continues to serve as the base for all future

[4] *See* **Appendix A**. Note: The Medicare Contractor's challenge included two additional group cases that subsequently consolidated into cases included here.
[5] *E.g.*, Case No. 19-1094GC, Providers' Preliminary Position Paper ("Providers' PPP") at 2 (Aug. 1, 2022).

calculations. Since the Providers allege this initial calculation was understated, they argue that the calculation for each subsequent year has also been understated.[6]

The Providers claim that the data sources used in collecting the 1981 data did not distinguish between patients who were discharged from the hospital, and patients who were transferred to another hospital or facility. They state that CMS views transfers as distinct from discharges, but in calculating the average cost per discharge using the 1981 data, CMS erroneously included transfers in the total number of discharges, thereby inflating the denominator of the cost to discharge ratio. They claim that CMS has acknowledged this error in at least one other context (*i.e.*, during the implementation of the capital PPS), and that this error was the reason for certain DRG weight recalibrations, but that CMS failed to fully correct the flawed Standardized Amount.[7]

In each case, the Providers are challenging the applicable FFY IPPS rates as set forth in the Federal Register.[8] They claim that the average cost per discharge should not include transfers, that CMS has acknowledged this as well as the fact that certain Standardized Amounts erroneously included transfers.[9] They argue the inclusion of transfers in the calculation of the standardized amount violates the express will of Congress, and thus is not entitled to judicial deference under *Chevron*;[10] and as the Secretary has acknowledged an error but declined to correct the standardized amount on a prospective basis, the agency's interpretation is not entitled to deference as it is "arbitrary, capricious or manifestly contrary to the statute."[11]

B. Jurisdictional Challenges

The Medicare Contractor filed challenges in thirty-one (31) different group cases, and the Providers filed responses in each case.[12] The Medicare Contractor argues that the merits of the appealed issue are illegitimate, but more importantly, that the Board lacks subject matter jurisdiction and need not even address the merits of the issue. It references the Board's April 6, 2023 decision dismissing five (5) different CIRP group appeals concerning the same issue. The Medicare Contractor argues the Board should apply the same rationale and find that 42 U.S.C. § 1395ww(d)(7)(A) precludes administrative review of the base year standardized amounts. It also claims that budget neutrality adjustments after the base year amount was calculated have corrected any potential errors from prior years, and that the data shows the base year was, in fact, initially set too high (rather than understated).

---

[6] *Id*. at 3.
[7] *Id.* at 5-6 (citing 56 Fed. Reg. 43358, 43386 (Aug. 30, 1991) (relating to Capital PPS).
[8] *Id*. at 4.
[9] *E.g.*, Case No. 19-1094GC, Providers' PPP at 5.
[10] Case No. 19-1094GC, Providers' PPP at 6-7. Citing *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984).
[11] *Id*. at 7. Citing *Lindeen v. Sec. & Exch. Comm'n*, 825 F.3d 646, 656 (D.C. Cir. 2016) (quoting *Chevron*, 467 U.S. at 843-44).
[12] *See* **Appendix A** for complete list of challenges and cases impacted. As previously noted, the challenges are all materially identical and two of the cases were subsequently consolidated into cases included here.

The Providers' responses to these challenges reiterated that the group appeal rests on the fact that each appeal's IPPS payments for the applicable FFY is "improperly low because of how the Secretary originally calculated and implemented the IPPS in FY 1984."[13] They claim that the budget-neutral adjustments and any preclusion provisions do not apply to their IPPS challenges. They ask the Board to deny the Jurisdictional Challenges.

The Providers counter the Medicare Contractor by arguing that budget neutrality adjustments are not applicable to these appeals. The Providers claim they do not seek to challenge the budget neutrality adjustments for FYs 1984 or 1985, rather "[t]hose provisions do not apply to the 33 appeals involved here, which contest the standardized amounts in FYs 2015 to 2023, not those of 1984 or 1985, and therefore dismissal is improper."[14] They argue that there is a strong presumption in favor of judicial review, and that "such a presumption may only be overcome by "clear and convincing evidence" of a specific legislative intent to preclude review of the matter at issue."[15]

Board Decision:

As described more fully below, the Board finds that it lacks substantive jurisdiction over each of the 31 groups because the initial 1983 standardized amounts,[16] set for the IPPS, are ***inextricably*** intertwined with the 1984 and 1985 budget neutrality adjustments to the "applicable percentage increases" for IPPS[17] and 42 U.S.C. § 1395ww(d)(7) prohibits administrative or judicial review of those budget neutrality adjustments. The fact that the Secretary's budget neutrality adjustment to the FY 1984 Federal Rates was 0.970[18] demonstrates that, contrary to the Providers' assertions, the initial standardized amount was ***not*** understated but rather was *overstated* by a factor of 0.030 (*i.e.*, 1.000 – 0.970) and, thus, these budget neutrality adjustments appears to have already automatically accounted for any such alleged errors in setting the initial base rate.[19] Indeed, it is only natural that Congress established the 1984 and 1985 budget neutrality adjustments since the initial base rate was initially set *using 1981 data*.

A. Statutory Background on IPPS and the Standardized Amount Used in IPPS Rates

Part A of the Medicare program covers "inpatient hospital services." Since October 1, 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services

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[13] *E.g.*, Case No. 19-1094GC *et al.*, Response to ASC Jurisdictional Challenges at 2 (Nov. 16, 2023).
[14] *Id.* at 3.
[15] *Id.* at 4. Citing *Abbot Labs v. Gardner*, 387 U.S. 136, 141 (1967).
[16] The Board notes that, initially, there was not just one standardized amount. Rather there were 20 average standard amounts per discharge according to urban/rural designation in each of the nine census divisions and the nation and each of these 20 rates is further divided into a labor and nonlabor portion. *See* 48 Fed. Reg. 39752, 39763 (Sept. 1, 1983).
[17] 42 U.S.C. § 1395ww(e) is entitled "Proportional adjustments in applicable percentage increases." The 1984 and 1985 budget neutrality adjustments are set forth is § 1395ww(e)(1)(B) which is cross-referenced for 1984 IPPS rates at § 1395ww(d)(2)(F) and for 1985 IPPS rates at § 1395ww(d)(3)(C).
[18] In the final rule published on January 3, 1984, the Secretary revised the Federal budget neutrality adjustment factor to 0.970. 49 Fed. Reg. 234, 334 (Jan. 3, 1984).
[19] *See infra* note 38 (discussing how the removal of nurse anesthetists costs were removed from IPPS and how that removal was *automatically* accounted for as part of the 1985 budget neutrality adjustment).

under the IPPS.[20] Under IPPS, Medicare pays a prospectively-determined rate per eligible discharge, subject to certain payment adjustments.[21]

In order to implement IPPS, "the statute require[d] that the Secretary determine national and regional adjusted DRG prospective payment rates for each DRG to cover the operating costs of inpatient hospital services."[22] The methodology for arriving at the appropriate rate structure is located at 42 U.S.C. § 1395ww(d)(2) and "requires that certain ***base period*** *cost data* be developed and modified in several specified ways (*i.e.*, inflated, standardized, grouped, and adjusted) resulting in 20 average standard amounts per discharge according to urban/rural designation in each of the nine census divisions and the nation."[23] Specifically, § 1395ww(d)(2) (Jan. 1985) stated, in pertinent part:

> (2) The Secretary shall determine a national adjusted DRG prospective payment rate, for each inpatient hospital discharge in fiscal year 1984 involving inpatient hospital services of a subsection (d) hospital in the United States, and shall determine a regional adjusted DRG prospective payment rate for such discharges in each region, for which payment may be made under part A of this subchapter. Each such rate shall be determined for hospitals located in urban or rural areas within the United States or within each such region, respectively, as follows:
>
> (A) DETERMINING ALLOWABLE INDIVIDUAL HOSPITAL COTS FOR BASE PERIOD.—The Secretary shall determine the allowable operating costs per discharge of inpatient hospital services for the hospital for the most recent cost reporting period for which data are available.
>
> (B) UPDATING FOR FISCAL YEAR 1984.—The Secretary shall update each amount determined under subparagraph (A) for fiscal year 1984 by—
>
> (i) updating for fiscal year 1983 by the estimated average rate of change of hospital costs industry-wide between the cost reporting period used under such subparagraph and fiscal year 1983 and the most recent case-mix data available, and
>
> (ii) projecting for fiscal year 1984 by the applicable percentage increase (as defined in subsection (b)(3)(B)) for fiscal year 1984.
>
> (C) STANDARDIZING AMOUNTS.—The Secretary shall standardize the amount updated under subparagraph (B) for each hospital by—

[20] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[21] *Id.*
[22] 48 Fed. Reg. 39752, 39763 (Sept. 1, 1983).
[23] *Id.* (emphasis added).

> (i) excluding an estimate of indirect medical education costs,[24]
>
> (ii) adjusting for variations among hospitals by area in the average hospital wage level, and
>
> (iii) adjusting for variations in case mix among hospitals.[25]

Thus, as quoted above, § 1395ww(d)(2)(A) requires that the Secretary determine a "base period" operating cost per discharge using the most recent cost reporting period for which data are available. Further, consistent with these statutory provisions, the Secretary used Medicare hospital cost reports for reporting periods ending in 1981 and set the 1984 "base period" operating cost per discharge amount using the 1981 operating costs per discharge amount *updated* by an inflationary factor.[26] The Providers dispute how the Secretary determined discharges" and allege that the Secretary improperly treated transfers as discharges for purposes of this calculation.

The Secretary then "standardized" the FFY 1984 base period operating cost per discharge using the process prescribed at 42 U.S.C. § 1395ww(d)(2)(c). The standardization process removed the effects of certain variable costs from the cost data, including (but not limited to) excluding costs associated with indirect medical education costs, adjusting for variations in average hospital wage levels, and adjusting for variations in case mix among hospitals.

The initial standardized amounts have been annually adjusted and/or updated. However, contrary to the characterization in the D.C. Circuit's 2011 decision in *Saint Francis Med. Ctr. v. Azar* ("*Saint Francis*"), the standardized amount is not adjusted each year simply for inflation.[27] Significantly, some of these annual adjustments were required to be *budget neutral* and are not subject to administrative review. In particular, 42 U.S.C. § 1395ww(e)(1)(B) provides the

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[24] Consistent with the concerns raised by the Board in **Appendix B**, the Board notes that Congress has amended this clause (i) numerous times and, as a result, it currently reads:

> (i) excluding an estimate of indirect medical education costs (taking into account, for discharges occurring after September 30, 1986, the amendments made by section 9104(a) of the Medicare and Medicaid Budget Reconciliation Amendments of 1985), except that the Secretary shall not take into account any reduction in the amount of additional payments under paragraph (5)(B)(ii) resulting from the amendment made by section 4621(a)(1) of the Balanced Budget Act of 1997 or any additional payments under such paragraph resulting from the application of section 111 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, of section 302 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, or the Medicare Prescription Drug, Improvement, and Modernization Act of 2003,

[25] The Board notes that Congress later added clause (iv) in 1985 and, consistent with the concerns raised by the Board in **Appendix B**, the Board notes that Congress has amended this clause numerous times and, as a result, it currently reads:

> (iv) for discharges occurring on or after October 1, 1986, excluding an estimate of the additional payments to certain hospitals to be made under paragraph (5)(F), except that the Secretary shall not exclude additional payments under such paragraph made as a result of the enactment of section 6003(c) of the Omnibus Budget Reconciliation Act of 1989, the enactment of section 4002(b) of the Omnibus Budget Reconciliation Act of 1990, the enactment of section 303 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, or the enactment of section 402(a)(1) 4 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

[26] *Id*. at 39763-64.

[27] 894 F.3d 290, 291 (D.C. Cir. 2011). *Saint Francis* did not analyze how the standardized amount is updated annually nor did it make specific legal holdings regarding the standardized amount.

budget neutrality adjustment for "the applicable percentage increases" to the standardized amounts for 1984 and 1985 and states, in pertinent part:

> **(e) Proportional adjustments in *applicable percentage increases***
>
> (1) . . . .
>
> (B) *For discharges occurring in fiscal year 1984 or fiscal year 1985*, *the Secretary shall provide* under subsections (d)(2)(F) and (d)(3)(C) for such equal proportional adjustment *in each of the average standardized amounts* otherwise computed for that fiscal year as may be necessary to assure that—
>
> (i) *the aggregate payment amounts* otherwise provided under subsection (d)(1)(A)(i)(II) and (d)(5) *for that fiscal year* for operating costs of inpatient hospital services of hospitals (excluding payments made under section 1395cc(a)(1)(F) of this title),
>
> *are not greater or less than*—
>
> (ii) the DRG percentage (as defined in subsection (d)(1)(C)) of *the payment amounts which would have been payable for such services* for those same hospitals for that fiscal year under this section *under the law as in effect before April 20, 1983* (excluding payments made under section 1395cc(a)(1)(F) of this title).[28]

The Secretary implemented the above budget neutrality provisions at 42 C.F.R. §§ 412.62(i) and 412.63(v) for the 1984 rate year and 1985 rate year respectively. Specifically, § 412.62(i) provides the following instruction for maintaining budget neutrality for the 1984 Federal IPPS rates:

> (i) *Maintaining budget neutrality.* (1) CMS adjusts each of the **reduced standardized amounts** determined under paragraphs (c) through (h) of this section **as required for fiscal year 1984** so that the estimated amount of aggregate payments made, excluding the hospital-specific portion (that is, the total of the Federal portion of transition payments, plus any adjustments and special treatment of certain classes of hospitals for Federal fiscal year 1984) **is not greater or less than** 25 percent of **the payment amounts that would have been payable** for the inpatient operating costs for those same hospitals for fiscal year 1984 **under the Social Security Act as in effect on April 19, 1983**.

[28] (Bold emphasis in original and italics and underline emphasis added.) The budget neutrality adjustment at 42 U.S.C. § 1395ww(e)(1)(B) is cross-referenced for 1984 at 1395ww(d)(2)(F) and for 1985 at § 1395ww(d)(3)(C).

> (2) The aggregate payments considered under this paragraph exclude payments for per case review by a utilization and quality control quality improvement organization, as allowed under section 1866(a)(1)(F) of the Act.[29]

Similarly, the regulation at 42 C.F.R. § 412.63(v) provides the following instruction for maintaining budget neutrality for the 1985 Federal rates for IPPS:

> (v) *Maintaining budget neutrality for fiscal year 1985.* (1) For fiscal year 1985, CMS will adjust each of **the reduced standardized amounts** determined under paragraph (c) of this section **as required for fiscal year 1985** to ensure that the estimated amount of aggregate payments made, excluding the hospital-specific portion (that is, the total of the Federal portion of transition payments, plus any adjustments and special treatment of certain classes of hospitals for fiscal year 1985) **is not greater or less** than 50 percent of the **payment amounts that would have been payable** for the inpatient operating costs for those same hospitals for fiscal year 1985 **under the law as in effect on April 19, 1983**.
> (2) The aggregate payments considered under this paragraph exclude payments for per case review by a utilization and quality control quality improvement organization, as allowed under section 1866(a)(1)(F) of the Act.[30]

Essentially, Congress mandated that the Secretary/CMS adjust the standardized amounts for both 1984 and 1985 to ensure that the estimated amount of aggregate payments made under IPPS was not *greater than **or** less than* what would have been payable for inpatient operating costs for the same hospitals under the prior reimbursement system (*i.e.*, reasonable costs subject to TEFRA limits). In other words, pursuant to budget neutrality, the size of the pie, expressed as average payment per case, is prescribed by law to be *no more **and** no less* than what would have been paid had IPPS not been implemented. Significantly, the reference points for maintaining budget neutrality for 1984 and 1985 are ***external*** to IPPS and, thus, ***fixed*** (no greater *and* no less) based on the best data available.[31] Since these points are ***fixed,*** it also means that it is capped (*i.e.*,

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[29] (Italics emphasis in original and bold and underline emphasis added.)
[30] (Italics emphasis in original and bold and underline emphasis added.)
[31] 48 Fed. Reg. 39752, 39887 (Sept. 1, 1983) provides the following discussion supporting the Board's pie concept:

> Section 1886(e)(1) of the Act requires that, for Federal fiscal years 1984 and 1985, prospective payments be adjusted so that aggregate payments for the operating costs of inpatient hospital services are neither more nor less than we estimate would have been paid under prior legislation for the costs of the same services. To implement this provision, we are making actuarially determined adjustments to the average standardized amounts used to determine Federal national and regional payment rates and to the updating factors used to determine the hospital-specific per case amounts incorporated in the blended transition payment rates for fiscal years 1984 and 1985. Section 1886(d)(6) of the Act requires that the annual published notice of the methodology, data and rates include an explanation of any budget neutrality adjustments. This section is intended to fulfill that requirement.

cannot be increased subsequently outside of the budget neutrality adjustment). Indeed, it is only natural that Congress established this structure for 1984 and 1985 budget neutrality adjustments since the initial base rate for IPPS was initially set ***using 1981 data***.

This conclusion is supported by the fact that the normal annual inflation adjustments to the standardized amount provided for in IPPS apply ***only*** for FY 1986 forward, as set forth in 42 U.S.C. § 1395ww(b)(3)(B)(3)(i) and cross referenced in § 1395ww(d)(3)(A). Specifically, 42 U.S.C. § 1395ww(b)(3)(B)(i) (2018) defines the term "applicable percentage increase" starting with fiscal year 1986 (as opposed to 1984):

> (B)(i) For purposes of subsection (d) and subsection (j) for discharges occurring during a fiscal year, the "applicable percentage increase" shall be—
>
> (I) ***for fiscal year 1986***, 1/2 percent,
>
> (II) for fiscal year ***1987***, 1.15 percent,
>
> (III) for fiscal year ***1988***, 3.0 percent for hospitals located in a rural area, 1.5 percent for hospitals located in a large urban area (as defined in subsection (d)(2)(D)), and 1.0 percent for hospitals located in other urban areas,
>
> (IV) for fiscal year ***1989***, the market basket percentage increase minus 1.5 percentage points for hospitals located in a rural area, the market basket percentage increase minus 2.0 percentage points for hospitals located in a large urban area, and the market basket percentage increase minus 2.5 percentage points for hospitals located in other urban areas,
>
> (V) for fiscal year ***1990***, the market basket percentage increase plus 4.22 percentage points for hospitals located in a rural area, the market basket percentage increase plus 0.12 percentage points for hospitals located in a large urban area, and the market basket percentage increase minus 0.53 percentage points for hospitals located in other urban areas,
>
> (VI) for fiscal year ***1991***, the market basket percentage increase minus 2.0 percentage points for hospitals in a large urban or other

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Although, for methodological reasons, the budget neutrality adjustment is calculated on a per discharge basis, it should be emphasized that the ultimate comparison is between the aggregate payments to be made under the prospective payment system and the aggregate payments that would have been incurred under the prior legislation. Therefore, changes in hospital behavior from that which would have occurred in the absence of the prospective payment system are required to be taken into account in determining the budget neutrality adjustment if they affect aggregate payment. For example, any expectation of increased admissions beyond the level that would have occurred under prior law would have to be considered in the adjustment. To assist in making the budget neutrality adjustment for, and take account of, fiscal year 1985, HCFA will monitor for changes in hospital behavior attributable to the new system.

urban area, and the market basket percentage increase minus 0.7 percentage point for hospitals located in a rural area,

(VII) for fiscal year ***1992***, the market basket percentage increase minus 1.6 percentage points for hospitals in a large urban or other urban area, and the market basket percentage increase minus 0.6 percentage point for hospitals located in a rural area,

(VIII) for fiscal year ***1993***, the market basket percentage increase minus 1.55 percentage point for hospitals in a large urban or other urban area, and the market basket percentage increase minus 0.55 1 for hospitals located in a rural area,

(IX) for fiscal year ***1994***, the market basket percentage increase minus 2.5 percentage points for hospitals located in a large urban or other urban area, and the market basket percentage increase minus 1.0 percentage point for hospitals located in a rural area,

(X) for fiscal year ***1995***, the market basket percentage increase minus 2.5 percentage points for hospitals located in a large urban or other urban area, and such percentage increase for hospitals located in a rural area as will provide for the average standardized amount determined under subsection (d)(3)(A) for hospitals located in a rural area being equal to such average standardized amount for hospitals located in an urban area (other than a large urban area),

(XI) for fiscal year ***1996***, the market basket percentage increase minus 2.0 percentage points for hospitals in all areas,

(XII) for fiscal year ***1997***, the market basket percentage increase minus 0.5 percentage point for hospitals in all areas,

(XIII) for fiscal year ***1998***, 0 percent,

(XIV) for fiscal year ***1999***, the market basket percentage increase minus 1.9 percentage points for hospitals in all areas,

(XV) for fiscal year ***2000***, the market basket percentage increase minus 1.8 percentage points for hospitals in all areas,

(XVI) for fiscal year ***2001***, the market basket percentage increase for hospitals in all areas,

(XVII) for fiscal year ***2002***, the market basket percentage increase minus 0.55 percentage points for hospitals in all areas,

(XVIII) for fiscal year ***2003***, the market basket percentage increase minus 0.55 percentage points for hospitals in all areas,

(XIX) for each of fiscal years ***2004*** through ***2006***, subject to clause (vii), the market basket percentage increase for hospitals in all areas; and

> (XX) ***for each subsequent fiscal year***, subject to clauses (viii), (ix), (xi), and (xii), the market basket percentage increase for hospitals in all areas.[32]

The "applicable percentage increase" as defined in § 1395ww(b)(3)(B) is incorporated into § 1395ww(d)(3)(A), as it relates to updating of the standardized amount:

> **(A) UPDATING** PREVIOUS STANDARDIZED AMOUNTS.—(i) For discharges occurring in a fiscal year beginning ***before*** October 1, 1987, the Secretary shall compute an average standardized amount for hospitals located in an urban area and for hospitals located in a rural area within the United States and for hospitals located in an urban area and for hospitals located in a rural area within each region, *equal to the respective average standardized amount computed for the previous fiscal year under paragraph (2)(D) or under this subparagraph*, ***increased for the fiscal year involved by the applicable percentage increase under subsection (b)(3)(B)***. With respect to discharges occurring on or after October 1, 1987, the Secretary shall compute urban and rural averages on the basis of discharge weighting rather than hospital weighting, making appropriate adjustments to ensure that computation on such basis does not result in total payments under this section that are greater or less than the total payments that would have been made under this section but for this sentence, and making appropriate changes in the manner of determining the reductions under subparagraph (C)(ii).
>
> (ii) For discharges occurring in a fiscal year beginning on or after October 1, 1987, and ending on or before September 30, 1994, the Secretary shall compute an average standardized amount for hospitals located in a large urban area, for hospitals located in a rural area, and for hospitals located in other urban areas, within the United States and within each region, equal to the respective average standardized amount computed for the previous fiscal year under this subparagraph increased by the applicable percentage increase under subsection (b)(3)(B)(i) with respect to hospitals located in the respective areas for the fiscal year involved.
>
> (iii) For discharges occurring in the fiscal year beginning on October 1, 1994, the average standardized amount for hospitals located in a rural area shall be equal to the average standardized amount for hospitals located in an urban area. For discharges occurring on or after October 1, 1994, the Secretary shall adjust the

[32] (Emphasis added.)

> ratio of the labor portion to non-labor portion of each average standardized amount to equal such ratio for the national average of all standardized amounts.
>
> (iv)(I) Subject to subclause (II), for discharges occurring in a fiscal year beginning on or after October 1, 1995, the Secretary shall compute an average standardized amount for hospitals located in a large urban area and for hospitals located in other areas within the United States and within each region equal to the respective average standardized amount computed for the previous fiscal year under this subparagraph increased by the applicable percentage increase under subsection (b)(3)(B)(i) with respect to hospitals located in the respective areas for the fiscal year involved.
>
> (II) For discharges occurring in a fiscal year (beginning with fiscal year 2004), the Secretary shall compute a standardized amount for hospitals located in any area within the United States and within each region equal to the standardized amount computed for the previous fiscal year under this subparagraph for hospitals located in a large urban area (or, beginning with fiscal year 2005, for all hospitals in the previous fiscal year) increased by the applicable percentage increase under subsection (b)(3)(B)(i) for the fiscal year involved.

Thus, while 42 U.S.C. § 1395ww(d)(2) provides the methodology for calculating the standardized amount to be used for each year, and that the amount is subject to the "applicable percentage increase" under subsection (b)(3)(B) *for years after 1984*, it remains that it is not always a simple inflationary or market basket adjustment. In particular, the FFY 1984 and 1985 budget neutrality adjustments (as referenced in § 1395ww(d)(2)(F) and in § 1395ww(d)(3)(C)) were the applicable percentage increases for FFYs 1984 and 1985 and, as described below, those adjustments are not administratively reviewable.

B. Jurisdictional Findings -- 42 U.S.C. § 1395ww(d)(7)(A) Precludes Administrative Review of the Base Year Standardized Amounts

The Providers essentially are challenging the standardized amount used in the IPPS rates for several FFYs claiming that the Secretary improperly treated transfers as discharges when using 1981 cost report data to determine the initial FFY 1984 base cost per discharge which, in turn, was standardized to arrive at the FFY 1984 standardized amounts. More specifically, the Providers maintain that, the understatement of the standardized amount in the FFY 1984 IPPS Final Rule caused a corresponding underpayment in IPPS payments in FFY 1984 ***and every FFY thereafter*** *because the standardized amount for all IPPS payments for every FFY are based on CMS's calculation of the FFY 1984 standardized amount*.[33]

[33] *E.g.*, PRRB Case 19-1094GC *et al.*, Providers' Response to MACs' Jurisdictional Challenges at 2 ("This error was embedded into the standardized amounts moving forward into subsequent cost reporting years.").

The published standardized amount for each FFY in these appeals reflects the prior year's standardized amount plus "the applicable percentage increase" as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i) (as referenced in 42 U.S.C. § 1395ww(d)(3(A)) as well as other potential adjustments. Significantly, the "applicable percentage increase[s]" for 1984 forward are ***not*** always simply a cost inflation adjustment or other similar percentage adjustment. To this point, for the first two (2) years of IPPS, Congress mandated that the budget neutrality adjustments for FFYs 1984 and 1985 serve as the "applicable percentage increase" for those years. As a result, the IPPS rates that the Secretary used *for the very first year of IPPS* and then the second year of IPPS were adjusted for budget neutrality. For FFYs 1986 and forward, Congress provided for an "applicable percentage increase" in 42 U.S.C. § 1395ww(b)(3)(B)(i) as referenced in 42 U.S.C. § 1395ww(d)(3(A). In addition, there are other *permanent* adjustments (*i.e*., adjustments not for that year only but that also apply on a going-forward basis) to the standardized amount that have occurred in other years outside of the "applicable percentage increase."[34] Thus, the standardized amount for a particular year is an amalgamation that builds upon the prior year's standardized amount and then adds additional adjustments for the current year.

The Providers are, essentially, seeking to peel back the amalgamated standardized amount for each applicable FFY *and, thus, reach back* ***more than 30 years*** to increase the initial 1984 base rate that was used to set the initial 1984 standardized amount***s***. They would then incorporate the alleged increased base rate into the FFY 1984 standardized amount***s*** and then simply carry or flow that *increase forward 35 years*. However, in order to peel the amalgamated standardized amounts for the FFYs at issue (singular[35]) *as used in the IPPS rates for each FFY* back to the initial standardized amount***s*** (plural[36]) used in FFY 1984, and then carry/flow any change forward *to the FFY at issue*, the Providers would have to pass through the FFY 1984 and 1985 budget neutrality adjustments which were the only "applicable percentage increase[s]" for those years. However, they cannot do so because the budget neutrality adjustments had the effect of ***fixing*** the pie for FFYs 1984 and 1985 to (*i.e*., no more ***and*** no less than) the aggregate amounts that would have been paid had IPPS not been implemented.[37] More specifically, the amalgamated standardized payment amount for each FFY at issue reflects the *fixed* FFY 1984 and 1985 budget neutrality adjustments (and not the initial FFY 1984 standardized amounts since the standardized amounts for both FFYs 1984 and 1985 were each adjusted for budget neutrality became *fixed* for purposes of subsequent years as a result of those budget neutrality adjustments). Indeed, it is only natural that Congress established the 1984 and 1985 budget neutrality adjustments in this manner since the initial FFY 1984 standardized amount for IPPS was initially set *using 1981 data*. Thus, in the Board's view, the Providers cannot get back to the FFY 1984 standardized amounts without first passing through the FFY 1984 and 1985 budget neutrality

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[34] *See* **Appendix B**.
[35] *See supra* note 16 accompanying text.
[36] *See id.*
[37] *See, e.g.,* 48 Fed. Reg. 39752, 39805 (Sept. 1, 1983) (stating: "Hospital Impact—During its first two years, aggregate payments under the prospective payment system will be adjusted, in accordance with Section 1886(e)(1) of the Act, to be "budget neutral"; that is, so that aggregate payments under the prospective payment system, including outlier payments, exceptions, and adjustments, will be neither more nor less than the estimated payment amounts to affected hospitals that would have resulted under the Social Security Act as in effect before April 20,1983.").

adjustments. Regardless, the Providers would not be able to flow forward any adjustments made to the FFY 1984 standardized amounts because:

(1) They, again, would not be able to get through the FFY 1984 and 1985 budget neutrality adjustments that Congress otherwise ***fixed*** to an external point (no greater and no less); and

(2) The IPPS rates paid for FFYs 1984 and 1985 are based on standardized amounts that were adjusted downwards as a result of the budget neutrality adjustment for FFY 1984 and also for FFY 1985 (*see* discussion below in Sections B.1 and B.2).[38]

Accordingly, the Board finds that the Providers challenge to the standardized amounts at issue are *inextricably* intertwined with the budget neutrality adjustments made for FFY 1984 and 1985.[39]

Furthermore, Congress has precluded Board (and judicial) review of the FFY 1984 and 1985 budget neutrality adjustments. Specifically, 42 U.S.C. § 1395ww(d)(7)(A) precludes administrative and juridical review of the neutrality adjustment at § 1395ww(e)(1):

> (7) There shall be no administrative or judicial review under section 1395oo of this title or otherwise of—
>
> (A) the determination of the requirement, or the proportional amount, of any adjustment effected pursuant to subsection (e)(1) or

[38] Indeed, the FY 1986 IPPS Final Rule included an example where the Secretary recognized an adjustment to the budget neutrality adjustments would be impacted by the removal of nurse anesthetists costs and confirmed that the adjustments to the standardized amounts had already taken this removal into account:

> c. Nonphysician anesthetist costs. In the August 31, 1984 final rule, we implemented section 2312 of Pub. L. 98-369, which provided that hospital costs for the services of nonphysician anesthetists will be paid in full as a reasonable cost pass-through for cost reporting periods beginning before October 1, 1987.
>
> We did not directly reduce the FY 1985 Federal rates to exclude the estimated costs of these services, *because any required adjustment would be incorporated in the budget neutrality adjustment factors applied to the national and regional standardized amounts*. (See 49 FR 34794; August 31, 1984). ***Since the FY 1986 standardized amounts are derived from an update of the FY 1985 amounts, which were adjusted for budget neutrality, the rates will automatically include the appropriate adjustment***. We are not making further adjustments to the Federal rates for this factor for either FY 1986 or FY 1987.

50 Fed. Reg. at 35708 (emphasis added). *See also* 52 Fed. Reg. 33034, 33064 (Sept. 1, 1987) (stating: "In the September 3, 1985 final rule, we noted that to the extent an adjustment was warranted to reflect the removal of these costs from the prospective payment rates for FY 1985, *it was incorporated in the overall* ***budget neutrality*** *adjustment* (50 FR 35708). Therefore, because this adjustment has already been built into the FY 1985 base from which the FY 1986, FY 1987, and proposed FY 1988 rates are derived, we did not propose to make further adjustments to the average standardized amounts for FY 1988.").

[39] The Board notes that the D.C. Circuit's decision in *Saint Francis* is not applicable to the 1984 and 1985 budget neutrality adjustments given the statutory provision precluding administrative and judicial review of those adjustments. Further, *Saint Francis* did not analyze how the standardized amount is updated annually nor did it make specific legal holdings regarding the standardized amount.

> the determination of the applicable percentage increase under paragraph (12)(A)(ii), . . .[40]

Similarly, the statute governing Board appeals is located at 42 U.S.C. § 1395oo and states in subsection (g)(2):

> The determinations and other decisions described in section 1395ww(d)(7) of this title shall not be reviewed by the Board or by any court pursuant to an action brought under subsection (f) or otherwise.

The Secretary incorporated the exclusion of the 1984 and 1985 budget neutrality provisions into the Board's governing regulations at 42 C.F.R. § 405.1804 which states in pertinent part:

> Neither administrative nor judicial review is available for controversies about the following matters:
>
> (a) The determination of the requirement, or the proportional amount, of the budget neutrality adjustment in the prospective payment rates required under section 1886(e)(1) of the Social Security Act [*i.e.* 42 U.S.C. § 1395ww(e)(1)].[41]

Since the FFY 1984 and 1985 budget neutrality adjustments are based on an ***external, fixed*** reference point (*i.e.*, no greater and no less than the reference point) and are not reviewable, the

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[40] With regard to implementing this statutory provision, 48 Fed. Reg. 39752, 39785 (Sept. 1, 1983) states:

> Section 1886(d)(7) of the Act precludes administrative and judicial review of the following:
> —A determination of the requirement, or the proportional amount, of any "budget neutrality" adjustment effected under section 1886(e)(1) of the Act; or
> —The establishment of DRGs, of the methodology for the classification of hospital discharges within DRGs, or of the appropriate weighting factors of DRGs under section 1886(d)(4) of the cost. It was the clear intent of Congress that a hospital would not be permitted to argue that the level of the payment that it receives under the prospective payment system is inadequate to cover its costs. Thus, as discussed above, neither the definition of the different DRGs, their weight in relation to each other, nor the method used to assign discharges to one of the groups is to be reviewable. However, if there is an error in the coding of an individual patient's case, review would be permitted. (See the Report of the Committee on Ways and Means on H.R. 1900, H. Report No. 98-25, (98th Cong., 1st Sess.) 143 (1982).) As noted below, we believe the appropriate review concerning coding errors should be conducted by the entity (i.e., the PSRO/PRO or fiscal intermediary) which made the initial determination.

[41] The Secretary recently clarified 42 C.F.R. § 405.1804(a) and affirmed that 42 U.S.C. § 1395ww(e)(1) "required that, for cost reporting periods beginning in FYs 1984 and 1985, the IPPS result in aggregate program reimbursement equal to 'what would have been payable' under the reasonable cost-based reimbursement provisions of prior law; that was, for FYs 1984 and 1985, the IPPS would be 'budget neutral.'" 78 Fed. Reg. 74825, 75162 (Dec. 10, 2013) (making technical change to the 42 C.F.R. § 405.1804(a)).

Board finds that the FFYs 1984 and 1985 budget neutrality adjustments effectively fixed the standardized amounts from that point forward for use in the IPPS system.[42]

Indeed, the Secretary's implementation of the fixed FFY 1984 and 1985 budget neutrality adjustments confirms that the Providers' allegation that the standardized rates for ***each FFY at issue*** are somehow understated due to alleged errors in the FFY 1984 base rate is moot.

1. *The Secretary determined that the initial standardized amounts for FFY 1984 were too high and, therefore, reduced the FFY 1984 standardized amounts through the FFY 1984 budget neutrality adjustment as reflected in the **final** FFY 1984 IPPS rates*.

In the interim final rule published on September 1, 1983, the Secretary issued a FFY 1984 budget neutrality adjustment to the FFY 1984 standardized amounts of 0.969:

> Section 1886(e)(1) of the Act requires that the prospective payment system result in aggregate program reimbursement equal to "what would have been payable" under the reasonable cost provisions of prior law; that is, for fiscal years 1984 and 1985, the prospective payment system should be "budget neutral."
>
> Under the Amendments, the prospective payment rates are a blend of a hospital-specific portion and a Federal portion. Section 1886(e)(1)(A) of the Act requires that aggregate payments for the hospital specific portion should equal the comparable share of estimated reimbursement under prior law. **Similarly, section 1886(e)(1)(B) of the Act requires that aggregate reimbursement for the Federal portion of the prospective payment rates plus any adjustments and special treatment of certain classes of hospitals should equal the corresponding share of estimated outlays prior to the passage of Pub. L. 98-21**. Thus, for fiscal year 1984, 75 percent of total projected reimbursement based on the hospital-specific portion should equal 75 percent of total estimated outlays under law as in effect prior to April 20, 1983. Likewise, total estimated prospective payment system outlays deriving from the 25 percent Federal portion, including adjustments and special payment provisions, should equal 25 percent of projected reimbursement under prior laws.
>
> **The adjustment of the Federal portion was determined as follows**:

[42] *See, e.g.,* 48 Fed. Reg. 39752, 39765 (Sept. 1, 1983) (stating "We point out that aside from being technically desirable, the effect of standardizing nonlabor hospital costs in Alaska and Hawaii is to decrease the reduction for budget neutrality stemming from the requirements in section 1886(e)(1)(B) of the Act.").

> • *Step 1*—Estimate total incurred payments for inpatient hospital operating costs for fiscal year 1984 that would have been made on a reasonable cost basis under Medicare prior to Pub. L. 98-21.
>
> • *Step 2*—Multiply total incurred payments by 25 percent, i.e., the Federal portion of total payment amounts for fiscal year 1984.
>
> • *Step 3*—Estimate the Federal portion of total payments that would have been made without adjusting for budget neutrality, but with the adjustment for outlier payments.
>
> • *Step 4*—Add an estimate of total adjustments and payments under special payment provisions to the Federal portion (e.g., outliers, indirect medical education).
>
> • *Step 5*—The difference between the step 2 and step 4 amounts is divided proportionally among the standardized amounts, resulting in the budget neutrality adjusted (standardized) amounts.
>
> **The resulting adjustment factor for the fiscal year 1984 <u>Federal portion</u> is .969**. Payment amounts of hospitals excluded from the prospective payment system (e.g., psychiatric and children's hospitals) and of hospitals not participating in prospective payment because of their participation in demonstrations and studies were not included in the calculations above.[43]

In the final rule published on January 3, 1984, the Secretary revised the Federal budget neutrality adjustment factor to 0.970 using the same methodology.[44] Significantly, in the January 1984 final rule, the Secretary suggests that, in calculating the budget neutrality adjustment factor, CMS made no attempt to adjust for transfers under IPPS:

> Regarding additional adjustments recommended by commenters, we made no adjustments to either the adjusted standardized amounts or to the budget neutrality estimates for conditions that could not be quantified on the basis of currently available data, even if there were a likelihood that these conditions might exist under prospective payment. For example, no adjustment was made for the likelihood that admissions would increase more rapidly under prospective payment than under the provisions of Pub. L. 97-248, or for costs that might be disallowed as a result of audit or desk review by the intermediaries. *Likewise, we made no attempt to quantify adjustments*

[43] 48 Fed. Reg. 39752, 39840-41 (Sept. 1, 1983) (bold, underline emphases added, and italics emphasis in original).
[44] 49 Fed. Reg. 234, 334 (Jan. 3, 1984).

> ***for the likelihood of transfers*** *under prospective payment*, emergency room services, and disallowed costs which are successfully appealed.[45]

Accordingly, while the Providers did not appeal the budget neutrality adjustment, the above excerpt suggests that the Providers' concern about the Secretary's alleged mistreatment of transfers may be misplaced and that the treatment of transfers in the context of the budget neutrality adjustment for FFY 1984 may have more significance.

Finally, the Secretary also declined to increase the base standardized amount to reflect the increased costs associated with the shift in costs of hospital-based physician services from Part B to Part A, as suggested in a comment. The Secretary noted that such an increase would simply be offset or neutralized by a corresponding increase in the budget neutrality adjustment for FFY 1984:

> Finally, applying such an adjustment to the average standardized amounts (and, by extension, to the per case budget neutrality estimates of Federal rate payments) would not actually increase the level of payments under budget neutrality. If we were to increase the initial standardized amounts to reflect this shift, the budget neutrality adjustment factor would have to be recalculated, would accordingly be increased, and the net result would be virtually identical. As a result, such an adjustment would have no effect on payment levels during FYs 1984 and 1985, which are subject to budget neutrality.[46]

Regardless, the Secretary's application of a 0.970 budget neutrality adjustment factor to the FFY 1984 standardized amounts for the Federal rates confirms that these standardized rates were too high and were reduced by a factor of 0.030. Thus, the ***final*** IPPS payment rates used for the first year of IPPS (*i.e.*, FFY 1984), as published on January 3, 1984, reflect the Secretary's FFY 1984 budget neutrality adjustment. Moreover, as previously noted, since the FFY 1984 budget neutrality adjustment is based on an ***external, fixed*** reference point (*i.e.*, no greater and no less than the reference point) and is not reviewable, the FFY 1984 budget neutrality adjustment effectively ***fixed*** the standardized amounts for FFY 1984 as used from that point forward (*i.e.*, as used both for the FFY 1984 IPPS payment rates and for subsequent years). Again, it is only natural that Congress established the 1984 and 1985 budget neutrality adjustments in this manner since the initial FFY 1984 standardized amount for IPPS was initially set *using 1981 data*.

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[45] *Id.* at 255 (Emphasis added.) *See also Id.* at 331 (stating as part of the discussion on the budget neutrality adjustments: "The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) established a DRG-adjusted limit on the allowable amount of inpatient operating costs per case and a per case limit on the rate of increase of operating costs of inpatient hospital services. Due to these per case limits, the incentives that influence hospital admission patterns are similar under TEFRA and prospective payment. Accordingly, ***we have assumed that the number of admissions under both prior law and the prospective payment system will be the same***. As a result, the budget neutrality factors can be calculated by comparing reimbursement per discharge for each of the systems, and there is no need to estimate an actual number of hospital admissions." (emphasis added)).

[46] *Id.* at 255.

2. *The FFY 1985 budget neutrality adjustment also reduced the FFY 1985 standardized amounts, reaffirming that the Secretary's determined that the initial standardized amounts for FFY 1984 were set too high.*

For FFY 1985, the Secretary applied a budget neutrality adjustment of 0.954 to the standardized amounts used for the Federal national rates and 0.950 to the standardized amounts used for the regional rates. The Secretary described these adjustments as follows:

> In accordance with section 1886(e)(1) of the Act, the prospective payment system should result in aggregate program reimbursement equal to "what would have been payable" under the reasonable cost provisions of prior law; that is, for FYs 1984 and 1985, the prospective payment system must be "budget neutral".
>
> During the transition period, the prospective payment rates are a blend of a hospital-specific portion and a Federal portion. ***Further, effective October 1,1984***, *the Federal portion will be a blend of national and regional rates*. As a result, we must determine three budget neutrality adjustments— one each for both the national and regional rates, and one for the hospital-specific portions. The methodology we are using to make these adjustments is explained in detail in section V. of this addendum.
>
> Based on the data available to date, we have computed the following Federal rate budget neutrality adjustment factors:
>
> Regional—.950
> National—.954[47]
>
> ****
>
> [T]he FY 1985 adjusted average standardized amounts (Federal rates) were required by law to be adjusted to achieve budget neutrality; that is, to ensure that aggregate payments for the operating costs of inpatient hospital services would be ***neither more nor less than*** *we estimated would have been paid under prior legislation for the costs of the same services*. (The technical explanation of how this adjustment was made was published in the August 31, 1984 final rule (49 FR 34791).) These budget neutrality-adjusted rates for FY 1985 are then to be used as the basis for the determination of rates for later years.
>
> Our FY 1985 budget neutrality adjustment factors were based on data and assumptions that resulted in standardized amounts that

[47] 49 Fed. Reg. 34728, 34769 (Aug. 31, 1984).

> were higher than necessary to achieve budget neutrality. Therefore, we have updated the FY 1985 standardized amounts using a factor that takes into account the overstatement of the FY 1985 amounts to ensure that accuracy of the FY 1986 standardized amounts. To this end, we have identified several factors, discussed in section III.A.3.c., below, that contributed to the overstatement of the FY 1985 standardized amounts. We have determined an appropriate percent value for each of them, and have combined them into a proposed composite correction factor for FY 1986 that equals —7.5 percent.[48]

Thus, like her budget neutrality adjustments made for FFY 1984, the Secretary again confirmed that the standardized amounts were too high and exercised her discretion to adjust down the standardized amounts to be used in the ***final*** FFY 1985 IPPS rates.

* * * * *

In summary, the Providers claim that the Budget Neutrality Preclusion Provisions are not applicable here because they only bar administrative and judicial review of *a **narrow** category of challenges* to the Secretary's determination of the requirement, or the proportional amount, of any budget neutrality adjustment effected pursuant to 42 U.S.C. § 1395ww(e)(1) in FFYs 1984 and 1985.[49]

The Board disagrees and finds that it lacks substantive jurisdiction over the issue raised in these appeals. The standardized amounts used for IPPS rates for FFYs 1984 and FFY 1985 are each based on the budget neutrality adjustment made for that FFY and the 1984 and 1985 budget neutrality adjustments are presumably designed to be corrective of the initial base rate that was set *using 1981 data*.[50] Therefore, the *final* FFY 1984 and 1985 standardized amounts are *inextricably intertwined* with those applicable budget neutrality adjustments.[51] Indeed, the standardized

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[48] 50 Fed. Reg. 35646, 35695 (Sept. 3 1985) (emphasis added). *See also* 49 Fed. Reg. at 34767 (stating "We believe the explicit language of section 2310 of Pub. L. 98-369 and section 1886(d)(3)(A) of the Act requires a reduction in the standardized amounts used to compute the Federal rates before adjusting for budget neutrality. . . . Thus, while the Federal rates . . . . have been reduced in this final rule to reflect the inflation factor prescribed by section 2310 of Pub. L. 98-369, we point out that the offset for budget neutrality has also been adjusted. The reduction in the regional and national standardized rates . . . attributable to section 2310 of Pub. L. 98-369 is entirely due to the revised budget neutrality adjustments for 1984 and 1985.").

[49] *E.g.,* Case No. 19-1094GC *et al.*, Response to ASC Jurisdictional Challenges at 3.

[50] The Board has included at **Appendix B** examples of other adjustments to the standardized amounts that have occurred outside of the FFY 1984 and 1985 budget neutrality adjustments. These intervening adjustments for FFYs 1986 and 2018 include both mandatory and discretionary revisions ***to the standardized amounts*** (as well as the Congress' decisions to revise or not revise the "applicable percentage increases" for FFYs 1986 and forward as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i)) and highlight the complexity of the issue before the Board, particularly where such adjustments were made in a budget neutral manner or were based on factoring in certain other estimated impacts

[51] *See DCH Reg'l Med. Ctr. v. Azar*, 925 F.3d 503, 507 (D.C. Cir. 2019) ("We cannot review the Secretary's method of estimation without also reviewing the estimate. And because the two are inextricably intertwined, section 1395ww(r)(3)(A) precludes review of both."); *Mercy Hosp., Inc. v. Azar*, 891 F.3d 1062, 1067 (D.C. Cir. 2018) ("As both a textual and a practical matter, the LIP adjustment is inextricably intertwined with the step-two rate, and so the

amounts were too high for FFYs 1984 and 1985 and the budget neutrality adjustments applied to those years reduced the standardized amounts (reduced by factors of approximately 0.03 for FFY 1984 and 0.05 for FFY 1985) and, thus, these budget neutrality adjustments appear to have already automatically accounted for any such alleged errors in setting the initial base rate (which again was based on *1981 data*).[52] Because 42 U.S.C. 1395ww(d)(7) prohibits administrative or judicial review of those adjustments and the resulting *final* standardized amounts for those years were carried/flowed forward, the Board may not review the standardized amount used for the FFYs being appealed as they relate to the issue in these appeals, *i.e.*, the alleged inaccuracies in the standardized amounts used for FFY 1984 as carried/flowed forward for all years following FFY 1984 to the FFYs being appealed. In this regard, the Board notes that the Providers may not simply pass through, or over, the budget neutrality adjustments for FFYs 1984 and 1985 because those adjustments are tied to an absolute *external* event (the Secretary's estimate, based on the best available data, of what would have been paid for those years if there were no IPPS) ***and*** were ***fixed*** (no greater *and* no less than what would have been paid had there been no IPPS). To do otherwise, would impact the very integrity of IPPS.

Accordingly, the Board finds, however, that: (1) the appealed issue is *inextricably* intertwined with the FFY 1984 and 1985 budget neutrality adjustments to the standardized amounts; (2) 42 U.S.C. §§ 1395oo(g)(2) and 1395ww(d)(7) (and related implementing regulations) prohibit administrative and judicial review of those budget neutrality adjustments; and (3) thus, it does not have substantive jurisdiction over the issue in fifty-one (31) CIRP and optional group cases

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shield that protects the step-two rate from review protects the LIP adjustment as well."); *Yale New Haven Hosp. v. Becerra*, 56 F.4th 9, 18 (2nd Cir. 2022) ("Thus, we join the D.C. Circuit in "reject[ing] the argument that 'an "estimate" is not the same thing as the "data" on which it is based.'" *DCH Reg'l Med. Ctr. v. Azar* . . . . We also adopt the D.C. Circuit's holding that "[i]n this statutory scheme, a challenge to the [Secretary's choice of what data to include and exclude] for estimating uncompensated care is ... a challenge to the estimates themselves. The statute draws no distinction between the two." *Id*. at 506. Indeed, the statutory text of section 1395ww(r)(2)(C)(i) explicitly and affirmatively defines the statutory term "estimate[ ]" to encompass "the Secretary['s] determin[ation]" of what data is the "be[st] proxy for the costs of [qualifying] hospitals for treating the uninsured" and, ultimately, of what data to "use" or not "use." 42 U.S.C. § 1395ww(r)(2)(C)(i)." (citations partially omitted)). Similarly, the Board notes that the Board erred in finding that it had jurisdiction in *Columbia/HCA 1984-1986 PPS Federal Rate/Malpractice Group v. Blue Cross & Blue Shield Ass'n*, PRRB Dec. 2000-D74 (Aug. 18, 2000). In that decision, the Board found that "the issue in this case, whether the federal portion of the PPS rates should be adjusted because it was based on 1981 hospital cost report data which incorporated an invalid 1979 Malpractice Rule, does not fall into either [of the] limitations on Board jurisdiction [at 42 U.S.C. §§ 1395ww(d)(7) or 1395oo(g)(2)]. The Board finds that it can determine whether the existing statute and regulations concerning the establishment of the federal portion of the PPS rate require or permit retroactive adjustments." *Id.* at 16. The Board further found that "the retroactive adjustment proposed by the Provider would increase the federal portion of the PPS rates ***and therefore require some adjustment to be made to maintain budget neutrality***. 42 U.S.C. § 1395ww(e) and 42 C.F.R. § 412.63(j)" but that "[b]ecause the Board has determined that the adjustments are not required, how those adjustments would be made are moot, and in any event would not be subject to review by the Board. 42 C.F.R. § 405.1804(a)." *Id.* at 18 (Emphasis added.) While the Board's 2000 decision got it right that the FFY 1984 budget neutrality provision is implicated and precluded from administrative review, the above case law demonstrates that the Board erred in finding it could review the FY 1984 standardized amounts. Rather, the case law (as well as the Board's discussion herein) demonstrates that any adjustment to the FFY 1984 standardized amounts would be *inextricably* tied to the ensuing budget neutrality adjustments made for FFYs 1984 and 1985.

[52] *See supra* note 38 (discussing how the removal of nurse anesthetists costs were removed from IPPS and how that removal was *automatically* accounted for as part of the 1985 budget neutrality adjustment).

listed in **Appendix A**. Accordingly, the Board hereby closes these thirty-one (31) group cases and removes them from the Board's docket.

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

Board Members Participating:

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For the Board:

1/23/2024

X Clayton J. Nix

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

Enclosures – Appendices A & B

cc: Danelle Decker, National Government Services, Inc. (J-K)
Byron Lamprecht, WPS Government Health Administrators (J-8 and J-5)
Wilson Leong, FSS
Jacqueline Vaughn, CMS OAA

APPENDIX A
Jurisdictional Challenges and Responses; Cases at Issue

On September 8, 2023, the Medicare Contractor filed a challenge to the following three (3) cases which all share a common lead Medicare Contractor, WPS Government Health Administrators (J-8):

19-1141GC	Baystate Health FFY 2019 Standardized Amount CIRP Group
19-1350GC	Baystate Health CY 2016 IPPS Standardized Amount CIRP Group
20-0184GC	Baystate Health FFY 2017 IPPS Standardized Amount CIRP Group

On September 11, 2023, the Medicare Contractor filed a challenge to the following three (3) cases which all share a common lead Medicare Contractor, WPS Government Health Administrators (J-5):

20-0522GC	Baystate Health FFY 2020 Standardized Amount CIRP Group
21-0724GC	Baystate Health FFY 2021 2021 Standardized Amount CIRP Group
23-0522GC	Baystate Health FFY 2023 Incorrect Standardized Amount CIRP Group

On September 18, 2023, the Medicare Contractor filed a challenge to the following twenty-five (25) cases which all share a common lead Medicare Contractor, National Government Services, Inc. (J-K):

19-1094GC	Lifespan FFY 2019 Incorrect Standardized Amount CIRP Group
19-1098GC	Wellforce FFY 2019 Standardized Amount CIRP Group
19-1110GC	Partners FFY 2019 Standardized Amount CIRP Group
19-1339GC	Partners CY 2015 2015 IPPS Standardized Amount CIRP Group
19-1405GC	Wellforce CY 2015 IPPS Standardized Amount CIRP Group
19-1993G	Verrill Dana FFY 2014 Verrill Dana Standardized Amount Group
19-2010G	Verrill Dana FFY 2013 Standardized Amount 2013 Group
19-2037GC	Partners CY 2016 Standardized Amount CIRP Group
20-0328GC	Wellforce FFY 2020 Incorrect Standardized Amount CIRP Group
20-0388GC	Lifespan FFY 2020 Incorrect Standardized Amount CIRP Group
20-0542GC	Partners FFY 2020 Standardized Amount CIRP Group
20-1701GC	Lifespan FFY 2015 Incorrect Standardized Amount CIRP Group
20-1877G	Verrill Dana FFY 2015-2017 Incorrect Standardized Amount Group
20-2080GC	Lifespan FFY 2017 Incorrect Standardized Amount CIRP Group
21-0096GC	Wellforce FFY 2021 Incorrect Standardized Amount CIRP Group
21-0163GC	Partners FFY 2021 Incorrect Standardized Amount CIRP Group
21-0294G	Verrill Dana FFY 2021 Incorrect 2021 Standardized Amount Group
21-0353GC	Lifespan FFY 2021 Incorrect Standardized Amount CIRP Group
21-1437GC	Lifespan FFY 2018 Incorrect Standardized Amount CIRP Group
21-1736GC	Partners FFY 2018 Incorrect Standardized Amount CIRP Group
21-1787GC	Wellforce FFY 2018 Incorrect Standardized Amount CIRP Group

21-1797GC	Wellforce FFY 2022 Incorrect Standardized Amount CIRP Group
22-0246GC	Partners FFY 2022 Incorrect Standardized Amount CIRP Group
22-0320GC	Lifespan FFY 2022 Incorrect Standardized Amount CIRP Group
23-0439GC	Wellforce FFY 2023 Incorrect Standardized Amount CIRP Group

APPENDIX B

The following are examples of other adjustments to the standardized amounts that have occurred outside of the FFY 1984 and 1985 budget neutrality adjustments and the "applicable percentage increases" for FFYs 1986 and forward as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i):

a. "Restandardization of base year costs per case used in [the] calculation of Federal rates" for both the labor and non-labor portions to reflect the survey-based wage index as discussed in the FY 1986 IPP Final Rule. 50 Fed. Reg. 35646, 35692 (Sept. 3, 1985).

b. Recalibration of DRG weights done in a budget neutral manner pursuant to 42 U.S.C. § 1395ww(d)(4)(C) at least every 4 years beginning with 1986.[53] An example of recalibration can be found in the FY 1986 IPPS Final Rule wherein the Secretary changed its methodology for calculating the DRG relative weights.[54]

c. Budget neutrality adjustments made to the standardized amount designated for urban hospitals and the one designated for rural hospitals when certain urban hospitals were deemed to be

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[53] The Secretary confirmed that, beginning in 1991, these adjustments are to be made in a budget neutral manner:

> Section 1886(d)(4)(C)(iii) of the Act requires that beginning with FY 1991, reclassification and recalibration changes be made in a manner that assures that the aggregate payments are neither greater than nor less than the aggregate payments that would have been made without the changes. Although normalization is intended to achieve this effect, equating the average case weight after recalibration to the average case weight before recalibration does not necessarily achieve budget neutrality with respect to aggregate payments to hospitals because payment to hospitals is affected by factors other than average case weight. Therefore, as discussed in section II.A.4.b. of the Addendum to this final rule, we are making a budget neutrality adjustment to implement the requirement of section 1886(d)(4)(C)(iii) of the Act.

59 Fed. Reg. 45330, 45348 (Sept. 1, 1994).

[54] 50 Fed. Reg. 35646, 35652 (Sept. 3, 1985). As part of this recalibration process, the Secretary responded to a comment on the use of transfers in the recalibration process as follows:

> *Comment:* A commenter was concerned that, by including transfer cases in the calculation of the relative weights, we might be inappropriately reducing the relative weights of DRGs in which there are significant proportions of transfer cases.
>
> *Response:* This commenter assumes that the charges for transfer cases are lower than charges for the average case in a DRG. Our data show that this assumption is not correct for many DRGs. To test the effect of including transfers in the calculation of the relative weights, we computed mean charges for each DRG, both with and without the transfer cases. We then conducted statistical tests to determine whether these two means differed significantly at the .05 confidence level (that is, there is only a .05 probability that the observed difference in the means would occur if the two sets of cases came from the same underlying population). The results indicate that transfers have a statistically significant effect on the mean charges of only 16 DRGs. For 13 of the 16 DRGs, inclusion of transfer cases tends to ***increase*** the mean charges. However, for three DRGs, the mean charges are reduced by the inclusion of the transfer cases.
>
> Since the inclusion of transfer cases raises the mean charges for some DRGs and lowers them for others, and because these effects are limited to such a small number of DRGs, we decided not to revise the method we used to recalibrate the relative weights. During FY 1986, we will be studying the entire issue of transfers and the appropriate payment for these cases. This study may reveal other ways of handling transfer cases in future recalibrations.

Id. at 35655-56.

urban effective with discharges occurring on or after October 1, 1988. 53 Fed. Reg. 38476, 38499-500, 38539 (Sept. 30, 1988) (implementing OBRA 87, Pub. L. 100-203, § 4005).[55]

d. Effective for FFY 1995, eliminating the initial two standardized amounts (one for urban hospital and another for rural hospitals)[56] and replacing them with one single standardized amount as specified at 42 C.F.R. § 1395ww(d)(3)(C)(iii).[57]

e. Budget neutrality provision at 42 U.S.C. § 1395ww(d)(3)(A)(vi) that allows Secretary to adjust standardized amount to eliminate the effect of "changes in coding or classification of discharges that do not reflect real changes in case mix."

f. The discretion of the Secretary in 42 U.S.C. § 1395ww(d)(3)(I)(i) to "provide by regulation for such other exceptions and adjustments to such payments amounts under this subsection as the Secretary deems appropriate."

g. The subsequent amendments that Congress made in 1994[58] and 1997[59] to add subparagraphs (I) and (J) to 42 U.S.C. § 1395ww(d)(5) to recognize and incorporate the concept of transfers into IPPS *in a budget neutral manner*. The Secretary made adjustments to the standardized amounts in order to implement the permanent incorporation of transfers into IPPS.[60]

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[55] *See also* 56 Fed. Reg. 43358, 43373 (Aug. 30, 1991) (stating "Consistent with the prospective payment system for operating costs, the September 1, 1987 capital final rule provided for separate standardized amounts for hospitals located in urban and rural areas. Subsequently, the Omnibus Budget Reconciliation Act of 1987 (Pub. L. 100-203) provided for a higher update factor for hospitals located in large urban areas than in other urban areas and thereby established three standardized amounts under the prospective payment system for operating costs. Large urban areas are defined as those metropolitan statistical areas (MSAs) with a population of more than 1 million (or New England County metropolitan statistical areas (NECMAs) with a population of more than 970,000). Beginning with discharges on or after April 1,1988 and continuing to F Y 1995, the Congress has also established higher update factors for rural hospitals than for urban hospitals. The differential updates have had the effect of substantially reducing the differential between the rural and other urban standardized amounts. Section 4002(c) of Public Law 101-508 provides for the elimination of the separate standardized amounts for rural and other urban hospitals in FY 1995 by equating the rural standardized amount to the other urban standardized amount. The separate standardized amount for large urban hospitals would continue. Currently, the large urban standardized amount under the prospective payment system for operating costs is 1.6 percent higher than the standardized amount for hospitals located in other urban areas.").

[56] *See* 42 U.S.C. §§ 1395ww(d)(2)(D), 1395ww(d)(3)(A); *supra* note 16.

[57] Omnibus Reconciliation Act of 1990, Pub. L. 101-508, § 4002(c), 104 Stat. 1388, 1388-33 – 1388-35 (1990).

[58] Social Security Act Amendments of 1994, § 109, Pub. L. 103-432, 108 Stat. 4398, 4408 (1994) placed the then-existing language of 42 U.S.C. § 1395ww(d)(5)(I) into clause (i) and added the following clause (ii): "(ii) In making adjustments under clause (i) for transfer cases (as defined by the Secretary) in a fiscal year, the Secretary may make adjustments to each of the average standardized amounts determined under paragraph (3) to assure that the aggregate payments made under this subsection for such fiscal year are not greater than or lesser than those that would have otherwise been made in such fiscal year."

[59] Balanced Budget Act of 1997, Pub. L. 105-33, § 4407, 111 Stat. 251, 401 (1997), further revised 42 U.S.C. § 1395ww(d)(5)(I) and added § 1395ww(d)(5)(J).

[60] *See* 60 Fed. Reg. 45778, 45854 (Sept. 1, 1995) ("[W]e are revising our payment methodology for transfer cases, so that we will pay double the per diem amount for the first day of a transfer case, and the per diem amount for each day after the first, up to the full DRG amount. For the data that we analyzed, this would result in additional payments for transfer cases of $159 million. *To implement this change in a budget neutral manner*, we adjusted the standardized amounts by applying a budget neutrality adjustment of 0.997583 in the proposed rule.").

To illustrate the complex nature of these issues, Board points to the Secretary's exercise of her discretion under 42 U.S.C. § 1395ww(d)(3)(I)(i) on making recommendations to Congress on whether to make adjustments to the "applicable percentage increases" or update factor for FFY 1986 as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i). In the September 1985 Final Rule,[61] the Secretary asserted that the FFY 1985 Federal rates were "overstated" and cited to the GAO's 1985 report entitled "Report to the Congress of the United States: Use of Unaudited Hospital Cost Data Resulted in Overstatement of Medicare Prospective Payment System Rates" and, pursuant to 42 U.S.C. § 1395ww(e)(4), made a recommendation to Congress that it not provide any increase to FFY 1985 standardized amounts but rather freeze the FFY 1986 amounts at the FFY 1985 levels (*i.e.*, recommended an update factor of 0 percent for FFY 1986).[62] The following excerpts from that rulemaking describe how the Secretary determined that the FFY 1985 standardized amounts were overstated when reviewing whether to recommend that Congress adjust the update factor for the FFY 1986 standardized amounts:

> Since the standardized amounts for FY 1985 are used as the basis for the determination of rates for later years, the level of the FY 1985 standardized amounts must be corrected for any experience that developed since they were published. *We believe that it is necessary, **each year**, to review the appropriateness of the level of the previous year's prospective payment rates for providing reasonable payment for inpatient hospital services furnished to beneficiaries*. Further, we think this review must include assessment of whether the previous year's prospective payment rates have established adequate incentives for the efficient and effective delivery of needed care.
>
> In addition to this general consideration, *the FY 1985 adjusted average standardized amounts* (***Federal rates***) *were required by law **to be adjusted to achieve budget neutrality***; that is, to ensure that aggregate payments for the operating costs of inpatient hospital services would be *neither more **nor** less than* we estimated would have been paid under prior legislation for the costs of the same services. (The technical explanation of how this adjustment was made was published in the August 31, 1984 final rule (49 FR 34791).) *These budget neutrality-adjusted rates for FY 1985 are then to be used as the basis for the determination of rates for later years*.
>
> *Our FY 1985 budget neutrality adjustment factors were based on data and assumptions that resulted in standardized amounts that were **higher** than necessary to achieve budget neutrality*. Therefore, *we have updated the FY 1985 standardized amounts using a factor that takes into account the **overstatement** of the FY 1985 amounts to*

[61] 50 Fed. Reg. 35646, 35704 (Sept. 3, 1985).
[62] U.S. Gov't Accountability Office, GAO/HRD-85-74, Use of Unaudited Hospital Cost Data Resulted in Overstatement of Medicare's Prospective Payment System Rates (1985).

ensure that accuracy of the FY 1986 standardized amounts. To this end, we have identified several factors, ***discussed in section II.A.3.c.***, below, that contributed to the overstatement of the FY 1985 standardized amounts. *We have determined an appropriate percent value for each of them, and have combined them into* ***a proposed composite correction factor*** *for FY 1986 that equals –7.5 percent*.

In addition, we have developed factors representing productivity, technological advances, and the elimination of ineffective practice patterns, which are necessary to ensure the cost-effective delivery of care. Each of these factors interacts with the others, to some extent, and has an impact on the quality of care. Making conservative assumptions, we have determined an appropriate percent value for each of these factors, taking into consideration their potential effect on quality. **We have combined these values into a composite policy target adjustment factor**, **as discussed in section III.3.e., below**. For FY 1986, this factor equals —1.5 percent.

The Secretary is required under section 1886(e)(4) of the Act to make those adjustments in establishing the update factor that are ". . . necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality." *Establishing FY 1986 prospective payment rates based on FY 1985 rates* ***that have been demonstrated to be overstated****, clearly would not comport with the statutory requirement that the rates represent payment for efficiently delivered care*.

Since the forecasted hospital market basket increase for FY 1986 is +4.27 percent, and the adjustment for Part B costs and FICA taxes is +.31 percent, it is clear that there is a potential justification of a –4.42 percent decrease in the FY 1986 standardized amounts as compared to those for FY 1985 as described below:

	Percent
Forecasted market basket increase..	+4.27
Part B costs and FICA taxes.....	+.31
Composite correction factor.....	–7.5
Composite policy target adjustment factor.....	–1.5

However, for the reasons discussed in section II.A.3.f., below, we have decided that such a decrease is undesirable. Therefore, we are

maintaining the FY 1986 standardized amounts at the same average level as FY 1985, in effect applying a zero percent update factor.[63]

****

(3) *Additional causes for the overstatement of FY 1985 Federal rates.* In addition to the factors above, which we believe we must correct, **other considerations also contributed significantly to the overstatement of the FY 1985 standardized amounts**.

When we set the standardized amounts for FY 1985, we made assumptions on hospital cost per case increases in order to estimate, for purposes of budget neutrality, the payments that would have been made had prior payment rules continued in effect. These assumed rates of increase in cost per case were 10.9 percent for 1983, 9.8 percent for 1984, and 9.8 percent for 1985. These assumptions were significantly higher than the actuarial estimates. The actuarially estimated rates of increase in cost per case (which ignore any effects of the prospective payment system such as shorter lengths of stay) are 9.8 percent for 1983, 8.1 percent for 1984, and 8.5 percent for 1985. After application of the revised market basket, discussed previously, use of these actuarial estimates would reduce the standardized amounts by an additional 1.2 percent.

For FY 1985, we also used 1981 unaudited, as-submitted cost reports (to get recent data as quickly as possible) to set the Federal rates. The hospital specific rates were set using later (1982 or 1983) cost reports that were fully audited. The audits adjusted the total cost for these reports downward by $2.2 billion, of which Medicare realized about $900 million in inpatient recoveries. **Since the cost data used to set the Federal rates do not reflect audit recoveries, it is likely that they are overstated by a similar amount**. We do not know precisely what proportion of this amount applies to capital-related costs and other costs that would not affect the Federal rates. However, approximately 90 percent of hospitals" total inpatient costs are operating costs, and if only 40 percent of the $900 million in audit recoveries is related to Federal payments for inpatient operating costs, there would have been, conservatively estimated, at least a one percent overstatement of allowable costs incorporated into the cost data to determine the FY 1985 standardized amounts.

[63] 50 Fed. Reg. at 35695 (bold, italics, and underline emphasis added).

> In addition, the General Accounting Office (GAO) recently conducted a study to evaluate the adequacy of the Standardized amounts. In its report to Congress dated July 18, 1985 (GAO/HRD-85-74), **GAO reported findings that the standardized amounts, as originally calculated, are overstated by as much as 4.3 percent because they were based on unaudited cost data and include elements of capital costs.** GAO recommended that the rates be adjusted accordingly.
>
> We believe that these causes for the overstatement of the standardized amounts are related to our own procedures and decisions. Thus, they are unlike both the market basket index, which is a technical measure of input prices, and the increases in case-mix, which would not have been passed through beyond the extent to which they affected the estimates of cost per case. Further, as discussed below, even without making these corrections, we could justify a negative update factor for FY 1986, although we are not establishing one. **Since we have decided to set FY 1986 standardized amounts at the same level as those for FY 1985, making corrections now to reflect the cost per case assumptions and the audit data would have no practical effect. Therefore, we have decided <u>at this time not</u> to correct the standardized amounts for these factors.**
>
> We received no comments on this issue.
>
> (4) ***Composite Correction Factor.*** We are adjusting the standardized amounts as follows to take into consideration the overstatement of the prior years, amounts:
>
> | | *Percent* |
> |---|---|
> | Case mix..... ..... | –6.3 |
> | Market basket..... | –1.2 |
> | Composite correction factor..... | –7.5[64] |

Congress did immediately act on the Secretary's September 3, 1985 recommendation because, shortly thereafter on September 30, 1985, it enacted § 5(a) of the Emergency Extension Act of 1985 ("EEA-85") to maintain existing IPPS payment rates for FFY 1986 at the FFY 1985 Rates (*i.e.*, provide a 0 percent update factor) until November 14, 1985 as specified in EEA-85 § 5(c).[65] Congress subsequently modified this freeze on several different occasions as explained in the interim final rule published on May 6, 1986:

---

[64] *Id.* at 35703-04 (bold and underline emphasis added).

[65] Pub. L. 99-107, § 5(a), 99 Stat. 479, 479 (1985). In July 1984, Congress had *already* reduced the 1 percent update factor planned for FFY 1986 to ¼ of a percentage point. Deficit Reduction Act of 1984, Pub. L. 98-369, § 2310(a), 98 Stat. 494, 1075 (1984). As part of the Emergency Extension Act of 1985, Congress further reduced the update factor for FFY 1986, presumably in response to the Secretary's recommendation.

> - Pub. L. 99-155, enacted December 14, 1985, extended the [EEA-85] delay through December 14, 1985.
>
> - Pub. L. 99-181, enacted December 13, 1985, extended the [EEA-85] delay through December 18, 1985.
>
> - Pub. L. 99-189, enacted December 18, 1985, extended the [EEA-85] delay through December 19, 1985.
>
> - Pub. L. 99-201 enacted December 23, 1985, extended the [EEA-85] delay through March 14, 1986.[66]

Second, on April 7, 1986, Congress further revised EEA-85 § 5(c) by extending the 0 percent update factor through April 30, 1986 and then specified that, for discharges on or after May 1, 1986, the update factor would be ½ of a percentage point.[67]

The examples highlight concerns about how certain future actions and decisions by the Secretary and Congress build upon prior decisions. Here, the Secretary's recommendation to Congress regard the FFY 1986 update factor were based on its analysis of the FFY 1984 and 1985 standardized amounts that had already been adjusted for budget neutrality. To the extent the 1984 standardized amounts had been *further* adjusted (*as **now** proposed by the Providers*), it could have potentially impacted the Secretary's recommendation to Congress for the FFY 1986 update factor as well as Congress' subsequent revisions to the updated factor. Accordingly, this highlights how revisiting and otherwise adjusting the FY 1984 standardized amounts can have ripple effects with the update factor and other adjustments that were made for subsequent years *based on analysis of the prior year(s) and other information*.

[66] 51 Fed. Reg. 16772, 16772 (May 6, 1986).
[67] *See id.* at 16773. *See also* Medicare and Medicaid Budget Reconciliation Amendments of 1985, Pub. L. 99-272, § 9101(a), 100 Stat. 151, 153 (1986).

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Jeffrey Haeffner
Northwell Health
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Westbury, NY 11590

RE: ***Dismissal for Untimely Filing Pursuant to Board Rules 20 and 20.1***

Northwell Health CY 2014 DSH SSI/Medicaid Medicare Part C Days CIRP Group
Case Number: 19-0187GC

Dear Mr. Haeffner:

The Provider Reimbursement Review Board (the "Board") has reviewed the subject common issue related party ("CIRP") group appeal in response to a November 30, 2023 "Rule 22 Jurisdictional Review" letter filed by the Medicare Contractor and the Board's subsequent December 15, 2023 Scheduling Order Rule 20 Certification." A brief history of the facts and the Board's determination are set forth below.

Pertinent Facts:

On April 2, 2020, Northwell Health ("Group Representative") designated the CIRP group to be fully formed.[1] The Board notes that the full formation date was prior to the implementation of Board Rule 20 and 20.1, which became effective November 1, 2021.

On November 7, 2022, the Board issued Alert 23 in which it advised the Parties that it was resuming normal operations. The Alert also reminded parties about the Rule 20/20.1 requirements in group appeals.

On May 12, 2023, the Board issued a Critical Due Dates ("CDD") notice in Case No. 19-0187GC, which advised that the Board was resuming its normal operations and was establishing new deadlines for those that were previously suspended. The CDD set the Parties' preliminary position paper due dates and reminded that "[t]he parties are responsible for pursuing the appeal in accordance with the Board's Rules." In accordance with those rules, a PDF copy of the Schedule of Provider ("SoP") with Support or a Rule 20 Certification should have been filed within 60 days of the CDD.

[1] The Board notes that the full formation date was prior to the implementation of Board Rule 20 and 20.1, which became effective November 1, 2021.

On September 28, 2023, Northwell Health filed a preliminary position paper which included exhibits with jurisdictional support for the group participants. The Board notes that the list of participants was not filed in the proper format (i.e., Model Form G), nor was the jurisdictional support submitted pursuant to the direction provided in the Board Rules.

On November 30, 2023, the Medicare Contractor filed its "Rule 22 Jurisdictional Review" and advised that the Group failed to file its Rule 20 certification or a SoP with support by the deadline. The Medicare Contractor indicated that it had reviewed the documentation & support in OH CDMS and found that some of the information related to an earlier consolidation of Case No. 19-0188GC was not included in the record. Therefore, the Medicare Contractor advised that it was unable to determine whether there are any jurisdictional impediments.

On December 15, 2023, the Board issued a Scheduling Order in which it directed the Group to file its Rule 20 Certification or a PDF copy of the SoP **with support** in accordance with Board Rule 20.1. Northwell Health was directed to use "other case correspondence" to upload its response by December 28, 2023. The Board also noted that, although jurisdictional documentation may have been previously submitted as exhibits to its preliminary position paper, Rule 20 Certifications and/or Rule 20.1 submissions must be stand-alone filings and never part of another filing (e.g., never embedded within a preliminary position paper filing, group status response, etc.).

On December 28, 2023, Northwell Health filed a SoP **without** the required supporting documentation. Again, the SoP was not filed in the correct format.

As set forth below, Northwell Health has failed to meet the requirements of Rules 20 and 20.1. Below is a discussion regarding Rule 20 and Rule 20.1 requirements and the information that was required in this case.

Rule 20/20.1 Background:

Rule 20 addresses the population of Issues/Providers in OH CDMS. Pursuant to Board Rule 20:

> If ***all*** the participants in a fully-formed group are ***populated*** under the Issues/Providers Tab in OH CDMS with supporting jurisdictional documentation (*see* Rule 21), then the representative is exempt from filing a ***hard copy*** of the schedule of providers with supporting jurisdictional documentation. In this instance, the Board uses the schedule of providers and supporting jurisdictional documentation that is created in OH CDMS using the information and documents included in each participating provider's request for transfer or direct add to the group.
>
> ***Prior to*** certifying that the group is fully formed or the date on which a group is fully formed, the group representative should review each participating provider's supporting jurisdictional

> documentation to ensure it is complete and, if not, file any additional documentation in OH CDMS.[2] If *all* of the participants in a fully-formed group are ***populated*** under the Issues/Providers Tab in OH CDMS, then ***within (60) sixty days of the full formation of the group***, the group representative must file a statement certifying that the group is *fully* populated in OH CDMS with the relevant supporting jurisdictional documentation (*i.e.*, all participants in the group are shown under the Issues/Providers Tab for the group in OH CDMS with the relevant supporting jurisdictional documentation).[3]

Board Rule 20.1 applies to **"Group Cases that Are Not Fully Populated in OH CDMS."** Pursuant to Board Rule 20.1:

> If any participants in a fully-formed group are ***not*** populated under the Issues/Providers Tab in OH CDMS with supporting jurisdictional documentation (*see* Rule 21), then the Representative must prepare a traditional schedule of providers (*i.e.* Model Form G at Appendix G), for *all* participants in the group **following the instructions in this Rule and Rule 21, unless the Board instructs otherwise.** Specifically, *within sixty (60) days of the full formation of the group* (see Rule 19), the group representative must prepare and file a schedule of providers with the supporting jurisdictional documentation for all providers in the group that demonstrates that the Board has jurisdiction over each participant named in the group appeal (*see* Rule 21) . . . .

Upon review, the Board notes that there are nine providers included in the listing Northwell Health submitted on December 28, 2023, and those providers appear to be populated behind the Participants tab in Case No. 19-0187GC. Therefore, it appears that Rule 20 would apply in this group, although, pursuant to the Medicare Contractor's Rule 22 Jurisdictional Review, documentation is missing. Consequently, the Representative should have filed its Rule 20 Certification and the Group Supplements for the missing documentation by the December 28, 2023 deadline set forth in the Board's December 15, 2023 Scheduling Order.[4]

---

[2] If all participants are populated but jurisdictional support is not complete, the Rule 20 Certification must certify that all participants are populated, but should include an identification of the documents that are missing and then ***only*** file in OH CDMS those additional missing documents. See, https://www.cms.gov/files/document/oh-cdms-prrb-user-manual-supplement-supplemental-document-uploads-individual-appeals.pdf.

[3] (Underline emphasis added.)

[4] Rule 20/20.1 Certifications must be stand-alone filings and never part of another filing *(e.g., never embedded within a preliminary position paper filing, group status response, etc.).*

Board Determination:

Pursuant to 42 C.F.R. § 405.1868:

> (a) The Board has full power and authority to make rules and establish procedures, not inconsistent with the law, regulations, and CMS Rulings, that are necessary or appropriate to carry out the provisions of section 1878 of the Act and of the regulations in this subpart. *The Board's powers include the authority to take appropriate actions in response to the* ***failure of a party*** *to a Board appeal* ***to comply with Board*** rules and ***orders*** or for inappropriate conduct during proceedings in the appeal.
>
> (b) *If a provider fails to meet a filing deadline or other requirement established by the Board in a rule or order, the Board may—*
>
> *(1) Dismiss the appeal with prejudice***;**
>
> (2) Issue an order requiring the provider to show cause why the Board should not dismiss the appeal; or
>
> (3) Take any other remedial action it considers appropriate.[5]

Because the Rule 20 Certification and Supplemental documentation was not timely filed, the Board hereby dismisses the subject group appeal pursuant to its authority under 42 C.F.R. § 405.1868. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

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

For the Board:

1/24/2024

X Kevin D. Smith, CPA

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

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services
Danelle Decker, National Government Services, Inc. (J-K)

[5] Italics and bold emphasis added.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

James Ravindran
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RE: ***Board Decision* – DSH Payment/SSI Percentage (Provider Specific)**
L.V. Stabler Memorial Hospital (Provider Number 01-0150)
FYE 1/31/2016
Case Number: 19-0238

Dear Mr. Ravindran and Mr. Lamprecht,

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

Background:

A. *Procedural History for Case No. 19-0238*

On April 23, 2018, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end January 31, 2016.

On October 19, 2018, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained six (6) issues:

1. DSH Payment/SSI Percentage (Provider Specific)
2. DSH/SSI Percentage (Systemic Errors)[1]
3. DSH Payment – Medicaid Eligible Days[2]
4. Uncompensated Care ("UCC") Distribution Pool[3]
5. 2 Midnight Census IPPS Payment Reduction[4]
6. Standardized Payment Amount[5]

As the Provider is owned by Quorum Health and, thereby, subject to the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1), the Provider transferred Issues 2 and 5 to Quorum

[1] On May 30, 2019, this issue was transferred to PRRB Case No. 19-1503GC.
[2] This issue was withdrawn on Jan. 19, 2024.
[3] This issue was withdrawn on Aug. 21, 2023.
[4] On May 30, 2019, this issue was transferred to PRRB Case No. 19-1504GC.
[5] This issue was withdrawn on June 7, 2019.

Health CIRP groups on May 30, 2019. After the withdrawal of Issues 3, 4, and 6 the remaining issue in this appeal is Issue 1.

On November 16, 2023, the Provider filed its final position paper.

On December 12, 2023, the Medicare Contractor filed a jurisdictional challenge, requesting the dismissal of Issue 1.[6]

On December 15, 2023, the Medicare Contractor filed its final position paper.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 19-1503GC

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

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

As the Provider is commonly owned by Quorum Health, the Provider transferred its Issue 2 – DSH/SSI Percentage to the CIRP group under 19-1503GC, Quorum Health CY 2010 & CY 2016 DSH SSI Percentage CIRP Group, on May 30, 2019. The Group Issue Statement in Case No. 19-1503GC reads:

> **Statement of the Issue:**
>
> Whether the Secretary properly calculated the Provider's [DSH]/[SSI] percentage, and whether CMS should be required to recalculate the SSI percentages using a denominator based solely upon covered and paid for Medicare Part A days, or alternatively, expand the numerator of the SSI percentage to include paid/covered/entitled as well as unpaid/non-covered/eligible SSI days?

[6] The Jurisdictional Challenge also challenged jurisdiction over Issue 3, which was subsequently withdrawn.
[7] Issue Statement at 1 (Oct. 19, 2018).

Statement of the Legal Basis

The Provider(s) contend(s) that the MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). The Provider(s) further contend(s) that the SSI percentages calculated by [CMS] and used by the MAC to settle their Cost Reports incorporates a new methodology inconsistent with the Medicare statute.

The Providers challenge their SSI percentages based on the following reasons:

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

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $5,000.

On November 16, 2023, the Provider filed its final position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

Provider Specific

The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation.

The Provider is seeking a *full and complete* set of the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. *See* 65 Fed. Reg. 50,548 (2000). Although some MEDPAR data is now routinely made available to the provider community, what is provided lacks all data records necessary to fully identify all patients properly includable in the

[8] Group Issue Statement, Case No. 19-1503GC.

> SSI fraction. The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction. The hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra (Appellants' reply brief included as Exhibit P-3).[9]

MAC's Contentions

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

The MAC argues that the Board lacks jurisdiction over the DSH Payment/SSI Percentage (Provider Specific) issue for three reasons. First, the MAC argues that the SSI realignment portion of the issue has been abandoned by the Provider:

> The MAC contends that the Provider has abandoned the issue of SSI realignment and, therefore, it should be considered withdrawn. The Provider did not brief this issue within its final position paper PRRB Rule 25.3 addresses issues that are not briefed in a provider's position paper. In relevant part, this rule states:
>
> > Any issue appealed, but not briefed by the Provider in its position paper will be considered withdrawn.[10]

Failing that, the MAC argues the realignment sub-issue is premature:

> The decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election. It is not a final contractor determination. A hospital must make a formal request to CMS in order to receive a realigned SSI percentage. Once the hospital elects to use its own fiscal year, it is bound by that decision, regardless of reimbursement impact.
>
> . . .
>
> The Provider's appeal is premature. The MAC requests that the Board dismiss this issue consistent with recent jurisdictional decisions.[11]

---

[9] Provider's Final Position Paper at 10-11 (Nov. 16, 2023).
[10] Jurisdictional Challenge at 7 (Dec. 12, 2023).
[11] *Id*.

In addition, the MAC argues that the DSH – SSI Percentage (Provider Specific) issue and the DSH – SSI Percentage (Systemic Errors) issue are considered the same issue by the Board.[12]

Finally, the MAC argues "the Provider did not file **complete** preliminary or final position papers in accordance with 42 C.F.R. § 405.1853 and Board Rules 25.2, 25.3 and 27.2"[13] The MAC posits that the Provider "failed to sufficiently develop and set forth the relevant facts and arguments regarding the merits of its claim in its Preliminary Position Paper."[14] In more detail:

> Within its Provider's Final Position Paper, the Provider makes the broad allegation that:
>
> > its SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation.
>
> Yet, the Provider offers no evidence or analysis to demonstrate that CMS calculated its SSI percentage inaccurately. The Providers failed to include any evidence to establish the material facts in this case relating to inaccuracies in the SSI Percentage calculation at issue or any evidence pertaining to the alleged systemic SSI ratio data match errors like those referenced in the *Baystate* case. The Provider merely repeats their appeal request which itself is a verbatim recitation of the deficiencies that the Board found in the *Baystate* case.[15]

Provider's Jurisdictional Response

The Board Rules require that Provider Responses to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[16] The Provider has not filed a response to the Jurisdictional Challenge and the time for doing so has elapsed. Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

Analysis and Recommendation

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2018), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if

[12] *Id*. at 4-6.
[13] *Id*. at 8.
[14] *Id*. at 9.
[15] *Id*. at 9-10.
[16] Board Rule 44.3, v. 2.0 (Aug. 2018).

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 jurisdictional analysis for Issue 1 has two relevant aspects to consider: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, and 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period. As set forth below, the Board should dismiss both aspects of Issue 1.

1. First Aspect of Issue 1

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH/SSI (Systemic Errors) issue that was appealed in PRRB Case No. 19-1503GC.

The DSH Payment/SSI Percentage (Provider Specific) issue in the present appeal concerns "whether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation."[17] The Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[18] The Provider argues that "its' SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[19]

The Provider's DSH/SSI (Systemic Errors) issue in group Case No. 19-1503GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage and the DSH SSI Percentage is improper due to a number of factors. Thus, the Board finds the DSH Payment/SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 19-1503GC.

In making this finding, the Board further notes that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, the Provider is pursuing that issue as part of the group under Case No. 19-1503GC, which is required since it is subject to the CIRP group regulations under 42 C.F.R. § 405.1837(b)(1). Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[20]

---

[17] Issue Statement at 1.
[18] *Id.*
[19] *Id.*
[20] The types of systemic errors documented in the *Baystate* did not uniformly impact the SSI calculation for all providers but that does not make the errors any less systemic. *See Baystate Medical Ctr. v. Mutual of Omaha Ins.*

The Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 19-1503GC.

To this end, the Board also reviewed the Provider's Final Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 19-1503GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider's Final Position Paper failed to comply with the Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" in its Final Position Paper and include *all* exhibits.

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

> **25.2.2 Unavailable and Omitted Documents**
>
> *If documents necessary to support your position are still unavailable,* identify the missing documents, explain why the documents remain unavailable, state the efforts made to obtain the documents, and explain when the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.[21]

The Board further notes that the Provider only cites to the 2000 Federal Register but additional issuances and developments on the availability of data underlying the SSI fraction, such MEDPAR data, have occurred. For example, as noted in the FY 2006 IPPS Final Rule, "[b]eginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108–173), we will arrange to furnish, consistent with the Privacy Act, MedPAR LDS data for a hospital's patients eligible for both SSI and Medicare at the hospital's request, regardless of whether there is a properly pending appeal relating to DSH payments. *We will make the information available for either the Federal fiscal year or, if the hospital's fiscal year differs from the Federal fiscal year, for the* ***months included in the 2 Federal fiscal years that encompass the hospital's cost reporting period***. Under this provision, *the hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather*

Co., PRRB Dec. No. 2006-D20 (Mar. 17, 2006). *See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).

[21] (Emphasis added).

than a Federal fiscal year. The data set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year." Further highlighting the perfunctory nature of the briefing is the fact that providers *can* obtain certain data used to calculate their DSH SSI ratios directly from the Centers for Medicare and Medicaid Services ("CMS") and in some cases on a self-service basis as explained on the following webpage:

> https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH.[22]

This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows:

> "DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[23]

Accordingly, the Board finds that the remaining issue in the instant appeal and the group issue from Group Case 19-1503GC are the same issue.[24] Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6,[25] the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

Additionally, in its Final Position Paper, the Provider stated, "The [Provider] hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra (Appellants' reply brief included as Exhibit P-3)."[26] The Board finds that this purported argument does not comply with the regulations and Board rules to *fully* develop the Provider's position in the Final Position Paper because the Provider merely lists a case name and does not explain further what the arguments are that it would like to incorporate into its appeal.

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

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.[27]

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[22] Last accessed January 24, 2024.
[23] Emphasis added.
[24] Moreover, even if it were not a prohibited duplicate, it was not properly in the individual appeal because it is a common issue that would be required to be in a Community Health CIRP group per 42 C.F.R. § 405.1837(b)(1).
[25] PRRB Rules v. 2.0.
[26] Provider's Final Position Paper at 10-11.
[27] (Emphasis added).

Therefore, the Board finds that the Provider did not comply with the Final Position Paper regulations and Board rules with respect to the purported *Advocate Christ* argument and dismisses that portion of the issue.

2. Second Aspect of Issue 1

The Board finds the second aspect of the DSH Payment/SSI Percentage (Provider Specific) issue was abandoned by the Provider. Board Rule 25.3 reads, in pertinent part:

> Any issue appealed, but not briefed by the Provider in its position paper will be considered withdrawn.

The Board finds that the realignment portion of the DSH Payment/SSI Percentage issue was not briefed in the final position paper and is therefore, abandoned.

The Board also notes that the realignment portion of the appealed issue—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—would have been dismissed by the Board even if it was briefed, as the issue is premature.

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

****

In summary, the Board hereby dismisses the DSH Payment/SSI Percentage (Provider Specific) issue from this appeal in its entirety, as it is duplicative of the issue in Case No. 19-1503GC and the realignment portion was not briefed in the Final Position Paper and is therefore abandoned. As no issues remain pending, the Board hereby closes Case No. 19-0238 and removes it from the Board's docket.

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

Board Members Participating:

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

For the Board:

1/24/2024

X Kevin D. Smith, CPA

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Glenn Bunting
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RE: ***Notice of Dismissal***
Moss Adams Standardized Amount CIRP Group Cases
Case Nos. 23-1522GC, *et al.* (*see* Appendix A listing 24 cases)

Dear Mr. Bunting:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal requests filed by the Providers in the twenty-four (24) above-referenced common issue related party ("CIRP") and optional group cases. The Medicare Contractor filed a Jurisdictional Challenge covering these twenty-four (24) group cases[1] and the Providers' Representative filed a response. As set forth below, the Board has determined that, consistent with 42 U.S.C. § 1395ww(d)(7) and 42 C.F.R. § 405.1840(b), it lacks substantive jurisdiction over the appealed issue and is therefore dismissing all twenty-four (24) CIRP and optional group cases in their entirety.

In summary, the Board finds that it lacks substantive jurisdiction over the issue raised in these appeals because the standardized amounts used for IPPS rates for FFYs 1984 and FFY 1985 are each based on the budget neutrality adjustment made for that FFY.[2] Therefore, the *final* FFY 1984 and 1985 standardized amounts are *inextricably intertwined* with those applicable budget neutrality adjustments.[3] Indeed, the standardized amounts were too high for FFYs 1984 and 1985 and the

[1] *See* **Appendix A**.

[2] The Board has included at **Appendix B** examples of other adjustments to the standardized amounts that have occurred outside of the FFY 1984 and 1985 budget neutrality adjustments. These intervening adjustments for FFYs 1986 and 2018 include both mandatory and discretionary revisions ***to the standardized amounts*** (as well as the Congress' decisions to revise or not revise the "applicable percentage increases" for FFYs 1986 and forward as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i)) and highlight the complexity of the issue before the Board, particularly where such adjustments were made in a budget neutral manner or were based on factoring in certain other estimated impacts.

[3] *See DCH Reg'l Med. Ctr. v. Azar*, 925 F.3d 503, 507 (D.C. Cir. 2019) ("We cannot review the Secretary's method of estimation without also reviewing the estimate. And because the two are inextricably intertwined, section 1395ww(r)(3)(A) precludes review of both."); *Mercy Hosp., Inc. v. Azar*, 891 F.3d 1062, 1067 (D.C. Cir. 2018) ("As both a textual and a practical matter, the LIP adjustment is inextricably intertwined with the step-two rate, and so the shield that protects the step-two rate from review protects the LIP adjustment as well."); *Yale New Haven Hosp. v. Becerra*, 56 F.4th 9, 18 (2nd Cir. 2022) ("Thus, we join the D.C. Circuit in "reject[ing] the argument that 'an "estimate" is not the same thing as the "data" on which it is based.'" *DCH Reg'l Med. Ctr. v. Azar* . . . . We also adopt the D.C. Circuit's holding that "[i]n this statutory scheme, a challenge to the [Secretary's choice of what data to include and exclude] for estimating uncompensated care is . . . a challenge to the estimates themselves. The statute draws no distinction between the two." *Id*. at 506. Indeed, the statutory text of section 1395ww(r)(2)(C)(i) explicitly and

budget neutrality adjustments applied to those years reduced the standardized amounts (reduced by factors of approximately 0.03 for FFY 1984 and 0.05 for FFY 1985) and, thus, these budget neutrality adjustments already automatically accounted for any such alleged errors in setting the initial base rate.[4] Because 42 U.S.C. 1395ww(d)(7) prohibits administrative or judicial review of those adjustments and the resulting *final* standardized amounts for those years were carried/flowed forward *for future FFYs*, the Board may not review the standardized amount used for the FFYs being appealed as they relate to the issue in these appeals, *i.e.*, the alleged inaccuracies in the standardized amounts used for FFY 1984 as carried/flowed forward for all years following FFY 1984 to the FFYs being appealed. In this regard, the Board notes that the Providers may not simply pass through, or over, the budget neutrality adjustments for FFYs 1984 and 1985, ***for purposes of future FFYs***, because those adjustments are tied to an absolute *external* event (the Secretary's estimate, based on the best available data, of what would have been paid for those years if there were no IPPS) ***and*** were ***fixed*** (no greater *and* no less than what would have been paid had there been no IPPS).[5] To do otherwise, would impact the very integrity of IPPS.

Procedural Background:

A. Appealed Issue

Moss Adams, LLP ("Providers' Representative") represents a number of providers in CIRP and optional groups which are challenging the IPPS standardized amount. The Medicare Contractor filed a Jurisdictional Challenge covering these twenty-four (24) group cases and the Providers' Representative filed a response to the challenge. The group issue statements, jurisdictional challenges, and responses thereto for all twenty-four (24) cases are materially identical and will be considered together.

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affirmatively defines the statutory term "estimate[ ]" to encompass "the Secretary['s] determin[ation]" of what data is the "be[st] proxy for the costs of [qualifying] hospitals for treating the uninsured" and, ultimately, of what data to "use" or not "use." 42 U.S.C. § 1395ww(r)(2)(C)(i)." (citations partially omitted)). Similarly, the Board notes that the Board erred in finding that it had jurisdiction in *Columbia/HCA 1984-1986 PPS Federal Rate/Malpractice Group v. Blue Cross & Blue Shield Ass'n*, PRRB Dec. 2000-D74 (Aug. 18, 2000). In that decision, the Board found that "the issue in this case, whether the federal portion of the PPS rates should be adjusted because it was based on 1981 hospital cost report data which incorporated an invalid 1979 Malpractice Rule, does not fall into either [of the] limitations on Board jurisdiction [at 42 U.S.C. §§ 1395ww(d)(7) or 1395oo(g)(2)]. The Board finds that it can determine whether the existing statute and regulations concerning the establishment of the federal portion of the PPS rate require or permit retroactive adjustments." *Id.* at 16. The Board further found that "the retroactive adjustment proposed by the Provider would increase the federal portion of the PPS rates ***and therefore require some adjustment to be made to maintain budget neutrality***. 42 U.S.C. § 1395ww(e) and 42 C.F.R. § 412.63(j)" but that "[b]ecause the Board has determined that the adjustments are not required, how those adjustments would be made are moot, and in any event would not be subject to review by the Board. 42 C.F.R. § 405.1804(a)." *Id.* at 18 (Emphasis added.) While the Board's 2000 decision got it right that the FFY 1984 budget neutrality provision is implicated and precluded from administrative review, the above case law demonstrates that the Board erred in finding it could review the FY 1984 standardized amounts. Rather, the case law (as well as the Board's discussion herein) demonstrate that any adjustment to the FFY 1984 standardized amounts would be *inextricably* tied to the ensuing budget neutrality adjustments made for FFYs 1984 and 1985.

[4] *See infra* note 37 (discussing how the removal of nurse anesthetists costs were removed from IPPS and how that removal was *automatically* accounted for as part of the 1985 budget neutrality adjustment).

[5] Moreover, *see supra* note 2 discussing other intervening discretionary and nondiscretionary adjustments to the standardized amounts that have occurred outside of the FFY 1984 and 1985 budget neutrality adjustments.

The group issue statement presented is:

> In 1983 CMS established the Inpatient Prospective Payment System (IPPS) and created DRG payments that originate from 1981 cost reporting data. The 1981 cost reporting data is considered a base year from which the calculation of every DRG payment since 1983 has originated, including the DRG payments applicable to this year.
>
> A recent decision by the United States Court of Appeals for the District of Columbia Circuit (D.C. Circuit) in St. Francis Medical Center v. Azar allows hospitals the opportunity to correct their Medicare reimbursement due to erroneous 1981 cost reporting data that CMS (acting through its predecessor agency HCFA) used to calculate IPPS standardized amounts in 1983. Specifically, the 1981 cost reporting data that CMS used to calculate the IPPS standardized amounts for 1983 erroneously characterized transfers of patients from one hospital to another as "patient discharges." This caused an overstatement of the number of discharges and understatement in the allowable operating costs, which were calculated on a "per discharge" basis. This, in turn, led to an understatement of the standardized payment amounts for 1983. These understated standardized amounts from 1983, as updated annually, have been used to determine IPPS payments for every year thereafter, meaning those Medicare payments were also understated. . . .
>
> . . . . A calculation of each Provider's estimated underpayment of this issue has been submitted.[6]

In some cases, the Provider has filed a Preliminary Position Paper,[7] but it does not expand on the issue statement in any material way.

B. Jurisdictional Challenges

The Medicare Contractor filed a challenge covering all twenty-four (24) CIRP and optional group cases listed in Appendix A. The Medicare Contractor argues that the merits of the appealed issue are illegitimate, but more importantly, that the Board lacks subject matter jurisdiction and need not even address the merits of the issue. It references the Board's April 6, 2023 decision dismissing five (5) different CIRP group appeals concerning the same issue. The Medicare Contractor argues the Board should apply the same rationale and find that 42 U.S.C. § 1395ww(d)(7)(A) precludes administrative review of the base year standardized amounts. It also claims that budget neutrality adjustments after the base year amount was calculated have corrected any potential errors from prior years, and that the data shows the base year was, in fact, initially set too high (rather than understated).

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[6] *E.g.*, Case 23-1522GC, Statement of Disputed Issue (Oct. 2, 2020).
[7] *E.g.,* Case 21-0028GC, Provider's Preliminary Position Paper (Apr. 1, 2022).

The Providers filed a Response to the Jurisdictional Challenge on December 6, 2023. They claim the Medicare Contractor is "piggybacking" the Board's April 6, 2023 decision finding it did not have substantive jurisdiction over the Standardized Amount issue.[8] The Providers disagree with the Board's previous decision and have articulated several reasons why they believe the issue "must be jurisdictionally accepted by the Board[.]"[9]

First, the Providers believe they meet all of the jurisdictional requirements set forth in 42 C.F.R. § 405.1840, and that none of the exception criteria set forth at § 405.1840(b)(2) apply.[10] They claim the appeals do not challenge CMS' development of the budget neutrality factor used for the 1984 and 1985 IPPS rates, which is precluded from review.[11] Instead, they are challenging the accuracy of the standardized amount, a separate variable used to calculate those rates, which they argue is not precluded from review. They note that the Board's jurisdiction is precluded with regard to the budget neutrality adjustment because it is specifically enumerated in 42 C.F.R. § 405.1804, while the standardized amount component of the IPPS rates is not listed as precluded therein.[12]

The Providers also dispute any notion that CMS would implement some type of fixed payment cap (pie) with regard to allowable claims in FYs 1984 and 1985. They claim that IPPS rates are set prospectively based on estimations, but that all allowable claims are paid even if they differ from those estimations.[13] They conclude their Response by reiterating that only one variable, the budget neutrality adjustment, is precluded from review, and that the law does not support the Board's position that the standardized amount variable for FYs 1984 and 1985 are precluded from review.[14]

Board Decision:

As described more fully below, the Board finds that it lacks substantive jurisdiction over each of the twenty-four (24) groups because the initial 1983 standardized amounts,[15] set for the IPPS, are ***inextricably*** intertwined with the 1984 and 1985 budget neutrality adjustments to the "applicable percentage increases" for IPPS[16] and 42 U.S.C. § 1395ww(d)(7) prohibits administrative or judicial review of those budget neutrality adjustments. The fact that the Secretary's budget

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[8] Response to Medicare Administrative Contractor (MAC) Jurisdictional Challenge Dated November 7, 2023 ("Response to Jurisdictional Challenge") at 1-2 (Dec. 6, 2023).
[9] *Id.* at 2.
[10] *Id.*, bullet 1.
[11] *Id.*, bullet 2.
[12] *Id.* at 2-3, bullets 3 and 4.
[13] *Id.* at 3, bullets 5 and 6.
[14] *Id.* at 4, bullet 7.
[15] The Board notes that, initially, there was not just one standardized amount. Rather there were 20 average standard amounts per discharge according to urban/rural designation in each of the nine census divisions and the nation and each of these 20 rates is further divided into a labor and nonlabor portion. *See* 48 Fed. Reg. 39752, 39763 (Sept. 1, 1983).
[16] 42 U.S.C. § 1395ww(e) is entitled "Proportional adjustments in applicable percentage increases." The 1984 and 1985 budget neutrality adjustments are set forth is § 1395ww(e)(1)(B) which is cross-referenced for 1984 IPPS rates at § 1395ww(d)(2)(F) and for 1985 IPPS rates at § 1395ww(d)(3)(C).

neutrality adjustment to the FY 1984 Federal Rates was 0.970[17] demonstrates that, contrary to the Providers' assertions, the initial standardized amount was ***not*** understated but rather was *overstated* by a factor of 0.030 (*i.e*., 1.000 – 0.970) and, thus, these budget neutrality adjustments already automatically accounted for any such alleged errors in setting the initial base rate. [18]

A. Statutory Background on IPPS and the Standardized Amount Used in IPPS Rates

Part A of the Medicare program covers "inpatient hospital services." Since October 1, 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the IPPS.[19] Under IPPS, Medicare pays a prospectively-determined rate per eligible discharge, subject to certain payment adjustments.[20]

In order to implement IPPS, "the statute require[d] that the Secretary determine national and regional adjusted DRG prospective payment rates for each DRG to cover the operating costs of inpatient hospital services."[21] The methodology for arriving at the appropriate rate structure is located at 42 U.S.C. § 1395ww(d)(2) and "requires that certain ***base period*** *cost data* be developed and modified in several specified ways (*i.e*., inflated, standardized, grouped, and adjusted) resulting in 20 average standard amounts per discharge according to urban/rural designation in each of the nine census divisions and the nation."[22] Specifically, § 1395ww(d)(2) (Jan. 1985) stated, in pertinent part:

> (2) The Secretary shall determine a national adjusted DRG prospective payment rate, for each inpatient hospital discharge in fiscal year 1984 involving inpatient hospital services of a subsection (d) hospital in the United States, and shall determine a regional adjusted DRG prospective payment rate for such discharges in each region, for which payment may be made under part A of this subchapter. Each such rate shall be determined for hospitals located in urban or rural areas within the United States or within each such region, respectively, as follows:
>
> (A) DETERMINING ALLOWABLE INDIVIDUAL HOSPITAL COTS FOR BASE PERIOD.—The Secretary shall determine the allowable operating costs per discharge of inpatient hospital services for the hospital for the most recent cost reporting period for which data are available.

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[17] In the final rule published on January 3, 1984, the Secretary revised the Federal budget neutrality adjustment factor to 0.970. 49 Fed. Reg. 234, 334 (Jan. 3, 1984).
[18] *See infra* note 37 (discussing how the removal of nurse anesthetists costs were removed from IPPS and how that removal was *automatically* accounted for as part of the 1985 budget neutrality adjustment).
[19] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[20] *Id.*
[21] 48 Fed. Reg. 39752, 39763 (Sept. 1, 1983).
[22] *Id.* (emphasis added).

> (B) UPDATING FOR FISCAL YEAR 1984.—The Secretary shall update each amount determined under subparagraph (A) for fiscal year 1984 by—
>
> (i) updating for fiscal year 1983 by the estimated average rate of change of hospital costs industry-wide between the cost reporting period used under such subparagraph and fiscal year 1983 and the most recent case-mix data available, and
>
> (ii) projecting for fiscal year 1984 by the applicable percentage increase (as defined in subsection (b)(3)(B)) for fiscal year 1984.
>
> (C) STANDARDIZING AMOUNTS.—The Secretary shall standardize the amount updated under subparagraph (B) for each hospital by—
>
> (i) excluding an estimate of indirect medical education costs,[23]
>
> (ii) adjusting for variations among hospitals by area in the average hospital wage level, and
>
> (iii) adjusting for variations in case mix among hospitals.[24]

Thus, as quoted above, § 1395ww(d)(2)(A) requires that the Secretary determine a "base period" operating cost per discharge using the most recent cost reporting period for which data are available. Further, consistent with these statutory provisions, the Secretary used Medicare hospital cost reports for reporting periods ending in 1981 and set the 1984 "base period"

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[23] Consistent with the concerns raised by the Board in **Appendix B**, the Board notes that Congress has amended this clause (i) numerous times and, as a result, it currently reads as follows:

> (i) excluding an estimate of indirect medical education costs (taking into account, for discharges occurring after September 30, 1986, the amendments made by section 9104(a) of the Medicare and Medicaid Budget Reconciliation Amendments of 1985), except that the Secretary shall not take into account any reduction in the amount of additional payments under paragraph (5)(B)(ii) resulting from the amendment made by section 4621(a)(1) of the Balanced Budget Act of 1997 or any additional payments under such paragraph resulting from the application of section 111 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, of section 302 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, or the Medicare Prescription Drug, Improvement, and Modernization Act of 2003,

[24] The Board notes that Congress later added clause (iv) in 1985 and, consistent with the concerns raised by the Board in **Appendix B**, the Board notes that Congress has amended this clause (iv) numerous times and, as a result, it currently reads as follows:

> (iv) for discharges occurring on or after October 1, 1986, excluding an estimate of the additional payments to certain hospitals to be made under paragraph (5)(F), except that the Secretary shall not exclude additional payments under such paragraph made as a result of the enactment of section 6003(c) of the Omnibus Budget Reconciliation Act of 1989, the enactment of section 4002(b) of the Omnibus Budget Reconciliation Act of 1990, the enactment of section 303 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, or the enactment of section 402(a)(1) 4 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

operating cost per discharge amount using the 1981 operating costs per discharge amount *updated* by an inflationary factor.[25] The Providers dispute how the Secretary determined "discharges" and allege that the Secretary improperly treated transfers as discharges for purposes of this calculation.

The Secretary then "standardized" the FFY 1984 base period operating cost per discharge using the process prescribed at 42 U.S.C. § 1395ww(d)(2)(c). The standardization process removed the effects of certain variable costs from the cost data, including (but not limited to) excluding costs associated with indirect medical education costs, adjusting for variations in average hospital wage levels, and adjusting for variations in case mix among hospitals.

The initial standardized amounts have been annually adjusted and/or updated. However, contrary to the characterization in the D.C. Circuit's 2011 decision in *Saint Francis Med. Ctr. v. Azar* ("*Saint Francis*"), the standardized amount is not adjusted each year simply for inflation.[26] Significantly, some of these annual adjustments were required to be *budget neutral* and are not subject to administrative review. In particular, 42 U.S.C. § 1395ww(c)(1)(B) provides the budget neutrality adjustment for "the applicable percentage increases" to the standardized amounts for 1984 and 1985 and states, in pertinent part:

> **(e) Proportional adjustments in *applicable percentage increases***
>
> (1) . . . .
>
> (B) *For discharges occurring in fiscal year 1984 or fiscal year 1985*, *the Secretary shall provide* under subsections (d)(2)(F) and (d)(3)(C) for such equal proportional adjustment *in each of the average standardized amounts* otherwise computed for that fiscal year as may be necessary to assure that—
>
> (i) *the aggregate payment amounts* otherwise provided under subsection (d)(1)(A)(i)(II) and (d)(5) *for that fiscal year* for operating costs of inpatient hospital services of hospitals (excluding payments made under section 1395cc(a)(1)(F) of this title),
>
> *are not greater or less than*—
>
> (ii) the DRG percentage (as defined in subsection (d)(1)(c)) of *the payment amounts which would have been payable for such services* for those same hospitals for that fiscal year under this

[25] *Id*. at 39763-64.
[26] 894 F.3d 290, 291 (D.C. Cir. 2011). *Saint Francis* did not analyze how the standardized amount is updated annually nor did it make specific legal holdings regarding the standardized amount.

> section *under the law as in effect before April 20, 1983* (excluding payments made under section 1395cc(a)(1)(F) of this title).[27]

The Secretary implemented the above budget neutrality provisions at 42 C.F.R. §§ 412.62(i) and 412.63(v) for the 1984 rate year and 1985 rate year respectively. Specifically, § 412.62(i) provides the following instruction for maintaining budget neutrality for the 1984 Federal IPPS rates:

> (i) *Maintaining budget neutrality.* (1) CMS adjusts each of the **reduced standardized amounts** determined under paragraphs (c) through (h) of this section **as required for fiscal year 1984** so that the estimated amount of aggregate payments made, excluding the hospital-specific portion (that is, the total of the Federal portion of transition payments, plus any adjustments and special treatment of certain classes of hospitals for Federal fiscal year 1984) **is not greater or less than** 25 percent of **the payment amounts that would have been payable** for the inpatient operating costs for those same hospitals for fiscal year 1984 **under the Social Security Act as in effect on April 19, 1983**.
>
> (2) The aggregate payments considered under this paragraph exclude payments for per case review by a utilization and quality control quality improvement organization, as allowed under section 1866(a)(1)(F) of the Act.[28]

Similarly, the regulation at 42 C.F.R. § 412.63(v) provides the following instruction for maintaining budget neutrality for the 1985 Federal rates for IPPS:

> (v) *Maintaining budget neutrality for fiscal year 1985.* (1) For fiscal year 1985, CMS will adjust each of **the reduced standardized amounts** determined under paragraph (c) of this section **as required for fiscal year 1985** to ensure that the estimated amount of aggregate payments made, excluding the hospital-specific portion (that is, the total of the Federal portion of transition payments, plus any adjustments and special treatment of certain classes of hospitals for fiscal year 1985) **is not greater or less** than 50 percent of the **payment amounts that would have been payable** for the inpatient operating costs for those same hospitals for fiscal year 1985 **under the law as in effect on April 19, 1983**.
>
> (2) The aggregate payments considered under this paragraph exclude payments for per case review by a utilization and quality

[27] (Bold emphasis in original and italics and underline emphasis added.) The budget neutrality adjustment at 42 U.S.C. § 1395ww(e)(1)(B) is cross-referenced for 1984 at 1395ww(d)(2)(F) and for 1985 at § 1395ww(d)(3)(C).
[28] (Italics emphasis in original and bold and underline emphasis added.)

> control quality improvement organization, as allowed under section 1866(a)(1)(F) of the Act.[29]

Essentially, Congress mandated that the Secretary/CMS adjust the standardized amounts for both 1984 and 1985 to ensure that the estimated amount of aggregate payments made under IPPS was not *greater than* ***or*** *less than* what would have been payable for inpatient operating costs for the same hospitals under the prior reimbursement system (*i.e*., reasonable costs subject to TEFRA limits). In other words, pursuant to budget neutrality, the size of the pie, expressed as average payment per case, is prescribed by law to be *no more* ***and*** *no less* than what would have been paid had IPPS not been implemented. Significantly, the reference points for maintaining budget neutrality for 1984 and 1985 are ***external*** to IPPS and, thus, ***fixed*** (no greater *and* no less) based on the best data available.[30] Since these points are ***fixed,*** it also means that it is capped (*i.e*., cannot be increased subsequently outside of the budget neutrality adjustment).

This conclusion is supported by the fact that the normal annual inflation adjustments to the standardized amount provided for in IPPS apply ***only*** for FY 1986 forward, as set forth in 42 U.S.C. § 1395ww(b)(3)(B)(3)(i) and cross referenced in § 1395ww(d)(3)(A). Specifically, 42 U.S.C. § 1395ww(b)(3)(B)(i) (2018) defines the term "applicable percentage increase" ***starting with fiscal year 1986*** (as opposed to 1984):

> (B)(i) For purposes of subsection (d) and subsection (j) for discharges occurring during a fiscal year, the "applicable percentage increase" shall be—
>
> (I) ***for fiscal year 1986***, 1⁄2 percent,

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[29] (Italics emphasis in original and bold and underline emphasis added.)

[30] 48 Fed. Reg. 39752, 39887 (Sept. 1, 1983) provides the following discussion supporting the Board's pie concept:

> Section 1886(e)(1) of the Act requires that, for Federal fiscal years 1984 and 1985, prospective payments be adjusted so that aggregate payments for the operating costs of inpatient hospital services are neither more nor less than we estimate would have been paid under prior legislation for the costs of the same services. To implement this provision, we are making actuarially determined adjustments to the average standardized amounts used to determine Federal national and regional payment rates and to the updating factors used to determine the hospital-specific per case amounts incorporated in the blended transition payment rates for fiscal years 1984 and 1985. Section 1886(d)(6) of the Act requires that the annual published notice of the methodology, data and rates include an explanation of any budget neutrality adjustments. This section is intended to fulfill that requirement.
>
> Although, for methodological reasons, the budget neutrality adjustment is calculated on a per discharge basis, it should be emphasized that the ultimate comparison is between the aggregate payments to be made under the prospective payment system and the aggregate payments that would have been incurred under the prior legislation. Therefore, changes in hospital behavior from that which would have occurred in the absence of the prospective payment system are required to be taken into account in determining the budget neutrality adjustment if they affect aggregate payment. For example, any expectation of increased admissions beyond the level that would have occurred under prior law would have to be considered in the adjustment. To assist in making the budget neutrality adjustment for, and take account of, fiscal year 1985, HCFA will monitor for changes in hospital behavior attributable to the new system.

(II) for fiscal year ***1987***, 1.15 percent,

(III) for fiscal year ***1988***, 3.0 percent for hospitals located in a rural area, 1.5 percent for hospitals located in a large urban area (as defined in subsection (d)(2)(D)), and 1.0 percent for hospitals located in other urban areas,

(IV) for fiscal year ***1989***, the market basket percentage increase minus 1.5 percentage points for hospitals located in a rural area, the market basket percentage increase minus 2.0 percentage points for hospitals located in a large urban area, and the market basket percentage increase minus 2.5 percentage points for hospitals located in other urban areas,

(V) for fiscal year ***1990***, the market basket percentage increase plus 4.22 percentage points for hospitals located in a rural area, the market basket percentage increase plus 0.12 percentage points for hospitals located in a large urban area, and the market basket percentage increase minus 0.53 percentage points for hospitals located in other urban areas,

(VI) for fiscal year ***1991***, the market basket percentage increase minus 2.0 percentage points for hospitals in a large urban or other urban area, and the market basket percentage increase minus 0.7 percentage point for hospitals located in a rural area,

(VII) for fiscal year ***1992***, the market basket percentage increase minus 1.6 percentage points for hospitals in a large urban or other urban area, and the market basket percentage increase minus 0.6 percentage point for hospitals located in a rural area,

(VIII) for fiscal year ***1993***, the market basket percentage increase minus 1.55 percentage point for hospitals in a large urban or other urban area, and the market basket percentage increase minus 0.55 1 for hospitals located in a rural area,

(IX) for fiscal year ***1994***, the market basket percentage increase minus 2.5 percentage points for hospitals located in a large urban or other urban area, and the market basket percentage increase minus 1.0 percentage point for hospitals located in a rural area,

(X) for fiscal year ***1995***, the market basket percentage increase minus 2.5 percentage points for hospitals located in a large urban or other urban area, and such percentage increase for hospitals located in a rural area as will provide for the average standardized amount determined under subsection (d)(3)(A) for hospitals located in a rural area being equal to such average standardized amount for hospitals located in an urban area (other than a large urban area),

> (XI) for fiscal year ***1996***, the market basket percentage increase minus 2.0 percentage points for hospitals in all areas,
>
> (XII) for fiscal year ***1997***, the market basket percentage increase minus 0.5 percentage point for hospitals in all areas,
>
> (XIII) for fiscal year ***1998***, 0 percent,
>
> (XIV) for fiscal year ***1999***, the market basket percentage increase minus 1.9 percentage points for hospitals in all areas,
>
> (XV) for fiscal year ***2000***, the market basket percentage increase minus 1.8 percentage points for hospitals in all areas,
>
> (XVI) for fiscal year ***2001***, the market basket percentage increase for hospitals in all areas,
>
> (XVII) for fiscal year ***2002***, the market basket percentage increase minus 0.55 percentage points for hospitals in all areas,
>
> (XVIII) for fiscal year ***2003***, the market basket percentage increase minus 0.55 percentage points for hospitals in all areas,
>
> (XIX) for each of fiscal years ***2004*** through ***2006***, subject to clause (vii), the market basket percentage increase for hospitals in all areas; and
>
> (XX) ***for each subsequent fiscal year***, subject to clauses (viii), (ix), (xi), and (xii), the market basket percentage increase for hospitals in all areas.[31]

The "applicable percentage increase" as defined in § 1395ww(b)(3)(B) is incorporated into § 1395ww(d)(3)(A), as it relates to updating of the standardized amount:

> **(B) UPDATING** PREVIOUS STANDARDIZED AMOUNTS.—(i) For discharges occurring in a fiscal year beginning ***before*** October 1, 1987, the Secretary shall compute an average standardized amount for hospitals located in an urban area and for hospitals located in a rural area within the United States and for hospitals located in an urban area and for hospitals located in a rural area within each region, ***equal to*** *the respective average standardized amount computed for the previous fiscal year under paragraph (2)(D) or under this subparagraph*, ***increased for the fiscal year involved by the applicable percentage increase under subsection (b)(3)(B)***. With respect to discharges occurring on or after October 1, 1987, the Secretary shall compute urban and rural averages on the basis of discharge weighting rather than hospital weighting, making appropriate adjustments to ensure that computation on such basis

[31] (Emphasis added.)

does not result in total payments under this section that are greater or less than the total payments that would have been made under this section but for this sentence, and making appropriate changes in the manner of determining the reductions under subparagraph (c)(ii).

(ii) For discharges occurring in a fiscal year beginning on or after October 1, 1987, and ending on or before September 30, 1994, the Secretary shall compute an average standardized amount for hospitals located in a large urban area, for hospitals located in a rural area, and for hospitals located in other urban areas, within the United States and within each region, equal to the respective average standardized amount computed for the previous fiscal year under this subparagraph increased by the applicable percentage increase under subsection (b)(3)(B)(i) with respect to hospitals located in the respective areas for the fiscal year involved.

(iii) For discharges occurring in the fiscal year beginning on October 1, 1994, the average standardized amount for hospitals located in a rural area shall be equal to the average standardized amount for hospitals located in an urban area. For discharges occurring on or after October 1, 1994, the Secretary shall adjust the ratio of the labor portion to non-labor portion of each average standardized amount to equal such ratio for the national average of all standardized amounts.

(iv)(I) Subject to subclause (II), for discharges occurring in a fiscal year beginning on or after October 1, 1995, the Secretary shall compute an average standardized amount for hospitals located in a large urban area and for hospitals located in other areas within the United States and within each region equal to the respective average standardized amount computed for the previous fiscal year under this subparagraph increased by the applicable percentage increase under subsection (b)(3)(B)(i) with respect to hospitals located in the respective areas for the fiscal year involved.

(II) For discharges occurring in a fiscal year (beginning with fiscal year 2004), the Secretary shall compute a standardized amount for hospitals located in any area within the United States and within each region equal to the standardized amount computed for the previous fiscal year under this subparagraph for hospitals located in a large urban area (or, beginning with fiscal year 2005, for all hospitals in the previous fiscal year) increased by the applicable percentage increase under subsection (b)(3)(B)(i) for the fiscal year involved.

Thus, while 42 U.S.C. § 1395ww(d)(2) provides the methodology for calculating the standardized amount to be used for each year, and that the amount is subject to the "applicable percentage increase" under subsection (b)(3)(B) *for years after 1984*, it remains that it is not always a simple inflationary or market basket adjustment. In particular, the FFY 1984 and 1985 budget neutrality adjustments (as referenced in § 1395ww(d)(2)(F) and in § 1395ww(d)(3)(C)) were the applicable percentage increases for FFYs 1984 and 1985 and, as described below, those adjustments are not administratively reviewable. As a result of those budget neutrality adjustments, the rate for each of those respective years is frozen *for purposes of future FFYs* through the operation of 42 U.S.C. §§ 1395ww(b)(3)(B), 1395ww(d)(3)(A), § 1395ww(d)(2)(F), and 1395ww(d)(3)(C) as discussed below.

B. Jurisdictional Findings -- 42 U.S.C. § 1395ww(d)(7)(A) Precludes Administrative Review of the Base Year Standardized Amounts

The Providers essentially are challenging the standardized amount used in the IPPS rates for several FFYs claiming that the Secretary improperly treated transfers as discharges when using 1981 cost report data to determine the initial FFY 1984 base cost per discharge which, in turn, was standardized to arrive at the FFY 1984 standardized amounts. More specifically, the Providers maintain that, the understatement of the standardized amount in the FFY 1984 IPPS Final Rule caused a corresponding underpayment in IPPS payments in FFY 1984 ***and every FFY thereafter*** *because the standardized amount for all IPPS payments for every FFY are based on CMS's calculation of the FFY 1984 standardized amount*.[32]

The published standardized amount for each FFY in these appeals reflects the prior year's standardized amount plus "the applicable percentage increase" as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i) (as referenced in 42 U.S.C. § 1395ww(d)(3(A)) as well as other potential adjustments. Significantly, the "applicable percentage increase[s]" for 1984 forward are ***not*** always simply a cost inflation adjustment or other similar percentage adjustment. To this point, for the first two (2) years of IPPS, Congress mandated that the budget neutrality adjustments for FFYs 1984 and 1985 serve as the "applicable percentage increase" for those years. As a result, the IPPS rates that the Secretary used *for the very first year of IPPS* and then the second year of IPPS were adjusted for budget neutrality. For FFYs 1986 and forward, Congress provided for an "applicable percentage increase" in 42 U.S.C. § 1395ww(b)(3)(B)(i) as referenced in 42 U.S.C. § 1395ww(d)(3(A). In addition, there are other *permanent* adjustments (*i.e.*, adjustments not for that year only but that also apply on a going-forward basis) to the standardized amount that have occurred in other years outside of the "applicable percentage increase."[33] Thus, the standardized amount for a particular year is an amalgamation that builds upon the prior year's standardized amount and then adds additional adjustments for the current year.

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[32] *E.g.*, PRRB Case 23-1522GC, Statement of Disputed Issue (July 18, 2023) ("These understated standardized amounts from 1983, as updated annually, have been used to determine IPPS payments for every year thereafter, meaning those Medicare payments were also understated.").
[33] *See* **Appendix B**.

The Providers are, essentially, seeking to peel back the amalgamated standardized amount for each applicable FFY *and, thus, reach back* ***more than 30 years*** to increase the initial 1984 base rate that was used to set the initial 1984 standardized amount***s***. They would then incorporate the alleged increased base rate into the FFY 1984 standardized amount***s*** and then simply carry or flow that *increase forward 35 years*. However, in order to peel the amalgamated standardized amounts for the FFYs at issue (singular[34]) *as used in the IPPS rates for each FFY* back to the initial standardized amount***s*** (plural[35]) used in FFY 1984, and then carry/flow any change forward *to the FFY at issue*, the Providers would have to pass through the FFY 1984 and 1985 budget neutrality adjustments which were the only "applicable percentage increase[s]" for those years. However, they cannot do so because the budget neutrality adjustments had the effect of ***fixing*** the pie for FFYs 1984 and 1985 to (*i.e.*, no more ***and*** no less than) the aggregate amounts that would have been paid had IPPS not been implemented.[36] More specifically, the amalgamated standardized payment amount for each FFY at issue reflects the *fixed* FFY 1984 and 1985 budget neutrality adjustments (and not the initial FFY 1984 standardized amounts since the standardized amounts for both FFYs 1984 and 1985 were each adjusted for budget neutrality became *fixed* for purposes of subsequent years as a result of those budget neutrality adjustments). Thus, in the Board's view, the Providers cannot get back to the FFY 1984 standardized amounts without first passing through the FFY 1984 and 1985 budget neutrality adjustments. Regardless, the Providers would not be able to flow forward any adjustments made to the FFY 1984 standardized amounts because: (1) they, again, would not be able to get through the FFY 1984 and 1985 budget neutrality adjustments that Congress otherwise ***fixed*** to an external point (no greater and no less); and (2) the IPPS rates paid for FFYs 1984 and 1985 are based on standardized amounts that were adjusted downwards as a result of the budget neutrality adjustment for FFY 1984 and also for FFY 1985 (*see* discussion below in Sections B.1 and B.2).[37] Accordingly, the Board finds that the Providers challenge to the

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[34] *See supra* note 15 accompanying text.

[35] *See id.*

[36] *See, e.g.,* 48 Fed. Reg. 39752, 39805 (Sept. 1, 1983) (stating: "Hospital Impact—During its first two years, aggregate payments under the prospective payment system will be adjusted, in accordance with Section 1886(e)(1) of the Act, to be "budget neutral"; that is, so that aggregate payments under the prospective payment system, including outlier payments, exceptions, and adjustments, will be neither more nor less than the estimated payment amounts to affected hospitals that would have resulted under the Social Security Act as in effect before April 20,1983.").

[37] Indeed, the FY 1986 IPPS Final Rule included an example where the Secretary recognized an adjustment to the budget neutrality adjustments would be impacted by the removal of nurse anesthetists costs and confirmed that the adjustments to the standardized amounts had already taken this removal into account:

> c. Nonphysician anesthetist costs. In the August 31, 1984 final rule, we implemented section 2312 of Pub. L. 98-369, which provided that hospital costs for the services of nonphysician anesthetists will be paid in full as a reasonable cost pass-through for cost reporting periods beginning before October 1, 1987.
>
> We did not directly reduce the FY 1985 Federal rates to exclude the estimated costs of these services, *because any required adjustment would be incorporated in the budget neutrality adjustment factors applied to the national and regional standardized amounts*. (See 49 FR 34794; August 31, 1984). ***Since the FY 1986 standardized amounts are derived from an update of the FY 1985 amounts, which were adjusted for budget neutrality, the rates will automatically include the appropriate adjustment***. We are not making further adjustments to the Federal rates for this factor for either FY 1986 or FY 1987.

50 Fed. Reg. at 35708 (emphasis added). *See also* 52 Fed. Reg. 33034, 33064 (Sept. 1, 1987) (stating: "In the September 3, 1985 final rule, we noted that to the extent an adjustment was warranted to reflect the removal of these costs from the prospective payment rates for FY 1985, *it was incorporated in the overall* ***budget neutrality***

standardized amounts at issue are *inextricably* tied to the budget neutrality adjustments made for FFY 1984 and 1985.[38]

Furthermore, Congress has precluded Board (and judicial) review of the FFY 1984 and 1985 budget neutrality adjustments. Specifically, 42 U.S.C. § 1395ww(d)(7)(A) precludes administrative and juridical review of the neutrality adjustment at § 1395ww(e)(1):

> (7) There shall be no administrative or judicial review under section 1395oo of this title or otherwise of—
>
> (A) the determination of the requirement, or the proportional amount, of any adjustment effected pursuant to subsection (e)(1) or the determination of the applicable percentage increase under paragraph (12)(A)(ii), . . .[39]

Similarly, the statute governing Board appeals is located at 42 U.S.C. § 1395oo and states in subsection (g)(2):

> The determinations and other decisions described in section 1395ww(d)(7) of this title shall not be reviewed by the Board or by any court pursuant to an action brought under subsection (f) or otherwise.

The Secretary incorporated the exclusion of the 1984 and 1985 budget neutrality provisions into the Board's governing regulations at 42 C.F.R. § 405.1804 which states in pertinent part:

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adjustment (50 FR 35708). Therefore, because this adjustment has already been built into the FY 1985 base from which the FY 1986, FY 1987, and proposed FY 1988 rates are derived, we did not propose to make further adjustments to the average standardized amounts for FY 1988.").

[38] The Board notes that the D.C. Circuit's decision in *Saint Francis* is not applicable to the 1984 and 1985 budget neutrality adjustments given the statutory provision precluding administrative and judicial review of those adjustments. Further, *Saint Francis* did not analyze how the standardized amount is updated annually nor did it make specific legal holdings regarding the standardized amount.

[39] With regard to implementing this statutory provision, 48 Fed. Reg. 39752, 39785 (Sept. 1, 1983) states:

> Section 1886(d)(7) of the Act precludes administrative and judicial review of the following:
> —A determination of the requirement, or the proportional amount, of any "budget neutrality" adjustment effected under section 1886(e)(1) of the Act; or
> —The establishment of DRGs, of the methodology for the classification of hospital discharges within DRGs, or of the appropriate weighting factors of DRGs under section 1886(d)(4) of the cost. It was the clear intent of Congress that a hospital would not be permitted to argue that the level of the payment that it receives under the prospective payment system is inadequate to cover its costs. Thus, as discussed above, neither the definition of the different DRGs, their weight in relation to each other, nor the method used to assign discharges to one of the groups is to be reviewable. However, if there is an error in the coding of an individual patient's case, review would be permitted. (See the Report of the Committee on Ways and Means on H.R. 1900, H. Report No. 98-25, (98th Cong., 1st Sess.) 143 (1982).) As noted below, we believe the appropriate review concerning coding errors should be conducted by the entity (i.e., the PSRO/PRO or fiscal intermediary) which made the initial determination.

> Neither administrative nor judicial review is available for controversies about the following matters:
>
> (a) The determination of the requirement, or the proportional amount, of the budget neutrality adjustment in the prospective payment rates required under section 1886(e)(1) of the Social Security Act [*i.e.* 42 U.S.C. § 1395ww(e)(1)].[40]

Since the FFY 1984 and 1985 budget neutrality adjustments are based on an ***external, fixed*** reference point (*i.e.*, no greater and no less than the reference point) and are not reviewable, the Board finds that the FFYs 1984 and 1985 budget neutrality adjustments effectively fixed the standardized amounts *from that point forward* for use in the IPPS system *for purposes of future FFYs*.[41]

Indeed, the Secretary's implementation of the fixed FFY 1984 and 1985 budget neutrality adjustments confirms that the Providers' allegation that the standardized rates for ***each FFY at issue*** are somehow understated due to alleged errors in the FFY 1984 base rate is moot.

1. *The Secretary determined that the initial standardized amounts for FFY 1984 were too high and, therefore, reduced the FFY 1984 standardized amounts through the FFY 1984 budget neutrality adjustment as reflected in the **final** FFY 1984 IPPS rates*.

In the interim final rule published on September 1, 1983, the Secretary issued a FFY 1984 budget neutrality adjustment to the FFY 1984 standardized amounts of 0.969:

> Section 1886(e)(1) of the Act requires that the prospective payment system result in aggregate program reimbursement equal to "what would have been payable" under the reasonable cost provisions of prior law; that is, for fiscal years 1984 and 1985, the prospective payment system should be "budget neutral."
>
> Under the Amendments, the prospective payment rates are a blend of a hospital-specific portion and a Federal portion. Section 1886(e)(1)(A) of the Act requires that aggregate payments for the hospital specific portion should equal the comparable share of estimated reimbursement under prior law. **Similarly, section**

[40] The Secretary recently clarified 42 C.F.R. § 405.1804(a) and affirmed that 42 U.S.C. § 1395ww (e)(1) "required that, for cost reporting periods beginning in FYs 1984 and 1985, the IPPS result in aggregate program reimbursement equal to 'what would have been payable' under the reasonable cost-based reimbursement provisions of prior law; that was, for FYs 1984 and 1985, the IPPS would be 'budget neutral.'" 78 Fed. Reg. 74825, 75162 (Dec. 10, 2013) (making technical change to the 42 C.F.R. § 405.1804(a)).

[41] *See, e.g.,* 48 Fed. Reg. 39752, 39765 (Sept. 1, 1983) (stating "We point out that aside from being technically desirable, the effect of standardizing nonlabor hospital costs in Alaska and Hawaii is to decrease the reduction for budget neutrality stemming from the requirements in section 1886(e)(1)(B) of the Act.").

> **1886(e)(1)(B) of the Act requires that aggregate reimbursement for the Federal portion of the prospective payment rates plus any adjustments and special treatment of certain classes of hospitals should equal the corresponding share of estimated outlays prior to the passage of Pub. L. 98-21**. Thus, for fiscal year 1984, 75 percent of total projected reimbursement based on the hospital-specific portion should equal 75 percent of total estimated outlays under law as in effect prior to April 20, 1983. Likewise, total estimated prospective payment system outlays deriving from the 25 percent Federal portion, including adjustments and special payment provisions, should equal 25 percent of projected reimbursement under prior laws.
>
> **The adjustment of the Federal portion was determined as follows**:
>
> - *Step 1*—Estimate total incurred payments for inpatient hospital operating costs for fiscal year 1984 that would have been made on a reasonable cost basis under Medicare prior to Pub. L. 98-21.
> - *Step 2*—Multiply total incurred payments by 25 percent, i.e., the Federal portion of total payment amounts for fiscal year 1984.
> - *Step 3*—Estimate the Federal portion of total payments that would have been made without adjusting for budget neutrality, but with the adjustment for outlier payments.
> - *Step 4*—Add an estimate of total adjustments and payments under special payment provisions to the Federal portion (e.g., outliers, indirect medical education).
> - *Step 5*—The difference between the step 2 and step 4 amounts is divided proportionally among the standardized amounts, resulting in the budget neutrality adjusted (standardized) amounts.
>
> **The resulting adjustment factor for the fiscal year 1984 Federal portion is .969**. Payment amounts of hospitals excluded from the prospective payment system (e.g., psychiatric and children's hospitals) and of hospitals not participating in prospective payment because of their participation in demonstrations and studies were not included in the calculations above.[42]

In the final rule published on January 3, 1984, the Secretary revised the Federal budget neutrality adjustment factor to 0.970 using the same methodology.[43] Significantly, in the January 1984

[42] 48 Fed. Reg. 39752, 39840-41 (Sept. 1, 1983) (bold, underline emphases added, and italics emphasis in original).
[43] 49 Fed. Reg. 234, 334 (Jan. 3, 1984).

final rule, the Secretary suggests that, in calculating the budget neutrality adjustment factor, CMS made no attempt to adjust for transfers under IPPS:

> Regarding additional adjustments recommended by commenters, we made no adjustments to either the adjusted standardized amounts or to the budget neutrality estimates for conditions that could not be quantified on the basis of currently available data, even if there were a likelihood that these conditions might exist under prospective payment. For example, no adjustment was made for the likelihood that admissions would increase more rapidly under prospective payment than under the provisions of Pub. L. 97-248, or for costs that might be disallowed as a result of audit or desk review by the intermediaries. *Likewise, we made no attempt to quantify adjustments* ***for the likelihood of transfers*** *under prospective payment*, emergency room services, and disallowed costs which are successfully appealed.[44]

Accordingly, *while the Providers did not appeal the 1984 budget neutrality adjustment*, the above excerpt suggests that the Providers' concern about the Secretary's alleged mistreatment of transfers may be misplaced and that the treatment of transfers in the in the context of the budget neutrality adjustment for FFY 1984 may have more significance.

Finally, the Secretary also declined to increase the base standardized amount to reflect the increased costs associated with the shift in costs of hospital-based physician services from Part B to Part A, as suggested in a comment. The Secretary noted that such an increase would simply be offset or neutralized by a corresponding increase in the budget neutrality adjustment for FFY 1984:

> Finally, applying such an adjustment to the average standardized amounts (and, by extension, to the per case budget neutrality estimates of Federal rate payments) would not actually increase the level of payments under budget neutrality. If we were to increase the initial standardized amounts to reflect this shift, the budget neutrality adjustment factor would have to be recalculated, would accordingly be increased, and the net result would be virtually identical. As a result, such an adjustment would have no effect on payment levels during FYs 1984 and 1985, which are subject to budget neutrality.[45]

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[44] *Id.* at 255 (Emphasis added.) *See also Id.* at 331 (stating as part of the discussion on the budget neutrality adjustments: "The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) established a DRG-adjusted limit on the allowable amount of inpatient operating costs per case and a per case limit on the rate of increase of operating costs of inpatient hospital services. Due to these per case limits, the incentives that influence hospital admission patterns are similar under TEFRA and prospective payment. Accordingly, ***we have assumed that the number of admissions under both prior law and the prospective payment system will be the same***. As a result, the budget neutrality factors can be calculated by comparing reimbursement per discharge for each of the systems, and there is no need to estimate an actual number of hospital admissions." (emphasis added)).

[45] *Id.* at 255.

Regardless, the Secretary's application of a 0.970 budget neutrality adjustment factor to the FFY 1984 standardized amounts ***prospectively set*** for the Federal rates for FFY 1984 confirms that these standardized rates were too high and were reduced by a factor of 0.030. Thus, the ***final*** IPPS payment rates *as used for the first year of IPPS* (*i.e.*, FFY 1984), as finalized on January 3, 1984, reflect the Secretary's FFY 1984 budget neutrality adjustment. Moreover, as previously noted, since the FFY 1984 budget neutrality adjustment is based on an ***external, fixed*** reference point (*i.e.*, no greater and no less than the reference point) and is not reviewable, the FFY 1984 budget neutrality adjustment effectively ***fixed*** the standardized amounts for FFY 1984 as used from that point forward (*i.e.*, as used both for the FFY 1984 IPPS payment rates and for subsequent years).

2. *The FFY 1985 budget neutrality adjustment also reduced the FFY 1985 standardized amounts, reaffirming that the Secretary's determined that the initial standardized amounts for FFY 1984 were set too high.*

For FFY 1985 in the August 31, 1984 IPPS final rule, the Secretary applied a budget neutrality adjustment of 0.954 to the standardized amounts used for the Federal national rates and 0.950 to the standardized amounts used for the regional rates. The Secretary described these adjustments as follows:

> In accordance with section 1886(e)(1) of the Act, the prospective payment system should result in aggregate program reimbursement equal to "what would have been payable" under the reasonable cost provisions of prior law; that is, for FYs 1984 and 1985, the prospective payment system must be "budget neutral".
>
> During the transition period, the prospective payment rates are a blend of a hospital-specific portion and a Federal portion. ***Further, effective October 1,1984***, *the Federal portion will be a blend of national and regional rates*. As a result, we must determine three budget neutrality adjustments— one each for both the national and regional rates, and one for the hospital-specific portions. The methodology we are using to make these adjustments is explained in detail in section V. of this addendum.
>
> Based on the data available to date, we have computed the following Federal rate budget neutrality adjustment factors:
>
> Regional—.950
> National—.954[46]
>
> ****
>
> [T]he FY 1985 adjusted average standardized amounts (Federal rates) were required by law to be adjusted to achieve budget neutrality; that is,

[46] 49 Fed. Reg. 34728, 34769 (Aug. 31, 1984).

> to ensure that aggregate payments for the operating costs of inpatient hospital services would be ***neither more nor less than*** *we estimated would have been paid under prior legislation for the costs of the same services*. (The technical explanation of how this adjustment was made was published in the August 31, 1984 final rule (49 FR 34791).) These budget neutrality-adjusted rates for FY 1985 are then to be used as the basis for the determination of rates for later years.
>
> Our FY 1985 budget neutrality adjustment factors were based on data and assumptions that resulted in standardized amounts that were higher than necessary to achieve budget neutrality. Therefore, we have updated the FY 1985 standardized amounts using a factor that takes into account the overstatement of the FY 1985 amounts to ensure that accuracy of the FY 1986 standardized amounts. To this end, we have identified several factors, discussed in section III.A.3.c., below, that contributed to the overstatement of the FY 1985 standardized amounts. We have determined an appropriate percent value for each of them, and have combined them into a proposed composite correction factor for FY 1986 that equals —7.5 percent.[47]

Thus, like her budget neutrality adjustments made for FFY 1984, the Secretary again confirmed that the standardized amounts were too high and exercised her discretion to ***prospectively*** adjust down the standardized amounts as used in the ***final*** IPPS rates for FFY 1985.

* * * * *

In summary, the Board finds that it lacks substantive jurisdiction over the issue raised in these appeals because the ***prospectively-set*** standardized amounts used for IPPS rates for FFYs 1984 and FFY 1985 are each based on the budget neutrality adjustment made for that FFY.[48] Therefore, the *final* FFY 1984 and 1985 standardized amounts are *inextricably intertwined* with those applicable budget neutrality adjustments.[49] Indeed, the Secretary determined that the

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[47] 50 Fed. Reg. 35646, 35695 (Sept. 3 1985) (emphasis added). *See also* 49 Fed. Reg. at 34767 (stating "We believe the explicit language of section 2310 of Pub. L. 98-369 and section 1886(d)(3)(A) of the Act requires a reduction in the standardized amounts used to compute the Federal rates before adjusting for budget neutrality. . . . Thus, while the Federal rates . . . . have been reduced in this final rule to reflect the inflation factor prescribed by section 2310 of Pub. L. 98-369, we point out that the offset for budget neutrality has also been adjusted. The reduction in the regional and national standardized rates . . . attributable to section 2310 of Pub. L. 98-369 is entirely due to the revised budget neutrality adjustments for 1984 and 1985.").

[48] The Board has included at **Appendix B** examples of other adjustments to the standardized amounts that have occurred outside of the FFY 1984 and 1985 budget neutrality adjustments. These intervening adjustments for FFYs 1986 and 2018 include both mandatory and discretionary revisions ***to the standardized amounts*** (as well as the Congress' decisions to revise or not revise the "applicable percentage increases" for FFYs 1986 and forward as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i)) and highlight the complexity of the issue before the Board, particularly where such adjustments were made in a budget neutral manner or were based on factoring in certain other estimated impacts

[49] *See DCH Reg'l Med. Ctr. v. Azar*, 925 F.3d 503, 507 (D.C. Cir. 2019) ("We cannot review the Secretary's method of estimation without also reviewing the estimate. And because the two are inextricably intertwined, section

standardized amounts for FFYs 1984 and 1985 were too high. Accordingly, the Secretary applied a budget neutrality adjustment to those years to reduce the standardized amounts by factors of approximately 0.03 for FFY 1984 and 0.05 for FFY 1985 and, thus, these budget neutrality adjustments already automatically accounted for any such alleged errors in setting the initial base rate.[50] Because 42 U.S.C. 1395ww(d)(7) prohibits administrative or judicial review of those adjustments and the resulting *final* standardized amounts for those years were carried/flowed forward *for purposes of future FFYs*, the Board may not review the standardized amount used for the FFYs being appealed as they relate to the issue in these appeals, *i.e.*, the alleged inaccuracies in the standardized amounts used for FFY 1984 as carried/flowed forward for all years following FFY 1984 to the FFYs being appealed. In this regard, the Board notes that the Providers may not simply pass through, or over, the budget neutrality adjustments for FFYs 1984 and 1985 because those adjustments are tied to an absolute *external* event (the Secretary's estimate, based on the best available data, of what would have been paid for those years if there were no IPPS) ***and*** were ***fixed*** (no greater *and* no less than what would have been paid had there been no IPPS). To do otherwise, would impact the very integrity of IPPS.

1395ww(r)(3)(A) precludes review of both."); *Mercy Hosp., Inc. v. Azar*, 891 F.3d 1062, 1067 (D.C. Cir. 2018) ("As both a textual and a practical matter, the LIP adjustment is inextricably intertwined with the step-two rate, and so the shield that protects the step-two rate from review protects the LIP adjustment as well."); *Yale New Haven Hosp. v. Becerra*, 56 F.4th 9, 18 (2nd Cir. 2022) ("Thus, we join the D.C. Circuit in "reject[ing] the argument that 'an "estimate" is not the same thing as the "data" on which it is based.'" *DCH Reg'l Med. Ctr. v. Azar* . . . . We also adopt the D.C. Circuit's holding that "[i]n this statutory scheme, a challenge to the [Secretary's choice of what data to include and exclude] for estimating uncompensated care is ... a challenge to the estimates themselves. The statute draws no distinction between the two." *Id*. at 506. Indeed, the statutory text of section 1395ww(r)(2)(C)(i) explicitly and affirmatively defines the statutory term "estimate[ ]" to encompass "the Secretary['s] determin[ation]" of what data is the "be[st] proxy for the costs of [qualifying] hospitals for treating the uninsured" and, ultimately, of what data to "use" or not "use." 42 U.S.C. § 1395ww(r)(2)(C)(i)." (citations partially omitted)). Similarly, the Board notes that the Board erred in finding that it had jurisdiction in *Columbia/HCA 1984-1986 PPS Federal Rate/Malpractice Group v. Blue Cross & Blue Shield Ass'n*, PRRB Dec. 2000-D74 (Aug. 18, 2000). In that decision, the Board found that "the issue in this case, whether the federal portion of the PPS rates should be adjusted because it was based on 1981 hospital cost report data which incorporated an invalid 1979 Malpractice Rule, does not fall into either [of the] limitations on Board jurisdiction [at 42 U.S.C. §§ 1395ww(d)(7) or 1395oo(g)(2)]. The Board finds that it can determine whether the existing statute and regulations concerning the establishment of the federal portion of the PPS rate require or permit retroactive adjustments." *Id.* at 16. The Board further found that "the retroactive adjustment proposed by the Provider would increase the federal portion of the PPS rates ***and therefore require some adjustment to be made to maintain budget neutrality***. 42 U.S.C. § 1395ww(e) and 42 C.F.R. § 412.63(j)" but that "[b]ecause the Board has determined that the adjustments are not required, how those adjustments would be made are moot, and in any event would not be subject to review by the Board. 42 C.F.R. § 405.1804(a)." *Id.* at 18 (Emphasis added.) While the Board's 2000 decision got it right that the FFY 1984 budget neutrality provision is implicated and precluded from administrative review, the above case law demonstrates that the Board erred in finding it could review the FY 1984 standardized amounts. Rather, the case law (as well as the Board's discussion herein) demonstrate that any adjustment to the FFY 1984 standardized amounts would be *inextricably* tied to the ensuing budget neutrality adjustments made for FFYs 1984 and 1985.

[50] *See supra* note 37 (discussing how the removal of nurse anesthetists costs were removed from IPPS and how that removal was *automatically* accounted for as part of the 1985 budget neutrality adjustment).

Conclusion:

The Providers claim the appeals do not challenge CMS' development of the budget neutrality factor used for the FFY 1984 and 1985 IPPS rates, which is precluded from review.[51] They also claim that the Budget Neutrality Preclusion Provisions bar administrative and judicial review of only a narrow category of challenges to the Secretary's determination of the requirement, or the proportional amount, of any budget neutrality adjustment effected pursuant to 42 U.S.C. § 1395ww(e)(1) in FFYs 1984 and 1985.[52] However, as explained above, the Board finds:

(1) The appealed issue is *inextricably* intertwined with the FFY 1984 and 1985 budget neutrality adjustments to the standardized amounts *for purposes of future FFYs* under the operation of 42 U.S.C. §§ 1395ww(b)(3)(B), 1395ww(d)(3)(A), and both 1395ww(d)(2)(F) and 1395ww(d)(3)(C) which reference 1395ww(e)(1)(B);[53] and

(2) 42 U.S.C. §§ 1395oo(g)(2) and 1395ww(d)(7) (and related implementing regulations[54]) prohibit administrative and judicial review of those budget neutrality adjustments; and

Accordingly, the Board it does not have *substantive* jurisdiction over the issue in twenty-four (24) CIRP and optional group cases listed in Appendix A, and hereby closes these group cases and removes them from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

1/24/2024

X Clayton J. Nix

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

cc: Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E)
Wilson Leong, FSS
Jacqueline Vaughn, CMS OAA

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[51] Response to Jurisdictional Challenge at 2, bullet 2.
[52] *Id.*, bullets 3 and 4.
[53] As FFY 1984 ran from October 1983 through September 1984, it is clear that the Secretary applied the FFY 1984 budget neutrality adjustment *prospectively* as issued in the September 1, 1983 interim final rule and finalized in the January 3, 1984 final rule (*see* Decision Section B.1). Thus, the Secretary effectively fixed the FFY 1984 standardized amounts on a *prospective* basis because the FFY 1984 budget neutrality adjustment (as discussed *supra*) is tied to an absolute *external* event (*the Secretary's* ***estimate***, based on the best available data, of what would have been paid for FFY 1984 if there were no IPPS) ***and*** was ***fixed*** (no greater *and* no less than what would have been paid had there been no IPPS for FFY 1984). Thus, *contrary to the Providers' contentions* (Response to Jurisdictional Challenge at 5, bullets 5-7), it is irrelevant what was *actually* paid in the aggregate for FFY 1984 for purposes of the FFY 1984 budget neutrality adjustment since the FFY 1984 base rate incorporated the FFY 1984 budget neutrality adjustment on a ***prospective*** basis.
[54] *See, e.g.*, 42 C.F.R. §§ 405.1804, 405.1840(b)(2).

APPENDIX A
Jurisdictional Challenges and Responses; Cases at Issue

On November 7, 2023, the Medicare Contractor filed a challenge to the following twenty four (24) cases which all share a common lead Medicare Contractor, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E):

19-1024GC	KPC Health FFY 2019 MCARE Pymt. Dispute CMS DRG Base Rate Calc. Errors CIRP Grp.
19-1028GC	PHH FFY 2019 MCARE Pymt. Dispute CMS DRG Base Rate Calculation Errors CIRP Grp.
19-2014GC	KPC Health CY 2016 MCARE Pymt. Dispute CMS DRG Base Rate Calc. Errors CIRP Grp.
19-2713GC	Hawaii Pacific Health FFY 2019 MCARE Payment Dispute CMS DRG Base Rate Calculation Errors CIRP Group
19-2756GC	John Muir Health FFY 2019 MCARE Pymt. Dispute CMS DRG Base Rate Calc. Errors CIRP Grp.
21-0028GC	John Muir Health FFY 2020 MCARE PYMT DISPUTE CMS DRG BASE RATE CALCULATION ERRORS CIRP Group
21-0031GC	PHH FFY 2020 MCARE PYMT DISPUTE CMS DRG BASE RATE CALCULATION ERRORS CIRP Group
21-0033GC	KPC Health FFY 2020 MCARE PYMT DISPUTE CMS DRG BASE RATE CALCULATION ERRORS CIRP Group
21-0035GC	Hawaii Pacific Health FFY 2020 MCARE PYMT DISPUTE CMS DRG BASE RATE CALCULATION ERRORS CIRP Group
21-0970GC	John Muir Health FFY 2021 MCARE PYMT DISPUTE CMS DRG BASE RATE CALCULATION ERRORS CIRP Group
21-0973GC	Hawaii Pacific Health FFY 2021 MCARE PYMT DISPUTE CMS DRG BASE RATE CALCULATION ERRORS CIRP Group
21-1025GC	KPC Health FFY 2021 MCARE PYMT DISPUTE CMS DRG BASE RATE CALCULATION ERRORS CIRP Group
21-1028GC	PHH FFY 2021 MCARE Pymnt Dispute CMS DRG Base Rate Calc. Errors CIRP Grp.
22-0691GC	PHH CY 2017 MCARE Pymt Dispute CMS DRG Base Rate Calculation Errors CIRP Group
22-0705GC	John Muir Health CY 2017 MCARE Pymt. Dispute CMS DRG Base Year Rate Calculation Errors CIRP Group
22-1156G	Moss Adams FFY 2019 MCARE Pymt Dispute CMS DRG Base Rate Calc. Errors Grp.
22-1157G	Moss Adams FFY 2020 MCARE Pymt Dispute CMS DRG Base Rate Calc. Errors Grp.
22-1210GC	Hawaii Pacific Health CY 2018 MCARE Payment Dispute CMS DRG Base Rate Calculation Errors CIRP Group
22-1315GC	KPC Health CY 2017 MCARE Pymt Dispute CMS DRG Base Rate Calc. Errors CIRP Grp.
22-1316GC	KPC Health CY 2018 MCARE Pymt Dispute CMS DRG Base Rate Calc. Errors CIRP Grp.
23-1254GC	PHH CY 2018 MCARE PYMT Dispute CMS DRG Base Rate Calculation CIRP Group
23-1341GC	Sharp Healthcare FFY 2018 MCARE Pymt Dispute CMS DRG Base Rate Calc. CIRP Grp.
23-1522GC	Hawaii Pacific Health CY 2019 MCARE Pymt Dispute CMS DRG Base Rate Calc. Errors CIRP Grp.
23-1568G	Moss Adams CY 2014 MCARE Pymt Dispute CMS DRG Base Rate Calc. Errors Grp.

APPENDIX B

The following are examples of other adjustments to the standardized amounts that have occurred outside of the FFY 1984 and 1985 budget neutrality adjustments and the "applicable percentage increases" for FFYs 1986 and forward as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i):

a. "Restandardization of base year costs per case used in [the] calculation of Federal rates" for both the labor and non-labor portions to reflect the survey-based wage index as discussed in the FY 1986 IPP Final Rule. 50 Fed. Reg. 35646, 35692 (Sept. 3, 1985).

b. Recalibration of DRG weights done in a budget neutral manner pursuant to 42 U.S.C. § 1395ww(d)(4)(C) at least every 4 years beginning with 1986.[55] An example of recalibration can be found in the FY 1986 IPPS Final Rule wherein the Secretary changed its methodology for calculating the DRG relative weights.[56]

c. Budget neutrality adjustments made to the standardized amount designated for urban hospitals and the one designated for rural hospitals when certain urban hospitals were

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[55] The Secretary confirmed that, beginning in 1991, these adjustments are to be made in a budget neutral manner:

> Section 1886(d)(4)(C)(iii) of the Act requires that beginning with FY 1991, reclassification and recalibration changes be made in a manner that assures that the aggregate payments are neither greater than nor less than the aggregate payments that would have been made without the changes. Although normalization is intended to achieve this effect, equating the average case weight after recalibration to the average case weight before recalibration does not necessarily achieve budget neutrality with respect to aggregate payments to hospitals because payment to hospitals is affected by factors other than average case weight. Therefore, as discussed in section II.A.4.b. of the Addendum to this final rule, we are making a budget neutrality adjustment to implement the requirement of section 1886(d)(4)(C)(iii) of the Act.

59 Fed. Reg. 45330, 45348 (Sept. 1, 1994).

[56] 50 Fed. Reg. 35646, 35652 (Sept. 3, 1985). As part of this recalibration process, the Secretary responded to a comment on the use of transfers in the recalibration process as follows:

> *Comment:* A commenter was concerned that, by including transfer cases in the calculation of the relative weights, we might be inappropriately reducing the relative weights of DRGs in which there are significant proportions of transfer cases.
>
> *Response:* This commenter assumes that the charges for transfer cases are lower than charges for the average case in a DRG. Our data show that this assumption is not correct for many DRGs. To test the effect of including transfers in the calculation of the relative weights, we computed mean charges for each DRG, both with and without the transfer cases. We then conducted statistical tests to determine whether these two means differed significantly at the .05 confidence level (that is, there is only a .05 probability that the observed difference in the means would occur if the two sets of cases came from the same underlying population). The results indicate that transfers have a statistically significant effect on the mean charges of only 16 DRGs. For 13 of the 16 DRGs, inclusion of transfer cases tends to ***increase*** the mean charges. However, for three DRGs, the mean charges are reduced by the inclusion of the transfer cases.
>
> Since the inclusion of transfer cases raises the mean charges for some DRGs and lowers them for others, and because these effects are limited to such a small number of DRGs, we decided not to revise the method we used to recalibrate the relative weights. During FY 1986, we will be studying the entire issue of transfers and the appropriate payment for these cases. This study may reveal other ways of handling transfer cases in future recalibrations.

Id. at 35655-56.

deemed to be urban effective with discharges occurring on or after October 1, 1988. 53 Fed. Reg. 38476, 38499-500, 38539 (Sept. 30, 1988) (implementing OBRA 87, Pub. L. 100-203, § 4005).[57]

d. Effective for FFY 1995, eliminating the initial two standardized amounts (one for urban hospital and another for rural hospitals)[58] and replacing them with one single standardized amount as specified at 42 C.F.R. § 1395ww(d)(3)(C)(iii).[59]

e. Budget neutrality provision at 42 U.S.C. § 1395ww(d)(3)(A)(vi) that allows Secretary to adjust standardized amount to eliminate the effect of "changes in coding or classification of discharges that do not reflect real changes in case mix."

f. The discretion of the Secretary in 42 U.S.C. § 1395ww(d)(3)(I)(i) to "provide by regulation for such other exceptions and adjustments to such payments amounts under this subsection as the Secretary deems appropriate."

g. The subsequent amendments that Congress made in 1994[60] and 1997[61] to add subparagraphs (I) and (J) to 42 U.S.C. § 1395ww(d)(5) to recognize and incorporate the concept of transfers into IPPS *in a budget neutral manner*. The Secretary made adjustments to the standardized amounts in order to implement the permanent incorporation of transfers into IPPS.[62]

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[57] *See also* 56 Fed. Reg. 43358, 43373 (Aug. 30, 1991) (stating "Consistent with the prospective payment system for operating costs, the September 1, 1987 capital final rule provided for separate standardized amounts for hospitals located in urban and rural areas. Subsequently, the Omnibus Budget Reconciliation Act of 1987 (Pub. L. 100-203) provided for a higher update factor for hospitals located in large urban areas than in other urban areas and thereby established three standardized amounts under the prospective payment system for operating costs. Large urban areas are defined as those metropolitan statistical areas (MSAs) with a population of more than 1 million (or New England County metropolitan statistical areas (NECMAs) with a population of more than 970,000). Beginning with discharges on or after April 1,1988 and continuing to F Y 1995, the Congress has also established higher update factors for rural hospitals than for urban hospitals. The differential updates have had the effect of substantially reducing the differential between the rural and other urban standardized amounts. Section 4002(c) of Public Law 101-508 provides for the elimination of the separate standardized amounts for rural and other urban hospitals in FY 1995 by equating the rural standardized amount to the other urban standardized amount. The separate standardized amount for large urban hospitals would continue. Currently, the large urban standardized amount under the prospective payment system for operating costs is 1.6 percent higher than the standardized amount for hospitals located in other urban areas.").
[58] *See* 42 U.S.C. §§ 1395ww(d)(2)(D), 1395ww(d)(3)(A); *supra* note 22 and accompanying text.
[59] Omnibus Reconciliation Act of 1990, Pub. L. 101-508, § 4002(c), 104 Stat. 1388, 1388-33 – 1388-35 (1990).
[60] Social Security Act Amendments of 1994, § 109, Pub. L. 103-432, 108 Stat. 4398, 4408 (1994) placed the then-existing language of 42 U.S.C. § 1395ww(d)(5)(I) into clause (i) and added the following clause (ii): "(ii) In making adjustments under clause (i) for transfer cases (as defined by the Secretary) in a fiscal year, the Secretary may make adjustments to each of the average standardized amounts determined under paragraph (3) to assure that the aggregate payments made under this subsection for such fiscal year are not greater than or lesser than those that would have otherwise been made in such fiscal year."
[61] Balanced Budget Act of 1997, Pub. L. 105-33, § 4407, 111 Stat. 251, 401 (1997), further revised 42 U.S.C. § 1395ww(d)(5)(I) and added § 1395ww(d)(5)(J).
[62] *See* 60 Fed. Reg. 45778, 45854 (Sept. 1, 1995) ("[W]e are revising our payment methodology for transfer cases, so that we will pay double the per diem amount for the first day of a transfer case, and the per diem amount for each day after the first, up to the full DRG amount. For the data that we analyzed, this would result in additional

To illustrate the complex nature of these issues, Board points to the Secretary's exercise of her discretion under 42 U.S.C. § 1395ww(d)(3)(I)(i) on making recommendations to Congress on whether to make adjustments to the "applicable percentage increases" or update factor for FFY 1986 as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i). In the September 1985 Final Rule,[63] the Secretary asserted that the FFY 1985 Federal rates were "overstated" and cited to the GAO's 1985 report entitled "Report to the Congress of the United States: Use of Unaudited Hospital Cost Data Resulted in Overstatement of Medicare Prospective Payment System Rates" and, pursuant to 42 U.S.C. § 1395ww(e)(4), made a recommendation to Congress that it not provide any increase to FFY 1985 standardized amounts but rather freeze the FFY 1986 amounts at the FFY 1985 levels (*i.e.*, recommended an update factor of 0 percent for FFY 1986).[64] The following excerpts from that rulemaking describe how the Secretary determined that the FFY 1985 standardized amounts were overstated when reviewing whether to recommend that Congress adjust the update factor for the FFY 1986 standardized amounts:

> Since the standardized amounts for FY 1985 are used as the basis for the determination of rates for later years, the level of the FY 1985 standardized amounts must be corrected for any experience that developed since they were published. *We believe that it is necessary,* ***each year****, to review the appropriateness of the level of the previous year's prospective payment rates for providing reasonable payment for inpatient hospital services furnished to beneficiaries*. Further, we think this review must include assessment of whether the previous year's prospective payment rates have established adequate incentives for the efficient and effective delivery of needed care.
>
> In addition to this general consideration, *the FY 1985 adjusted average standardized amounts* (***Federal rates***) *were required by law* ***to be adjusted to achieve budget neutrality***; that is, to ensure that aggregate payments for the operating costs of inpatient hospital services would be *neither more* ***nor*** *less than* we estimated would have been paid under prior legislation for the costs of the same services. (The technical explanation of how this adjustment was made was published in the August 31, 1984 final rule (49 FR 34791).) *These budget neutrality-adjusted rates for FY 1985 are then to be used as the basis for the determination of rates for later years*.

payments for transfer cases of $159 million. *To implement this change in a budget neutral manner*, we adjusted the standardized amounts by applying a budget neutrality adjustment of 0.997583 in the proposed rule.").

[63] 50 Fed. Reg. 35646, 35704 (Sept. 3, 1985).

[64] U.S. Gov't Accountability Office, GAO/HRD-85-74, Use of Unaudited Hospital Cost Data Resulted in Overstatement of Medicare's Prospective Payment System Rates (1985).

Our FY 1985 budget neutrality adjustment factors were based on data and assumptions that resulted in standardized amounts that were ***higher*** *than necessary to achieve budget neutrality*. Therefore, *we have updated the FY 1985 standardized amounts using a factor that takes into account the* ***overstatement*** *of the FY 1985 amounts to ensure that accuracy of the FY 1986 standardized amounts*. To this end, we have identified several factors, ***discussed in section II.A.3.c.***, below, that contributed to the overstatement of the FY 1985 standardized amounts. *We have determined an appropriate percent value for each of them, and have combined them into* ***a proposed composite correction factor*** *for FY 1986 that equals –7.5 percent*.

In addition, we have developed factors representing productivity, technological advances, and the elimination of ineffective practice patterns, which are necessary to ensure the cost-effective delivery of care. Each of these factors interacts with the others, to some extent, and has an impact on the quality of care. Making conservative assumptions, we have determined an appropriate percent value for each of these factors, taking into consideration their potential effect on quality. **We have combined these values into a composite policy target adjustment factor**, **as discussed in section III.3.e., below**. For FY 1986, this factor equals —1.5 percent.

The Secretary is required under section 1886(e)(4) of the Act to make those adjustments in establishing the update factor that are ". . . necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality." *Establishing FY 1986 prospective payment rates based on FY 1985 rates* ***that have been demonstrated to be overstated****, clearly would not comport with the statutory requirement that the rates represent payment for efficiently delivered care*.

Since the forecasted hospital market basket increase for FY 1986 is +4.27 percent, and the adjustment for Part B costs and FICA taxes is +.31 percent, it is clear that there is a potential justification of a –4.42 percent decrease in the FY 1986 standardized amounts as compared to those for FY 1985 as described below:

	Percent
Forecasted market basket increase..	+4.27
Part B costs and FICA taxes.....	+.31
Composite correction factor.....	–7.5
Composite policy target adjustment factor.....	–1.5

However, for the reasons discussed in section II.A.3.f., below, we have decided that such a decrease is undesirable. Therefore, we are maintaining the FY 1986 standardized amounts at the same average level as FY 1985, in effect applying a zero percent update factor.[65]

****

(3) *Additional causes for the overstatement of FY 1985 Federal rates.* In addition to the factors above, which we believe we must correct, **other considerations also contributed significantly to the overstatement of the FY 1985 standardized amounts**.

When we set the standardized amounts for FY 1985, we made assumptions on hospital cost per case increases in order to estimate, for purposes of budget neutrality, the payments that would have been made had prior payment rules continued in effect. These assumed rates of increase in cost per case were 10.9 percent for 1983, 9.8 percent for 1984, and 9.8 percent for 1985. These assumptions were significantly higher than the actuarial estimates. The actuarially estimated rates of increase in cost per case (which ignore any effects of the prospective payment system such as shorter lengths of stay) are 9.8 percent for 1983, 8.1 percent for 1984, and 8.5 percent for 1985. After application of the revised market basket, discussed previously, use of these actuarial estimates would reduce the standardized amounts by an additional 1.2 percent.

For FY 1985, we also used 1981 unaudited, as-submitted cost reports (to get recent data as quickly as possible) to set the Federal rates. The hospital specific rates were set using later (1982 or 1983) cost reports that were fully audited. The audits adjusted the total cost for these reports downward by $2.2 billion, of which Medicare realized about $900 million in inpatient recoveries. **Since the cost data used to set the Federal rates do not reflect audit recoveries, it is likely that they are overstated by a similar amount**. We do not know precisely what proportion of this amount applies to capital-related costs and other costs that would not affect the Federal rates. However, approximately 90 percent of hospitals" total inpatient costs are operating costs, and if only 40 percent of the $900 million in audit recoveries is related to Federal payments for inpatient operating costs, there would have been, conservatively estimated, at least a one percent overstatement of allowable costs incorporated into the cost data to determine the FY 1985 standardized amounts.

[65] 50 Fed. Reg. at 35695 (bold, italics, and underline emphasis added).

> In addition, the General Accounting Office (GAO) recently conducted a study to evaluate the adequacy of the Standardized amounts. In its report to Congress dated July 18, 1985 (GAO/HRD-85-74), **GAO reported findings that the standardized amounts, as originally calculated, are overstated by as much as 4.3 percent because they were based on unaudited cost data and include elements of capital costs.** GAO recommended that the rates be adjusted accordingly.
>
> We believe that these causes for the overstatement of the standardized amounts are related to our own procedures and decisions. Thus, they are unlike both the market basket index, which is a technical measure of input prices, and the increases in case-mix, which would not have been passed through beyond the extent to which they affected the estimates of cost per case. Further, as discussed below, even without making these corrections, we could justify a negative update factor for FY 1986, although we are not establishing one. **Since we have decided to set FY 1986 standardized amounts at the same level as those for FY 1985, making corrections now to reflect the cost per case assumptions and the audit data would have no practical effect. Therefore, we have decided <u>at this time not</u> to correct the standardized amounts for these factors.**
>
> We received no comments on this issue.
>
> (4) ***Composite Correction Factor.*** We are adjusting the standardized amounts as follows to take into consideration the overstatement of the prior years, amounts:
>
> | | *Percent* |
> |---|---|
> | Case mix..... ..... | –6.3 |
> | Market basket..... | –1.2 |
> | Composite correction factor..... | –7.5[66] |

Congress did immediately act on the Secretary's September 3, 1985 recommendation because, shortly thereafter on September 30, 1985, it enacted § 5(a) of the Emergency Extension Act of 1985 ("EEA-85") to maintain existing IPPS payment rates for FFY 1986 at the FFY 1985 Rates (*i.e.*, provide a 0 percent update factor) until November 14, 1985 as specified in EEA-85 § 5(c).[67]

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[66] *Id.* at 35703-04 (bold and underline emphasis added).

[67] Pub. L. 99-107, § 5(a), 99 Stat. 479, 479 (1985). In July 1984, Congress had *already* reduced the 1 percent update factor planned for FFY 1986 to ¼ of a percentage point. Deficit Reduction Act of 1984, Pub. L. 98-369, § 2310(a),

Congress subsequently modified this freeze on several different occasions as explained in the interim final rule published on May 6, 1986:

> - Pub. L. 99-155, enacted December 14, 1985, extended the [EEA-85] delay through December 14, 1985.
>
> - Pub. L. 99-181, enacted December 13, 1985, extended the [EEA-85] delay through December 18, 1985.
>
> - Pub. L. 99-189, enacted December 18, 1985, extended the [EEA-85] delay through December 19, 1985.
>
> - Pub. L. 99-201 enacted December 23, 1985, extended the [EEA-85] delay through March 14, 1986.[68]

Second, on April 7, 1986, Congress further revised EEA-85 § 5(c) by extending the 0 percent update factor through April 30, 1986 and then specified that, for discharges on or after May 1, 1986, the update factor would be ½ of a percentage point.[69]

The examples highlight concerns about how certain future actions and decisions by the Secretary and Congress build upon prior decisions. Here, the Secretary's recommendation to Congress regard the FFY 1986 update factor were based on its analysis of the FFY 1984 and 1985 standardized amounts that had already been adjusted for budget neutrality. To the extent the 1984 standardized amounts had been *further* adjusted (*as **now** proposed by the Providers*), it could have potentially impacted the Secretary's recommendation to Congress for the FFY 1986 update factor as well as Congress' subsequent revisions to the updated factor. Accordingly, this highlights how revisiting and otherwise adjusting the FY 1984 standardized amounts can have ripple effects with the update factor and other adjustments that were made for subsequent years *based on analysis of the prior year(s) and other information*.

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98 Stat. 494, 1075 (1984). As part of the Emergency Extension Act of 1985, Congress further reduced the update factor for FFY 1986, presumably in response to the Secretary's recommendation.

[68] 51 Fed. Reg. 16772, 16772 (May 6, 1986).

[69] *See id.* at 16773. *See also* Medicare and Medicaid Budget Reconciliation Amendments of 1985, Pub. L. 99-272, § 9101(a), 100 Stat. 151, 153 (1986).

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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

RE: ***Notice of Dismissal of Untimely Appeals***
Case Nos. 24-0669GC, *et al.* (*see* attached listing of 80 cases)

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("PRRB") is in receipt of the above-captioned nineteen (19) common issue related party ("CIRP") group appeals and 61 individual appeals, that were filed between January 16, 2024 and January 24, 2024 by the Providers' designated representative, James Ravindran of Quality Reimbursement Services, Inc. ("QRS") based on an appeal of the final rule published in the Federal Register on June 9, 2023 ("June 9, 2023 Final Rule") involving Part C days as used in the disproportionate share calculation ("DSH") by the Centers for Medicare and Medicaid Services ("CMS").[1] Set forth below is the Board's decision dismissing the above-captioned 80 CIRP group and individual cases for failure of the Providers' to *timely* file their appeals of the June 9, 2023 Final Rule by the Wednesday, December 6, 2023 filing deadline consistent with 42 U.S.C. § 1395oo(a)(1)(3), 42 C.F.R. §§ 405.1835(a)(3) and 405.1837(a)(1) and Board Rules 4.3.2 and 7.1.1.

Background

Between January 16, 2024 and January 24, 2024, QRS filed appeal requests in the Office of Hearings Case and Document Management System ("OH CDMS") to establish the above-captioned 19 CIRP group cases and 61 individual appeals. The appeal request filed for each case identifies the final determination being appealed as the June 9, 2023, Final Rule and describe the statement of issue as follows:

> **ISSUE TITLE**
>
> [DSH] – Inclusion of Part C Days in Denominator of the Medicare Fraction- Challenge to Part C Days retroactive final rule.
>
> **STATEMENT OF ISSUE**
>
> The issue is whether Part C days are properly included in the denominator of the Medicare Fraction per a July 8, 2023, retroactive

[1] 88 Fed. Reg. 37772 (June 9, 2023).

> final rule issued by [CMS], which is binding on the [Medicare contractor], or whether such final rule is illegal and cannot be enforced.
>
> The Provider appeals [Providers appeal] the Secretary's determination, which it calls a "final action," embodied in a July 8, 2023, retroactive final rule, that requires Part C Days to be included in the Medicare Fraction of the disproportionate payment percentage for discharges occurring prior to October 1, 2013 ("the Part C Days Final Rule"). The Part C Days Final Rule ***became effective on August 8, 2023***. The Providers challenge the procedural and substantive validity of the Part C Days Final Rule. Specifically, the Providers assert that the Part C Days Final Rule is procedurally invalid the retroactive nature of the rule violates the rulemaking provisions of the Social Security Act and the Administrative Procedure Act, and is contrary to the D.C. Circuit's opinion in *Northeast Hospital v. Sebelius*, and established precedent regarding the applicability of a pre-existing rule when a later rule is vacated (as was the 2004 final rule on Part C days). The Part C Days Final Rule is substantively invalid because it is arbitrary and capricious. Specifically, the Part C Days Final Rule is arbitrary and capricious because CMS did acknowledge that putting Part C Days in the Medicare Fraction was a departure from its policy or practice prior to the vacated 2004 rule. The Part C Days Final Rule also failed to account for hospitals' reliable interest on the pre-2004 final rule practice or policy, and also failed to recognize the enormous adverse financial impact on hospitals due to the change from the pre-2004 final rule practice or policy.[2]

However, each of these 80 appeals were filed more than ***180 days*** after the publication of the June 9, 2023 Final Rule provision that implemented the Final Rule for "Treatment of Medicare Part C Days in the Calculation of a Hospital's Medicare Disproportionate Patient Percentage."[3] Notwithstanding, each of these appeal requests identified, *in error*, that the "final determination date" from which they are appealing is August 8, 2023 – the ***effective date*** of the provision, rather than the date of ***notice***, *i.e.*, the publication date, of June 9, 2023.

Decision of the Board

The Board finds that the above-captioned 80 appeals were ***not*** timely filed as required by the Board's enabling statute at 42 U.S.C. § 1395oo(a)(3), which specifies that appeals of Federal Register Notices (*i.e.*, appeals under 42 U.S.C. § 1395(a)(1)(ii)) must be filed "*within . . . 180 days*

[2] Providers' Appeals Issue Statement

[3] 88 Fed. Reg. 37772 (June 9, 2023). Cases have confirmed that providers may appeal from a final rule in certain instances. *See Wash. Hosp. Ctr. v. Bowen*, 795 F.2d 139, 146 (D.C. Cir. 1986) ("[A] year end cost report is *not* a report which is necessary in order for the Secretary to make PPS payments, and the appeals provision applicable to PPS recipients cannot be read to require hospitals to file cost reports and await NPRs prior to filing a PRRB appeal"); *Dist. of Columbia Hosp. Ass'n Wage Index Group Appeal*, HCFA Adm'r Dec., Medicare & Medicaid Guide (CCH) ¶ 41,025 (Jan. 15, 1993) (publication of the wage index in the Federal Register is a final determination which can be appealed to the Board). *See also infra* note 20.

*after **notice** of the Secretary's final determination.*"[4] These appeals were filed in OH CDMS more than a month past the filing deadline of 180 days after the issuance of the June 9, 2023 Federal Register provision that implemented the Final Rule for "Treatment of Medicare Part C Days in the Calculation of a Hospital's Medicare Disproportionate Patient Percentage."

Consistent with 42 U.S.C. § 1395oo(a)(3), 42 C.F.R. § 405.1835(a)(3) specifies that a provider's appeal request must be filed no later than 180 days after the "date of receipt" of the final determination being appealed:

> (3) Unless the provider qualifies for a good cause extension under § 405.1836, the date of receipt by the Board of the provider's hearing request must be no later than 180 days after the date of receipt by the provider of the final contractor or Secretary determination.

The regulation at 42 C.F.R. § 405.1837(a)(1) makes clear that this requirement applies to provider's participating in a group appeal whether by transfer or direct add.[5] To this end, Board Rule 7.1.1 specifies that the appeal request must "[i]dentify the date the final determination ***was issued***"[6] and Board Rule 4.3.2 specifies in connection with appeals based on a Federal Register Notice that: (1) "[t]he date of receipt of a Federal Register Notice is the date the Federal Register is published"; and (2) "[t]he appeal period begins on the date of publication and ends 180 days from that date."

The Board is bound by all of the provisions of Title XVIII of the Act (the Social Security Act, as amended) and the regulations issued thereunder.[7] The Board cannot apply a regulation or instruction which is contrary to a statute and other regulations that deal specifically with the matter at hand: the date a provider is deemed to have notice of the contents of the Federal Register. In this case, the laws and regulations governing the publication of Federal Register notices specifically define the time of notice as that of publication. These laws and regulations have been incorporated into Title XVIII.

The Secretary[8] has enacted Part 401 of Title 42 of the Code of Federal Regulations which is entitled "General Administrative Requirements." Subpart B, §§ 401.101(a)(1) and (2) of this Part states that "[t]he regulations in this subpart: (1) Implement section 1106(a)[9] of the Social Security Act [relating to disclosure of information] as it applies to [CMS] . . . [and] (2) Relate to the

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[4] (Emphasis added.)
[5] 42 C.F.R. § 405.1837(a)(1) specifies that a provider's right to participate in a group is dependent, in part, on the "[t]he provider satisfy[ying] individually the requirements for a Board hearing under § 405.1835(a) or § 405.1835(c), except for the $10,000 amount in controversy requirement in § 405.1835(a)(2) or § 405.1835(c)(3)." NOTE – none of the providers in these 80 appeals have alleged that they are appealing from the nonissuance of an NPR or revised NPR consistent with § 405.1835(c) and, to that end, there is no information in the records for these cases to support such an allegation consistent with Board Rule 7.5.
[6] (Emphasis added.)
[7] *See* 42 C.F.R. § 405.1867.
[8] of the Department of Health and Human Services.
[9] 42 U.S.C. § 1306(a).

availability to the public, under 5 U.S.C. § 552,[10] of records of CMS." These laws and regulations set out which records are available and how they may be obtained, and they supplement the regulations of CMS relating to the availability of information. Section 401.106 of this subpart, which deals with publication of materials under 5 U.S.C. § 552, requires publication to serve as notice and identifies the Federal Register as the vehicle to be used to give notice. Section 552(a) states in part that:

> (1) Each agency shall separately state and currently publish in the Federal Register for the guidance of the public-
>
> * * * *
>
> (D) substantive rules of general applicability adopted as authorized by law, and statements of general policy or interpretations of general applicability formulated and adopted by the agency; and
> (E) each amendment, revision, or repeal of the foregoing.

In order to comply with the statutes and regulations requiring that public notice be given, the Secretary annually publishes the schedules of the Inpatient Prospective Payment System ("IPPS") rates as well as other IPPS policies in the Federal Register pursuant to the requirements of 42 C.F.R. § 412.8(b)(2). The Secretary may issue other changes as Federal Register Notices outside of this annual ratesetting process as was done here with the issuance of the Part C days policy published in the June 9, 2023 Final Rule. These processes were created to comply with 5 U.S.C. § 552 of the Freedom of Information Act which requires that agencies publish regulations and notices in the Federal Register.[11]

With regard to the Notices published in the Federal Register, 44 U.S.C. § 1507 states in part that:

> A document required. . .to be published in the Federal Register is not valid as against a person who has not had actual knowledge of it until the duplicate originals or certified copies of the document have been filed with the Office of the Federal Register and a copy made available for public inspection as provided by section 1503. . . . *[F]iling of a document, required or authorized to be published [in the Federal Register] by section 1505. . .is sufficient to give notice* of the contents of the document to a person subject to or affected by it.[12]

Reflecting new technology and the ability to transmit information immediately upon publication, the Government Printing Office ("GPO") promulgated 1 C.F.R. § 5.10 which authorizes publication of the Federal Register on the internet at the GPO website.[13] The GPO website containing the Federal Register is updated daily at 6 a.m. Monday through Friday, except

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[10] 5 U.S.C. § 550 *et seq.* contains the Administrative Procedures Act; 5 U.S.C. § 552 deals with the availability of government information and is known as the Freedom of Information Act ("FOIA").
[11] *See also* 42 C.F.R. Part 401, Subpart B.
[12] (Emphasis added).
[13] *See also* 44 U.S.C. § 4101 (the Superintendent of Documents is to maintain an electronic director and system of online access to the Federal Register).

holidays.[14] Consequently, the Provider is deemed to have notice of the Part C days policy at issue on the date the Federal Register was published and made available online. Indeed, the Board notes that Notices are often available for public inspection several days ***prior to*** the official publication date and, here, the June 9, 2023 Final Rule was posted to the public at 4:15 pm on June 7, 2023, 2 days in advance of the June, 9, 2023 publication date.[15]

With respect to statutes and regulations dealing with the Federal Register, the Supreme Court has found that:

> Congress has provided that the appearance of rules and regulations in the Federal Register give legal notice of their contents . . . .
>
> . . . Regulations [are] binding on all who sought to come within the [Act], regardless of actual knowledge of what is in the Regulations or of the hardship resulting from innocent ignorance.[16]

The statutes governing the Board (44 U.S.C. § 1507 as applied through the requirements of 42 C.F.R. § 401.101 and the Administrative Procedures Act ("APA")) are clear on their face: ***the date of publication*** of the Federal Register is the date the Providers are deemed to have notice of the June 9, 2023 Final Rule. The Board is bound by all of the provisions of Title XVIII which includes, by reference, the provisions of the Administrative Procedures Act and the Public Printing and Documents law which require that CMS publish its notices and regulations in the Federal Register. In publishing materials in the Federal Register, CMS must comply with the statutes and regulations governing the Superintendent of Documents and the Governing Printing Office.

Pursuant 42 U.S.C. § 1395oo(a)(3), the Board's enabling statute, providers have 180 days "after *notice* of the Secretary's final determination" to file an appeal. To this end, Board Rule 4.3.2 confirms that the appeal period for a final rule published in the Federal Register appeal ends 180 days from the date of ***publication***, not the effective date that may be listed in a provision:

> The date of receipt of a Federal Register Notice is the date the Federal Register is ***published***. The appeal period begins on the date of publication and ends 180 days from that date.[17]

In this case, the notice of the Secretary's determination is, by law, the date the Federal Register is issued by the Superintendent of Documents, or June 9, 2023. Here, the 180th day for appealing was ***Wednesday, December 6, 2023***. The above-captioned appeals were not filed with the Board until ***more than a month after this deadline*** (specifically between January 16, 2024 and January 22, 2024) and, thus, were not timely filed.[18]

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[14] *See* http://www.gpo.gov/help/index.html#about_federal_register.htm.
[15] https://www.federalregister.gov/public-inspection/2023/06/07 (last accessed Jan. 19, 2024).
[16] *Fed. Crop Ins. Corp. v. Merrill*, 332 U.S. 380, 385 (1947).
[17] Emphasis added.
[18] The Providers in these 80 appeals have not requested good cause exception under 42 C.F.R. § 405.1836 and have not presented any evidence suggesting that they would qualify under the criteria specified in that regulation.

Based on the above findings, the Board concludes that it does not have jurisdiction over the above-captioned 80 appeals for failure of the Providers' to *timely* file these appeals of the June 9, 2023 Final Rule by the Wednesday, December 6, 2023 filing deadline consistent with 42 U.S.C. § 1395oo(a)(1)(3), 42 C.F.R. §§ 405.1835(a)(3) and 405.1837(a)(1) and Board Rules 4.3.2 and 7.1.1 and, as such, hereby dismisses them. Accordingly, the Board closes the above-captioned 80 cases and removes them from the Board's docket.[19,20] Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

1/25/2024

X Clayton J. Nix

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

Enclosure – Listing of 80 Individual Cases

cc: Wilson Leong, Federal Specialized Services
Dana Johnson, Palmetto GBA c/o National Government Services, Inc.
Byron Lamprecht, WPS Government Health Administrators
Cecile Huggins, Palmetto GBA

[19] The Board notes that for each of the 61 individual appeals addressed in this letter, the only issue pending is the appeal of the June 9, 2023 Part C final rule.

[20] Regardless, even if the Board had not dismissed these appeals as being untimely filed (more than a month late), the Board would find that the Providers appeals were premature as they failed to appeal from a "final determination" consistent with the jurisdictional dismissal decisions issued in: (1) Case No. 23-1498 on Nov. 27, 2023 which similarly appealed the June 9, 2023 Final Rule (available at: https://www.cms.gov/files/document/prrb-jurisdictional-decisions-11-1-2023-through-11-30-2023.pdf (last accessed Jan. 19, 2023)); (2) Case Nos. 23-1796GC, *et al*. on Oct. 25, 2023 which appealed the § 1115 waiver day policy finalized in the August 28, 2023 FY 2024 IPPS Final Rule (available at: https://www.cms.gov/files/document/prrb-jurisdictional-decisions-10-1-2023-through-10-31-2023.pdf (last accessed Jan. 19, 2023)). Moreover, even if it were a final determination, the Board would also need to conduct further review to confirm, *based on the information/documentation included in the relevant appeal request*, whether the Providers have established (consistent with 42 C.F.R. §§ 405.1835(b)(1) and 405.1837(c)(1), (3)) that the June 9, 2023 Final Rule is, ***in fact***, applicable to them (*i.e.*, confirm for the fiscal years at issue that either: (a) no NPR has been issued; or (b) they had a Board appeal of the Part C issue that was subsequently remanded per CMS Ruling 1739-R).

Listing of 19 CIRP Cases and 61 Individual Cases

24-0669GC	WVU Medicine CY 2009 Treatment of Part C Days Final Rule CIRP Group
24-0670GC	WVU Medicine CY 2010 Treatment of Part C Days Final Rule CIRP Group
24-0671GC	CHS CY 2006 Treatment of Part C Days Final Rule CIRP Group
24-0672GC	WVU Medicine CY 2011 Treatment of Part C Days Final Rule CIRP Group
24-0709GC	Ballad Health CY 2007 Treatment of Part C Days Final Rule CIRP Group
24-0712GC	Ballad Health CY 2008 Treatment of Part C Days Final Rule CIRP Group
24-0713GC	Ballad Health CY 2009 Treatment of Part C Days Final Rule CIRP Group
24-0716GC	Ballad Health CY 2010 Treatment of Part C Days Final Rule CIRP Group
24-0719GC	Ballad Health CY 2011 Treatment of Part C Days Final Rule CIRP Group
24-0721GC	Ballad Health CY 2012 Treatment of Part C Days Final Rule CIRP Group
24-0723GC	Ballad Health CY 2013 Treatment of Part C Days Final Rule CIRP Group
24-0738GC	MultiCare Health CY 2006 Treatment of Part C Days Final Rule CIRP Group
24-0740GC	MultiCare Health CY 2007 Treatment of Part C Days Final Rule CIRP Group
24-0741GC	MultiCare Health CY 2008 Treatment of Part C Days Final Rule CIRP Group
24-0743GC	MultiCare Health CY 2009 Treatment of Part C Days Final Rule CIRP Group
24-0745GC	MultiCare Health CY 2010 Treatment of Part C Days Final Rule CIRP Group
24-0746GC	MultiCare Health CY 2011 Treatment of Part C Days Final Rule CIRP Group
24-0747GC	MultiCare Health CY 2012 Treatment of Part C Days Final Rule CIRP Group
24-0748GC	MultiCare Health CY 2013 Treatment of Part C Days Final Rule CIRP Group
24-0749	Community Memorial Hospital San Buenaventura (05-0394), FFY 2006
24-0750	Community Memorial Hospital San Buenaventura (05-0394), FFY 2007
24-0751	Community Memorial Hospital San Buenaventura (05-0394), FFY 2008
24-0752	Community Memorial Hospital San Buenaventura (05-0394), FFY 2009
24-0753	Community Memorial Hospital San Buenaventura (05-0394), FFY 2010
24-0754	Community Memorial Hospital San Buenaventura (05-0394), FFY 2013
24-0755	Saint Francis Hospital and Medical Center (07-0002), FFY 2006
24-0756	Saint Francis Hospital and Medical Center (07-0002), FFY 2007
24-0757	Saint Francis Hospital and Medical Center (07-0002), FFY 2008
24-0758	Saint Francis Hospital and Medical Center (07-0002), FFY 2009
24-0759	Saint Francis Hospital and Medical Center (07-0002), FFY 2010
24-0760	Saint Francis Hospital and Medical Center (07-0002), FFY 2011
24-0761	Saint Francis Hospital and Medical Center (07-0002), FFY 2012
24-0762	Saint Francis Hospital and Medical Center (07-0002), FFY 2013
24-0763	Stamford Hospital (07-0006), FFY 2005
24-0764	Stamford Hospital (07-0006), FFY 2006
24-0765	Stamford Hospital (07-0006), FFY 2007
24-0766	Stamford Hospital (07-0006), FFY 2008
24-0767	Stamford Hospital (07-0006), FFY 2009
24-0768	Stamford Hospital (07-0006), FFY 2010
24-0769	Stamford Hospital (07-0006), FFY 2011
24-0770	Stamford Hospital (07-0006), FFY 2012
24-0771	Stamford Hospital (07-0006), FFY 2013
24-0773	Saint Mary's Hospital (07-0016), FFY 2007

24-0775	Saint Mary's Hospital (07-0016), FFY 2008
24-0776	Middlesex Hospital (07-0020), FFY 2005
24-0777	Middlesex Hospital (07-0020), FFY 2006
24-0778	Middlesex Hospital (07-0020), FFY 2007
24-0779	Middlesex Hospital (07-0020), FFY 2008
24-0780	Middlesex Hospital (07-0020), FFY 2009
24-0781	Middlesex Hospital (07-0020), FFY 2010
24-0783	Middlesex Hospital (07-0020), FFY 2011
24-0784	Middlesex Hospital (07-0020), FFY 2012
24-0785	Middlesex Hospital (07-0020), FFY 2013
24-0786	Backus Hospital (07-0024), FFY 2006
24-0787	Backus Hospital (07-0024), FFY 2008
24-0788	Backus Hospital (07-0024), FFY 2009
24-0789	Backus Hospital (07-0024), FFY 2010
24-0790	Backus Hospital (07-0024), FFY 2011
24-0791	Backus Hospital (07-0024), FFY 2012
24-0792	Backus Hospital (07-0024), FFY 2013
24-0793	Naples Community Hospital (10-0018), FFY 2006
24-0794	Naples Community Hospital (10-0018), FFY 2007
24-0795	Naples Community Hospital (10-0018), FFY 2008
24-0796	Naples Community Hospital (10-0018), FFY 2009
24-0797	Naples Community Hospital (10-0018), FFY 2010
24-0798	Naples Community Hospital (10-0018), FFY 2011
24-0799	Naples Community Hospital (10-0018), FFY 2012
24-0800	Naples Community Hospital (10-0018), FFY 2013
24-0803	Cox Medical Centers (26-0040), FFY 2007
24-0804	Cox Medical Centers (26-0040), FFY 2008
24-0806	Cox Medical Centers (26-0040), FFY 2009
24-0807	Cox Medical Centers (26-0040), FFY 2010
24-0808	Cox Medical Centers (26-0040), FFY 2011
24-0809	Cox Medical Centers (26-0040), FFY 2012
24-0811	Cox Medical Centers (26-0040), FFY 2013
24-0813	The Nebraska Medical Center (28-0013), FFY 2008
24-0814	The Nebraska Medical Center (28-0013), FFY 2009
24-0816	The Nebraska Medical Center (28-0013), FFY 2011
24-0817	The Nebraska Medical Center (28-0013), FFY 2012
24-0818	The Nebraska Medical Center (28-0013), FFY 2013

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Baltimore, MD 21244
410-786-2671

Via Electronic Delivery

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

RE: ***Board Decision***
Western Arizona Regional Medical Center (03-0101)
FYE: 08/31/2017
Case Number: 20-0142

Dear Mr. Ravindran,

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the documentation in Case No. 20-0142 pursuant to a Jurisdiction Challenge and Motion to Dismiss filed by the Medicare Administrative Contracto ("MAC"). The Board's analysis and determination is set forth below.

Background:

A. Procedural History for Case No. 20-0142

On April 15, 2019, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end August 31, 2017.

On October 3, 2019, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained five (5) issues:

1. DSH Payment/SSI Percentage (Provider Specific)
2. DSH/SSI Percentage (Systemic Errors)[1]
3. DSH – Medicaid Eligible Days[2]
4. UCC Distribution Pool
5. 2 Midnight Census IPPS Payment Reduction[3]

As the Provider is commonly owned by Community Health Systems, Inc. ("CHS"), and thereby, subject to the mandatory Common Issue Related Party ("CIRP") regulation at 42 C.F.R. § 405.1837(b)(1), the Provider transferred Issues 2 and 4 to CHS groups on April 21, 2020. As a result of a withdrawal and the transfers, the remaining issues in this appeal are Issue 1 (the DSH – SSI Percentage (Provider Specific) issue) and Issue 4 (UCC Distribution Pool).

[1] On April 21, 2020, this issue was transferred to PRRB Case No. 20-0997GC.
[2] On January 2, 2024, the Provider withdrew this issue.
[3] On April 21, 2020, this issue was transferred to PRRB Case No. 20-0999GC.

On August 25, 2020, the Medicare Contractor filed a jurisdictional challenge on both remaining issues, Issues 1 and 4. To date, the Provider has not responded.

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

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

> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> …
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[4]

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

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

On May 27, 2020, the Provider submitted its preliminary position paper to the MAC. The following is the Provider's complete position on Issue 1 set forth therein:

> **Provider Specific**
>
> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation based on the Provider's Fiscal Year End (August 31).

[4] Provider's Request for Hearing, Issue Statement (October 3, 2019)
[5] Group Issue Statement

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

Medicare Contractor's Contentions

Issue 1 – DSH SSI Percentage (Provider Specific)

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

> The decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election. It is not a final intermediary determination. A hospital must make a formal request to CMS in order to receive a realigned SSI percentage. Once the hospital elects to use its own fiscal year end, it is bound by that decision, regardless of reimbursement impact
>
> . . . .
>
> The Provider's appeal is premature. To date, the Provider has not requested to have its SSI percentage realigned in accordance with 42 C.F.R. § 412.106(b)(3). Thus, the Provider has not exhausted all available remedies for this issue. The MAC requests that the Board dismiss this issue consistent with recent jurisdictional decisions.[6]

Issue 4 – UCC Distribution Pool

The MAC argues "that the Board does not have jurisdiction over the UCC DSH payment issue because jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2)."[7]

[6] Medicare Contractor's Jurisdictional Challenge, (August 25, 2020) .
[7] *Id.*

The MAC also contends that this issue is a duplicate of PRRB Case Nos. 16-0769GC and 17-1042GC, and should therefore, be dismissed.[8]

Provider's Response

The Board Rules require that Provider Responses to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[9] The Provider has not filed a response to the Jurisdictional Challenges and the time for doing so has elapsed. Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

Board Analysis and Decision:

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

A. DSH Payment/ SSI Percentage (Provider Specific)

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

1. First Aspect of Issue 1

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

The DSH Payment/SSI Percentage (Provider Specific) issue in the present appeal concerns "whether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation."[10] The Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[11] The Provider argues that "its SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . disagrees with the [Medicare Contractor]'s

[8] *Id.*
[9] Board Rule 44.4.3, v. 2.0 (Aug. 2018).
[10] Issue Statement at 1.
[11] *Id.*

calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[12]

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 20-0997GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds the DSH Payment/SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 20-0997GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[13], the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

In making this finding, the Board further notes that CMS regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, is pursuing that issue as part of the group under Case 20-0997GC which it is required to do since it is a common issue subject to the mandatory CIRP rules at 42 C.F.R. § 405.1837(b)(1). Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in Baystate, may impact the SSI percentage for each provider differently.[14] The Provider is misplaced in referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 20-0997GC in its appeal request and failed to respond to the Jurisdictional Challenge.

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 20-0997GC, but instead refers to systemic Baystate data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with the Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be fully developed and include all available documentation necessary to provide a thorough understanding of the parties' positions." For example, the Provider claims that SSI entitlement can be ascertained from State records but fails to explain how or establish what those alleged records show, or identify any days in dispute based on those records (much less explain how the State record issue would be provider specific and not subject to the CIRP group rules and not already part of the CIRP group to which it transferred the systemic issue). Here, it is clear that the Provider failed to fully develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" in its Preliminary Position Paper and include all exhibits.

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

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[12] *Id.*

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

[14] 5 The types of systemic errors documented in the Baystate did not uniformly impact the SSI calculation for all providers but that does not may the errors any less systemic. See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co., PRRB Dec. No. 2006-D20 (Mar. 17, 2006). See also Baystate Med. Ctr. v. Leavitt, 545 F. Supp. 2d 20 (D.D.C. 2008).

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

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

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

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

2. Second Aspect of Issue 1

[15] Last accessed February 24, 2023.

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

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

B. UCC Distribution Pool

The Board finds that it does not have jurisdiction over the DSH UCC payment issue in the above-referenced appeal because jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2).[16]

1. Bar on Administrative Review

The Board does not generally have jurisdiction over Uncompensated Care DSH payment issues because 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2) preclude administrative and judicial review of certain aspects of the UCC payment calculation. Based on these provisions, judicial and administrative review is precluded 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).[17]
>
> (B) Any period selected by the Secretary for such purposes.

2. Interpretation of Bar on Administrative Review

a. Tampa General v. Sec'y of HHS

In *Florida Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Servs*. ("*Tampa General*"),[18] the U.S. Court of Appeals for the District of Columbia Circuit ("D.C. Circuit")

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[16] 7 The Provider was also a participant in PRRB Case Nos. 16-0769GC (appealing from the Fed. Reg. dated Aug. 17, 2015 and covers service dates July 1, 2016 through Sept. 30, 2016) and 17-1042GC (appealing from the Fed. Reg. dated Aug. 22, 2016 and covers service dates Oct. 1, 2016 through June 30, 2017). Both CIRP Group appeals have been dismissed for a lack of jurisdiction.

[17] Paragraph (2) is a reference to the three factors that make up the uncompensated care payment: (1) 75 percent of estimated DSH payments that would be paid in absence of § 1395ww(r); (2) 1 minus the percentage of individuals under age 65 who are uninsured in 2013 for the FY 2014 calculation; and (3) the hospital specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital with potential to receive DSH payments, to the amount of uncompensated care for all subsection (d) hospitals that receive payment under 42 U.S.C. § 1395ww(r)(2)(C). 78 Fed. Reg. 50496, 50627, 50631 and 50634.

[18] 830 F.3d 515 (D.C. Cir. 2016).

upheld the D.C. District Court's decision[19] that there is no judicial or administrative review of uncompensated care DSH payments. In that case, 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 D.C. Circuit 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 hospital was seeking review of an "estimate" used by the Secretary to determine the factors used to calculate additional payments. The D.C. Circuit went on to hold that "the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well."[20] 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.[21]

The D.C. Circuit went on to address the provider'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.[22]

b. DCH Regional Med. Ctr. v. Azar

The D.C. Circuit Court revisited the judicial and administrative bar on review of uncompensated care DSH payments again in *DCH Regional Med. Ctr. v. Azar* ("*DCH v. Azar*").[23] 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. Indeed, 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 estimation without reviewing the estimate itself."[24] 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 it 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, the D.C. Circuit found the same relationship existed with regard to the methodology used to generate the estimates.[25]

[19] 89 F. Supp. 3d 121 (D.D.C. 2015).
[20] 830 F.3d 515, 517.
[21] *Id.* at 519.
[22] *Id.* at 521-22.
[23] 925 F.3d 503 (D.C. Cir. 2019) ("*DCH v. Azar*").
[24] *Id.* at 506.
[25] *Id.* at 507.

c. Scranton Quincy Hosp. Co. v. Azar

Recently, in *Scranton Quincy Hosp. Co. v. Azar* ("*Scranton*"),[26] the D.C. District Court considered a similar challenge and held that administrative review was precluded. In *Scranton*, the providers were challenging how the Secretary determined the amount of uncompensated care that would be used in calculating Factor 3 for their FY 2015 DSH adjustments.[27] For 2015 payments, the Secretary announced she would calculate DSH payments based on Medicaid and SSI patient days from 2012 cost reports, unless that cost report was unavailable or was for a period less than twelve months. In that scenario, the Secretary would calculate the FY 2015 DSH payments based on either the 2012 or 2011 cost report that was closest to a full twelve month cost report.[28] Since the providers in *Scranton* changed ownership in FY 2012, each had two cost reports that began in 2012: an initial cost report less than twelve months and a subsequent cost report that was a full twelve months.[29] Nevertheless, the Secretary used each hospital's shorter cost reporting period in calculating the Factor 3 values for their FY 2015 DSH payments.[30]

In *Scranton*, the providers argued that, unlike the providers in *Tampa General* and *DCH v. Azar* who were specifically attacking the methodology and policies adopted by the Secretary, they were simply trying to enforce those policies. The D.C. District Court was not persuaded, finding that the complaint was still about the method used and the particular data the Secretary chose to rely upon when estimating the amount of uncompensated care calculated. Just like in *Tampa General* and *DCH v. Azar*, the selection of one cost report for FY 2012 over another was "inextricably intertwined" with the Secretary's estimate in Factor 3 and not subject to administrative review. Similarly, the challenge to the decision to use one cost report over another was also a challenge to a "period selected by the Secretary," which is also barred from review.[31]

Finally, and perhaps most importantly, the D.C. District Court found that any allegations that the Secretary departed from her own policy and/or acted *ultra vires* did not alter its decision. The D.C. District Court found that, in the context of the bar on review of the Secretary's estimates used and periods chosen for calculating the factors in the UCC payment methodology, "saying that the Secretary wrongly departed from his own policies when he chose the data for the estimate or selected the period involved is fundamentally indistinguishable from a claim that he chose the wrong data or selected the wrong period."[32] While there is some case law to support that claims of *ultra vires* acts may be subject to review in narrow circumstances where such review is precluded by statute, the criteria in *Scranton* were not met.[33] For review to be available in these circumstances, the following criteria must satisfied:

> (i) the statutory preclusion of review is implied rather than express; (ii) there is no alternative procedure for review of the statutory claim; and (iii)

[26] 514 F. Supp. 249 (D.D.C. 2021).
[27] *Id.* at 255-56.
[28] *Id.* (quoting 79 Fed. Reg. 49854, 50018 (Aug. 22, 2014)).
[29] *Id.* One provider had a cost report for the six-month period from July 1, 2011 to December 31, 2011 and another for the twelve-month period from July 1, 2012 to June 30, 2013, while the second had a cost report for the nine-month period from October 1, 2011 to June 30, 2012 and another for the twelve-month period from July 1, 2012 to June 30, 2013.
[30] *Id.*
[31] *Id.* at 262-64.
[32] *Id.* at 265.
[33] *Id.* (discussing *Leedom v. Kyne*, 358 U.S. 184, 188 (1958)).

> the agency plainly acts in excess of its delegated powers and contrary to a specific prohibition in the statute that is clear and mandatory.[34]

The D.C. District Court found that the preclusion of review for this issue was express, not implied, which fails to satisfy the first prong of this test. Second, the departure from the period to be used announced in the Secretary's rulemaking does not satisfy the third prong, which requires a violation of a clear statutory command.[35] The D.C. District Court ultimately upheld the Board's decision that it lacked jurisdiction to consider the providers' appeals.

d. Ascension Borgess Hospital v. Becerra

Even more recently, the D.C. Circuit revisited, once again, the judicial and administrative bar on review of uncompensated care DSH payments again in *Ascension Borgess Hospital v. Becerra* ("*Ascension*").[36] In *Ascension*, the providers sought an order declaring the Worksheet S-10 audit protocol was unlawful, vacating the payments based on the Worksheet S-10 audit, requiring the Secretary to recalculate those payments, and setting aside the Board decisions refusing to exercise jurisdiction over their appeals.[37] Ultimately, the D.C. Circuit found that 42 U.S.C. § 1395ww(r)(3) bars administrative and judicial review of the providers claims. In making this finding, the D.C. Circuit pointed to its earlier decisions in *Tampa General* and *DCH v. Azar* where it "repeatedly applied a "functional approach" focused on whether the challenged action was " 'inextricably intertwined' with the unreviewable estimate itself" and eschewing "categorical distinction between inputs and outputs."[38] The D.C. Circuit further dismissed the applicability of the Supreme Court's 2019 decision in *Azar v. Allina Health Servs*.[39] noting that "[t]he scope of the Medicare Act's notice-and-comment requirement would be relevant in evaluating the merits of plaintiffs' claims—i.e., that the Worksheet S-10 audit protocol establishes or changes a substantive legal standard within the meaning of § 1395hh(a)(2)—***but has no bearing on whether these claims are barred by the Preclusion Provision***."[40]

The Board finds that the same findings are applicable to the Provider's challenge to their FFY 2016 UCC payments. The Providers here are challenging their uncompensated care DSH Payment amounts, as well as the general rules governing the methodology used in calculating those amounts, for FFY 2016. The challenge to CMS' notice and comment procedures focuses on a lack of information and underlying data used by the Secretary to determine the UCC payments, but *Tampa General* held that the underlying data cannot be reviewed or challenged. Likewise, the Provider's arguments centering on the *Allina* decision claim that certain data should recalculated or revised. Again, a challenge to the underlying data used in calculating UCC DSH payments is not subject to administrative or judicial review. Likewise, any challenge to the methodology used to determine the payment amounts was rejected in *DSCH v. Azar*, finding that the methodology was just as "inextricably intertwined" with the actual estimates as the underlying data, and barred from review.

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[34] *Id.* at 264 (quoting *DCH v. Azar*, 925 F.3d at 509-510).
[35] *Id.* at 264-6511 (quoting *DCH v. Azar*, 925 F.3d at 509).
[36] Civ. No. 20-139, 2021 WL 3856621 (D.D.C. August 30, 2021).
[37] *Id.* at *4.
[38] *Id.* at *9.
[39] 139 S. Ct. 1804 (2019).
[40] *Ascension* at *8 (bold italics emphasis added).

Decision

Accordingly, based on the record before it, the Board hereby dismisses:

1. The DSH Payment/SSI Percentage (Provider Specific) issue from appeal because it is duplicative of the issue in PRRB Case No. 20-0997GC and there is no final determination from which the Provider can appeal the SSI realignment portion of the issue and the Provider failed to properly develop the issue to establish it as a separate and distinct issue;

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

In making these dismissals, the Board notes that the Provider failed to respond to the relevant Jurisdictional Challenge. 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. As no issues remain, the appeal is now closed.

Board Members:

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

For the Board:

1/26/2024

X Robert A. Evarts, Esq.

Robert A. Evarts, Esq.
Board Member
Signed by: PIV

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Stephanie Webster, Esq.
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RE: ***Notice of Dismissal***
Tampa General Hospital (Prov. No. 10-0128)
FYE 9/30/2008
Case No. 24-0356

Dear Ms. Webster:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request of Tampa General Hospital ("Tampa" or "Provider") filed by Tampa's designated representative, Stephanie Webster of Ropes & Gray, LLP (Ropes & Gray), on December 4, 2023 to establish the above-referenced individual appeal pertaining to Tampa's fiscal year ("FY") 2008. Set forth below is the decision of the Board to dismiss Tampa's appeal.

Issue in Dispute

On **December 4, 2023**, Ropes & Gray filed Tampa's appeal request and *specifically* identified the determination being appealed as the final rule published in the June 9, 2023 Federal Register ("June 9, 2023 Final Rule") *as it* ***retroactively*** *pertains to Tampa's FY 2008*.[1]

The ***sole*** issue in this appeal relates to the aftermath of the *Allina* litigation and concerns the proper treatment in Tampa's *FY 2008* Medicare disproportionate share hospital ("DSH") calculation of days for patients who were enrolled in Medicare Advantage plans under Part C of the Medicare statute ("Part C days"). Tampa contends that Part C days must be excluded in their entirety from the SSI fraction *pertaining to* ***its FY 2008*** and that those days instead must be included in the numerator of the Medicaid fraction (but only for those patients eligible for Medicaid) as used in its DSH adjustment calculation *for FY 2008*.[2]

Accordingly, Tampa seeks to challenge the CMS policy adopted in the June 9, 2023 Final Rule to be applied *retroactively* to its FY 2008 and estimates the amount in controversy as $644,158 for its FY 2008.[3]

[1] 88 Fed. Reg. 37772 (June 9, 2023). *See also infra* note 65.
[2] Statement of Issue included with the December 4, 2023 appeal request.
[3] 88 Fed. Reg. 37772 (June 9, 2023).

Statutory and Regulatory Background:

A. Medicare DSH Payment

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the inpatient prospective payment system ("IPPS").[4] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[5]

The IPPS statute contains several provisions that adjust reimbursement based on hospital-specific factors.[6] This case involves the hospital-specific DSH adjustment, which requires the Secretary to provide increased IPPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[7]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[8] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.[9] The DPP is defined as the sum of two fractions expressed as percentages.[10] Those two fractions are referred to as the "Medicare/SSI fraction" and the "Medicaid fraction." Both of these fractions consider whether a patient was "entitled to benefits under part A."

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

> the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were ***entitled to benefits under part A*** of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were ***entitled to benefits under part A*** of this subchapter . . . .[11]

The Medicare/SSI fraction is computed annually by the Centers for Medicare and Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[12]

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[4] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[5] *Id.*
[6] *See* 42 U.S.C. § 1395ww(d)(5).
[7] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[8] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[9] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[10] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[11] (Emphasis added.)
[12] 42 C.F.R. § 412.106(b)(2)-(3).

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

> the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX [the Medicaid program], but who were ***not entitled to benefits under part A of this subchapter,*** and the denominator of which is the total number of the hospital's patient days for such period.[13]

The Medicare contractor determines the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A and divides that number by the total number of patient days in the same period.[14]

B. Establishment of Medicare Part C and Treatment of Part C Days in the DSH Calculation

The Medicare program permits its beneficiaries to receive services from managed care entities. The managed care statute implementing payments to health maintenance organizations ("HMOs") and competitive medical plans ("CMPs") is found at 42 U.S.C. § 1395mm. The statute at 42 U.S.C. § 1395mm(a)(5) provides for "payment to the eligible organization under this section for individuals enrolled under this section with the organization and entitled to benefits under part A of this subchapter and enrolled under part B of this subchapter . . ." Inpatient hospital days for Medicare beneficiaries enrolled in HMOs and CMPs prior to 1999 are referred to as Medicare HMO patient care days.

In the September 4, 1990 Federal Register, the Secretary[15] stated that:

> Based on the language of section 1886(d)(5)(F)(vi) of the Act [42 U.S.C. § 1395ww(d)(5)(F)(vi)], which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A," we believe it is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs, and therefore, were unable to fold this number into the calculation [of the DSH adjustment]. However, as of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[16]

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[13] (Emphasis added.)
[14] 42 C.F.R. § 412.106(b)(4).
[15] of Health and Human Services.
[16] 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[17]

With the creation of Medicare Part C in 1997,[18] Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C days in the SSI ratios used by the Medicare contractors to calculate DSH payments for the fiscal years 2001-2004.[19]

No further guidance regarding the treatment of Part C days in the DSH calculation was provided until the 2004 Inpatient Prospective Payment System ("IPPS") proposed rules were published in the Federal Register. In that notice the Secretary stated that:

> . . . once a beneficiary has elected to join an M+C plan, that beneficiary's benefits are no longer administered under Part A . . . . *once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage. These patient days should be included in the count of total patient days in the Medicaid fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction . . . .*[20]

The Secretary purportedly changed her position in the Federal fiscal year ("FFY") 2005 IPPS final rule, by noting she was "revising our regulations at [42 C.F.R.] § 412.106(b)(2)(i) to include the days associated with [Part C] beneficiaries in the Medicare fraction of the DSH calculation."[21] In response to a comment regarding this change, the Secretary explained that:

> *. . . We do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A. We agree with the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction.*

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[17] *Id.*
[18] The Medicare Part C program did not begin operating until January 1, 1999. *See* P.L. 105-33, 1997 HR 2015, *codified as* 42 U.S.C. § 1394w-21 Note (c) "Enrollment Transition Rule.- An individual who is enrolled [in Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered to be enrolled with that organization on January 1, 1999, under part C of Title XVIII . . . if that organization as a contract under that part for providing services on January 1, 1999 . . . ." This was also known as Medicare+Choice. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub.L. 108-173), enacted on December 8, 2003, replaced the Medicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.
[19] 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).
[20] 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).
[21] 69 Fed. Reg. at 49099.

> *Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.*[22]

This statement would require inclusion of Medicare Part C inpatient days in the Medicare fraction of the DSH calculation.

Although the change in DSH policy regarding 42 C.F.R. § 412.106(b)(2)(i) was included in the August 11, 2004, Federal Register, no change to the regulatory language was published until August 22, 2007, when the FFY 2008 IPPS final rule was issued.[23] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change adopted in the FFY 2005 IPPS final rule. These "technical corrections" are reflected at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).[24] As a result of these rulemakings, Part C days were required to be included in the Medicare fraction as of October 1, 2004 (the "Part C DSH policy"). Subsequently, as part of the FFY 2011 IPPS final rule published on August 15, 2010, the Secretary made a minor revision to §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) "to clarify" the Part C DSH policy by replacing the word "or" with "including."[25]

There has been substantial litigation over whether enrollees in Part C plans are "entitled to benefits" under Medicare Part A when determining their placement in either the DSH Medicare or Medicaid fraction. First, in 2011, the D.C. Circuit held that the Secretary's Part C policy in the FY 2005 IPPS Final Rule could not be applied retroactively for fiscal years 1999 through 2002, but did not address whether it could be applied to later years or whether the interpretation was reasonable.[26] Then, in 2014, the U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[27] vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.[28] In vacating the final rule, it

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[22] *Id.* (emphasis added).
[23] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[24] *Id*. at 47411.
[25] 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: "We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word 'or' with the word 'including' in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B)."); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff'd in part and rev'd in part*, 746 F. 3d 1102 (D.C. Cir. 2014).
[26] *Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1, 17 (D.C. Cir. 2011).
[27] 746 F. 3d 1102 (D.C. Cir. 2014).
[28] *Id*. at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").

reasoned that this deprived the public of adequate opportunity for notice and comment before the final rule was promulgated in 2004.[29] However, the Secretary has not acquiesced to that decision.

During that litigation, in 2013, the Secretary promulgated a new rule that would include Part C days in the Medicare fraction for fiscal years 2014 and beyond.[30] However, at that point, no new rule had been adopted for fiscal years 2004-2013 following the D.C. Circuit's decision in *Allina I* to vacate the 2004 rule. In 2014 the Secretary published Medicare fractions for fiscal year 2012 which included Part C days.[31] A number of hospitals appealed this action. In *Azar v. Allina Health Services* ("*Allina II*"),[32] the Supreme Court held that the Secretary did not undertake appropriate notice-and-comment rulemaking when it applied its policy to fiscal year 2012, despite having no formal rule in place.[33] There was no rule to vacate in this instance, and the Supreme Court merely affirmed the D.C. Circuit's decision to remand the case "for proceedings consistent with [its] opinion."[34] The Supreme Court did not reach the question of whether the policy to count Part C days in the Medicare fraction was impermissible or unreasonable.[35]

On August 6, 2020, the Secretary published a notice of proposed rulemaking to adopt a policy to include Part C days in the Medicare fraction for fiscal years prior to 2013.[36] On August 17, 2020, CMS issued CMS Ruling 1739-R stating that, as "CMS has announced its intention to conduct the rulemaking required by the Supreme Court's decision in Allina [II]":

> This Ruling provides notice that the Provider Reimbursement Review Board (PRRB) and other Medicare administrative appeals tribunals lack jurisdiction over certain provider appeals regarding the treatment of patient days associated with patients enrolled in Medicare Advantage plans in the Medicare and Medicaid fractions of the disproportionate patient percentage; this ruling applies only to appeals regarding patient days with discharge dates before October 1, 2013 that arise from Notices of Program Reimbursement (NPRs) that are issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013 or that arise from an appeal based on an untimely NPR under 42 U.S.C. 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for that fiscal year pre-dates the new final rule.[37]

The Secretary did not change the proposed rule and issued it in final on June 9, 2023.[38] *On the **same** day*, Tampa filed an appeal request with the Board to establish this case *and* a request for

[29] *Id.* at 2011.
[30] 78 Fed. Reg. 50496, 50614 (Aug. 19, 2013).
[31] *See Allina Health Services v. Price*, 863 F.3d 937, 939-940 (D.C. Cir. 2017).
[32] 139 S.Ct. 1804 (2019).
[33] *Id.* at 1817.
[34] *Id.*; *Allina Health Services v. Price*, 863 F.3d at 945.
[35] 139 S.Ct at 1814.
[36] 85 Fed. Reg. 47723 (Aug. 6, 2020).
[37] CMS Ruling 1739-R at 1-2.
[38] 88 Fed. Reg. 37772 (June 9, 2023).

EJR to challenge this final rule. Relevant to the instant EJR Request, the June 9, 2023 Final Rule provides the following guidance on the extent to which it is to be applied *retroactively*:

> [T]he Secretary has determined that it is in the public interest for CMS to adopt a retroactive policy for the treatment of MA patient days in the Medicare and Medicaid fractions through notice and comment rulemaking for discharges before October 1, 2013 (the effective date of the FY 2014 IPPS final rule). CMS must calculate DSH payments for periods that include discharges occurring before the effective date of the prospective FY 2014 IPPS final rule for hundreds of hospitals whose DSH payments ***for those periods are still open or have not yet been finally settled***, encompassing thousands of cost reports.[39]

Further, the June 9, 2023 Final Rule provided the following clarification on the intent and purpose of CMS Ruling 1739-R:

> The Ruling was not intended to cut off appeal rights and will not operate to do so. It was intended to promote judicial economy by announcing HHS's response to the Supreme Court's decision in *Allina II*. After the Supreme Court made clear that CMS could not resolve the avowedly gap-filling issue of whether Part C enrollees are or are not "entitled to benefits under part A" for years before FY 2014 without rulemaking, HHS issued the Ruling [1739-R] so that providers would not need to continue litigating over DPP fractions that were issued in the absence of a valid rule. In other words, the point of the Ruling was to avoid wasting judicial, provider, and agency resources on cases in which the Secretary agreed that, after the Supreme Court's decision in *Allina II*, he could not defend such appeals of fractions issued in the absence of a valid regulation.[40]

Tampa's Appeal Request

Tampa's appeal request in Case No. 24-0356 included a "Statement of Jurisdiction" asserting that Tampa had met the applicable statutory conditions for appeal because: (1) it "is dissatisfied with the Secretary's final determination to include part C days as part-A-entitled days retroactively" and (2) "the estimated $644,158 amount in controversy for this appeal reflected in the accompanying worksheet exceeds $10,000."[41] Tampa asserts that it has a right under 42 U.S.C. § 1395oo(a)(1)(A)(ii) to appeal the June 9, 2023 as a "final determination" of the Secretary. Tampa also asserts that it previously received a Notice of Program Reimbursement ("NPR") for its FY 2008 but confirms that it is not appealing from that NPR under 42 U.S.C. § 1395oo(a)(1)(A)(i).

[39] *Id.* at 37775 (emphasis added).
[40] 88 Fed. Reg. at 37788 (emphasis in original).
[41] Appeal Request, Statement of Jurisdiction (citations omitted).

The "Statement of Issue" included with the appeal request in Case No. 24-0356 states that the issue concerns the proper treatment in the Medicare DSH calculation of days for Medicare Part C patients in the aftermath of the *Allina* litigation. Tampa contends that the Part C days must be included in the numerator of the Medicaid fraction and excluded from the numerator and denominator of the SSI fraction. Pursuant to 42 U.S.C. § 1395oo(a)(1)(A)(ii) and *Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 149 (D.C. Cir. 1986), Tampa insists it "need not wait until an NPR has been issued" to appeal this final determination, and that appealing this final rule is no different than appealing from different final rules where the Board has found jurisdiction, such as appeals from Federal Registers announcing CMS' 2-Midnight Rule.

Tampa characterized the relevant background facts as follows:

1. In the FY 2005 IPPS Final Rule, CMS first announced a policy change to count Part C days in the SSI fraction and to exclude those days from the numerator of the Medicaid fraction.

2. In *Allina I*, the D.C. Circuit vacated that policy change.

3. In *Allina II*, the Supreme Court affirmed a D.C. Circuit decision that the Secretary's continued application of the same Part C days policy from the FY 2005 IPPS Final Rule in the 2012 SSI fractions published in 2015 was procedurally invalid because 42 U.S.C. § 1395hh(a)(2) required the Secretary to adopt that policy through notice-and-comment rulemaking. The Supreme Court's decision "did not address the D.C. Circuit's alternate ruling that the readopted policy was also invalid under 42 U.S.C. § 1395hh(a)(4) because the Secretary failed to engage in notice-and-comment rulemaking and the policy could not 'take effect' under the terms of the statute until after proper notice-and-comment rulemaking."[42]

4. In the June 9, 2023 Final Rule, CMS adopted the same Part C days policy that had been vacated by *Allina I* and made it retroactive for periods prior to October 1, 2013.

Based on the above, Tampa maintains that the retroactive re-adoption of the Part C days policy in the June 9, 2023 Final Rule "is substantively and procedurally invalid and must be set aside because it was taken without observance of procedure required by law, and it is otherwise contrary to law, arbitrary and capricious, an abuse of discretion, and unsupported by substantial evidence."[43]
In its appeal request, Tampa asserts the following facts which appear to relate to :

1. "As reflected in agency records," it ***did*** receive an NPR for the fiscal year at issue in this case on November 8, 2017;

2. It then "appealed that determination to the Board in Case No. 18-1267G (Akin Gump 2008 DSH Medicare Advantage Days Group 3) and then to Court in *Florida Health Sciences Center, Inc. v. Price*, No. 17-cv-1751 (D.D.C.)"; and

[42] Appeal Request, Statement of Issue (citing to 139 S. Ct. at 1816).
[43] *Id.* (citing 4 U.S.C. § 706(2)).

3. This federal litigation was then consolidated into *In re Allina II-Type DSH Adjustment Cases*, No. 19-mc-190 (D.D.C.); and

4. "[T]he Court in the consolidation then remanded the case back to the agency [*i.e.*, CMS]."

However, Tampa did not include any documentation in its appeal request to verify or support these factual assertions consistent with 42 C.F.R. § 405.1835(b)(1) and (3). In particular, Tampa did not include any documentation regarding the nature and status of the remand under the litigation identified as *In re Allina II-Type DSH Adjustment Cases* (*e.g.*, whether Tampa's FY 2008 was covered by the remand, whether a settlement agreement had been reached, whether the Court's Remand Order was still open/pending, whether that Remand Order precludes action by the Board on the matter at issue in this case).

Finally, Tampa asserts that, *sometime* in "August 2023" (*i.e.,* subsequent to the issuance of the June 9, 2023 Final Rule), CMS has published SSI fractions on its website for the fiscal year under appeal here pursuant to that final rule. Notably, Tampa did not include an exhibit in support of this assertion but rather included the following link to SSI fractions posted "pursuant to CMS-1739-F using the data it has available to it": https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatientpps/disproportionate-share-hospital-dsh.[44]

Decision of the Board

Tampa has emphasized that it is ***not*** appealing the June 9, 2023 Final Rule pursuant to 42 U.S.C. § 1395oo(a)(1)(A)(i), but rather pursuant to 42 U.S.C. § 1395oo(a)(1)(A)(ii), which allows an appeal from a Secretary determination. Specifically, this statutory provision allows an appeal if a provider:

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

Pursuant to 42 C.F.R. § 405.1835(a)(1), an individual provider generally has a right to a hearing before the Board "with respect to a final contractor or Secretary determination ***for the provider's cost reporting period***"[45] if:

- It "is dissatisfied *with the contractor's final determination of the total amount of reimbursement* ***due the provider***, as set forth in the contractor's written notice specified

[44] Further, no last visited date is provided and no information is provided on whether an SSI percentage was posted *at that time* for Tampa. The Board takes administrative notice that, as of January 26, 2024, the website shows a "last modified" date of October 16, 2023 and includes a "Note to Providers on CMS 1739-F SSI Rations" that "CMS has determined the posted fractions pursuant to CMS-1739-F using the data available to it" with links to, among other things, "CMS 1739-F SSI Ratios."
[45] 42 C.F.R. § 405.1835(a) (emphasis added).

under § 405.1803"[46] In other words, providers must appeal from a "final determination" that impacts payment for the period under appeal.[47]

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

- The amount in controversy is $10,000 or more.[48]

Satisfying the criteria set out in 42 C.F.R. § 405.1835(a) is required before the Board can exercise jurisdiction over an appeal.[49]

42 C.F.R. § 405.1835(b) specifically requires that a provider's request for a hearing must meet the requirements of paragraph (b), subsections (1-4), and paragraph (b)(1) specifically notes that the hearing request must include "[a] demonstration that the provider satisfies the requirements for a Board hearing as specified in paragraph (a)." Specifically, subsection (b) states in pertinent part:

> (b) *Contents of request for a Board hearing on final contractor determination*. The provider's request for a Board hearing under paragraph (a) of this section must be submitted in writing in the manner prescribed by the Board, and the request must include the elements described in paragraphs (b)(1) through (4) of this section. If the provider submits a hearing request that does not meet the requirements of paragraph (b)(1), (2), or (3) of this section, the Board may dismiss with prejudice the appeal or take any other remedial action it considers appropriate.
>
> (1) **A <u>demonstration</u> that the provider <u>satisfies the requirements</u> for a Board hearing as specified in paragraph (a) of this section**, including a specific identification of the final contractor or Secretary determination under appeal.

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[46] 42 C.F.R. § 405.1835(a)(1) (emphasis added).

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

[48] 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835 – 1840.

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

> (2) **For each specific item under appeal**, a separate explanation of why, and a description of how, the provider is dissatisfied **with the specific aspects of the final . . . determination under appeal**, including an account of all of the following:
>
> (i) **Why the provider believes Medicare payment is incorrect for each disputed item** (or, where applicable, why the provider is unable to determine whether Medicare payment is correct because **it does not have access to underlying information concerning the calculation of its payment**).
>
> (ii) How and why the provider believes Medicare payment must be determined differently for each disputed item.
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> ****
>
> (3) A copy of the final contractor or Secretary determination under appeal **and any other documentary evidence the provider considers necessary to satisfy the hearing request requirements of paragraphs (b)(1) and (b)(2) of this section**.[50]

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

> (2) With respect to a hospital that receives payments for inpatient hospital services under the prospective payment system (part 412 of this chapter), the term means a final determination of the total amount of payment due the hospital, pursuant to § 405.1803 following the close of the hospital's cost reporting period, under that system for the period covered by the final determination.
>
> (3) For purposes of appeal to the Provider Reimbursement Review Board, the term is synonymous with the phrases "intermediary's final determination," "final determination of the organization serving as its fiscal intermediary," "Secretary's final determination" and "final determination of the Secretary," as those phrases are used in section 1878(a) of the Act, and with the phrases "final contractor determination" and "final Secretary determination" as those phrases are used in this subpart.

Set forth below are 2 *independent* bases for the Board's decision to dismiss this case.

[50] (Italics emphasis in original and bold and underline emphasis added.)

A. The Part C Policy finalized in the June 9, 2023 Final Rule Is Not an Appealable "Final Determination" under 42 U.S.C. § 1395oo(a)(1)(A)(ii).

The "final determination" being appealed in this case is a change in policy adopted/finalized in the June 9, 2023 Final Rule. However, the adoption/finalization of this policy in the June 9, 2023 Final Rule is not a "final determination" directly appealable to the Board *for purposes of 42 U.S.C. § 1395oo(a)(1)(A)(ii)*. Rather, Tampa's appeal is premature as described below.

Unlike DRG rates and other adjustments such as the wage index,[51] a hospital's eligibility for a DSH payment (and, if eligible, the amount of that payment) during a particular fiscal year is not ***prospectively*** set or determined as part of the relevant IPPS final rule. In this regard, 42 U.S.C. § 1395ww(d)(5)(F) refers to the DSH adjustment being calculated "with respect to a [hospital's] cost reporting period" and uses days associated with inpatients stays *occurring during that cost reporting period*.[52] To this end, DSH eligibility ***and*** payment, if any, is determined, calculated, and finalized *annually* through the cost report audit/settlement process as made clear in 42 C.F.R. § 412.106(i) which sets forth the following instructions regarding the determination of a hospital's eligibility for a DSH payment for each fiscal year and, if so, how much:

> (i) *Manner and timing of [DSH] payments*. (1) **Interim** [DSH] **payments** are made **during the payment year to each hospital that is estimated to be eligible** for payments under this section at the time of the annual final rule for the hospital inpatient prospective payment system, **subject to the final determination of eligibility at the time of cost report settlement for each hospital**.
>
> (2) **Final payment determinations are made at the time of cost report settlement**, based on the **final** determination of each hospital's eligibility for payment under this section.[53]

The Secretary makes clear that this regulation is based on "our ***longstanding*** *process* of making ***interim*** *eligibility* determinations for Medicare DSH payments *with* ***final*** *determination* ***at cost report settlement***."[54] Examples of other adjustments to IPPS payment rates that are based, in whole

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[51] Another example is the Two-Midnight Rule which impacted *prospectively* set payment rates.

[52] The Board notes that the Medicare DSH adjustment provision under 42 U.S.C. § 1395ww(d)(5)(F) was enacted by § 9105 of the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") and became effective for discharges occurring on or after May 1, 1986. Pub. L. 99-272, § 9105, 100 Stat. 82, 158-60. As such, it was enacted several years after the initial legislation that established the IPPS.

[53] (Italics emphasis in original and bold and underline emphasis added.) This section was added as part of the FY 2014 IPPS Final Rule. 78 Fed. Reg. 50496, 50646, (Aug. 19, 2013). It was initially codified at § 412.106(h) (*id.*), but was later redesignated as § 412.106(i) (87 Fed. Reg. 48780, 49049 (Aug. 10, 2022)).

[54] 78 Fed. Reg. at 50627. *See also* Provider Reimbursement Manual, CMS Pub. 15-1 ("PRM 15-1"), § 2807.2(B)(5) (last revised Aug. 1993, Transmittal 371) (stating: "*At* ***final*** ***settlement*** *of the cost report*, the intermediary determines the final disproportionate share adjustment based on the actual bed size and disproportionate share patient percentage for the cost reporting period." (emphasis added)). In the preamble to the FY 2014 IPPS Final Rule, the Secretary discussed the DSH eligibility and payment process and the following are excerpts from that discussion:

or in part, on certain data/costs claimed on the as-filed cost report and then determined and reimbursed through the cost report audit and settlement process include bad debts,[55] direct graduate medical education ("GME"),[56] and indirect GME.[57]

Here, Tampa's appeal request did not include a copy of the alleged NPR for FY 2008 and relevant audit adjustment pages and, as a result, it is unclear whether that NPR addressed consistent with 42

> *Comment*: Several commenters requested that CMS undertake additional audits to verify the data used to compute the 25-percent empirically justified Medicare DSH payment adjustments. Other commenters requested that CMS grant additional time for hospitals to verify the data and adjust their cost reports to ensure that the data used to compute the adjustment are accurate and up to date. Some commenters requested that CMS establish procedures to allow a hospital initially determined not to be eligible for Medicare DSH payments to begin receiving empirically justified Medicare DSH payments if data become available that indicate that the hospital would be eligible.
> *Response*: As we have emphasized, we are maintaining the well-established methodology and payment processes used under the current Medicare DSH payment adjustment methodology for purposes of making the empirically justified Medicare DSH payment adjustments. Hospitals are quite familiar with the cost reporting requirements and auditing procedures employed under the current Medicare DSH payment adjustment methodology. Hospitals are also familiar with the current process of determining **interim eligibility** for Medicare DSH payments **with final determination at cost report settlement**. Therefore, we do not believe that it would be warranted to add additional complexity to these procedures by adopting any of these recommendations.
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> ****
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> **For the reasons discussed above regarding the empirically justified Medicare DSH payments** [*i.e.*, the DSH payment calculation made under 42 U.S.C. § 1395ww(d)(5)(F)], **we do not believe that it is necessary or advisable to depart from our longstanding process of making interim eligibility determinations for Medicare DSH payments with final determination at cost report settlement.** As we discuss in greater detail in section V.E.3.f. of the preamble to this final rule, we will make interim eligibility determinations based on data from the most recently available SSI ratios and Medicaid fractions prior to the beginning of the payment year. We will then make final determinations of eligibility at the time of settlement of each hospital's cost report. Therefore, we proposed that, at cost report settlement, the fiscal intermediary/MAC will issue a notice of program reimbursement that includes a determination concerning whether each hospital is eligible for empirically justified Medicare DSH payments and, therefore, eligible for uncompensated care payments in FY 2014 and each subsequent year. In the case where a hospital received interim payments for its empirically justified Medicare DSH payments and uncompensated care payments for FY 2014 or a subsequent year on the basis of estimates prior to the payment year, but is determined to be ineligible for the empirically justified Medicare DSH payment at cost report settlement, the hospital would no longer be eligible for either payment and CMS would recoup those monies. For a hospital that did not receive interim payments for its empirically justified Medicare DSH payments and uncompensated care payments for FY 2014 or a subsequent year, but at cost report settlement is determined to be eligible for DSH payments, the uncompensated care payment for such a hospital is calculated based on the Factor 3 value determined prospectively for that fiscal year.

Id. at 50626-27 (emphasis added).

[55] 42 C.F.R. §§ 412.2(f)(4), 412.115(a) (stating: "An additional payment is made to each hospital in accordance with § 413.89 of this chapter for bad debts attributable to deductible and coinsurance amounts related to covered services received by beneficiaries.).

[56] 42 C.F.R. § 412.2(f)(7) (stating that hospitals receive an additional payment for "[t]he direct graduate medical education costs for approved residency programs in medicine, osteopathy, dentistry, and podiatry as described in §§413.75–413.83 of this chapter.").

[57] 42 C.F.R. §§ 412.2(f)(2), 412.105. *See also* PRM 15-1 § 2807.2(B)(6) (stating: "*At **final settlement** of the cost report*, the intermediary determines the indirect teaching adjustment based on the actual number of full time equivalent residents and average daily census for the cost reporting period. (emphasis added)).

C.F.R. § 412.106(i) both: (1) whether Tampa is eligible for a DSH payment *for FY 2008*; and (2) if so, how much.[58] Further, Tampa has alleged that it pursued an appeal of the Part C days issue from that FY 2008 NPR as part of an *optional* group appeal and that the case was ultimately remanded back to the agency; however, as discussed *infra*, it is unclear whether Tampa FY 2008 participated in that group or what the status of that remand is (*e.g*., whether Tampa FY 2008 remained in the group at remand, whether the remand is still pending versus a settlement agreement being reached or a determination being issued, or whether the Remand Order might precludes this appeal).

The four corners of the June 9, 2023 Final Rule confirms that Tampa's appeal is *premature* because the final rule confirm that: (1) it is ***not*** a final determination appealable to the Board; *and* (2) the Secretary did ***not*** otherwise intend for it to be a final determination appealable to the Board. The June 9, 2023 Final Rule simply finalizes the adoption of the Part C days policy at issue for open and prospective cost reporting periods. It does not make a determination on *any* specific hospital's DSH eligibility and, if so, how much (much less Tampa's for FY 2008). Moreover, it does not publish *any* specific hospital's SSI percentage (much less Tampa's for FY 2008) that would be used in DSH calculations for those hospitals whose eligibility would later be either determined as part of their cost report settlement process for the relevant fiscal year or redetermined through the issuance of a revised NPR (here, based on the Tampa's contentions, it appears that it would be redetermined through the issuance of a revised NPR). Further, the following excerpts from the June 9, 2023 Final Rule discussing a hospital's right to challenge the Part C days policy adopted therein make clear that the Secretary did not consider the final rule to be an appealable "final determination":

1. "Additionally, the Secretary has determined that it is in the public interest for CMS to adopt a retroactive policy for the treatment of MA patient days in the Medicare and Medicaid fractions through notice and comment rulemaking for discharges before October 1, 2013 (the effective date of the FY 2014 IPPS final rule). *CMS must calculate DSH payments for periods that include discharges occurring before the effective date of the prospective FY 2014 IPPS final rule for hundreds of hospitals* ***whose DSH payments for those periods are still open or have not yet been finally settled, encompassing thousands of cost reports***. *In order to calculate these payments, CMS* ***must*** *establish Medicare fractions for* ***each*** *applicable cost reporting period* during the time period for which there is currently no regulation in place that expressly addresses the treatment of Part C days."[59]

2. "We do not agree that it is arbitrary or capricious to treat hospitals' Part C days differently on the basis of the timing of their appeals vis-a-vis Supreme Court and lower court decisions. The instructions to contractors that issued after the *Northeast* decision cannot control over the holding of the Supreme Court in *Allina II.* It is also not unusual for cost

[58] In this regard, a provider that did not qualify for a DSH payment adjustment for a particular fiscal year may appeal that finding by challenging multiple components of the DSH adjustment calculation which, if successful, could result in the provider qualifying for a DSH adjustment for that year. Further, the fact that a hospital has received a DSH payment in ***prior*** fiscal years, does not mean or guarantee that the hospital will (or continue to) be eligible for and receive a DSH payment in subsequent fiscal year. For each fiscal year, the Medicare contractor determines whether a hospital is eligible for a DSH payment and, if so, how much based on multiple variables associated with that fiscal year (*e.g*., the number of Medicaid eligible days in the relevant fiscal year).

[59] 88 Fed. Reg. at 37774-75 (emphasis added).

reports to be finalized differently from one another with respect to a legal issue depending on the outcome of litigation raising that issue and the status of a hospital's appeal at the time of a final non-appealable decision. Providers will also be able to request to have their Medicare fraction realigned to be based on their individual cost reporting periods rather than the Federal fiscal year, in accordance with the normal rules. **Providers who remain dissatisfied after receiving NPRs and revised NPRs that reflect the interpretation adopted in this final action retain appeals rights and can challenge the reasonableness of the Secretary's interpretation set forth in this final action**."[60]

3. "Providers who have pending appeals reflecting fractions calculated in the absence of a valid rule will receive NPRs or revised NPRs reflecting DSH fractions calculated pursuant to this new final action and *will have appeal rights with respect to the treatment of Part C days in the calculation of the DSH fractions* ***contained in the NPRs or revised NPRs***. Providers whose appeals of the Part C days issue have been remanded to the Secretary *will likewise receive NPRs or revised NPRs* reflecting fractions calculated pursuant to this new final action, *with attendant appeal rights*. Because NPRs and revised NPRs will reflect the application of a new DSH Part C days rule, CMS will have taken action under the new action, and *the new or revised* ***NPRs*** *will provide hospitals with a* ***vehicle to appeal*** *the new final action* even if the Medicare fraction or DSH payment does not change numerically."[61]

4. "*When the Secretary's treatment of Part C days in this final action is reflected* ***in NPRs and revised NPRs****, providers*, including providers whose appeals were remanded under the [CMS] Ruling [1739-R], *will be able to challenge the agency's interpretation* ***by appealing those NPRs and revised NPRs***. While some providers have already received reopening notices and had their NPRs held open for resolution of the Part C days issue, the issuance of new NPRs and revised NPRs pursuant to remands under the Ruling are not reopenings."[62]

The above discussion in the preamble to the June 9, 2023 Final Rule makes clear that hospitals covered by that Final Rule would *not* be able to ***directly*** appeal from the Final Rule since the finalized policy is not applied in the Final Rule to any specific hospitals and the preamble's discussion of a hospital's right to challenge that finalized policy is only in the context of yet-to-be issued NPRs (original or revised) that: (1) would be issued *following the publication of new SSI percentages*; and (2) would both would apply the finalized policy and would be used to determine DSH eligibility for a hospital's prior period that is still open for resolution (whether through issuance of an original or revised NPR)[63] and, if so, the amount of the DSH payment.

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[60] *Id.* at 37787 (underline and bold emphasis added and italics emphasis in original).
[61] *Id.* at 37788 (emphasis added).
[62] *Id.* (emphasis added).
[63] Just because a hospital was eligible for a DSH payment in the original NPR, does not mean that the hospital would *continue* to be eligible for a DSH payment following the issuance of a revised NPR pursuant to the June 9, 2023 Final Rule. Similarly, the converse may be true. As such, a hospital eligibility status may change following the issuance of a revised NPR pursuant to the June 9, 2023 Final Rule. Moreover, there could be other DSH variables at play in the NPR/revised NPR such as consideration of Medicaid eligible days (removal or addition of such days) depending on what other issues may remain open in the relevant fiscal year.

The Board recognizes that Tampa points to the *Allina II* litigation[64] in support of its contention that the Board has jurisdiction over Tampa's challenge to the adoption of the DSH Part C payment standard in the June 9, 2023 final rule[65] but finds that it has no relevance to the ***jurisdictional*** issue that the Board is addressing in the instant case because that litigation did *not* address the Board's *jurisdiction* over the underlying appeals of the nine (9) Plaintiff hospitals in *Allina II* (*i.e.*, it does not address whether the publication of the SSI ratios was a "final determination" *for purposes of 42 U.S.C. § 1395oo(a)(1)(A)(ii)*).[66]

Similarly, the Board declines to follow D.C. District Court's decision in *Battle Creek*[67] and instead finds the D.C. District Court's 2022 decision in *Memorial Hospital* to be instructive. *Memorial Hospital* concerns another variable used in the DSH adjustment calculation. Specifically, the providers in that case appealed ***the publication of their DSH SSI ratios*** (which is one step *after* the case at hand where Tampa is appealing the June 9, 2023 Final Rule adopting/finalizing a policy ***prior to*** the planned publication of the DSH SSI ratios reflecting that Final Rule[68]). The providers

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[64] *Allina II* began as *Allina Health Servs. v. Burwell*, No. 14-01415, (D.D.C. Aug. 19, 2014) resulting in *Allina Health Servs. v. Burwell*, 201 F. Supp. 3d 94 (D.D.C. 2016), *reversed Allina Health Servs. v. Price*, 863 F.3d 937 (D.C. Cir. 2017), *aff'd sub nom. Azar v. Allina Health Servs.*, 139 S. Ct. 1804 (2019) ("*Allina II*").

[65] Provider's Statement of Jurisdiction (citing to *Allina Health Servs. v. Price*, 863 F.3d 937, 940–43 (D.C. Cir. 2017), *aff'd sub nom. Azar v. Allina Health Servs.*, 139 S. Ct. 1804 (2019)).

[66] Rather, it addresses the Board's "no-authority determination" when it granted EJR. This is not a *jurisdictional* issue under 42 U.S.C. § 1395oo(a)(1), but rather an issue relating to whether the Board appropriately granted EJR pursuant to 42 U.S.C. § 1395oo(f)(1). Further, the Board takes administrative notice that, in the Complaint filed to establish the *Allina II* litigation, ***none*** of the 9 Plaintiff hospitals based their right to appeal on the publication of the SSI fractions pursuant to 42 U.S.C. § 1395oo***(a)(1)(A)(ii)***. Rather, the Complaint makes clear that each of the 9 Plaintiff hospitals based their right to appeal *on the failure of the Medicare Contractor to timely issue an NPR as set forth in 42 U.S.C. § 1395oo**(a)(1)(B)*** as implemented at 42 C.F.R. § 405.1835(c) (2014). *Allina Health Servs. v. Burwell*, No. 14-01415, Complaint at ¶¶ 38-39 (D.D.C. Aug. 19, 2014) (stating: 38. . . . None of the [9] plaintiff Hospitals has received an NPR reflecting final Medicare DSH payment determinations for their cost reporting periods beginning in federal fiscal years 2012. 39. As a result, *the [9] plaintiff Hospitals timely filed appeals to the Board*, ***pursuant to 42 U.S.C. §§ 1395oo(a)(1)(B)***, to challenge the agency's treatment of Medicare part C days as Medicare part A days for purposes of the part A/SSI fraction and the Medicaid fraction of the Medicare DSH calculation for their 2012 cost years." (footnote omitted and emphasis added)).

[67] The Board recognizes that, in *Battle Creek*, the D.C. District Court addressed a jurisdictional issue involving DSH SSI fractions ***similar to*** the jurisdictional issue that the *same* Court (different judge) issued in *Memorial Hospital* but reached a different conclusion. However, the Board disagrees with the *Battle Creek* decision and maintains that *Memorial Hospital* is a better-reasoned decision and, in particular, provides a more thoughtful analysis and application of the D.C. Circuit's decision in *Washington Hospital*. Indeed, the *Battle Creek* decision does not even discuss (much less reference) the *Memorial Hospital* decision that was issued 19 months earlier by a different judge in the ***same*** Court. Finally, *Battle Creek* is distinguishable from the case at hand. *Battle Creek* addressed whether the publication of SSI fractions is a final determination. In contrast, Tampa did not appeal the publication of SSI fractions but rather a final rule adopting and finalizing the policy at issue ***prior to*** the issuance of new SSI fractions to be used in the *alleged* yet-to-be issued revised NPR for FY 2008. To this end, in finalizing that policy adoption in the June 9, 2023 Final Rule, the Secretary announced that "CMS must calculate DSH payments for periods that include discharges occurring before the effective date of the prospective FY 2014 IPPS final rule for hundreds of hospitals whose DSH payments ***for those periods are still open or have not yet been finally settled*** . . . ." 88 Fed. Reg. at 37774 (emphasis added).

[68] Tampa's appeal request is very clear that it was filed to appeal from the June 9, 2023 Final Rule, as opposed to appeal from the subsequent publication of SSI fractions. Indeed, it is not clear from the record before the Board whether a new SSI percentage for Tampa's FY 2008 has been in fact issued *pursuant to the implementation of the June 9, 2023 Final Rule as set forth therein*. To this end, the Board notes that 42 C.F.R. § 405.1835(b)(3) requires an appeal request to include a copy of the final determination being appealed, but neither Tampa's appeal request nor the

in *Memorial Hospital* argued that there are certain instances where a provider can appeal prior to receiving an NPR and gave citations to certain D.C. Circuit cases in support. However, the D.C. District Court distinguished these cases because "the secretarial determination at issue was either the only determination on which payment depended or clearly promulgated as a final rule."[69] The D.C. District Court ultimately agreed with the Board that this was not an appealable final determination. In its discussion, the D.C. District Court agreed with the Secretary that the publication of the SSI ratios, *even if the publication of the SSI fractions had been issued as "final,"* it could and would not be a final determination "as to the amount of payment" because the SSI fractions are "just one of the variables that determines whether hospitals receive a DSH payment ***and***, ***if so***, *for how much*."[70] The D.C. District Court concluded:

> A challenge to *an* ***element*** *of payment* under 42 U.S.C. § 1395oo(a)(1)(A)(ii) is ***only*** *appropriate* ***if***, as the D.C. Circuit has explained, "*the Secretary ha[s] firmly established '****the only variable factor*** in the final determination as to the amount of payment under § 1395ww(d).'" *Monmouth Med. Ctr. v. Thompson*, 257 F.3d 807, 811 (D.C. Cir. 2001) (quoting *Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 147 (D.C. Cir. 1986)) (emphasis added); *see also Samaritan Health Serv. v. Sullivan*, 1990 WL 33141 at *3 (9th Cir. 1990) (unpublished table decision) ("We have held that if the Secretary's classification of a hospital effectively fixes the hospital's reimbursement rate, then that decision is a 'final determination' as referred to 42 U.S.C. § 1395oo(a)(1)(A)(ii).").[71]

Accordingly, the Court upheld the Board's decision to dismiss because the DSH SSI fraction was only one of the variables that determine whether a hospital receives a DSH payment (and, if so, for how much) and the publication of a hospital's SSI fraction is not a determination as to the amount of payment received.[72]

This is what makes this case distinguishable from the facts presented in the D.C. Circuit's decisions in *Washington Hospital* where the determination that was appealed finalized the only hospital-specific variable used in setting the per-patient payment amount. Specifically, the hospitals in *Washington Hospital* appealed their "Final Notice of Base Period Cost and Target Amount Per Discharge" and the D.C. Circuit found: (a) "the ***only*** ***variable*** *factor* in the final determination as to the amount of payment under § 1395ww(d) is the hospital's target amount . . . .";[73] and (b) "The amount is the per-patient amount calculated under § 1395ww(d) and is final once

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record before the Board contains a copy of that SSI publication or even a precise date of ***when*** such a SSI percentage was issued/published (*e.g.*, the alleged publication of the SSI percentages could have occurred earlier than the nebulous "August 2023" alleged by Tampa in the Statement of Issue included in its appeal request). A precise issuance date is need in order to confirm whether an appeal is timely under 42 C.F.R. § 405.1835(a)(3).

[69] 2022 WL 888190 at *8.

[70] *Id.* at *9 (emphasis added).

[71] *Id.* at *8.

[72] *Id.* at *9.

[73] 795 F.2d at 143 (emphasis added).

the Secretary has published the DRG amounts (as has) and finally determined the hospital's target amount. Here each of the hospitals has received a 'Final Notice of Base Period Cost and Target Amount per Discharge.' The statute requires no more to trigger the hospital's right to appeal PPS Payments to the PRRB."[74]

Similar to the D.C. District Court's decision in *Memorial Hospital*, while the policy at issue in this case was promulgated/finalized in the June 9, 2023 Final Rule, it is ***not*** a "final determination" as to the amount of the DSH payment to be received by Tampa for FY 2008. Rather, the June 9, 2023 Final Rule reflects "just one of the variables that determines whether hospitals receive a DSH payment [for the relevant fiscal year] ***and***, ***if so***, *for how much*"; and any "***final*** *payment* determination"[75] on whether a hospital receives a DSH payment for a particular fiscal year and, if so, for how much *is made during the cost report audit/settlement process as explained at 42 C.F.R. § 412.106(i)*.[76] In this regard, the Board again notes that the June 9, 2023 Final Rule did not make a determination on any specific hospital's DSH eligibility and, if so, the amount of DSH payment. Rather, as it relates to this appeal, the Final Rule adopts a policy that is to be applied *retroactively* but only to certain hospitals and makes clear that, *following the publication of new SSI percentages*, those affected hospitals who had open cost reporting periods for this issue would be issued an NPR (original or revised) that both would apply the finalized policy and would determine: (a) DSH eligibility for a hospital's prior period that is still open for resolution (whether through issuance of an original or revised NPR); and (b) if so, the amount of the DSH payment.[77]

In summary, the Board finds that the June 9, 2023 Final Rule appealed in the instant case is not an appealable "final determination" within the context of 42 U.S.C. § 1395oo(a)(1)(A)(ii) and 42 C.F.R. § 405.1835(a)[78] and the appeal (as alleged) is premature.[79] Accordingly, the Board finds it is appropriate dismiss the instant appeal and remove it from the Board's docket, since satisfying the criteria set out in 42 C.F.R. § 405.1835(a) is required before the Board can exercise jurisdiction over an appeal,[80] and since Tampa has failed to demonstrate in its hearing request that those criteria have been met for the year under appeal (*i.e.*, FY 2008).[81]

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[74] *Id.* at 147 (footnote omitted).
[75] 42 C.F.R. § 412.106(i)(2) (emphasis added).
[76] 2022 WL 888190 at *9 (emphasis added).
[77] *See supra* note 63 and accompanying text (discussing that there may be other DSH variables at play for a hospital in this NPR/revised NPR, outside of the Part C days policy issued in the June 9, 2023 Final Rule and the subsequently published SSI ratios implementing this policy).
[78] *See also supra* note 68 (confirming that Tampa did not *also* appeal from the publication of SSI percentages issued subsequent to and pursuant to the June 9, 2023 Final Rule).
[79] The Board's dismissal does not mean that the Secretary's policy finalized in the June 9, 2023 Final Rule cannot be appealed. As noted *supra* in the preamble to the June 9, 2023 Final Rule, providers may appeal NPRs or revised NPRs that are subsequently issued and reflect this policy *as it relates to prior periods held open for this issue*. This may encompass Tampa depending on the nature and status of the alleged remand referenced by Tampa and the issuance of a revised NPR consistent with that remand.
[80] 42 C.F.R. § 405.1840(a), (b).
[81] 42 C.F.R. § 405.1835(b).

B. Even if the June 9, 2023 Final Rule Could Be Appealed as a "Final Determination" Under 42 U.S.C. § 1395oo(a)(1)(A)(ii), Tampa's Appeal Request Failed to Meet the Minimum Content Requirements under 42 C.F.R. § 405.1835(b)(1)-(3) to Demonstrate that the Final Rule Was Applicable to It.

As quoted above, 42 C.F.R. § 405.1835(b) specifies the content requirements for a Request for Hearing before the Board. Tampa asserts that it was issued an NPR for the cost reporting period under appeal, but the NPR has not been included in the record. Similarly, Tampa contends that it appealed that NPR to the Board for the Part C issue as part of the *optional* group under Case No. 18-1267G (Akin Gump 2008 DSH Medicare Advantage Days Group 3) and then that this case was ultimately remanded from federal district court to CMS. However, Tampa does not include as part of its appeal request any documentation relating to that *prior* appeal and related remand, notwithstanding: (1) Tampa's responsibilities under 42 C.F.R. § 405.1835(b)(1)-(3) as quoted above, and (2) the fact that Board Rule 35.3 specifies that evidence must be submitted into the record by a party including evidence from another Board case:

> The Board will ***not*** be responsible for supplementing any record with evidence *from a previous hearing*. All evidence submitted into the record, ***must*** be done by the parties.[82]

Without having the NPR or any additional documentation on the alleged remand as it relates to Tampa's FY 2008, the Board cannot confirm that the June 9, 2023 Final Rule is, in fact, applicable to Tampa's FY 2008 (*i.e.*, that Tampa's FY 2008 remains open for resolution of the Part C days issue raised in the this appeal through the operation of the June 9, 2023 Final Rule). In this regard, the Board is unable determine whether Tampa even qualified for a DSH payment during its FY 2008 since the record does not include a copy of the original FY 2008 NPR with the relevant audit adjustment pages alleged to have been issued to Tampa for its FY 2008. More importantly, based on the record before it, the Board is unable to determine a number of material facts, including but not limited to:

- Whether Tampa for its FY 2008 original NPR was a participant in *optional* group under Case No. 18-1267G as alleged in the Statement if Issue included in the appeal request;
- Whether Tampa for FY 2008 remained a participant in that *optional* group when it was allegedly ultimately remanded back to CMS;
- What the nature of the remand was; and
- What the status of the remand is (*e.g.*, whether it is open or whether it is closed based on a settlement agreement or an NPR/revised NPR being issued).

[82] (Emphasis added.) Moreover, the Board notes that the *optional* group under Case No. 18-1267G is a legacy case and, as such, the records for that case are not accessible on OH CDMS. As a result, those records are not readily available to the Board for purposes of confirming whether Tampa was a participant in that case for FY 2008. Regardless, these records would not address what happened to the case once it was appealed to federal court. Again, this serves to illustrate why the Board makes clear in its Rules that it is a provider's responsibility to enter into a record any relevant documentation from prior proceedings before the Board.

Indeed, if the alleged remand is still pending before CMS with Tampa as a participant for FY 2008, then the Remand Order itself is relevant since it might otherwise preclude Board consideration of this appeal.[83] These factual documentary gaps demonstrate how Tampa's appeal request is *fatally flawed*. Accordingly, the Board finds that, as confirmed by these factual documentary gaps in the record, even if the June 9, 2023 Final Rule were an appealable "final determination" under 42 U.S.C. § 1395oo(a)(1)(A)(ii), it is unclear whether that Final Rule is applicable *to Tampa's FY 2008* because Tampa has failed to comply with the content requirements of 42 C.F.R. § 405.1835(b)(1)-(3) requiring its appeal request demonstrate that the Provider satisfies the requirements for Board hearing and that the "final determination" being appealed, *in fact*, involves a payment determination ***retroactively*** *applicable to Tampa's FY 2008*. This finding serves as an alternative and *independent* basis for the Board's dismissal of this appeal.

C. Conclusion

The Board finds that: (1) the Part C policy issued in the June 9, 2023 Final Rule that Tampa appealed for its FY 2008 is not an appealable "final determination" within the context of 42 U.S.C. § 1395oo(a)(1)(A)(ii) and 42 C.F.R. § 405.1835(a); and (2) even if the June 28, 2023 Final Rule could be appealable as a "final determination" under 42 U.S.C. § 1395oo(a)(1)(A)(ii), Tampa's appeal request failed to meet the content requirements under 42 C.F.R. § 405.1835(b) based on its failure to demonstrate that the June 9, 2023 Final Rule was, in fact, a payment determination *retroactively* applicable to it for FY 2008. Based on the foregoing, the Board hereby dismisses Case No. 24-0356 in its entirety 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.
Robert A. Evarts, Esq.
Kevin D. Smith, CPA
Ratina Kelly, CPA

For the Board:

1/26/2024

X Clayton J. Nix

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

cc: Geoff Pike, First Coast Service Options, Inc. (J-N)
Wilson Leong, FSS

[83] *See also* CMS Ruling 1739-R; Board Rule 4.6 (entitled "No Duplicate Filings" and specifying in Board Rule 4.6.2 that "Appeals of the same issue from distinct determinations covering the same time period must be pursued in a single appeal").

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Board Decision* – SSI Percentage (Provider Specific)**
Clearview Regional Medical Center (Provider Number 11-0046)
FYE: 09/30/2016
Case Number: 19-1847

Dear Messrs. Ravindran and Lamprecht:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the documentation in Case No. 19-1847. The Board's decision is set forth below.

Background:

A. Procedural History for Case No. 19-1847

On March 27, 2019, the Board received Provider's Individual Appeal Request appealing their September 27, 2018 Notice of Program Reimbursement ("NPR") for the fiscal year ending September 30, 2016. The initial appeal contained the following five (5) issues:

1. DSH/SSI Percentage (Provider Specific)
2. DSH/SSI Percentage
3. DSH Payment – Medicaid Eligible Days
4. Uncompensated Care Distribution Pool
5. 2-Midnight Census IPPS Payment Reduction

Issues 2 and 5 were transferred to group cases on October 22, 2019. On December 14, 2020, the CIRP Group case containing Issue 5 was withdrawn by the Provider. On August 21, 2023, Issue 4 was withdrawn by the Provider. On August 23, 2023, Issue 3 was withdrawn by the Provider. The only remaining issue is Issue 1- DSH/SSI Percentage (Provider Specific).

The Provider is subject to the mandatory rules governing common issue related party ("CIRP") groups at 42 C.F.R. § 405.1837(b)(1) since the Provider is owed by Quorum Health. Accordingly, on November 16, 2017, the Provider's Issue 2 was directly added to case number 19-1503GC, *Quorum Health CY 2010 & CY 2016 DSH SSI Percentage CIRP Group.*

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 19-1503GC

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

> The Provider contends that the MAC did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. §1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations.
>
> The Provider contends that its' [sic] SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation[.]
>
> The Provider contends that the SSI percentage issued by CMS is flawed.
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395 (d)(5)(F)(i).
>
> The Provider also contends that CMS inconsistently interprets the term "entitled" as it is used in the statute. CMS requires SSI payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the denominator. CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Secondary Payer and Exhausted days of care) as Medicare Part A days, yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment.[1]

On March 25, 2019, the Board received a request to form a Common Issue Related Part ("CIRP") group appeal titled *Quorum Health CY 2016 DSH SSI Percentage CIRP Group*, which was assigned case number 19-1503GC. The Provider in the instant appeal (19-1847) was directly added to the CIRP group on October 22, 2019.

[1] Individual Appeal Request, Issue 1.

The DSH/SSI Percentage issue in case number 19-1503GC is described as follows:

Statement of the Issue:

Whether the Secretary properly calculated the Provider's [DSH/SSI] percentage, and whether CMS should be required to recalculate the SSI percentages using a denominator based solely upon covered and paid for Medicare Part A days, or alternatively, expand the numerator of the SSI percentage to included paid/covered/entitled as well as unpaid/non-covered/eligible SSI days?

Statement of the Legal Basis

The Provider(s) contend(s) that the MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute at 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). The Provider(s) further contend(s) that the SSI percentages calculated by [CMS] and used by the MAC to settle their Cost Reports incorporates a new methodology inconsistent with the Medicare statute.

The Providers challenge their SSI percentages based on the following reasons:

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

COVERED DAYS VS. TOTAL DAYS

The statutory language defines the Medicare/SSI fraction as consisting solely of days for patients who were "entitled to benefits under part A" of Medicare. The numerator includes only those part A days for patients who are also entitled to SSI benefits. The denominator of the Medicare/SSI fraction includes all Part A days. As set forth in the statutory language above, the numerator of the Medicaid fraction consists of days of patients who were both

> eligible for medical assistance under Title XIX, or Medicaid and not entitled to benefits under Part A of Title XVII (sic), or Medicare. The denominator for the Medicaid fraction is the hospital's total patient days for the period.
>
> CMS considers an individual to be "entitled to benefits under Part A" regardless of whether the days were "covered" or paid by Medicare. This means that now Part C days, Exhausted Benefit days, and Medicare Secondary Payer ("MSP") days are included in the denominator of the Medicare/SSI fraction even when there is no payment by Medicare, which is a departure from the treatment of these days as excluded from the Medicare/SSI fraction prior to the 2004 rule.
>
> The Provider(s) contend(s) that if CMS includes unpaid Medicare Part A days in the denominator of the Medicare/SSI fraction, then unpaid SSI eligible patient days must be included in the numerator of the Medicare/SSI fraction, utilizing SSI payment codes that reflect the individuals' eligibility for SSI – even if the individuals did not receive SSI payments, as a matter of statutory consistency.[2]

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $14,000.

MAC's Contentions:

The Medicare Contractor filed a Jurisdictional Challenge on March 2, 2023 which only addressed the Medicaid Eligible Days issue. The Jurisdictional Challenge did not address the DSH/SSI Provider Specific issue. However, the Medicare Contractor argues in its Preliminary Position Paper that "the [Board] lacks jurisdiction over the realignment of the SSI percentage, based on the provider's fiscal year. Because the provider is not challenging a final determination, but merely wants to change its election of the fiscal year end for the SSI percentage of the DSH computation the [Board] does not have jurisdiction over this issue. The provider did not pursue its available remedy; therefore, it is not appropriate to include this issue in the appeal." [3]

Board Analysis and Decision:

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

[2] PRRB Case 19-1503GC, Group Issue Statement.
[3] Medicare Contractor's Preliminary Position Paper at 9 (March 17, 2020).

A. DSH – SSI Percentage (Provider Specific)

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

1. First Aspect of Issue 1

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—in the present appeal concerns "[w]hether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation."[4] The Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[5] The Provider argues that "its' SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[6]

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 19-1503GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds the DSH Payment/SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 19-1503GC.

In making this finding, the Board further notes that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, the Provider is pursuing that issue as part of the CIRP group under Case 19-1503GC. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[7] The Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or

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

give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 19-1503GC.

Accordingly, the Board finds that the remaining issue in the instant appeal and the group issue from Group Case 19-1503GC are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5[8], the Board dismisses this component of the DSH – SSI Percentage (Provider Specific) issue.

2. Second Aspect of Issue 1

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

The Board finds that, under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." Without this written request, the Medicare Contractor cannot issue a final determination with which the Provider can be dissatisfied for appeal purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding DSH SSI Percentage realignment. Therefore, the Board finds that it lacks jurisdiction in this aspect of the appeal. Further, the Board notes that the Provider's cost reporting period ends on 9/30, which is congruent with the federal fiscal year end. Accordingly, a realignment of the DSH SSI percentage would have no effect on settlement or reimbursement in this case.

****

In summary, the Board hereby dismisses the SSI Provider Specific issue from this appeal as it is duplicative of the issue in Case No. 19-1503GC and there is no final determination from which the Provider can appeal the SSI realignment portion of the issue. As no issues remain pending, the Board hereby closes Case No. 19-1847 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.

[8] PRRB Rules v. 1.3 (July 2015).

Board Members Participating:

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

For the Board:

1/29/2024

X Kevin D. Smith, CPA

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

cc: Wilson Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Board Decision***
Memorial Healthcare System 2010 Medicare DSH Eligible Days Sampling CIRP Grp.
FYE 04/30/2010
Case No. 14-2720GC

Dear Messrs. Polston and Pike:

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the record in the common issue related party ("CIRP") group in Case No. 14-2720GC, pursuant to a Jurisdictional Challenge filed by the Medicare Contractor ("MAC"). The Board's decision is set forth below.

Background

A. Background of Case No. 14-2720GC

On **February 28, 2014**, Memorial Healthcare System ("MHS") filed a CIRP group appeal to establish Case No. 14-2720GC entitled "Memorial Healthcare System 2010 Medicare DSH Eligible Days Sampling CIRP Group." The group was established with the following two participants that were *directly* added as part of the group appeal request:

- Memorial Regional Hospital (Prov. No. 10-0038)
- Memorial Hospital West (Prov. No. 10-0281)

MHS' group appeal request describes the group issue as relating to "the statistical sampling process" and the "audit sample results":

> **1) Description of the Issue**
>
> This group appeal concerns the determination of the Providers' Medicare disproportionate share hospital ("DSH") adjustment payments under the prospective payment system ("PPS") for operating and capital-related costs of inpatient hospital services. *The common issue relates to the Intermediary's statistical sampling process used in adjusting Medicaid eligible days in determining the Providers' disproportionate patient percentages ("DPP") for the purpose of the Medicare DSH adjustment.* The common issue is *whether in determining the Providers' DPP, the*

> *Intermediary used a valid statistical sampling approach that provides reasonable certainty that the audit sample results are representative of the universe*. The Providers challenge the Intermediary's exclusion of Medicaid eligible days from the Medicaid percentage pursuant to 42 U.S.C. § l395ww(d)(5)(F)(vi)(II) *based on its audit sample results* in the determination of theft DSH adjustment payments. Further, the Providers contend that *the Intermediary's statistical approach was not consistent with generally accepted statistical procedures* as recommended by CMS and as used by the DHHS Office of the Inspector General.[1]

MHS' group appeal request also included the following description of the legal basis for the group appeal with similar focus on whether the sample should have been extrapolated to the defined universe:

> **2) Legal Basis for the Appeal**
>
> The Medicare statute is clear that patient days associated with patients *eligible for medical assistance under a State Medicaid plan*, but not also entitled to Medicare Part A, must be included in the numerator of the Medicaid fraction used to determine the Providers' DPP. 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II) defines the Medicaid fraction as:
>
> > The fraction (expressed as a percentage). The numerator of which is the number of the hospital's patient days for such period which consists of patients who (for such days) *were eligible for medical assistance under a State plan approved under subchapter XIX of this chapter*, [the Medicaid program], but who were not entitled to benefits under part A of this subchapter, and the denominator of which is the total number of the hospital's patient days for such period.
>
> The Providers maintain that the [MAC's] judgmental samples used to determine allowable Medicaid eligible days were not statistically valid and, therefore, the findings from the samples should not have been extrapolated to the entire populations. The Providers note that in *Girling Healthcare, Inc. v. Blue Cross and Blue Shield Association*, Medicare and Medicaid Guide (CCH) ¶ 45,646 (Sept. 10, 1997), the Board held that based on errors found in a judgmental sample, the results should not have been extrapolated. Thus, the disallowed Medicaid eligible days based on extrapolation should instead be included in the Medicaid utilization, since the [MAC's] sample

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

> results do not justify any disallowance of Medicaid eligible days beyond those actually identified in the samples.[2]

Consistent with the description and legal basis for the group issue, the direct add request filed for each of the participants included an amount in controversy based upon the Medicaid eligible days excluded from the calculation as a result of the extrapolation from the results of the statistical sampling as follows:

1. Memorial Hospital West – "exclusion of these extrapolated 3,548 Title XIX eligible days net of the actual non-allowable days of 143"; and

2. Memorial Regional Hospital – "exclusion of these extrapolated 3,549 Title XIX eligible days net of actual nonallowable days of 263."

On **February 14, 2023**, MHS designated the group fully formed with the two participants that were used to establish the group.

On **February 14, 2023**, the Board issued a Notice of CIRP Group Fully Formed and Critical Due Dates Notice setting filing deadlines for the parties preliminary position papers and gave the following instruction regarding the Providers' preliminary position paper:

> Group's Preliminary Position Paper – The position paper ***must*** ***state*** *the material facts* that support the appealed claim, ***identify*** *the controlling authority* (e.g., statutes, regulations, policy, or case law), ***and*** ***provide*** *arguments applying the material facts to the controlling authorities*. This filing ***must*** ***include*** *any exhibits the Group will use* to support its position and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. See Board Rule 25.[3]

On **April 17, 2023**, MHS timely filed the Providers' preliminary position paper.[4] Similarly, on **July 10, 2023**, the MAC timely filed its preliminary position paper.

On **May 15, 2023**, the Board issued a Notice of Hearing and Critical Due Dates setting the hearing date and deadlines for filing final position papers. This Notice gave the following instruction regarding the Providers' final position paper:

> Group's Final Position Paper – The position paper ***must*** ***state*** *the material facts* that support the appealed claim, ***identify*** *the controlling authority* (e.g., statutes, regulations, policy, or case law), ***and*** ***provide*** *arguments applying the material facts to the*

[2] Statement of Group Issue (Feb. 28, 2014) (emphasis in original).
[3] (Emphasis added.)
[4] While the February 14, 2023 Notice set the filing deadline for April 15, 2023, that date fell on a Saturday and, under Board Rules, the deadline was automatically extended to the next business day, Monday, April 17, 2023.

> *controlling authorities*. This filing ***must*** also ***include*** *any exhibits the Group will use* to support its position\. See Board Rule 27 for more specific content requirements. If the Group misses its due date, the Board will dismiss the cases.[5]

On **July 21, 2023**, the MAC filed a Jurisdictional Challenge contending that: (1) MHS is improperly trying to add in a new issue involving 1115 waiver days in its preliminary position paper; *and* (2) the Providers have failed to adequately set for the relevant facts and arguments in its preliminary position paper regarding the statistical sampling issue that was appealed. Consistent with Board Rule 44.4.3, the Providers had a response to the MAC's Jurisdictional Challenge by Monday, August 21, 2023 (*i.e.,* 30 days[6]); however, the Provider *failed* to file any response.

On **November 21, 2023**, MHS timely filed the Providers' Final Position Paper. With respect to Medicaid eligible days, the Final Position Paper states:

> The Providers in this group appeal challenge adjustments that First Coast Service Options (the "MAC") made to their DSH payments. First, the MAC disallowed some of the Medicaid eligible days claimed by the Providers based on its analysis of statistical samplings of those days. But the MAC's statistical samplings were flawed for two reasons. First, the MAC did not afford the Providers an opportunity to present 100% support for all their Medicaid days *in lieu of extrapolation*. Had the MAC offered this, the Providers would have been able to claim additional Medicaid eligible days. Second, the MAC's analysis did not account for the Section 1115 days that the Provider claimed in the cost report. *The MAC simply disallowed all Section 1115 days* ***without including them in the universe of sampled days***. And the MAC's errors did not end there. The MAC also manually entered the wrong DSH adjustment percentage for both providers. *The DSH adjustments that the MAC used* ***erroneously*** *excluded the sampled Medicaid eligible days that the MAC had extrapolated for its review*. As a result, the Providers' DSH payments were understated. The Providers ask that the Board reverse the MAC's adjustments with respect to the (1) traditional Medicaid eligible days were disallowed as a result of the statistical sampling analysis, (2) the Section 1115 days that were disallowed wholesale without any even being reviewed, and (3) the MAC's erroneous adjustment to the Providers' DSH adjustment percentages.

On **December 21, 2023**, the Medicare Contractor timely filed its Final Position Paper.

On **January 23, 2024**, MHS filed notice that its designated representative had changed to Mark Polston of King and Spalding, LLP.

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[5] (Emphasis added and footnote omitted.)
[6] As the 30th day fell on Sunday, August 20th, the deadline moved to the next business day, *i.e*., Monday, August 21st.

B. Background of Participants' Appeal Documents

Memorial Regional Hospital is appealing from an original Notice of Program Reimbursement ("NPR") that was issued on August 27, 2013. The Provider indicated that it was appealing Audit Adjustment Nos. 5, 51 & 53. Two of these audit adjustments were "To Adjust DSH components. Medicaid HMO days and DSH factor;" and the third was "To Adjust for Disproportionate Share on Worksheet E Part A & WS S-3 Part I of the Cost Report."[7] As noted above, the direct add request explains that the amount in controversy for Memorial Regional Hospital is $796,062 based on the "exclusion of these extrapolated 3,549 Title XIX eligible days net of actual nonallowable days of 263."

.

Memorial Hospital West is also appealing from an original NPR that was issued on August 27, 2013. The Provider indicated that it was appealing Audit Adjustment Nos. 4, 7, 23 & 25. Two of these adjustments were "To disallow LIP days consistent with prior year determination and adjust DSH percentage;" and the other two adjustments were "To adjust DSH% based on Medicaid Eligible Testing performed by auditor." As noted above, the direct add request explains that the amount in controversy for Memorial Hospital West is $865,128 based on "exclusion of these extrapolated 3,549 Title XIX eligible days net of actual nonallowable days of 263."

MAC's Contentions in its Jurisdictional Challenge

The MAC contends that the Providers are attempting to add the issue of Section 1115 waiver days to the appeal through the group's preliminary position paper. Additionally, the MAC argues the Providers have violated the regulation at 42 C.F.R. § 405.1853(b)(2) and Board Rule 25 because the Providers' preliminary position paper is incomplete. The MAC states:

> The Providers complain that they were not afforded the opportunity to present 100% support for all the Medicaid eligible days. The appeal is now over 9 years old, and the Providers have had this whole time to supply "100% support for all the Medicaid eligible days in their cost report." The purpose of filing an appeal is supposed to be for the providers to explain their position and provide support for that position.[8]

The MAC also contends that the Provider failed to properly brief the statistical sampling issue in Sections IV.A and C of their preliminary position and quote each section which are each only 4 sentences long. The MAC argues that the preliminary position paper is incomplete relative to the statistical sampling issue because:

> These two small sections are the entire argument presented for the issue of statistical sampling . . . The Providers did not submit any supporting documentation, nor did they even offer an explanation on where they disagree, other than in general terms. The Providers

[7] Documents submitted with the Group Appeal Request (Feb. 28, 2014).
[8] *Id*.

> complain that they were not afforded the opportunity to present 100% support for all the Medicaid eligible days. The appeal is now over 9 years old, and the Providers have had this whole time to supply "100% support for all the Medicaid eligible days in their cost report." The purpose of filing an appeal is supposed to be for the providers to explain their position and provide support for that position.
>
> ****
>
> The MAC contends that the Providers have violated the regulations and Board Rule 25 because the Providers' preliminary position paper did not set forth the relevant facts and arguments regarding the merits of the Providers' claims and failed to include all supporting documentation or properly identify unavailable/ missing documentation, explain why they are missing, and explain the efforts to obtain them.

Accordingly, the MAC requests the Board dismiss the entirety of this case because: (1) "[t]he Providers are attempting to add the issue of Section 1115 waiver days to the appeal"; and (2) "the Providers did not properly brief the issue of statistical sampling in its preliminary position paper with a fully developed narrative. Providers from the group appeal."

Provider's Response

The Board Rules require that Provider Responses to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[9] The Provider has not filed a response to the Jurisdictional Challenge and the time for doing so has elapsed. Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

Board Analysis and Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2014), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in 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.

Specifically, in connection with a group appeal, 42 C.F.R. § 405.1837 (2014) governs "Group appeals" and specifies in subsection (a) that a provider has a right to a Board hearing as part of a group appeal if certain conditions are met:

[9] Board Rule 44.3, v. 2.0 (Aug. 2018).

> (a) *Right to Board hearing as part of a group appeal: Criteria*. **A provider . . . has a right to a Board hearing**, as part of a group appeal with other providers, with respect to a final contractor or Secretary determination for the provider's cost reporting period, **only if**—
>
> (1) **The provider satisfies individually the requirements for a Board hearing under § 405.1835(a)** or § 405.1835(c), except for the $10,000 amount in controversy requirement in § 405.1835(a)(2) or § 405.1835(c)(3).
>
> (2) The matter at issue in the group appeal involves **a single question of fact or interpretation of law**, regulations, or CMS Rulings that is common to each provider in the group; and
>
> (3) The amount in controversy is, in the aggregate, $50,000 or more, as determined in accordance with § 405.1839 of this subpart.[10]

Further, subsection (c) of § 405.1837 (2014) specifies that a group appeal request must contain certain minimum information:

> (c) *Contents of request for a group appeal*. **The request for a Board hearing as a group appeal** must be in writing to the Board, and the request **must include all of the following**:
>
> (1) A demonstration that the request satisfies the requirements for a Board hearing as a group appeal, as specified in paragraph (a) of this section.
>
> (2) **An explanation (for each specific item at issue) of each provider's dissatisfaction with** the final contractor or Secretary **determination under appeal**, **including** an account of—
>
> - **Why** the provider believes Medicare **payment is incorrect** for **each** disputed item;
>
> (ii) **How and why** the provider believes Medicare **payment must be determined differently** for **each** disputed item; and
>
> ****
>
> (3) A copy of each final contractor or Secretary determination under appeal, and any other documentary evidence the providers

[10] (Emphasis added.)

> consider to satisfy the hearing request requirements of paragraphs (c)(1) and (c)(2) of this section, and **a precise description of the one question of fact or interpretation of law, regulations, or CMS Rulings that is common to the particular matter at issue in the group appeal**.[11]

Consistent with the directive in § 405.1837(c)(3) that the appeal request include "a ***precise*** *description* of the one question of fact or interpretation of law, regulations, or CMS Rulings that is common to the particular matter at issue in the group appeal," Board Rules 13 and Board Rules 7 and 8 (as referenced in Board Rule 13) provide the following guidance on the content of group appeal requests, in pertinent part:

> **Rule 7 – Issue Statement and Claim of Dissatisfaction**
>
> *For each issue* under appeal, *give a brief summary of the determination being appealed and the basis for dissatisfaction*. (See Rule 8 for special instructions regarding multi-component disputes.)
>
> **7.1 – NPR or Revised NPR Adjustments**
>
> **A. Identification of Issue**
>
> Give a concise issue statement describing:
>
> - the adjustment, including the adjustment number,
> - why the adjustment is incorrect, and
> - how the payment should be determined differently.
>
> ****
>
> **B. No Access to Data**
>
> If the Provider, through no fault of its own, does not have access to the underlying information to determine whether the adjustment is correct, describe why the underlying information is unavailable.
>
> ****
>
> **Rule 8 – Framing Issues for Adjustments Involving Multiple Components**
>
> **8.1 – General**
>
> *Some issues may have multiple components*. To comply with the 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. See common examples below.

[11] (Emphasis added.)

> **8.2 – Disproportionate Share Cases** (e.g., dual eligible, general assistance, charity care, HMO days, etc.)
>
> **8.3 – Bad Debts Cases** (e.g., crossover, use of collection agency, 120-day presumption, indigence determination, etc.)
>
> **8.4 – Graduate Medical Education/Indirect Medical Education** (e.g., managed care days, resident count, outside entity rotations, etc.)
>
> **8.5 – Wage Index** (e.g., wage vs. wage-related, rural floor, data corrections, etc.)
>
> ****
>
> **Rule 13 – Common Gorup Issue**
>
> The matter at issue must involve a ***single*** common question of fact or interpretation of law, regulation or CMS policy or ruling. A group case is not appropriate if facts that must be proved are unique to the respective Providers or if the undisputed controlling facts are not common to all group members. Likewise, a group appeal is inappropriate if the Board could make different findings for the various Providers in the group. However, for illustration purposes in a brief or hearing, facts relating to a specific Provider(s) may be presented as representative of all group members. *Refer to Rules 7 and 8 for guidance*.[12]

Finally, consistent with the 42 C.F.R. § 405.1837(a)(1) instruction that a group appeal may contain only one issue, § 405.1837(f)(1) specifies that no issues may be added to a group appeal:

> (f) *Limitations on group appeals.*
>
> (1) After the date of receipt by the Board of a group appeal hearing request under paragraph (c) of this section, **a provider may not add other questions** of fact or law to the appeal, regardless of whether the question is common to other members of the appeal (as described in § 405.1837(a)(2) and (g) of this subpart). [13]

A. § 1115 Waiver Days Issue

As an initial matter, the Board notes that the two Providers in this group appeal were directly added to the group from their final determinations, therefore the group issue statement fully governs. However, the ***issue statement*** for the group appeal does not address § 1115 waiver days notwithstanding the directive in § 405.1837(c) that an group appeal request must include "a

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

precise *description* of the one question of fact or interpretation of law . . . common to the particular matter at issue in the group appeal" and the directive in Board Rule 8 (as applicable through Board Rule 13) that, when an issue has multiple components, "***each*** contested *component* must be appealed as a ***separate*** issue ***and*** *described as* ***narrowly*** *as possible*."[14] Rather, it only concerns the statistical sampling and the extrapolation of that sampling onto the universe for which the statistical sampling was done. To this end, the amounts in controversy included with the participants' direct add requests was limited to the extrapolation of the sample and did not include any amounts in controversy related to the § 1115 waiver days.

Consistent with §405.1837(c) and Board Rule 8 (as applicable via Board Rule 13), the § 1115 waiver days is a separate issue for which a separate group would need to be created since no § 1115 waiver days were included in the universe for which the statistical sampling was done and on which the extrapolation of the sampling audit was projected. Rather, all § 1115 waiver days were excluded from the sampling universe *in toto* (apparently based on the MAC's finding that the Florida § 1115 waiver program at issue did not meet the criteria in 42 C.F.R. § 412.106(b)(2) to be included in the Medicaid fraction for purposes of the DSH calculation). In sum, as alleged by the Providers, the NPRs at issues treated the § 1115 waiver days as a *separate* class of days and were not audited but were excluded from the numerator of the Medicaid fraction *in toto*.[15]

The CIRP group appeal was filed with the Board in February of 2014, and the regulations at 42 C.F.R. § 405.1837(a)(2) (2013) specified that a group appeal only "involve[] a single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group." Board Rule 13 echoes this regulation by stating that "[t]he matter at issue [in a group] must involve a ***single*** common question of fact or interpretation of law, regulation or CMS policy or ruling." Further, consistent with the requirement that a group contain only one issue, no issues can be added to a group subsequent to the group appeal request being filed as explained at 42 C.F.R. § 405.1837(f)(1):

> (f) *Limitations on group appeals.*
>
> (1) After the date of receipt by the Board of a group appeal hearing request under paragraph (c) of this section, **a provider may not add other questions of fact or law to the appeal**, regardless of whether the question is common to other members of the appeal (as described in § 405.1837(a)(2) and (g) of this subpart).[16]

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[14] (Emphasis added.)

[15] The fact that the MAC defined the universe of claims audited to exclude § 1115 waiver days does not in and of itself create any statistical sampling issues. In this regard, the Board notes that the MAC excluded all § 1115 waiver days and the Providers' issue in the preliminary position paper regarding these days is not one related to statistical sampling but rather the substance of the exclusion of these days. No where does the group appeal request contest, much less mention, the MACs exclusion's of the § 115 waiver days from the numerator of the Medicaid fraction. In this regard, notwithstanding the content requirements for group appeal requests in 42 C.F.R. § 405.1837(c)(2), there is no discussion of "[w]y the provider believes Medicare payment is incorrect" relative to the § 1115 days issue, "[h]ow and why the provider believes Medicare payment must be determined differently" for the § 1115 days issue.

[16] (Emphasis added.)

Here, the group issue statement (*i.e.*, the "precise description of the one question" in the group) only addressed one issue, namely the statistical sampling issue and failed to include the separate § 1115 waiver day issue. Furthermore, the first time that MHS raised the issue of 1115 waiver days was in the Providers' Preliminary Position Paper (more than 9 years after the appeal was filed[17]).

Indeed, even though the group was fully formed on February 14, 2023 and MHS filed a Rule 20 certification confirming, among other things, that "all relevant supporting jurisdictional documentation for this group has been fully populated in OH CDMS," MHS has not calculated an amount in controversy for this separate issue notwithstanding the following instruction in 42 C.F.R. § 405.1839(b)(2):

> (2) *Aggregation of claims*. (i) For purposes of satisfying the amount in controversy requirement, group members are not allowed to aggregate claims involving different issues.
>
> (A) A group appeal must involve a single question of fact or interpretation of law, regulations, or CMS Ruling that is common to each provider (as described in § 405.1837(a)(2) of this subpart).
>
> (B) The single issue that is common to each provider may exist over different cost reporting periods.

Indeed, MHS has failed to, even at that late date, identify the alleged § 1115 waiver days that the MAC otherwise excluded from the numerator of each participant's respective Medicaid fraction for the year at issue in either its preliminary or final position paper filings (even though these filings were made in 2023 more than 9 years after this group appeal was established).[18] The fact that no amount in controversy for the § 1115 waiver days issue was calculated and included in the jurisdictional documentation for the participants further confirms that this issue is not properly part of this group case.

In this regard, the Board notes that § 1115 waiver days are not traditional Medicaid eligible days and indeed were only incorporated into the DSH calculation effective January 20, 2000.[19] Rather, they relate to Medicaid expansion program(s) and are only includable in the DSH adjustment calculation if they meet the requirements in 42 C.F.R. § 412.106(b)(4) relating to section 1115 Waiver days. Indeed, not every state Medicaid program has a qualifying 1115 expansion program ***and*** not every inpatient day associated with beneficiary enrolled in an 1115 waiver program qualifies to be included in the Medicaid fraction.[20] In contrast, every state has a Medicaid state plan and every state Medicaid plan includes inpatient hospital benefits.

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[17] Significantly, the primary support for the Providers' position on the § 1115 waiver day issue discussed in the Providers' preliminary position paper is the following 2019 decision of the U.S. District Court for the District of Columbia ("D.C.") as affirmed in 2020 by the U.S. Court of Appeals for D.C.: *Bethesda Health, Inc. v. Azar*, 389 F. Supp. 32 (D.D.C. 2019), *aff'd*, 980 F.3d 121 (D.C. Cir. 2020).

[18] The Board further notes that the Providers' final position paper appears to be identical to their preliminary position paper.

[19] 65 FR 47054, 47087 (Aug. 1, 2000).

Specifically, § 412.106(b)(4) states in pertinent part:

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

Because the 1115 Waiver days issue is a distinct issue and was not included in the group appeal and cannot later be added to the group, the Board finds that the issue is not properly part of this group. In agreeing with the Medicare Contractor's Challenge, the Board notes that MHS failed to file any response to that Challenge. Accordingly, consistent with 42 C.F.R. §§ 405.1837(a)(2), (c)(2)-(3) and (f)(1) and 405.1839(b)(2) and Board Rules 7, 8 and 13, the Board hereby dismisses the issue of § 1115 waiver days as it was not initially appealed as part of the group issue statement.[20]

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[20] *See also Evangelical Commty Hosp. v. Becerra*, No. 21-cv-01368, 2022 WL 4598546 at *5 (D.D.C. 2022):

> The Board acts reasonably, and not arbitrarily and capriciously, when it applies its "claims-processing rules faithfully to [a provider's] appeal." *Akron*, 414 F. Supp. 3d at 81. The regulations require that a RFH provide "[a]n explanation [ ]for each specific item under appeal." 42 C.F.R. § 405.1835(b)(2). The Board rules further explain that "[s]ome issues may have multiple components," and that "[t]o comply with the 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." Board Rules § 8.1. The Board rules also specifically delineate how a provider should address, as here, a challenge to a Disproportionate Share Hospital reimbursement. Board Rule 8.2 explains that an appeal challenging a Disproportionate Share Hospital payment adjustment is a "common example" of an appeal involving issues with "multiple components" that must be appealed as "separate issue[s] and described as narrowly as possible." Board Rules §§ 8.1, 8.2.

B. Statistical Sampling Issue

The Board agrees with the MAC's position on the issue of the statistical sampling issue and dismisses it, as the record was not developed on that initial issue in either the preliminary or final position paper filings which appear to be identical.

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

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board through a schedule applicable to a specific case or through general instructions.[21]

Similarly, with regard to position papers,[22] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available documentation* as exhibits to ***fully*** support your position."[23] This requirement is consistent with 42 C.F.R. § 405.1853(b)(3). To the extent evidence contains PHI, it is to be redacted consistent with Board Rule 1.4 unless the confidential information itself is necessary to support your position in which case "you must file a request seeking permission from the Board to submit unredacted PHI/PII with the Board, ***at least fourteen (14) days prior to the document deadline***."[24] At no point did the Providers pursue this process notwithstanding

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Plaintiffs did not follow these rules. In their RFH, Plaintiffs described Issue 4 simply as follows: "The intermediary erred by incorrectly calculating the SSI percentage for inclusion in the 'Medicare Fraction' for purposes of the calculation of the provider's [disproportionate share] payment." Ex. 1 at 3. This description does not specify which portion of the calculation was incorrect nor how the fraction should have been calculated differently. Recall, a Disproportionate Share Hospital reimbursement is determined by calculating a provider's Medicare-SSI and Medicaid fractions, which make up the provider's Disproportionate Patient Percentage. The Medicare-SSI Fraction alone has multiple component parts that a provider could challenge. Plaintiffs did not specify which specific portion of the fraction they sought to challenge or what would have constituted correct data for the Disproportionate Share Hospital calculation. This provides sufficient basis to support the Board's dismissal. The Board's procedural rules empower the body to dismiss a provider's appeal when the provider's RFH or Preliminary Position Paper is deficient. *See* 42 C.F.R. § 405.1868(b); Board Rules § 41.2. Because Plaintiffs did not comply with the specificity requirement, the Board acted reasonably in dismissing their Issue 4 claims.

[21] (Emphasis added).

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

[23] (Emphasis added).

[24] (Emphasis in original.)

their obligation to enter into the record *all* relevant available documents to be relied on by the Providers for this issue consistent with the Notice of Critical Due Dates and Board Rule 25.2 (consistent with the Board's authority under 42 C.F.R. § 405.1853(b)(3)).[25]

Finally, the Boad notes Board Rule 25.3 provides filing requirements for position papers (applicable to final position papers through Board Rule 27.2):

> **25.3 Filing Requirements to Board**
>
> The Board requires the parties file a ***complete*** preliminary position paper that includes a fully developed narrative (Rule 25.1), all exhibits (Rule 25.2), a listing of exhibits, and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. If the provider fails to brief an appealed issue in its position paper, the Board will consider the unbriefed issue abandoned and effectively withdrawn.
>
> **COMMENTARY**: Note that the change to require filing of the ***complete*** preliminary position paper was effective on August 29, 2018. Accordingly, failure to file a ***complete*** preliminary position paper with the Board will result in the Board dismissing your appeal or taking other actions in accordance with 42 C.F.R. § 405.1868. (See Rule 23.4.)[26]

The Board finds that the Providers have failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation included in the Critical Due Dates Notices and Board rules and regulations. In this regard, the Board notes that, consistent with Board Rule 41.2 and 42 C.F.R. § 405.1868(b), it may dismiss a case or relevant issue(s) on its own motion if it has a reasonable basis to believe that the case or relevant issue(s) are abandoned and/or upon failure of the provider or group to comply with Board procedures of filing deadlines. To highlight the Providers' abandonment, the Board notes that, not only did the Providers not formally respond to the Challenge within the time allotted under Board Rule 44.4.3, but the Providers failed to address the deficiencies cited by the MAC when it subsequently its final

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[25] If documents are not available, Board Rule 25.2.2 specifies the information that must be included in the position paper regarding their unavailability and when they will become available. However, neither the Providers' preliminary position paper nor final position paper asserts that any documents are unavailable. Specifically Board Rule 25.2.2 states:

> If documents necessary to support your position are still unavailable, then provide the following information in the position papers:
>
> 1. Identify the missing documents;
> 2. Explain why the documents remain unavailable;
> 3. State the efforts made to obtain the documents; and
> 4. Explain when the documents will be available.
>
> Once the documents become available, promptly forward them to the Board and the opposing party. Common examples of unavailable documentation include pending discovery requests, pending [FOIA] requests . . ., or similar requests for information pending with a state Medicaid agency.

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

position paper. More specifically, even though the MAC's Challenge was filed *4 months prior to the Providers' final position paper*, the Providers final position paper did ***not*** address *any* of the deficiencies cited by the MAC in its Challenge as quoted above. Rather, it appears to be verbatim the same document (with the same exhibits that did not address the statistical sampling issue). As such, the Providers' final position paper contains the same deficiencies cited by the MAC in its Challenge on this issue (as quoted above).

Accordingly, the Board agrees with the MAC's Challenge for this issue (as quoted above) and finds that the Providers have effectively abandoned the statistical sampling issue by failing to properly and *fully* brief that issue in either the group's Preliminary or Final Position Paper.[27] In this regard, in the final position paper, the argument sections for this issue are located in Sections IV.A and C of the final position paper; however, they are perfunctory and, in the aggregate, contain only 8 sentences without any reference to supporting exhibits/documents in the record (and include none with the filing related to the arguments in Section IV.A and C). In particular, the opening sentence for Section IV.A is: "The Providers contend that the statistical sampling analyses that the MAC used to adjust their traditional Medicaid eligible days were not based on a representative sampling of those days."[28] However, there is no explanation for that generic contention (*i.e.*, they failed to "set forth the relevant facts and arguments regarding . . . the merits of the provider's Medicare payment claims for each remaining issue"[29] or "***fully*** develop[] [the issue] and include ***all*** available documentation necessary to provide a thorough understanding of the parties' positions"[30]). Similar broad, sweeping, unsupported statements are made in Section IV.B and, again, without any reference to records entered into the record (whether in that filing or earlier).

Finally, the Board questions whether the statistical sampling issue was appropriate for a group issue because the outcome may be fact-dependent by Provider. However, as discussed above, the Providers failed to properly and sufficiently develop the issue as part of the position paper process for the Board to understand the Providers' position and resolve those concerns. Specifically, due to the failure of the Providers to properly ***fully*** develop the group issue in their position paper with all relevant exhibits,[31] it remains unclear, at this late date, what the controlling fact disputes are and whether the "facts that must be proved are unique to the respective Providers or if the undisputed controlling facts are not common to all group members."[32]

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[27] *See also* Commentary to Board Rule 23.3 stating: "The regulations and Board Rules impose preliminary position paper requirements that ensure full development of the parties' positions in order to foster efficient use of the administrative review process. The due date timeframe is set to give the parties the optimal opportunity to ***fully*** develop their case. . . . [T]he Board requires preliminary position papers to be ***fully*** developed and include ***all*** available documentation necessary to provide a thorough understanding of the parties' positions." (Underline emphasis added).

[28] If the sample is representative of the universe defined by the MAC, the Board never reaches the third sentence assertion: "This could have been avoided had the MAC afforded the Providers the opportunity to present 100% support for all the Medicaid eligible days in their cost report."

[29] 42 C.F.R. § 405.1853(b)(2).

[30] Commentary to Board Rule 23.3 (underline emphasis added).

[31] Board Rule 25.2.1; Commentary to Board Rule 23.3 states position papers must "be ***fully*** developed and include ***all*** available documentation necessary to provide a thorough understanding of the parties' positions." (Underline emphasis added.) This requirements are consistent with 42 C.F.R. § 405.1853(b)(2)-(3).

[32] Board Rule 13 (March 2013).

In summary, consistent with 42 C.F.R. §§ 405.1853(b)(2)-(3) and Board Rules 25, 27 and 41.2, the Board dismisses the statistical sampling issue that was initially appealed in the group appeal request as the Providers effectively abandoned the issue notwithstanding the fact that they have had over 9 years to develop the statistical sampling issue prior to filing the position papers and failed to comply with the position paper filing requirements.[33]

Decision

As explained more fully above, the Board (1) dismisses the §1115 waiver days issue as the Providers improperly attempted to add this issue to the appeal in its preliminary position paper filing; and (2) dismisses the remainder of the appeal in its entirety as the Providers have failed to properly brief its originally-appealed statistical sampling in its preliminary position paper (as well as the final position paper).[34] As no issue remains in the appeal, the Board closes Case No. 14-2720GC]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:

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For the Board:

1/30/2024

X Clayton J. Nix

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Chair
Signed by: PIV

cc: Wilson Leong, Federal Specialized Services

[33] *See also supra* note 20; 42 C.F.R. § 405.1871(a)(3) (confirming that "the provider carrie[s the] burden of production of evidence and burden of proof by establishing, by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue"); Commentary to Board Rule 23.3 stating "[T]he Board requires preliminary position papers to be ***fully*** developed and include ***all*** available documentation necessary to provide a thorough understanding of the parties' positions." (underline emphasis added)).

[34] In agreeing with the MAC's Jurisdictional Challenge regarding both points, the Board is not saying they pertains to "jurisdiction" *per se* or that the Board is denying "jurisdiction." The MAC may file a "jurisdictional challenge" that may pertain to non-jurisdictional issues. In this regard, the Board notes that that 42 C.F.R. § 405.1840 is entitled "Board Jurisdiction" but it also addresses certain claim filing requirements such as timelines or filing deadlines. However, whether an appeal was timely is not a jurisdictional requirement but rather is a claim filing requirement as the Supreme Court made clear in *Sebelius v. Auburn Reg. Med. Ctr.*, 568 U.S. 145 (2013). *See also* Board Rule 4.1 ("The Board will dismiss appeals that fail *to meet the timely filing requirements* ***and/or*** *jurisdictional requirements*. Similarly, the Board notes that 42 C.F.R. §§ 405.1835(b) and 405.1837(c) address claim filing requirements.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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

RE: ***Notice of Dismissal of Untimely Appeals***
Case Nos. 24-0827GC, *et al.* (*see* attached listing of 104 cases)

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("PRRB") is in receipt of the above-captioned 87 individual and seventeen (17) common issue related party ("CIRP") group appeals that were filed on January 25, 26, and 29, 2024 by the Providers' designated representative, James Ravindran of Quality Reimbursement Services, Inc. ("QRS") based on an appeal of the final rule published in the Federal Register on June 9, 2023 ("June 9, 2023 Final Rule") involving Part C days as used in the disproportionate share calculation ("DSH") by the Centers for Medicare and Medicaid Services ("CMS").[1] Set forth below is the Board's decision dismissing the above-captioned 104 individual and CIRP group cases for failure of the Providers' to *timely* file their appeals of the June 9, 2023 Final Rule by the Wednesday, December 6, 2023 filing deadline consistent with 42 U.S.C. § 1395oo(a)(1)(3), 42 C.F.R. §§ 405.1835(a)(3) and 405.1837(a)(1) and Board Rules 4.3.2 and 7.1.1.

Background

On January 25, 26, and 29, 2024, QRS filed appeal requests in the Office of Hearings Case and Document Management System ("OH CDMS") to establish the above-captioned 87 individual and 17 CIRP group cases. The appeal request filed for each case identifies the final determination being appealed as the June 9, 2023, Final Rule and describe the statement of issue as follows:

> **ISSUE TITLE**
>
> [DSH] – Inclusion of Part C Days in Denominator of the Medicare Fraction- Challenge to Part C Days retroactive final rule.
>
> **STATEMENT OF ISSUE**
>
> The issue is whether Part C days are properly included in the denominator of the Medicare Fraction per a July 8, 2023, retroactive

[1] 88 Fed. Reg. 37772 (June 9, 2023).

> final rule issued by [CMS], which is binding on the [Medicare contractor], or whether such final rule is illegal and cannot be enforced.
>
> The Provider appeals [Providers appeal] the Secretary's determination, which it calls a "final action," embodied in a July 8, 2023, retroactive final rule, that requires Part C Days to be included in the Medicare Fraction of the disproportionate payment percentage for discharges occurring prior to October 1, 2013 ("the Part C Days Final Rule"). The Part C Days Final Rule ***became effective on August 8, 2023***. The Providers challenge the procedural and substantive validity of the Part C Days Final Rule. Specifically, the Providers assert that the Part C Days Final Rule is procedurally invalid the retroactive nature of the rule violates the rulemaking provisions of the Social Security Act and the Administrative Procedure Act, and is contrary to the D.C. Circuit's opinion in *Northeast Hospital v. Sebelius*, and established precedent regarding the applicability of a pre-existing rule when a later rule is vacated (as was the 2004 final rule on Part C days). The Part C Days Final Rule is substantively invalid because it is arbitrary and capricious. Specifically, the Part C Days Final Rule is arbitrary and capricious because CMS did acknowledge that putting Part C Days in the Medicare Fraction was a departure from its policy or practice prior to the vacated 2004 rule. The Part C Days Final Rule also failed to account for hospitals' reliable interest on the pre-2004 final rule practice or policy, and also failed to recognize the enormous adverse financial impact on hospitals due to the change from the pre-2004 final rule practice or policy.[2]

However, each of these 104 individual and group appeals were filed more than ***180 days*** after the publication of the June 9, 2023 Final Rule provision that implemented the Final Rule for "Treatment of Medicare Part C Days in the Calculation of a Hospital's Medicare Disproportionate Patient Percentage."[3] Notwithstanding, each of these appeal requests identified, *in error*, that the "final determination date" from which they are appealing is August 8, 2023 – the ***effective date*** of the provision, rather than the date of ***notice***, *i.e.*, the publication date, of June 9, 2023.

Decision of the Board

The Board finds that the above-captioned 46 appeals were ***not*** timely filed as required by the Board's enabling statute at 42 U.S.C. § 1395oo(a)(3), which specifies that appeals of Federal Register Notices (i.e., appeals under 42 U.S.C. § 1395(a)(1)(ii)) must be filed "*within . . . 180 days*

[2] Providers' Appeals Issue Statement.
[3] 88 Fed. Reg. 37772 (June 9, 2023). *See also Wash. Hosp. Ctr. v. Bowen*, 795 F.2d 139, 146 (D.C. Cir. 1986) ("[A] year end cost report is *not* a report which is necessary in order for the Secretary to make PPS payments, and the appeals provision applicable to PPS recipients cannot be read to require hospitals to file cost reports and await NPRs prior to filing a PRRB appeal") and *Dist. of Columbia Hosp. Ass'n Wage Index Group Appeal*, HCFA Adm'r Dec., Medicare & Medicaid Guide (CCH) ¶ 41,025 (Jan. 15, 1993) (publication of the wage index in the Federal Register is a final determination which can be appealed to the Board).

after ***notice*** *of the Secretary's final determination.*"[4] These appeals were filed in OH CDMS more than a month past the filing deadline of 180 days after the issuance of the June 9, 2023 Federal Register provision that implemented the Final Rule for "Treatment of Medicare Part C Days in the Calculation of a Hospital's Medicare Disproportionate Patient Percentage."

Consistent with 42 U.S.C. § 1395oo(a)(3), 42 C.F.R. § 405.1835(a)(3) specifies that a provider's appeal request must be filed no later than 180 days after the "date of receipt" of the final determination being appealed:

> (3) Unless the provider qualifies for a good cause extension under § 405.1836, the date of receipt by the Board of the provider's hearing request must be no later than 180 days after the date of receipt by the provider of the final contractor or Secretary determination.

The regulation at 42 C.F.R. § 405.1837(a)(1) makes clear that this requirement applies to provider's participating in a group appeal whether by transfer or direct add.[5] To this end, Board Rule 7.1.1 specifies that the appeal request must "[i]dentify the date the final determination ***was issued***"[6] and Board Rule 4.3.2 specifies in connection with appeals based on a Federal Register Notice that: (1) "[t]he date of receipt of a Federal Register Notice is the date the Federal Register is published"; and (2) "[t]he appeal period begins on the date of publication and ends 180 days from that date."

The Board is bound by all of the provisions of Title XVIII of the Act (the Social Security Act, as amended) and the regulations issued thereunder.[7] The Board cannot apply a regulation or instruction which is contrary to a statute and other regulations that deal specifically with the matter at hand: the date a provider is deemed to have notice of the contents of the Federal Register. In this case, the laws and regulations governing the publication of Federal Register notices specifically define the time of notice as that of publication. These laws and regulations have been incorporated into Title XVIII.

The Secretary[8] has enacted Part 401 of Title 42 of the Code of Federal Regulations which is entitled "General Administrative Requirements." Subpart B, §§ 401.101(a)(1) and (2) of this Part states that "[t]he regulations in this subpart: (1) Implement section 1106(a)[9] of the Social Security Act [relating to disclosure of information] as it applies to [CMS] . . . [and] (2) Relate to the

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[4] (Emphasis added.)
[5] 42 C.F.R. § 405.1837(a)(1) specifies that a provider's right to participate in a group is dependent, in part, on the "[t]he provider satisfy[ying] individually the requirements for a Board hearing under § 405.1835(a) or § 405.1835(c), except for the $10,000 amount in controversy requirement in § 405.1835(a)(2) or § 405.1835(c)(3)." NOTE – none of the providers in these 50 appeals have alleged that they are appealing from the nonissuance of an NPR or revised NPR consistent with § 405.1835(c) and, to that end, there is no information in the records for these cases to support such an allegation consistent with Board Rule 7.5.
[6] (Emphasis added.)
[7] *See* 42 C.F.R. § 405.1867.
[8] of the Department of Health and Human Services.
[9] 42 U.S.C. § 1306(a).

availability to the public, under 5 U.S.C. § 552,[10] of records of CMS." These laws and regulations set out which records are available and how they may be obtained, and they supplement the regulations of CMS relating to the availability of information. Section 401.106 of this subpart, which deals with publication of materials under 5 U.S.C. § 552, requires publication to serve as notice and identifies the Federal Register as the vehicle to be used to give notice. Section 552(a) states in part that:

> (1) Each agency shall separately state and currently publish in the Federal Register for the guidance of the public-
>
> * * * *
>
> (D) substantive rules of general applicability adopted as authorized by law, and statements of general policy or interpretations of general applicability formulated and adopted by the agency; and
> (E) each amendment, revision, or repeal of the foregoing.

In order to comply with the statutes and regulations requiring that public notice be given, the Secretary annually publishes the schedules of the Inpatient Prospective Payment System ("IPPS") rates as well as other IPPS policies in the Federal Register pursuant to the requirements of 42 C.F.R. § 412.8(b)(2). The Secretary may issue other changes as Federal Register Notices outside of this annual ratesetting process as was done here with the issuance of the Part C days policy published in the June 9, 2023 Final Rule. These processes were created to comply with 5 U.S.C. § 552 of the Freedom of Information Act which requires that agencies publish regulations and notices in the Federal Register.[11]

With regard to the Notices published in the Federal Register, 44 U.S.C. § 1507 states in part that:

> A document required. . .to be published in the Federal Register is not valid as against a person who has not had actual knowledge of it until the duplicate originals or certified copies of the document have been filed with the Office of the Federal Register and a copy made available for public inspection as provided by section 1503. . . . *[F]iling of a document, required or authorized to be published [in the Federal Register] by section 1505. . .is sufficient to give notice* of the contents of the document to a person subject to or affected by it.[12]

Reflecting new technology and the ability to transmit information immediately upon publication, the Government Printing Office ("GPO") promulgated 1 C.F.R. § 5.10 which authorizes publication of the Federal Register on the internet at the GPO website.[13] The GPO website containing the Federal Register is updated daily at 6 a.m. Monday through Friday, except

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[10] 5 U.S.C. § 550 *et seq.* contains the Administrative Procedures Act; 5 U.S.C. § 552 deals with the availability of government information and is known as the Freedom of Information Act ("FOIA").
[11] *See also* 42 C.F.R. Part 401, Subpart B.
[12] (Emphasis added).
[13] *See also* 44 U.S.C. § 4101 (the Superintendent of Documents is to maintain an electronic director and system of online access to the Federal Register).

holidays.[14] Consequently, the Provider is deemed to have notice of the Part C days policy at issue on the date the Federal Register was published and made available online. Indeed, the Board notes that Notices are often available for public inspection several days ***prior to*** the official publication date and, here, the June 9, 2023 Final Rule was posted to the public at 4:15 pm on June 7, 2023, 2 days in advance of the June, 9, 2023 publication date.[15]

With respect to statutes and regulations dealing with the Federal Register, the Supreme Court has found that:

> Congress has provided that the appearance of rules and regulations in the Federal Register give legal notice of their contents . . . .
>
> . . . Regulations [are] binding on all who sought to come within the [Act], regardless of actual knowledge of what is in the Regulations or of the hardship resulting from innocent ignorance.[16]

The statutes governing the Board (44 U.S.C. § 1507 as applied through the requirements of 42 C.F.R. § 401.101 and the Administrative Procedures Act ("APA")) are clear on their face: ***the date of publication*** of the Federal Register is the date the Providers are deemed to have notice of the June 9, 2023 Final Rule. The Board is bound by all of the provisions of Title XVIII which includes, by reference, the provisions of the Administrative Procedures Act and the Public Printing and Documents law which require that CMS publish its notices and regulations in the Federal Register. In publishing materials in the Federal Register, CMS must comply with the statutes and regulations governing the Superintendent of Documents and the Governing Printing Office.

Pursuant 42 U.S.C. § 1395oo(a)(3), the Board's enabling statute, providers have 180 days "after *notice* of the Secretary's final determination" to file an appeal. To this end, Board Rule 4.3.2 confirms that the appeal period for a final rule published in the Federal Register appeal ends 180 days from the date of ***publication***, not the effective date that may be listed in a provision:

> The date of receipt of a Federal Register Notice is the date the Federal Register is ***published***. The appeal period begins on the date of publication and ends 180 days from that date.[17]

In this case, the notice of the Secretary's determination is, by law, the date the Federal Register is issued by the Superintendent of Documents, or June 9, 2023. Here, the 180th day for appealing was ***Wednesday, December 6, 2023***. The above-captioned appeals were not filed with the Board until ***more than a month after this deadline*** (specifically between January 25, 2024 and January 29, 2024) and, thus, were not timely filed.[18]

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[14] *See* http://www.gpo.gov/help/index.html#about_federal_register.htm.
[15] https://www.federalregister.gov/public-inspection/2023/06/07 (last accessed Jan. 19, 2024).
[16] *Fed. Crop Ins. Corp. v. Merrill*, 332 U.S. 380, 385 (1947).
[17] Emphasis added.
[18] The Providers in these 104 appeals have not requested good cause exception under 42 C.F.R. § 405.1836 and have not presented any evidence suggesting that they would qualify under the criteria specified in that regulation.

Based on the above findings, the Board concludes that it does not have jurisdiction over the above-captioned 104 appeals for failure of the Providers' to *timely* file these appeals of the June 9, 2023 Final Rule by the Wednesday, December 6, 2023 filing deadline consistent with 42 U.S.C. § 1395oo(a)(1)(3), 42 C.F.R. §§ 405.1835(a)(3) and 405.1837(a)(1) and Board Rules 4.3.2 and 7.1.1 and, as such, hereby dismisses them. Accordingly, the Board closes the above-captioned 104 cases and removes them from the Board's docket.[19] Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. §§ 405.1875 and 405.1877.

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For the Board:

1/30/2024

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Michael Redmond, Novitas Solutions, Inc. (J-H, J-L)
Geoff Pike, First Coast Service Options, Inc. (J-N)

[19] Regardless, even if the Board had not dismissed these appeals as being untimely filed (more than a month late), the Board would find that the Providers appeals were premature as they failed to appeal from a "final determination" consistent with the jurisdictional dismissal decisions issued in: (1) Case No. 23-1498 on Nov. 27, 2023 which similarly appealed the June 9, 2023 Final Rule (available at: https://www.cms.gov/files/document/prrb-jurisdictional-decisions-11-1-2023-through-11-30-2023.pdf (last accessed Jan. 19, 2023)); (2) Case Nos. 23-1796GC, *et al*. on Oct. 25, 2023 which appealed the § 1115 waiver day policy finalized in the August 28, 2023 FY 2024 IPPS Final Rule (available at: https://www.cms.gov/files/document/prrb-jurisdictional-decisions-10-1-2023-through-10-31-2023.pdf (last accessed Jan. 19, 2023)). Moreover, even if it were a final determination, the Board would also need to conduct further review to confirm, *based on the information/documentation included in the relevant appeal request*, whether the Providers have established (consistent with 42 C.F.R. §§ 405.1835(b)(1) and 405.1837(c)(1), (3)) that the June 9, 2023 Final Rule is, ***in fact***, applicable to them (*i.e.*, confirm for the fiscal years at issue that either: (a) no NPR has been issued; or (b) they had a Board appeal of the Part C issue that was subsequently remanded per CMS Ruling 1739-R).

Listing of 17 CIRP Groups and 87 Individual Appeals

24-0827GC	Yale-New Haven CY 2007 Treatment of Part C Days Final Rule CIRP Group
24-0829GC	Yale-New Haven CY 2008 Treatment of Part C Days Final Rule CIRP Group
24-0830GC	Yale-New Haven CY 2009 Treatment of Part C Days Final Rule CIRP Group
24-0831GC	Yale-New Haven CY 2010 Treatment of Part C Days Final Rule CIRP Group
24-0832GC	Yale-New Haven CY 2011 Treatment of Part C Days Final Rule CIRP Group
24-0833GC	Yale-New Haven CY 2012 Treatment of Part C Days Final Rule CIRP Group
24-0834GC	Yale-New Haven CY 2013 Treatment of Part C Days Final Rule CIRP Group
24-0837GC	Banner Health CY 2011 Treatment of Part C Days Final Rule CIRP Group
24-0838GC	Banner Health CY 2012 Treatment of Part C Days Final Rule CIRP Group
24-0839GC	Banner Health CY 2013 Treatment of Part C Days Final Rule CIRP Group
24-0840GC	Nuvance Health CY 2006 Treatment of Part C Days Final Rule CIRP Group
24-0841GC	Nuvance Health CY 2007 Treatment of Part C Days Final Rule CIRP Group
24-0842GC	Nuvance Health CY 2008 Treatment of Part C Days Final Rule CIRP Group
24-0826	Yale New Haven Hospital (07-0022), FFY 2006
24-0835	Banner University Medical Center Tucson (03-0064), FFY 2009
24-0848GC	Nuvance Health CY 2009 Treatment of Part C Days Final Rule CIRP Group
24-0849GC	Nuvance Health CY 2010 Treatment of Part C Days Final Rule CIRP Group
24-0850GC	Nuvance Health CY 2011 Treatment of Part C Days Final Rule CIRP Group
24-0851GC	Nuvance Health CY 2012 Treatment of Part C Days Final Rule CIRP Group
24-0852	Norwalk Hospital Association (07-0034), FFY 2013
24-0853	Mary Lanning Healthcare (28-0032), FFY 2008
24-0854	Mary Lanning Healthcare (28-0032), FFY 2009
24-0855	Mary Lanning Healthcare (28-0032), FFY 2010
24-0856	Mary Lanning Healthcare (28-0032), FFY 2011
24-0857	Mary Lanning Healthcare (28-0032), FFY 2012
24-0858	Mary Lanning Healthcare (28-0032), FFY 2013
24-0861	New York Downtown Hospital (33-0064), FFY 2005
24-0862	New York Downtown Hospital (33-0064), FFY 2006
24-0863	New York Downtown Hospital (33-0064), FFY 2007
24-0864	New York Downtown Hospital (33-0064), FFY 2008
24-0865	New York Downtown Hospital (33-0064), FFY 2009
24-0866	New York Downtown Hospital (33-0064), FFY 2012
24-0867	St. Vincent Hospital (39-0009), FFY 2005
24-0868	St. Vincent Hospital (39-0009), FFY 2007
24-0869	St. Vincent Hospital (39-0009), FFY 2008
24-0870	St. Vincent Hospital (39-0009), FFY 2009
24-0871	St. Vincent Hospital (39-0009), FFY 2010
24-0872	St. Vincent Hospital (39-0009), FFY 2012

24-0873	St. Vincent Hospital (39-0009), FFY 2013
24-0874	University Medical Center (45-0686), FFY 2006
24-0875	University Medical Center (45-0686), FFY 2007
24-0876	University Medical Center (45-0686), FFY 2008
24-0877	University Medical Center (45-0686), FFY 2009
24-0878	University Medical Center (45-0686), FFY 2010
24-0879	University Medical Center (45-0686), FFY 2011
24-0886	Virginia Mason Memorial Hospital (50-0036), FFY 2007
24-0887	Virginia Mason Memorial Hospital (50-0036), FFY 2008
24-0889	Virginia Mason Memorial Hospital (50-0036), FFY 2009
24-0890	Virginia Mason Memorial Hospital (50-0036), FFY 2010
24-0891	Virginia Mason Memorial Hospital (50-0036), FFY 2011
24-0892	Virginia Mason Memorial Hospital (50-0036), FFY 2012
24-0893	Virginia Mason Memorial Hospital (50-0036), FFY 2013
24-0895	Harrison Medical Center (50-0039), FFY 2007
24-0896	Harrison Medical Center (50-0039), FFY 2008
24-0897	Harrison Medical Center (50-0039), FFY 2009
24-0898	Harrison Medical Center (50-0039), FFY 2011
24-0899	Harrison Medical Center (50-0039), FFY 2012
24-0900	Harrison Medical Center (50-0039), FFY 2013
24-0901	Olympic Medical Center (50-0072), FFY 2007
24-0902	Olympic Medical Center (50-0072), FFY 2008
24-0903	University of Kansas Hospital (17-0040), FFY 2009
24-0904	University of Kansas Hospital (17-0040), FFY 2010
24-0905	University of Kansas Hospital (17-0040), FFY 2011
24-0906	University of Kansas Hospital (17-0040), FFY 2012
24-0907	University of Kansas Hospital (17-0040), FFY 2013
24-0908	John Dempsey Hospital (07-0036), FFY 2005
24-0909	John Dempsey Hospital (07-0036), FFY 2006
24-0910	John Dempsey Hospital (07-0036), FFY 2007
24-0911	John Dempsey Hospital (07-0036), FFY 2008
24-0912	John Dempsey Hospital (07-0036), FFY 2009
24-0913	John Dempsey Hospital (07-0036), FFY 2010
24-0914	John Dempsey Hospital (07-0036), FFY 2011
24-0915	John Dempsey Hospital (07-0036), FFY 2012
24-0916	John Dempsey Hospital (07-0036), FFY 2013
24-0917	Indian River Memorial Hospital, Inc. (10-0105), FFY 2005
24-0918	Indian River Memorial Hospital, Inc. (10-0105), FFY 2007
24-0919	Indian River Memorial Hospital, Inc. (10-0105), FFY 2008

24-0920	Indian River Memorial Hospital, Inc. (10-0105), FFY 2009
24-0921	Indian River Memorial Hospital, Inc. (10-0105), FFY 2010
24-0922	Indian River Memorial Hospital, Inc. (10-0105), FFY 2011
24-0923	Indian River Memorial Hospital, Inc. (10-0105), FFY 2012
24-0924	Indian River Memorial Hospital, Inc. (10-0105), FFY 2013
24-0925	MedStar Washington Hospital Center (09-0011), FFY 2006
24-0926	St. Cloud Hospital (24-0036), FFY 2006
24-0927	St. Cloud Hospital (24-0036), FFY 2008
24-0928	St. Cloud Hospital (24-0036), FFY 2009
24-0929	St. Cloud Hospital (24-0036), FFY 2010
24-0930	CHI St. Alexius Health (35-0002), FFY 2007
24-0931	CHI St. Alexius Health (35-0002), FFY 2008
24-0932	CHI St. Alexius Health (35-0002), FFY 2009
24-0933	CHI St. Alexius Health (35-0002), FFY 2010
24-0934	CHI St. Alexius Health (35-0002), FFY 2011
24-0935	Sanford Medical Center Bismarck (35-0015), FFY 2006
24-0936	Sanford Medical Center Bismarck (35-0015), FFY 2007
24-0937	Sanford Medical Center Bismarck (35-0015), FFY 2008
24-0938	Sanford Medical Center Bismarck (35-0015), FFY 2009
24-0939	Sanford Medical Center Bismarck (35-0015), FFY 2010
24-0940	Christus Mother Frances Hospital (45-0102), FFY 2010
24-0941	Christus Mother Frances Hospital (45-0102), FFY 2011
24-0942	Christus Mother Frances Hospital (45-0102), FFY 2012
24-0943	Longmont United Hospital (06-0003), FFY 2007
24-0944	Longmont United Hospital (06-0003), FFY 2008
24-0945	Longmont United Hospital (06-0003), FFY 2010
24-0946	Longmont United Hospital (06-0003), FFY 2010

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Nicholas Putnam
Strategic Reimbursement Group, LLC
360 West Butterfield Road, Suite 310
Elmhurst, IL 60126

RE: ***Dismissal for Untimely Filing Pursuant to Board Rules 20 and 20.1***

SRG Aurora CYs 2013 – 2014 SSI Calculation Error CIRP Group
Case Number: 18-0278GC

SRG Aurora 2014 Medicaid Eligible Medicare Unmatched Days CIRP Group
Case Number: 18-0281GC

SRG Aurora 2013 Unmatched Medicaid Days CIRP Group
Case Number: 17-1304GC

SRG Aurora 2013 Medicaid Eligible Medicare Unmatched Days CIRP Group
Case Number: 17-1305GC

Dear Mr. Putnam:

The Provider Reimbursement Review Board (the "Board") has reviewed the subject common issue related party ("CIRP") group appeals in response to the November, 2023 Motions to Dismiss filed by the Medicare Contractor, the Board's December, 2023 Scheduling Orders and the responses filed by Strategic Reimbursement Group, LLC ("Strategic"). The Board notes that all four of the respective CIRP groups were filed prior to the implementation of the Office of Hearing Case & Document Management System ("OH CDMS"). However, the electronic records for the CIRP groups, which are considered "Legacy" cases, have now all been populated.[1] A brief history of the facts and the Board's determination are set forth below.

Rule 20 Certification Background:

On November 1, 2021, the Board issued revised Board Rules which changed certain procedures for group appeals. Specifically, Rule 20 addresses the population of Issues/Providers in the Office of Hearings Case & Document Management System ("OH CDMS"). Rule 20 advises that, ***within (60) sixty days of the full formation of the group***, the group representative must file a statement certifying that the group is fully populated in OH CDMS *with the relevant supporting jurisdictional*

[1] Case No. 17-1304G and 17-1305G were both populated on 6/2/2022 in OH CDMS; Case No. 18-0278GC was populated on 10/28/2021 and Case No. 18-0281GC was populated on 10/20/2022.

documentation (*i.e*., all participants in the group are shown under the Participants Tab for the group in OH CDMS with the relevant supporting *jurisdictional* documentation).

On November 7, 2022, the Board issued Alert 23, which gave notice that effective December 7, 2022, the Board was resuming its normal operations following the COVID- 19 Pandemic. The Alert 23 included a reminder to the Parties regarding the Rule 20 Certification requirement.

Pertinent Facts:

Strategic designated ***Case Nos. 17-1304GC and 17-1305GC*** to be fully formed as of August 1, 2023 and ***Case Nos. 18-0278GC and 18-0281GC*** to be fully formed as of August 14, 2023.
Based on these full formation dates, the Rule 20 Certifications (or, if applicable, Schedules of Providers with support per Rule 20.1*, explained in further detail below*) were due as follows:

- ***Case Nos. 17-1304GC and 17-1305GC*** - due on September 30, 2023 (*which fell on a Saturday, thereby extending the submission deadline to the following business day, which would have been Monday,* **October 2, 2023**.)

- ***Case Nos. 18-0278GC and 18-0281GC*** - due on Friday, **October 13, 2023**.

On November 29, 2023, in ***Case Nos. 17-1304GC & 17-1305GC*** the Medicare Contractor filed its "Rule 22 Jurisdiction Review letters" advising that it was unable to review the groups for jurisdiction impediments because the groups had not filed any jurisdictional documents. On the same date, the Medicare Contractor filed Motions to Dismiss in these cases. The Medicare Contractor advised that it had conferred with Strategic by email in each group, requesting that it provide the jurisdictional documents or a Rule 20 letter by October 31, 2023. Since Strategic had not responded, the Medicare Contractor cited Board Rule 41.2 which permits dismissal of a case if the provider or group fails to comply with Board procedures or filing deadlines.

Similarly, on December 11th, 2023 in ***Case Nos. 18-0278GC and 18-0281GC***, the Medicare Contractor filed its Rule 22 Jurisdiction Review letters, again, advising that it was unable to review for jurisdiction impediments because the groups had not filed any jurisdictional documents. On November 30, 2023 and December 11, 2023, respectively, the Medicare Contractor filed Motions to Dismiss in each case. As in Case Nos. 17-1304GC and 17-1305GC, it advised that it had conferred with Strategic by email (*on November 15, 2023*) requesting that Strategic provide the jurisdictional documents or a Rule 20 letter by November 22, 2023. Since Strategic had not responded in either case, the Medicare Contractor requested dismissal pursuant to Board Rule 41.2.

On December 18th (Case No. 18-0278GC), December 21st (Case No. 18-0281GC), December 26th (Case No. 17-1304GC) and December 28th, 2023 (Case No. 17-1305GC), Strategic responded to the Medicare Contractor's Motions to Dismiss in accordance with the Board's Scheduling Orders. Strategic argued that it did not file the Rule 20 Certifications because in all four groups it received the Board's notices of "Population of Issues, Participants, and Case Actions in OH CDMS" which advised the Parties that the " . . . complete record" had been uploaded and that the Board would rely on the electronic record going forward.

The Board's notice stated that,

> . . . should you discover that there is a discrepancy or a filing omitted in your electronic record, please file a notice to the Board through OH CDMS as soon as practicable. ***In particular prior to submitting a request for EJR or within (30) days of hearing, the Board expects that you will compare the electronic record in OHCDMS for this case with your records and notify the Board of any discrepancies or errors through a filing in OH CDMS.***[2]

In each group, Strategic explained that it interpreted this (*bolded*) statement in the notices to mean that it had more time to submit missing jurisdictional documentation, because it had not yet requested an EJR, nor had hearings been scheduled in any of the four groups. Therefore, Strategic was under the impression that there was still time to notify the Board as to whether the electronic records were complete or not.

As set forth below, Strategic has failed to meet the requirements of Rules 20 and 20.1. Below is a discussion regarding Rule 20 and Rule 20.1 requirements and the information that was required in these cases.

Rule 20/20.1 Background:

Rule 20 addresses the population of Issues/Providers in OH CDMS. Pursuant to Board Rule 20:

> If ***all*** the participants in a fully-formed group are ***populated*** under the Issues/Providers Tab in OH CDMS with supporting jurisdictional documentation (*see* Rule 21), then the representative is exempt from filing a ***hard copy*** of the schedule of providers with supporting jurisdictional documentation. In this instance, the Board uses the schedule of providers and supporting jurisdictional documentation that is created in OH CDMS using the information and documents included in each participating provider's request for transfer or direct add to the group.
>
> ***Prior to*** certifying that the group is fully formed or the date on which a group is fully formed, the group representative should review each participating provider's supporting jurisdictional documentation to ensure it is complete and, if not, file any additional documentation in OH CDMS.[3] If *all* of the participants in a fully-formed group are ***populated*** under the Issues/Providers Tab in OH CDMS, then ***within (60) sixty days of the full formation of the group***, the group representative must file a statement certifying that the group is *fully* populated in OH CDMS with the relevant supporting jurisdictional documentation (*i.e.*, all participants in the group are shown under the Issues/Providers Tab for the group in OH CDMS with the relevant supporting jurisdictional documentation).[4]

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[2] Bold and Italic emphasis added.

[3] If all participants are populated but jurisdictional support is not complete, the Rule 20 Certification must certify that all participants are populated but should include an identification of the documents that are missing and then ***only*** file in OH CDMS those additional missing documents. See, https://www.cms.gov/files/document/oh-cdms-prrb-user-manual-supplement-supplemental-document-uploads-individual-appeals.pdf.

[4] (Underline emphasis added.)

Board Rule 20.1 applies to **"Group Cases that Are Not Fully Populated in OH CDMS."** Pursuant to Board Rule 20.1:

> If any participants in a fully-formed group are ***not*** populated under the Issues/Providers Tab in OH CDMS with supporting jurisdictional documentation (*see* Rule 21), then the Representative must prepare a traditional schedule of providers (*i.e.* Model Form G at Appendix G), for *all* participants in the group **following the instructions in this Rule and Rule 21, unless the Board instructs otherwise.** Specifically, *within sixty (60) days of the full formation of the group* (see Rule 19), the group representative must prepare and file a schedule of providers with the supporting jurisdictional documentation for all providers in the group that demonstrates that the Board has jurisdiction over each participant named in the group appeal (*see* Rule 21) . . . .

Because Case Nos. 17-1304GC, 17-1305GC, 18-0278GC and 18-0281GC were populated behind the Participants tab in OH CDMS, it appears that Rule 20 applied and, as such, the Representative was required to file a Rule 20 Certification in each group within the 60-day period allotted under Board Rule 20.[5]

Board Determination:

Pursuant to 42 C.F.R. § 405.1868:

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

[5] Rule 20/20.1 Certifications must be stand-alone filings and never part of another filing *(e.g., never embedded within a preliminary position paper filing, group status response, etc.).*

The Board is also cognizant of the fact that, on numerous occasions, it has explained the background and requirements of Board Rule 20 and Rule 20.1, as well as its expectations regarding future filings. Many times, as a courtesy, the Board has extended Strategic additional time to correct such deficiencies, however Strategic continues to miss or make deficient filings related to this Board Rule.

In these cases, the Board notes that the Medicare Contractor made Strategic aware of the Rule 20/20.1 deficiencies in the groups, not only in its Rule 22 Jurisdiction Review letters, but also by email and by filing Motions to Dismiss. Further, Strategic was reminded of the deficiencies when the Board issued Scheduling Orders in each group, requiring that it respond to the Medicare Contractor's Motions and to file the requisite Rule 20 or 20.1 documentation, as relevant. Although Strategic filed responses addressing why it believed the groups should not be dismissed, it failed to timely file the missing Rule 20 Certifications.

The Board also finds that Strategic's explanation (*that it misinterpreted the Board's notices regarding population of the electronic records*) does not justify its failure to file the Rule 20 Certifications. Even if it was Strategic's initial understanding that the groups could be populated at a future date, having subsequently received various notifications from the Medicare Contractor, in addition to the Board's Scheduling Orders, as well as the numerous notices in other Strategic groups regarding the Board's expectations related to Rule 20 submissions, the Board holds Strategic accountable for missing the required Certifications in these groups.

Accordingly, because the Rule 20 Certifications (or full SoPs with supporting documentation if applicable) were not timely filed, the Board hereby dismisses Case Nos. 17-1304GC, 17-1305GC, 18-0278GC and 18-0281GC pursuant to its authority under 42 C.F.R. § 405.1868. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

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

For the Board:

1/31/2024

X Kevin D. Smith, CPA

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

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services
Pam VanArsdale, National Government Services, Inc. (J-6)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Daniel Hettich
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RE: ***Notice of Dismissal***
King & Spalding Standardized Amount CIRP Group Cases
Case Nos. 19-0847GC, *et al.* (*see* **Appendix A** listing 29 group cases)

Dear Mr. Hettich:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal requests filed by the Providers in the twenty-nine (29) above-referenced common issue related party ("CIRP") *and* optional group cases.[1] The Medicare Contractor has filed Jurisdictional Challenges in all of those group cases and the Providers' Representative filed responses to these challenges. As set forth below, the Board has determined that, consistent with 42 U.S.C. § 1395ww(d)(7) and 42 C.F.R. § 405.1840(b), it lacks substantive jurisdiction over the appealed issue and is therefore dismissing all twenty-nine (29) CIRP and optional group cases in their entirety.

In summary, the Board finds that it lacks substantive jurisdiction over the issue raised in these appeals because the standardized amounts used for IPPS rates for FFYs 1984 and FFY 1985 are each based on the budget neutrality adjustment made for that FFY and the 1984 and 1985 budget neutrality adjustments are presumably designed to be corrective of the initial base rate that was set *using 1981 data*.[2] Therefore, the *final* FFY 1984 and 1985 standardized amounts are *inextricably intertwined* with those applicable budget neutrality adjustments.[3] Indeed, the standardized amounts were too high for FFYs 1984 and 1985 and the budget neutrality adjustments applied to those years reduced the standardized amounts (reduced by factors of approximately 0.03 for FFY 1984 and 0.05 for FFY 1985) and, thus, these budget neutrality adjustments already automatically accounted for any such alleged errors in setting the initial base rate.[4] Because 42 U.S.C. 1395ww(d)(7) prohibits

[1] *See* **Appendix A**.
[2] The Board has included at **Appendix B** examples of other adjustments to the standardized amounts that have occurred outside of the FFY 1984 and 1985 budget neutrality adjustments. These intervening adjustments for FFYs 1986 and 2018 include both mandatory and discretionary revisions ***to the standardized amounts*** (as well as the Congress' decisions to revise or not revise the "applicable percentage increases" for FFYs 1986 and forward as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i)) and highlight the complexity of the issue before the Board, particularly where such adjustments were made in a budget neutral manner or were based on factoring in certain other estimated impacts
[3] *See infra* note 54 (citing to decisions that discuss similar circumstances involving Medicare provisions found to be inextricably tied to certain other provisions for which Congress precluded administrative and judicial review).
[4] *See infra* note 41 (discussing how the removal of nurse anesthetists costs were removed from IPPS and how that removal was *automatically* accounted for as part of the 1985 budget neutrality adjustment).

administrative or judicial review of those adjustments and the resulting *final* FFY 1985 standardized amounts were carried/flowed forward *for future FFYs*, the Board may not review the standardized amount used for the FFYs being appealed as they relate to the issue in these appeals, *i.e.*, the alleged inaccuracies in the standardized amounts used for FFY 1984 as carried/flowed forward for all years following FFY 1985 to the FFYs being appealed. In this regard, the Board notes that the Providers may not simply pass through, or over, the budget neutrality adjustments for FFYs 1984 and 1985, ***for purposes of future FFYs***, because those adjustments are tied to an absolute *external* event (the Secretary's estimate, based on the best available data, of what would have been paid for those years if there were no IPPS) ***and*** were ***fixed*** (no greater *and* no less than what would have been paid had there been no IPPS).[5] To do otherwise, would impact the very integrity of IPPS.

Background:

King & Spalding, LLP ("Providers' Representative") represents a number of providers in common issue related party ("CIRP") and optional groups which are challenging the IPPS standardized amount. The Medicare Contractor filed four (4) Jurisdictional Challenges covering twenty-nine (29) group cases.[6] The Providers' Representative filed responses to these challenges. The group issue statements, jurisdictional challenges, and responses thereto for all twenty-nine (29) cases are materially identical and can be considered together.

The group issue statement presented is:

> Here, [the Providers] contend that their reimbursement is understated due to errors made when the standardized amount was first calculated in 1983 that have not since been corrected. More specifically, the Providers assert that CMS failed to distinguish between patient discharges and transfers at the time the standardized amount was first calculated, and as a result, the standardized amount is understated. Because this error has not since been corrected, the Providers are entitled to additional Medicare reimbursement so that they are paid as if the error had not occurred in the first instance. *See St. Francis Med. Ctr. V. Azar*, 894 F.3d 290 (D.C. Cir. 2018).[7]

Procedural Background:

A. Appealed Issue

In the Providers' group issue statements, they explain that the IPPS requires the categorization of different types of discharges (diagnostic related groups, or "DRGs"), and payment rates applicable to each discharge category. Their appeals challenge the latter, arguing that the data used to

[5] Moreover, *see supra* note 2 discussing other intervening discretionary and nondiscretionary adjustments to the standardized amounts that have occurred outside of the FFY 1984 and 1985 budget neutrality adjustments.
[6] *See* **Appendix A**.
[7] *E.g.*, Case 19-0847GC, Providers' Preliminary Position Paper at 1 (Jul. 10, 2020).

establish the initial "flat rate" payable per discharge resulted in an understated payment rate. CMS opted to use 1981 as a "base year" to calculate these rates, and thus data was collected from hospitals' 1981 cost reports to determine average costs for each discharge category. The data was adjusted for inflation and standardized, but the Providers argue that the initial calculation of this standardized amount continues to serve as the base for all future calculations. Since the Providers allege this initial calculation was understated, they argue that the calculation for each subsequent year has also been understated.[8]

The Providers claim that the data sources used in collecting the 1981 data did not distinguish between patients who were discharged from the hospital, and patients who were transferred to another hospital or facility. They state that CMS views transfers as distinct from discharges, but in calculating the average cost per discharge using the 1981 data, CMS erroneously included transfers in the total number of discharges, thereby inflating the denominator of the cost to discharge ratio. They claim that CMS has acknowledged this error in at least one other context (*i.e.*, during the implementation of the capital PPS), and that this error was the reason for certain DRG weight recalibrations, but that CMS failed to fully correct the flawed Standardized Amount.[9]

In each case, the Providers are challenging the applicable FFY IPPS rates as set forth in the Federal Register.[10] They argue the appeals are not barred by the "predicate facts" provision of 42 C.F.R. § 405.1885(a)(1)(iii) and that there is no impediment to CMS correcting its erroneous data to remediate the flawed Standardized Amount.[11] They claim that the average cost per discharge should not include transfers, that CMS has acknowledged this as well as the fact that certain Standardized Amounts erroneously included transfers, and that this practice violates both the Medicare Act and Administrative Procedure Act.[12] They argue the inclusion of transfers in the calculation of the standardized amount violates the express will of Congress, and thus is not entitled to judicial deference under *Chevron*;[13] and as the Secretary has acknowledged an error but declined to correct the standardized amount on a prospective basis, the agency's interpretation is not entitled to deference as it is "arbitrary, capricious or manifestly contrary to the statute."[14]

B. Jurisdictional Challenges

The Medicare Contractor filed challenges in twenty-nine (29) different group cases, and the Providers filed responses in each case.[15] The Medicare Contractor argues that the merits of the appealed issue are illegitimate, but more importantly, that the Board lacks subject matter jurisdiction and need not even address the merits of the issue. It references the Board's April 6,

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[8] *Id.*
[9] *Id.* at 5 (citing 56 Fed. Reg. 43358, 43386 (Aug. 30, 1991) (related to capital PPS).
[10] *Id*. at 1 ("The issue in this group appeal relates to CMS's treatment of the national standardized amount in the Fiscal Year 2019 [IPPS] Final Rule. *See* 83 Fed. Reg. 41144, 41711-27 (Aug. 17, 2018) at Provider Exhibit 1.")
[11] *Id*. at 5-7.
[12] *Id*. at 9-10.
[13] *Id*. at 7-8. Citing *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984).
[14] *Id*. at 7. Citing *Lindeen v. Sec. & Exch. Comm'n*, 825 F.3d 646, 656 (D.C. Cir. 2016) (quoting *Chevron*, 467 U.S. at 843-44).
[15] *See* **Appendix A** for a list of challenges and cases impacted. Again, the challenges are all materially identical.

2023 decision dismissing five (5) different CIRP group appeals concerning the same issue. The Medicare Contractor argues the Board should apply the same rationale and find that 42 U.S.C. § 1395ww(d)(7)(A) precludes administrative review of the base year standardized amounts. It also claims that budget neutrality adjustments after the base year amount was calculated have corrected any potential errors from prior years, and that the data shows the base year was, in fact, initially set too high (rather than understated).

The Providers' responses to these challenges reiterated that the group appeal rests on the fact that each appeal's IPPS payments for the applicable FFY is "CMS's calculation of the "costs per discharge" in the first step of the methodology prescribed by statute for calculating the original, 1983 standardized amounts."[16] They claim that the budget-neutral adjustments and any preclusion provisions do not apply to their IPPS challenges. The ask the Board to deny the Jurisdictional Challenges.

The Providers counter the Medicare Contractor by arguing that budget neutrality adjustments are not applicable to these appeals. They go on to state that "[b]y its explicit and unambiguous terms, the budget neutrality preclusion provision invoked by the MAC bars administrative and judicial review only of challenges to the budget neutrality adjustments made pursuant to 42 U.S.C. § 1395ww(e)(1) in FFYs 1984 and 1985."[17] They argue that there is a strong presumption in favor of judicial review, and that in this instance there is not clear indication that Congress intended to preclude review of more recent FFY Standardized Amounts or the predicate facts related to the methodology for calculating the 1983 Standardized Amount.[18]

Board Decision:

As described more fully below, the Board finds that it lacks substantive jurisdiction over each of the 29 groups because the initial 1983 standardized amounts,[19] set for the IPPS, are ***inextricably*** intertwined with the 1984 and 1985 budget neutrality adjustments to the "applicable percentage increases" for IPPS[20] and 42 U.S.C. § 1395ww(d)(7) prohibits administrative or judicial review of those budget neutrality adjustments. The fact that the Secretary's budget neutrality adjustment to the FY 1984 Federal Rates was 0.970[21] demonstrates that, contrary to the Providers' assertions, the initial standardized amount was ***not*** understated but rather was *overstated* by a factor of 0.030 (*i.e.*, 1.000 – 0.970) and, thus, these budget neutrality adjustments appears to have already automatically

[16] *E.g.*, PRRB Case 19-0847GC *et al.*, Providers' Response to MACs' Jurisdictional Challenges at 2 (Nov. 20, 2023).
[17] *Id.*
[18] *See Id.* at 1 and 3-4.
[19] The Board notes that, initially, there was not just one standardized amount. Rather there were 20 average standard amounts per discharge according to urban/rural designation in each of the nine census divisions and the nation and each of these 20 rates is further divided into a labor and nonlabor portion. *See* 48 Fed. Reg. 39752, 39763 (Sept. 1, 1983).
[20] 42 U.S.C. § 1395ww(e) is entitled "Proportional adjustments in applicable percentage increases." The 1984 and 1985 budget neutrality adjustments are set forth is § 1395ww(e)(1)(B) which is cross-referenced for 1984 IPPS rates at § 1395ww(d)(2)(F) and for 1985 IPPS rates at § 1395ww(d)(3)(C).
[21] In the final rule published on January 3, 1984, the Secretary revised the Federal budget neutrality adjustment factor to 0.970. 49 Fed. Reg. 234, 334 (Jan. 3, 1984).

accounted for any such alleged errors in setting the initial base rate.[22] Indeed, it is only natural that Congress established the 1984 and 1985 budget neutrality adjustments since the initial base rate was initially set *using 1981 data*.

A. Statutory Background on IPPS and the Standardized Amount Used in IPPS Rates

Part A of the Medicare program covers "inpatient hospital services." Since October 1, 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the IPPS.[23] Under IPPS, Medicare pays a prospectively-determined rate per eligible discharge, subject to certain payment adjustments.[24]

In order to implement IPPS, "the statute require[d] that the Secretary determine national and regional adjusted DRG prospective payment rates for each DRG to cover the operating costs of inpatient hospital services."[25] The methodology for arriving at the appropriate rate structure is located at 42 U.S.C. § 1395ww(d)(2) and "requires that certain ***base period*** *cost data* be developed and modified in several specified ways (i.e., inflated, standardized, grouped, and adjusted) resulting in 20 average standard amounts per discharge according to urban/rural designation in each of the nine census divisions and the nation."[26] Specifically, § 1395ww(d)(2) (Jan. 1985) stated, in pertinent part:

> (2) The Secretary shall determine a national adjusted DRG prospective payment rate, for each inpatient hospital discharge in fiscal year 1984 involving inpatient hospital services of a subsection (d) hospital in the United States, and shall determine a regional adjusted DRG prospective payment rate for such discharges in each region, for which payment may be made under part A of this subchapter. Each such rate shall be determined for hospitals located in urban or rural areas within the United States or within each such region, respectively, as follows:
>
> (A) DETERMINING ALLOWABLE INDIVIDUAL HOSPITAL COTS FOR BASE PERIOD.—The Secretary shall determine the allowable operating costs per discharge of inpatient hospital services for the hospital for the most recent cost reporting period for which data are available.
>
> (B) UPDATING FOR FISCAL YEAR 1984.—The Secretary shall update each amount determined under subparagraph (A) for fiscal year 1984 by—
>
> (i) updating for fiscal year 1983 by the estimated average rate of change of hospital costs industry-wide between the cost reporting period used

[22] *See infra* note 41 (discussing how the removal of nurse anesthetists costs were removed from IPPS and how that removal was *automatically* accounted for as part of the 1985 budget neutrality adjustment).
[23] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[24] *Id.*
[25] 48 Fed. Reg. 39752, 39763 (Sept. 1, 1983).
[26] *Id.* (emphasis added).

> under such subparagraph and fiscal year 1983 and the most recent case-mix data available, and
>
> (ii) projecting for fiscal year 1984 by the applicable percentage increase (as defined in subsection (b)(3)(B)) for fiscal year 1984.
>
> (C) STANDARDIZING AMOUNTS.—The Secretary shall standardize the amount updated under subparagraph (B) for each hospital by—
>
> (i) excluding an estimate of indirect medical education costs,[27]
>
> (ii) adjusting for variations among hospitals by area in the average hospital wage level, and
>
> (iii) adjusting for variations in case mix among hospitals.[28]

Thus, as quoted above, § 1395ww(d)(2)(A) requires that the Secretary determine a "base period" operating cost per discharge using the most recent cost reporting period for which data are available. Further, consistent with these statutory provisions, the Secretary used Medicare hospital cost reports for reporting periods ending in 1981 and set the 1984 "base period" operating cost per discharge amount using the 1981 operating costs per discharge amount *updated* by an inflationary factor.[29] The Providers dispute how the Secretary determined "discharges" and allege that the Secretary improperly treated transfers as discharges for purposes of this calculation.

The Secretary then "standardized" the FFY 1984 base period operating cost per discharge using the process prescribed at 42 U.S.C. § 1395ww(d)(2)(c). The standardization process removed

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[27] Consistent with the concerns raised by the Board in **Appendix B**, the Board notes that Congress has amended this clause (i) numerous times and, as a result, it currently reads as follows:

> (i) excluding an estimate of indirect medical education costs (taking into account, for discharges occurring after September 30, 1986, the amendments made by section 9104(a) of the Medicare and Medicaid Budget Reconciliation Amendments of 1985), except that the Secretary shall not take into account any reduction in the amount of additional payments under paragraph (5)(B)(ii) resulting from the amendment made by section 4621(a)(1) of the Balanced Budget Act of 1997 or any additional payments under such paragraph resulting from the application of section 111 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, of section 302 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, or the Medicare Prescription Drug, Improvement, and Modernization Act of 2003,

[28] The Board notes that Congress later added clause (iv) in 1985 and, consistent with the concerns raised by the Board in **Appendix B**, the Board notes that Congress has amended this clause (iv) numerous times and, as a result, it currently reads as follows:

> (iv) for discharges occurring on or after October 1, 1986, excluding an estimate of the additional payments to certain hospitals to be made under paragraph (5)(F), except that the Secretary shall not exclude additional payments under such paragraph made as a result of the enactment of section 6003(c) of the Omnibus Budget Reconciliation Act of 1989, the enactment of section 4002(b) of the Omnibus Budget Reconciliation Act of 1990, the enactment of section 303 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, or the enactment of section 402(a)(1) 4 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

[29] *Id*. at 39763-64.

the effects of certain variable costs from the cost data, including (but not limited to) excluding costs associated with indirect medical education costs, adjusting for variations in average hospital wage levels, and adjusting for variations in case mix among hospitals.

The initial standardized amounts have been annually adjusted and/or updated. However, contrary to the characterization in the D.C. Circuit's 2011 decision in *Saint Francis Med. Ctr. v. Azar* ("*Saint Francis*"), the standardized amount is not adjusted each year simply for inflation.[30] Significantly, some of these annual adjustments were required to be *budget neutral* and are not subject to administrative review. In particular, 42 U.S.C. § 1395ww(e)(1)(B) provides the budget neutrality adjustment for "the applicable percentage increases" to the standardized amounts for 1984 and 1985 and states, in pertinent part:

> **(e) Proportional adjustments in *applicable percentage increases***
>
> (1) . . . .
>
> (B) *For discharges occurring in fiscal year 1984 or fiscal year 1985*, *the Secretary* shall provide under subsections (d)(2)(F) and (d)(3)(C) for such equal proportional adjustment *in each of the average standardized amounts* otherwise computed for that fiscal year as may be necessary to assure that—
>
> (i) *the aggregate payment amounts* otherwise provided under subsection (d)(1)(A)(i)(II) and (d)(5) *for that fiscal year* for operating costs of inpatient hospital services of hospitals (excluding payments made under section 1395cc(a)(1)(F) of this title),
>
> *are not greater or less than*—
>
> (ii) the DRG percentage (as defined in subsection (d)(1)(C)) of *the payment amounts which would have been payable for such services* for those same hospitals for that fiscal year under this section *under the law as in effect before April 20, 1983* (excluding payments made under section 1395cc(a)(1)(F) of this title).[31]

The Secretary implemented the above budget neutrality provisions at 42 C.F.R. §§ 412.62(i) and 412.63(v) for the 1984 rate year and 1985 rate year respectively. Specifically, § 412.62(i) provides the following instruction for maintaining budget neutrality for the 1984 Federal IPPS rates:

> (i) *Maintaining budget neutrality.* (1) CMS adjusts each of the **reduced standardized amounts** determined under paragraphs (c)

[30] 894 F.3d 290, 291 (D.C. Cir. 2011). *Saint Francis* did not analyze how the standardized amount is updated annually nor did it make specific legal holdings regarding the standardized amount.

[31] (Bold emphasis in original and italics and underline emphasis added.) The budget neutrality adjustment at 42 U.S.C. § 1395ww(e)(1)(B) is cross-referenced for 1984 at 1395ww(d)(2)(F) and for 1985 at § 1395ww(d)(3)(C).

> through (h) of this section **as required for fiscal year 1984** so that the estimated amount of aggregate payments made, excluding the hospital-specific portion (that is, the total of the Federal portion of transition payments, plus any adjustments and special treatment of certain classes of hospitals for Federal fiscal year 1984) **is not greater or less than** 25 percent of **the payment amounts that would have been payable** for the inpatient operating costs for those same hospitals for fiscal year 1984 **under the Social Security Act as in effect on April 19, 1983**.
>
> (2) The aggregate payments considered under this paragraph exclude payments for per case review by a utilization and quality control quality improvement organization, as allowed under section 1866(a)(1)(F) of the Act.[32]

Similarly, the regulation at 42 C.F.R. § 412.63(v) provides the following instruction for maintaining budget neutrality for the 1985 Federal rates for IPPS:

> (v) *Maintaining budget neutrality for fiscal year 1985.* (1) For fiscal year 1985, CMS will adjust each of **the reduced standardized amounts** determined under paragraph (c) of this section **as required for fiscal year 1985** to ensure that the estimated amount of aggregate payments made, excluding the hospital-specific portion (that is, the total of the Federal portion of transition payments, plus any adjustments and special treatment of certain classes of hospitals for fiscal year 1985) is **not greater or less** than 50 percent of the **payment amounts that would have been payable** for the inpatient operating costs for those same hospitals for fiscal year 1985 **under the law as in effect on April 19, 1983**.
>
> (2) The aggregate payments considered under this paragraph exclude payments for per case review by a utilization and quality control quality improvement organization, as allowed under section 1866(a)(1)(F) of the Act.[33]

Essentially, Congress mandated that the Secretary/CMS adjust the standardized amounts for both 1984 and 1985 to ensure that the estimated amount of aggregate payments made under IPPS was not *greater than **or** less than* what would have been payable for inpatient operating costs for the same hospitals under the prior reimbursement system (*i.e.*, reasonable costs subject to TEFRA limits). In other words, pursuant to budget neutrality, the size of the pie, expressed as average payment per case, is prescribed by law to be *no more **and** no less* than what would have been paid had IPPS not been implemented. Significantly, the reference points for maintaining budget

[32] (Italics emphasis in original and bold and underline emphasis added.)
[33] (Italics emphasis in original and bold and underline emphasis added.)

neutrality for 1984 and 1985 are ***external*** to IPPS and, thus, ***fixed*** (no greater *and* no less) based on the best data available.[34] Since these points are ***fixed,*** it also means that it is capped (*i.e.*, cannot be increased subsequently outside of the budget neutrality adjustment).

This conclusion is supported by the fact that the normal annual inflation adjustments to the standardized amount provided for in IPPS apply ***only*** for FY 1986 forward, as set forth in 42 U.S.C. § 1395ww(b)(3)(B)(3)(i) and cross referenced in § 1395ww(d)(3)(A). Specifically, 42 U.S.C. § 1395ww(b)(3)(B)(i) (2018) defines the term "applicable percentage increase" ***starting with fiscal year 1986*** (as opposed to 1984):

> (B)(i) For purposes of subsection (d) and subsection (j) for discharges occurring during a fiscal year, the "applicable percentage increase" shall be—
>
> (I) ***for fiscal year 1986***, 1/2 percent,
>
> (II) for fiscal year ***1987***, 1.15 percent,
>
> (III) for fiscal year ***1988***, 3.0 percent for hospitals located in a rural area, 1.5 percent for hospitals located in a large urban area (as defined in subsection (d)(2)(D)), and 1.0 percent for hospitals located in other urban areas,
>
> (IV) for fiscal year ***1989***, the market basket percentage increase minus 1.5 percentage points for hospitals located in a rural area, the market basket percentage increase minus 2.0 percentage points for hospitals located in a large urban area, and the market basket

[34] 48 Fed. Reg. 39752, 39887 (Sept. 1, 1983) provides the following discussion supporting the Board's pie concept:

> Section 1886(e)(1) of the Act requires that, for Federal fiscal years 1984 and 1985, prospective payments be adjusted so that aggregate payments for the operating costs of inpatient hospital services are neither more nor less than we estimate would have been paid under prior legislation for the costs of the same services. To implement this provision, we are making actuarially determined adjustments to the average standardized amounts used to determine Federal national and regional payment rates and to the updating factors used to determine the hospital-specific per case amounts incorporated in the blended transition payment rates for fiscal years 1984 and 1985. Section 1886(d)(6) of the Act requires that the annual published notice of the methodology, data and rates include an explanation of any budget neutrality adjustments. This section is intended to fulfill that requirement.
>
> Although, for methodological reasons, the budget neutrality adjustment is calculated on a per discharge basis, it should be emphasized that the ultimate comparison is between the aggregate payments to be made under the prospective payment system and the aggregate payments that would have been incurred under the prior legislation. Therefore, changes in hospital behavior from that which would have occurred in the absence of the prospective payment system are required to be taken into account in determining the budget neutrality adjustment if they affect aggregate payment. For example, any expectation of increased admissions beyond the level that would have occurred under prior law would have to be considered in the adjustment. To assist in making the budget neutrality adjustment for, and take account of, fiscal year 1985, HCFA will monitor for changes in hospital behavior attributable to the new system.

percentage increase minus 2.5 percentage points for hospitals located in other urban areas,

(V) for fiscal year ***1990***, the market basket percentage increase plus 4.22 percentage points for hospitals located in a rural area, the market basket percentage increase plus 0.12 percentage points for hospitals located in a large urban area, and the market basket percentage increase minus 0.53 percentage points for hospitals located in other urban areas,

(VI) for fiscal year ***1991***, the market basket percentage increase minus 2.0 percentage points for hospitals in a large urban or other urban area, and the market basket percentage increase minus 0.7 percentage point for hospitals located in a rural area,

(VII) for fiscal year ***1992***, the market basket percentage increase minus 1.6 percentage points for hospitals in a large urban or other urban area, and the market basket percentage increase minus 0.6 percentage point for hospitals located in a rural area,

(VIII) for fiscal year ***1993***, the market basket percentage increase minus 1.55 percentage point for hospitals in a large urban or other urban area, and the market basket percentage increase minus 0.55 1 for hospitals located in a rural area,

(IX) for fiscal year ***1994***, the market basket percentage increase minus 2.5 percentage points for hospitals located in a large urban or other urban area, and the market basket percentage increase minus 1.0 percentage point for hospitals located in a rural area,

(X) for fiscal year ***1995***, the market basket percentage increase minus 2.5 percentage points for hospitals located in a large urban or other urban area, and such percentage increase for hospitals located in a rural area as will provide for the average standardized amount determined under subsection (d)(3)(A) for hospitals located in a rural area being equal to such average standardized amount for hospitals located in an urban area (other than a large urban area),

(XI) for fiscal year ***1996***, the market basket percentage increase minus 2.0 percentage points for hospitals in all areas,

(XII) for fiscal year ***1997***, the market basket percentage increase minus 0.5 percentage point for hospitals in all areas,

(XIII) for fiscal year ***1998***, 0 percent,

(XIV) for fiscal year ***1999***, the market basket percentage increase minus 1.9 percentage points for hospitals in all areas,

(XV) for fiscal year ***2000***, the market basket percentage increase minus 1.8 percentage points for hospitals in all areas,

> (XVI) for fiscal year ***2001***, the market basket percentage increase for hospitals in all areas,
>
> (XVII) for fiscal year ***2002***, the market basket percentage increase minus 0.55 percentage points for hospitals in all areas,
>
> (XVIII) for fiscal year ***2003***, the market basket percentage increase minus 0.55 percentage points for hospitals in all areas,
>
> (XIX) for each of fiscal years ***2004*** through ***2006***, subject to clause (vii), the market basket percentage increase for hospitals in all areas; and
>
> (XX) ***for each subsequent fiscal year***, subject to clauses (viii), (ix), (xi), and (xii), the market basket percentage increase for hospitals in all areas.[35]

The "applicable percentage increase" as defined in § 1395ww(b)(3)(B) is incorporated into § 1395ww(d)(3)(A), as it relates to updating of the standardized amount:

> **(B) UPDATING** PREVIOUS STANDARDIZED AMOUNTS.—(i) For discharges occurring in a fiscal year beginning ***before*** October 1, 1987, the Secretary shall compute an average standardized amount for hospitals located in an urban area and for hospitals located in a rural area within the United States and for hospitals located in an urban area and for hospitals located in a rural area within each region, ***equal to*** *the respective average standardized amount computed for the previous fiscal year under paragraph (2)(D) or under this subparagraph*, ***increased for the fiscal year involved by the applicable percentage increase under subsection (b)(3)(B)***. With respect to discharges occurring on or after October 1, 1987, the Secretary shall compute urban and rural averages on the basis of discharge weighting rather than hospital weighting, making appropriate adjustments to ensure that computation on such basis does not result in total payments under this section that are greater or less than the total payments that would have been made under this section but for this sentence, and making appropriate changes in the manner of determining the reductions under subparagraph (C)(ii).
>
> (ii) For discharges occurring in a fiscal year beginning on or after October 1, 1987, and ending on or before September 30, 1994, the Secretary shall compute an average standardized amount for hospitals located in a large urban area, for hospitals located in a rural area, and for hospitals located in other urban areas, within the United States and within each region, equal to the respective average

[35] (Emphasis added.)

> standardized amount computed for the previous fiscal year under this subparagraph increased by the applicable percentage increase under subsection (b)(3)(B)(i) with respect to hospitals located in the respective areas for the fiscal year involved.
>
> (iii) For discharges occurring in the fiscal year beginning on October 1, 1994, the average standardized amount for hospitals located in a rural area shall be equal to the average standardized amount for hospitals located in an urban area. For discharges occurring on or after October 1, 1994, the Secretary shall adjust the ratio of the labor portion to non-labor portion of each average standardized amount to equal such ratio for the national average of all standardized amounts.
>
> (iv)(I) Subject to subclause (II), for discharges occurring in a fiscal year beginning on or after October 1, 1995, the Secretary shall compute an average standardized amount for hospitals located in a large urban area and for hospitals located in other areas within the United States and within each region equal to the respective average standardized amount computed for the previous fiscal year under this subparagraph increased by the applicable percentage increase under subsection (b)(3)(B)(i) with respect to hospitals located in the respective areas for the fiscal year involved.
>
> (II) For discharges occurring in a fiscal year (beginning with fiscal year 2004), the Secretary shall compute a standardized amount for hospitals located in any area within the United States and within each region equal to the standardized amount computed for the previous fiscal year under this subparagraph for hospitals located in a large urban area (or, beginning with fiscal year 2005, for all hospitals in the previous fiscal year) increased by the applicable percentage increase under subsection (b)(3)(B)(i) for the fiscal year involved.

Thus, while 42 U.S.C. § 1395ww(d)(2) provides the methodology for calculating the standardized amount to be used for each year, and that the amount is subject to the "applicable percentage increase" under subsection (b)(3)(B) *for years after 1984*, it remains that it is not always a simple inflationary or market basket adjustment. In particular, the FFY 1984 and 1985 budget neutrality adjustments (as referenced in § 1395ww(d)(2)(F) and in § 1395ww(d)(3)(C)) were the applicable percentage increases for FFYs 1984 and 1985 and, as described below, those adjustments are not administratively reviewable. As a result of those budget neutrality adjustments, the rate for each of those respective years is frozen following FFY 1985 *for purposes of future FFYs* through the operation of 42 U.S.C. §§ 1395ww(b)(3)(B), 1395ww(d)(3)(A), 1395ww(d)(2)(F), and 1395ww(d)(3)(C) as discussed below.

B. Jurisdictional Findings -- 42 U.S.C. § 1395ww(d)(7)(A) Precludes Administrative Review of the Base Year Standardized Amounts

The Providers essentially are challenging the standardized amount used in the IPPS rates for several FFYs claiming that the Secretary improperly treated transfers as discharges when using 1981 cost report data to determine the initial FFY 1984 base cost per discharge which, in turn, was standardized to arrive at the FFY 1984 standardized amounts. More specifically, the Providers maintain that, the understatement of the standardized amount in the FFY 1984 IPPS Final Rule caused a corresponding underpayment in IPPS payments in FFY 1984 ***and every FFY thereafter*** *because the standardized amount for all IPPS payments for every FFY are based on CMS's calculation of the FFY 1984 standardized amount*.[36]

The published standardized amount for each FFY in these appeals reflects the prior year's standardized amount plus "the applicable percentage increase" as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i) (as referenced in 42 U.S.C. § 1395ww(d)(3)(A)) as well as other potential adjustments. Significantly, the "applicable percentage increase[s]" for 1984 forward are ***not*** always simply a cost inflation adjustment or other similar percentage adjustment. To this point, for the first two (2) years of IPPS, Congress mandated that the budget neutrality adjustments for FFYs 1984 and 1985 serve as the "applicable percentage increase" for those years. As a result, the IPPS rates that the Secretary used *for the very first year of IPPS* and then the second year of IPPS were adjusted for budget neutrality. For FFYs 1986 and forward, Congress provided for an "applicable percentage increase" in 42 U.S.C. § 1395ww(b)(3)(B)(i) as referenced in 42 U.S.C. § 1395ww(d)(3)(A). In addition, there are other *permanent* adjustments (*i.e*., adjustments not for that year only but that also apply on a going-forward basis) to the standardized amount that have occurred in other years outside of the "applicable percentage increase."[37] Thus, the standardized amount for a particular year is an amalgamation that builds upon the prior year's standardized amount and then adds additional adjustments for the current year.

The Providers are, essentially, seeking to peel back the amalgamated standardized amount for each applicable FFY *and, thus, reach back* ***more than 30 years*** to increase the initial 1984 base rate that was used to set the initial 1984 standardized amount***s***. They would then incorporate the alleged increased base rate into the FFY 1984 standardized amount***s*** and then simply carry or flow that *increase forward 35 years*. However, in order to peel the amalgamated standardized amounts for the FFYs at issue (singular[38]) *as used in the IPPS rates for each FFY* back to the initial standardized amount***s*** (plural[39]) used in FFY 1984, and then carry/flow any change forward *to the FFY at issue*, the Providers would have to pass through the FFY 1984 and 1985 budget neutrality adjustments which were the only "applicable percentage increase[s]" for those years. However, they cannot do so because the budget neutrality adjustments had the effect of ***fixing*** the pie for

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[36] *E.g.*, PRRB Case 19-08470GC *et al.*, Group Issue Statement at 1 ("[T]he number of discharges used in the calculation of the standardized amount was overstated . . . Because this error has not been corrected, the flawed data has remained embedded in the IPPS system, and hospitals' total Medicare reimbursement has been understated in each succeeding year, continuing today.").
[37] *See* **Appendix B.**
[38] *See supra* note 19 accompanying text.
[39] *See Id.*

FFYs 1984 and 1985 to (*i.e.*, no more ***and*** no less than) the aggregate amounts that would have been paid had IPPS not been implemented.[40] More specifically, the amalgamated standardized payment amount for each FFY at issue reflects the *fixed* FFY 1984 and 1985 budget neutrality adjustments (and not the initial FFY 1984 standardized amounts since the standardized amounts for both FFYs 1984 and 1985 were each adjusted for budget neutrality became *fixed* for purposes of subsequent years as a result of those budget neutrality adjustments). Thus, in the Board's view, the Providers cannot get back to the FFY 1984 standardized amounts without first passing through the FFY 1984 and 1985 budget neutrality adjustments. Regardless, the Providers would not be able to flow forward any adjustments made to the FFY 1984 standardized amounts because:

> (1) they, again, would not be able to get through the FFY 1984 and 1985 budget neutrality adjustments that Congress otherwise ***fixed*** to an external point (no greater and no less); and
>
> (2) the IPPS rates paid for FFYs 1984 and 1985 are based on standardized amounts that were adjusted downwards as a result of the budget neutrality adjustment for FFY 1984 and also for FFY 1985 (*see* discussion below in Sections B.1 and B.2).[41]

Accordingly, the Board finds that the Providers challenge to the standardized amounts at issue are *inextricably* tied to the budget neutrality adjustments made for FFY 1984 and 1985.[42]

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[40] *See, e.g.,* 48 Fed. Reg. 39752, 39805 (Sept. 1, 1983) (stating: "Hospital Impact—During its first two years, aggregate payments under the prospective payment system will be adjusted, in accordance with Section 1886(e)(1) of the Act, to be "budget neutral"; that is, so that aggregate payments under the prospective payment system, including outlier payments, exceptions, and adjustments, will be neither more nor less than the estimated payment amounts to affected hospitals that would have resulted under the Social Security Act as in effect before April 20,1983.").

[41] Indeed, the FY 1986 IPPS Final Rule included an example where the Secretary recognized an adjustment to the budget neutrality adjustments would be impacted by the removal of nurse anesthetists costs and confirmed that the adjustments to the standardized amounts had already taken this removal into account:

> c. Nonphysician anesthetist costs. In the August 31, 1984 final rule, we implemented section 2312 of Pub. L. 98-369, which provided that hospital costs for the services of nonphysician anesthetists will be paid in full as a reasonable cost pass-through for cost reporting periods beginning before October 1, 1987.
>
> We did not directly reduce the FY 1985 Federal rates to exclude the estimated costs of these services, *because any required adjustment would be incorporated in the budget neutrality adjustment factors applied to the national and regional standardized amounts*. (See 49 FR 34794; August 31, 1984). ***Since the FY 1986 standardized amounts are derived from an update of the FY 1985 amounts, which were adjusted for budget neutrality, the rates will automatically include the appropriate adjustment***. We are not making further adjustments to the Federal rates for this factor for either FY 1986 or FY 1987.

50 Fed. Reg. at 35708 (emphasis added). *See also* 52 Fed. Reg. 33034, 33064 (Sept. 1, 1987) (stating: "In the September 3, 1985 final rule, we noted that to the extent an adjustment was warranted to reflect the removal of these costs from the prospective payment rates for FY 1985, *it was incorporated in the overall* ***budget neutrality adjustment*** (50 FR 35708). Therefore, because this adjustment has already been built into the FY 1985 base from which the FY 1986, FY 1987, and proposed FY 1988 rates are derived, we did not propose to make further adjustments to the average standardized amounts for FY 1988.").

[42] The Board notes that the D.C. Circuit's decision in *Saint Francis* is not applicable to the 1984 and 1985 budget neutrality adjustments given the statutory provision precluding administrative and judicial review of those

Furthermore, Congress has precluded Board (and judicial) review of the FFY 1984 and 1985 budget neutrality adjustments. Specifically, 42 U.S.C. § 1395ww(d)(7)(A) precludes administrative and juridical review of the neutrality adjustment at § 1395ww(e)(1):

> (7) There shall be no administrative or judicial review under section 1395oo of this title or otherwise of—
>
> (A) the determination of the requirement, or the proportional amount, of any adjustment effected pursuant to subsection (e)(1) or the determination of the applicable percentage increase under paragraph (12)(A)(ii), . . .[43]

Similarly, the statute governing Board appeals is located at 42 U.S.C. § 1395oo and states in subsection (g)(2):

> The determinations and other decisions described in section 1395ww(d)(7) of this title shall not be reviewed by the Board or by any court pursuant to an action brought under subsection (f) or otherwise.

The Secretary incorporated the exclusion of the 1984 and 1985 budget neutrality provisions into the Board's governing regulations at 42 C.F.R. § 405.1804 which states in pertinent part:

> Neither administrative nor judicial review is available for controversies about the following matters:
>
> (a) The determination of the requirement, or the proportional amount, of the budget neutrality adjustment in the prospective

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adjustments. Further, *Saint Francis* did not analyze how the standardized amount is updated annually nor did it make specific legal holdings regarding the standardized amount.

[43] With regard to implementing this statutory provision, 48 Fed. Reg. 39752, 39785 (Sept. 1, 1983) states:

> Section 1886(d)(7) of the Act precludes administrative and judicial review of the following:
> —A determination of the requirement, or the proportional amount, of any "budget neutrality" adjustment effected under section 1886(e)(1) of the Act; or
> —The establishment of DRGs, of the methodology for the classification of hospital discharges within DRGs, or of the appropriate weighting factors of DRGs under section 1886(d)(4) of the cost. It was the clear intent of Congress that a hospital would not be permitted to argue that the level of the payment that it receives under the prospective payment system is inadequate to cover its costs. Thus, as discussed above, neither the definition of the different DRGs, their weight in relation to each other, nor the method used to assign discharges to one of the groups is to be reviewable. However, if there is an error in the coding of an individual patient's case, review would be permitted. (See the Report of the Committee on Ways and Means on H.R. 1900, H. Report No. 98-25, (98th Cong., 1st Sess.) 143 (1982).) As noted below, we believe the appropriate review concerning coding errors should be conducted by the entity (i.e., the PSRO/PRO or fiscal intermediary) which made the initial determination.

> payment rates required under section 1886(e)(1) of the Social Security Act [*i.e.* 42 U.S.C. § 1395ww(e)(1)].[44]

Since the FFY 1984 and 1985 budget neutrality adjustments are based on an ***external, fixed*** reference point (*i.e.*, no greater and no less than the reference point) and are not reviewable, the Board finds that the FFYs 1984 and 1985 budget neutrality adjustments effectively fixed the standardized amounts from FFY 1985 forward for use in the IPPS system *for purposes of future FFYs*.[45]

Moreover, the Secretary's implementation of the fixed FFY 1984 and 1985 budget neutrality adjustments confirms that the Providers' allegation that the standardized rates for ***each FFY at issue*** are somehow understated due to alleged errors in the FFY 1984 base rate is moot.

1. *The Secretary determined that the initial standardized amounts for FFY 1984 were too high and, therefore, reduced the FFY 1984 standardized amounts through the FFY 1984 budget neutrality adjustment as reflected in the **final** FFY 1984 IPPS rates*.

In the interim final rule published on September 1, 1983, the Secretary issued a FFY 1984 budget neutrality adjustment to the FFY 1984 standardized amounts of 0.969:

> Section 1886(e)(1) of the Act requires that the prospective payment system result in aggregate program reimbursement equal to "what would have been payable" under the reasonable cost provisions of prior law; that is, for fiscal years 1984 and 1985, the prospective payment system should be "budget neutral."
>
> Under the Amendments, the prospective payment rates are a blend of a hospital-specific portion and a Federal portion. Section 1886(e)(1)(A) of the Act requires that aggregate payments for the hospital specific portion should equal the comparable share of estimated reimbursement under prior law. **Similarly, section 1886(e)(1)(B) of the Act requires that aggregate reimbursement for the Federal portion of the prospective payment rates plus any adjustments and special treatment of certain classes of hospitals should equal the corresponding share of estimated outlays prior to the passage of Pub. L. 98-21**. Thus, for fiscal year 1984, 75 percent of total projected reimbursement based on the

[44] The Secretary recently clarified 42 C.F.R. § 405.1804(a) and affirmed that 42 U.S.C. § 1395ww (e)(1) "required that, for cost reporting periods beginning in FYs 1984 and 1985, the IPPS result in aggregate program reimbursement equal to 'what would have been payable' under the reasonable cost-based reimbursement provisions of prior law; that was, for FYs 1984 and 1985, the IPPS would be 'budget neutral.'" 78 Fed. Reg. 74825, 75162 (Dec. 10, 2013) (making technical change to the 42 C.F.R. § 405.1804(a)).

[45] *See, e.g.,* 48 Fed. Reg. 39752, 39765 (Sept. 1, 1983) (stating "We point out that aside from being technically desirable, the effect of standardizing nonlabor hospital costs in Alaska and Hawaii is to decrease the reduction for budget neutrality stemming from the requirements in section 1886(e)(1)(B) of the Act.").

> hospital-specific portion should equal 75 percent of total estimated outlays under law as in effect prior to April 20, 1983. Likewise, total estimated prospective payment system outlays deriving from the 25 percent Federal portion, including adjustments and special payment provisions, should equal 25 percent of projected reimbursement under prior laws.
>
> **The adjustment of the Federal portion was determined as follows**:
>
> - *Step 1*—Estimate total incurred payments for inpatient hospital operating costs for fiscal year 1984 that would have been made on a reasonable cost basis under Medicare prior to Pub. L. 98-21.
> - *Step 2*—Multiply total incurred payments by 25 percent, i.e., the Federal portion of total payment amounts for fiscal year 1984.
> - *Step 3*—Estimate the Federal portion of total payments that would have been made without adjusting for budget neutrality, but with the adjustment for outlier payments.
> - *Step 4*—Add an estimate of total adjustments and payments under special payment provisions to the Federal portion (e.g., outliers, indirect medical education).
> - *Step 5*—The difference between the step 2 and step 4 amounts is divided proportionally among the standardized amounts, resulting in the budget neutrality adjusted (standardized) amounts.
>
> **The resulting adjustment factor for the fiscal year 1984 <u>Federal portion</u> is .969**. Payment amounts of hospitals excluded from the prospective payment system (e.g., psychiatric and children's hospitals) and of hospitals not participating in prospective payment because of their participation in demonstrations and studies were not included in the calculations above.[46]

In the final rule published on January 3, 1984, the Secretary revised the Federal budget neutrality adjustment factor to 0.970 using the same methodology.[47] Significantly, in the January 1984 final rule, the Secretary suggests that, in calculating the budget neutrality adjustment factor, CMS made no attempt to adjust for transfers under IPPS:

> Regarding additional adjustments recommended by commenters, we made no adjustments to either the adjusted standardized amounts or to the budget neutrality estimates for conditions that could not be

[46] 48 Fed. Reg. 39752, 39840-41 (Sept. 1, 1983) (bold, underline emphases added, and italics emphasis in original).
[47] 49 Fed. Reg. 234, 334 (Jan. 3, 1984).

> quantified on the basis of currently available data, even if there were a likelihood that these conditions might exist under prospective payment. For example, no adjustment was made for the likelihood that admissions would increase more rapidly under prospective payment than under the provisions of Pub. L. 97-248, or for costs that might be disallowed as a result of audit or desk review by the intermediaries. *Likewise, we made no attempt to quantify adjustments* ***for the likelihood of transfers*** *under prospective payment*, emergency room services, and disallowed costs which are successfully appealed.[48]

Accordingly, while the Providers did not appeal the 1984 or 1985 budget neutrality adjustments, the above excerpt suggests that the Providers' concern about the Secretary's alleged mistreatment of transfers may be misplaced and that the treatment of transfers in the in the context of the budget neutrality adjustment for FFY 1984 may have more significance.

Finally, the Secretary also declined to increase the base standardized amount to reflect the increased costs associated with the shift in costs of hospital-based physician services from Part B to Part A, as suggested in a comment. The Secretary noted that such an increase would simply be offset or neutralized by a corresponding increase in the budget neutrality adjustment for FFY 1984:

> Finally, applying such an adjustment to the average standardized amounts (and, by extension, to the per case budget neutrality estimates of Federal rate payments) would not actually increase the level of payments under budget neutrality. If we were to increase the initial standardized amounts to reflect this shift, the budget neutrality adjustment factor would have to be recalculated, would accordingly be increased, and the net result would be virtually identical. As a result, such an adjustment would have no effect on payment levels during FYs 1984 and 1985, which are subject to budget neutrality.[49]

Regardless, the Secretary's application of a 0.970 budget neutrality adjustment factor to the FFY 1984 standardized amounts ***prospectively set*** for the Federal rates for FFY 1984 confirms that these standardized rates were too high and were reduced by a factor of 0.030. Thus, the ***final*** IPPS payment rates as used for the first year of IPPS (*i.e.*, FFY 1984), as finalized on January 3, 1984, reflect the Secretary's FFY 1984 budget neutrality adjustment. Moreover, as previously noted, since the FFY 1984 budget neutrality adjustment is based on an ***external, fixed*** reference point (*i.e.*,

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[48] *Id.* at 255 (Emphasis added.) *See also Id.* at 331 (stating as part of the discussion on the budget neutrality adjustments: "The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) established a DRG-adjusted limit on the allowable amount of inpatient operating costs per case and a per case limit on the rate of increase of operating costs of inpatient hospital services. Due to these per case limits, the incentives that influence hospital admission patterns are similar under TEFRA and prospective payment. Accordingly, ***we have assumed that the number of admissions under both prior law and the prospective payment system will be the same***. As a result, the budget neutrality factors can be calculated by comparing reimbursement per discharge for each of the systems, and there is no need to estimate an actual number of hospital admissions." (emphasis added)).

[49] *Id.* at 255.

no greater and no less than the reference point) and is not reviewable, the FFY 1984 budget neutrality adjustment effectively ***fixed*** the standardized amounts for FFY 1984 as used from that point forward (*i.e.*, as used both for the FFY 1984 IPPS payment rates and for subsequent years).

2. *The FFY 1985 budget neutrality adjustment also reduced the FFY 1985 standardized amounts, reaffirming that the Secretary's determined that the initial standardized amounts for FFY 1984 were set too high.*

For FFY 1985 in the August 31, 1984 IPPS final rule, the Secretary applied a budget neutrality adjustment of 0.954 to the standardized amounts used for the Federal national rates and 0.950 to the standardized amounts used for the regional rates and ***specifically confirmed*** that *"*[t]hese budget neutrality-adjusted rates for FY 1985 are then to be used *as the basis for the determination of rates* ***for later years***."[50] The Secretary described these adjustments as follows:

> In accordance with section 1886(e)(1) of the Act, the prospective payment system should result in aggregate program reimbursement equal to "what would have been payable" under the reasonable cost provisions of prior law; that is, for FYs 1984 and 1985, the prospective payment system must be "budget neutral".
>
> During the transition period, the prospective payment rates are a blend of a hospital-specific portion and a Federal portion. ***Further, effective October 1,1984***, *the Federal portion will be a blend of national and regional rates*. As a result, we must determine three budget neutrality adjustments— one each for both the national and regional rates, and one for the hospital-specific portions. The methodology we are using to make these adjustments is explained in detail in section V. of this addendum.
>
> Based on the data available to date, we have computed the following Federal rate budget neutrality adjustment factors:
>
> Regional—.950
> National—.954[51]
>
> ****
>
> [T]he FY 1985 adjusted average standardized amounts (Federal rates) were required by law to be adjusted to achieve budget neutrality; that is, to ensure that aggregate payments for the operating costs of inpatient hospital services would be ***neither more nor less than*** *we estimated would have been paid under prior legislation for the costs of the same services*. (The technical explanation of how this adjustment was made was published in the

[50] 50 Fed. Reg. 35646, 35695 (Sept. 3 1985) (emphasis added).
[51] 49 Fed. Reg. 34728, 34769 (Aug. 31, 1984).

> August 31, 1984 final rule (49 FR 34791).) ***These budget neutrality-adjusted rates for FY 1985 are then to be used as the basis for the determination of rates for later years***. Our FY 1985 budget neutrality adjustment factors were based on data and assumptions that resulted in standardized amounts that were higher than necessary to achieve budget neutrality. Therefore, we have updated the FY 1985 standardized amounts using a factor that takes into account the overstatement of the FY 1985 amounts to ensure that accuracy of the FY 1986 standardized amounts. To this end, we have identified several factors, discussed in section III.A.3.c., below, that contributed to the overstatement of the FY 1985 standardized amounts. We have determined an appropriate percent value for each of them, and have combined them into a proposed composite correction factor for FY 1986 that equals —7.5 percent.[52]

Thus, like her budget neutrality adjustments made for FFY 1984, the Secretary again confirmed that the standardized amounts were too high and exercised her discretion to ***prospectively*** adjust down the standardized amounts as used in the ***final*** IPPS rates for FFY 1984. Again, as noted above, the Secretary confirmed that the FFY 1985 budget-neutrality adjusted rates are used *in determining the rates for subsequent FFYs*.

* * * * *

In summary, the Providers claim that the Budget Neutrality Preclusion Provisions are not applicable here because they only bar administrative and judicial review of *a **narrow** category of challenges* to the Secretary's determination of the requirement, or the proportional amount, of any budget neutrality adjustment effected pursuant to 42 U.S.C. § 1395ww(e)(1) in FFYs 1984 and 1985.[53]

The Board disagrees and finds that it lacks substantive jurisdiction over the issue raised in these appeals because the ***prospectively-set*** standardized amounts used for IPPS rates for FFYs 1984 and FFY 1985 are each based on the budget neutrality adjustment made for that FFY.[54] Therefore, the *final* FFY 1984 and 1985 standardized amounts are *inextricably intertwined* with those applicable

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[52] 50 Fed. Reg. 35646, 35695 (Sept. 3 1985) (emphasis added). *See also* 49 Fed. Reg. at 34767 (stating "We believe the explicit language of section 2310 of Pub. L. 98-369 and section 1886(d)(3)(A) of the Act requires a reduction in the standardized amounts used to compute the Federal rates before adjusting for budget neutrality. . . . Thus, while the Federal rates . . . . have been reduced in this final rule to reflect the inflation factor prescribed by section 2310 of Pub. L. 98-369, we point out that the offset for budget neutrality has also been adjusted. The reduction in the regional and national standardized rates . . . attributable to section 2310 of Pub. L. 98-369 is entirely due to the revised budget neutrality adjustments for 1984 and 1985.").

[53] *E.g.,* Case No. 19-1094GC *et al.*, Response to ASC Jurisdictional Challenges at 3.

[54] The Board has included at **Appendix B** examples of other adjustments to the standardized amounts that have occurred outside of the FFY 1984 and 1985 budget neutrality adjustments. These intervening adjustments for FFYs 1986 and 2018 include both mandatory and discretionary revisions ***to the standardized amounts*** (as well as the Congress' decisions to revise or not revise the "applicable percentage increases" for FFYs 1986 and forward as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i)) and highlight the complexity of the issue before the Board, particularly where such adjustments were made in a budget neutral manner or were based on factoring in certain other estimated impacts

budget neutrality adjustments.[55] Indeed, the Secretary determined that the standardized amounts for FFYs 1984 and 1985 were too high. Accordingly, the Secretary applied a budget neutrality adjustment to those years to reduce the standardized amounts by factors of approximately 0.03 for FFY 1984 and 0.05 for FFY 1985 and, thus, these budget neutrality adjustments appear to have already automatically accounted for any such alleged errors in setting the initial base rate.[56] Because 42 U.S.C. 1395ww(d)(7) prohibits administrative or judicial review of those adjustments and the resulting *final* standardized amounts for those years were carried/flowed forward *for purposes of future FFYs* (as confirmed by the Secretary in the FY 1986 IPPS final rule quoted above), the Board may not review the standardized amount used for the FFYs being appealed as they relate to the issue in these appeals, *i.e.*, the alleged inaccuracies in the standardized amounts used for FFY 1984 as carried/flowed forward for all years following FFY 1985 to the FFYs being appealed. In this regard, the Board notes that the Providers may not simply pass through, or over, the budget neutrality adjustments for FFYs 1984 and 1985 because those adjustments are tied to an absolute *external* event (the Secretary's estimate, based on the best available data, of what would have been paid for those years if there were no IPPS) ***and*** were ***fixed*** (no greater *and* no less than what would have been paid had there been no IPPS). To do otherwise, would impact the very integrity of IPPS.

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[55] *See DCH Reg'l Med. Ctr. v. Azar*, 925 F.3d 503, 507 (D.C. Cir. 2019) ("We cannot review the Secretary's method of estimation without also reviewing the estimate. And because the two are inextricably intertwined, section 1395ww(r)(3)(A) precludes review of both."); *Mercy Hosp., Inc. v. Azar*, 891 F.3d 1062, 1067 (D.C. Cir. 2018) ("As both a textual and a practical matter, the LIP adjustment is inextricably intertwined with the step-two rate, and so the shield that protects the step-two rate from review protects the LIP adjustment as well."); *Yale New Haven Hosp. v. Becerra*, 56 F.4th 9, 18 (2nd Cir. 2022) ("Thus, we join the D.C. Circuit in "reject[ing] the argument that 'an "estimate" is not the same thing as the "data" on which it is based.'" *DCH Reg'l Med. Ctr. v. Azar* . . . . We also adopt the D.C. Circuit's holding that "[i]n this statutory scheme, a challenge to the [Secretary's choice of what data to include and exclude] for estimating uncompensated care is ... a challenge to the estimates themselves. The statute draws no distinction between the two." *Id*. at 506. Indeed, the statutory text of section 1395ww(r)(2)(C)(i) explicitly and affirmatively defines the statutory term "estimate[ ]" to encompass "the Secretary['s] determin[ation]" of what data is the "be[st] proxy for the costs of [qualifying] hospitals for treating the uninsured" and, ultimately, of what data to "use" or not "use." 42 U.S.C. § 1395ww(r)(2)(C)(i)." (citations partially omitted)). Similarly, the Board notes that the Board erred in finding that it had jurisdiction in *Columbia/HCA 1984-1986 PPS Federal Rate/Malpractice Group v. Blue Cross & Blue Shield Ass'n*, PRRB Dec. 2000-D74 (Aug. 18, 2000). In that decision, the Board found that "the issue in this case, whether the federal portion of the PPS rates should be adjusted because it was based on 1981 hospital cost report data which incorporated an invalid 1979 Malpractice Rule, does not fall into either [of the] limitations on Board jurisdiction [at 42 U.S.C. §§ 1395ww(d)(7) or 1395oo(g)(2)]. The Board finds that it can determine whether the existing statute and regulations concerning the establishment of the federal portion of the PPS rate require or permit retroactive adjustments." *Id.* at 16. The Board further found that "the retroactive adjustment proposed by the Provider would increase the federal portion of the PPS rates ***and therefore require some adjustment to be made to maintain budget neutrality***. 42 U.S.C. § 1395ww(e) and 42 C.F.R. § 412.63(j)" but that "[b]ecause the Board has determined that the adjustments are not required, how those adjustments would be made are moot, and in any event would not be subject to review by the Board. 42 C.F.R. § 405.1804(a)." *Id.* at 18 (Emphasis added.) While the Board's 2000 decision got it right that the FFY 1984 budget neutrality provision is implicated and precluded from administrative review, the above case law demonstrates that the Board erred in finding it could review the FY 1984 standardized amounts. Rather, the case law (as well as the Board's discussion herein) demonstrates that any adjustment to the FFY 1984 standardized amounts would be *inextricably* tied to the ensuing budget neutrality adjustments made for FFYs 1984 and 1985.

[56] *See supra* note 41 (discussing how the removal of nurse anesthetists costs were removed from IPPS and how that removal was *automatically* accounted for as part of the 1985 budget neutrality adjustment).

Accordingly, the Board finds that: (1) the appealed issue is *inextricably* intertwined with the FFY 1984 and 1985 budget neutrality adjustments to the standardized amounts *for purposes of future FFYs* under the operation of 42 U.S.C. §§ 1395ww(b)(3)(B), 1395ww(d)(3)(A), and both 1395ww(d)(2)(F) and 1395ww(d)(3)(C) which references 1395ww(e)(1)(B); and; (2) 42 U.S.C. §§ 1395oo(g)(2) and 1395ww(d)(7) (and related implementing regulations[57]) prohibit administrative and judicial review of those budget neutrality adjustments. Based on these findings, the Board concludes that it does not have substantive jurisdiction over the issue in twenty-nine (29) CIRP and optional group cases listed in **Appendix A**, and hereby closes these twenty-nine (29) group cases and removes them from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

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For the Board:

1/31/2024

X Clayton J. Nix

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Chair
Signed by: PIV

cc: Pamela VanArsdale, National Government Services, Inc. (J-6)
Cecile Huggins, Palmetto GBA (J-J)
Dana Johnson, Palmetto GBA c/o National Government Services, Inc. (J-M)
Michael Redmond, Novitas Solutions, Inc. (J-H)
Wilson Leong, FSS

[57] *See, e.g.*, 42 C.F.R. §§ 405.1804, 405.1840(b)(2).

APPENDIX A
Jurisdictional Challenges and Responses; Cases at Issue

On September 13, 2023, the Medicare Contractor filed a challenge to the following five (5) cases which all share a common lead Medicare Contractor, National Government Services, Inc. (J-6):

19-1029GC	Allina Health FFY 2019 Understated Standardized Amount CIRP Group
20-1139GC	Allina Health FFY 2020 Understated Standardized Amount CIRP Group
21-1118GC	Allina Health FFY 2021 Understated Standardized Amount CIRP Group
22-0730GC	Allina Health FFY 2022 Understated Standardized Amount CIRP Group
23-0887GC	Allina Health FFY 2023 Understated Standardized Amount CIRP Group

On September 18, 2023, the Medicare Contractor filed a challenge to the following eleven (11) cases which all share a common lead Medicare Contractor, Palmetto GBA (J-J):

20-1153GC	Phoebe Putney Hlth Systm FFY 2020 Understated Standardized Amount CIRP Group
20-1154GC	Tift Regional Health Syst FFY 2020 Understated Standardized Amount CIRP Group
20-1155G	King & Spalding FFY 2020 Understated Standardized Amount Group
21-1123GC	Tift Regional Health Syst FFY 2021 Understated Standardized Amount CIRP Group
21-1124GC	Phoebe Putney Hlth Systm FFY 2021 Understated Standardized Amount CIRP Group
21-1125G	King & Spalding FFY 2021 Understated Standardized Amount Group
22-0707GC	Phoebe Putney Hlth Systm FFY 2022 Understated Standardized Amount CIRP Group
22-0727GC	Tift Regional Health Syst FFY 2022 Understated Standardized Amount CIRP Group
22-0739G	King & Spalding FFY 2022 Understated Standardized Amount Group
23-0890GC	Phoebe Putney Hlth Systm FFY 2023 Understated Standardized Amount CIRP Group
23-0892G	King & Spalding FFY 2023 Understated Standardized Amount Group

On September 19, 2023, the Medicare Contractor filed a challenge to the following eight (8) cases which all share a common lead Medicare Contractor, Palmetto GBA c/o National Government Services, Inc. (J-M):

19-0847GC	Tidelands Health FFY 2019 Understated Standardized Amount CIRP Group
20-1136GC	Medical Univ of SC FFY 2020 Understated Standardized Amount CIRP Group
20-1151GC	Tidelands Health FFY 2020 Understated Standardized Amount CIRP Group
21-1120GC	Tidelands Health FFY 2021 Understated Standardized Amount CIRP Group
22-0726GC	Medical Univ of SC FFY 2022 Understated Standardized Amount CIRP Group
22-0728GC	Tidelands Health FFY 2022 Understated Standardized Amount CIRP Group
23-0889GC	Medical Univ of SC FFY 2023 Understated Standardized Amount CIRP Group
23-0891GC	Tidelands Health FFY 2023 Understated Standardized Amount CIRP Group

On December 4, 2023, the Medicare Contractor filed a challenge to the following five (5) cases which all share a common lead Medicare Contractor, Novitas Solutions, Inc. (J-H):

19-1159GC	Ochsner Health System FFY 2019 Understated Standardized Amount CIRP Group
20-1138GC	Ochsner Health System FFY 2020 Understated Standardized Amount CIRP Group
21-1117GC	Ochsner Health System FFY 2021 Understated Standardized Amount CIRP Group
22-0718GC	Ochsner Health System FFY 2022 Understated Standardized Amount CIRP Group
23-0886GC	Ochsner Health System FFY 2023 Understated Standardized Amount CIRP Group

APPENDIX B

The following are examples of other adjustments to the standardized amounts that have occurred outside of the FFY 1984 and 1985 budget neutrality adjustments and the "applicable percentage increases" for FFYs 1986 and forward as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i):

a. "Restandardization of base year costs per case used in [the] calculation of Federal rates" for both the labor and non-labor portions to reflect the survey-based wage index as discussed in the FY 1986 IPP Final Rule. 50 Fed. Reg. 35646, 35692 (Sept. 3, 1985).

b. Recalibration of DRG weights done in a budget neutral manner pursuant to 42 U.S.C. § 1395ww(d)(4)(C) at least every 4 years beginning with 1986.[58] An example of recalibration can be found in the FY 1986 IPPS Final Rule wherein the Secretary changed its methodology for calculating the DRG relative weights.[59]

c. Budget neutrality adjustments made to the standardized amount designated for urban hospitals and the one designated for rural hospitals when certain urban hospitals were

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[58] The Secretary confirmed that, beginning in 1991, these adjustments are to be made in a budget neutral manner:

> Section 1886(d)(4)(C)(iii) of the Act requires that beginning with FY 1991, reclassification and recalibration changes be made in a manner that assures that the aggregate payments are neither greater than nor less than the aggregate payments that would have been made without the changes. Although normalization is intended to achieve this effect, equating the average case weight after recalibration to the average case weight before recalibration does not necessarily achieve budget neutrality with respect to aggregate payments to hospitals because payment to hospitals is affected by factors other than average case weight. Therefore, as discussed in section II.A.4.b. of the Addendum to this final rule, we are making a budget neutrality adjustment to implement the requirement of section 1886(d)(4)(C)(iii) of the Act.

59 Fed. Reg. 45330, 45348 (Sept. 1, 1994).

[59] 50 Fed. Reg. 35646, 35652 (Sept. 3, 1985). As part of this recalibration process, the Secretary responded to a comment on the use of transfers in the recalibration process as follows:

> *Comment:* A commenter was concerned that, by including transfer cases in the calculation of the relative weights, we might be inappropriately reducing the relative weights of DRGs in which there are significant proportions of transfer cases.
>
> *Response:* This commenter assumes that the charges for transfer cases are lower than charges for the average case in a DRG. Our data show that this assumption is not correct for many DRGs. To test the effect of including transfers in the calculation of the relative weights, we computed mean charges for each DRG, both with and without the transfer cases. We then conducted statistical tests to determine whether these two means differed significantly at the .05 confidence level (that is, there is only a .05 probability that the observed difference in the means would occur if the two sets of cases came from the same underlying population). The results indicate that transfers have a statistically significant effect on the mean charges of only 16 DRGs. For 13 of the 16 DRGs, inclusion of transfer cases tends to ***increase*** the mean charges. However, for three DRGs, the mean charges are reduced by the inclusion of the transfer cases.
>
> Since the inclusion of transfer cases raises the mean charges for some DRGs and lowers them for others, and because these effects are limited to such a small number of DRGs, we decided not to revise the method we used to recalibrate the relative weights. During FY 1986, we will be studying the entire issue of transfers and the appropriate payment for these cases. This study may reveal other ways of handling transfer cases in future recalibrations.

Id. at 35655-56.

deemed to be urban effective with discharges occurring on or after October 1, 1988. 53 Fed. Reg. 38476, 38499-500, 38539 (Sept. 30, 1988) (implementing OBRA 87, Pub. L. 100-203, § 4005).[60]

d. Effective for FFY 1995, eliminating the initial two standardized amounts (one for urban hospital and another for rural hospitals)[61] and replacing them with one single standardized amount as specified at 42 C.F.R. § 1395ww(d)(3)(C)(iii).[62]

e. Budget neutrality provision at 42 U.S.C. § 1395ww(d)(3)(A)(vi) that allows Secretary to adjust standardized amount to eliminate the effect of "changes in coding or classification of discharges that do not reflect real changes in case mix."

f. The discretion of the Secretary in 42 U.S.C. § 1395ww(d)(3)(I)(i) to "provide by regulation for such other exceptions and adjustments to such payments amounts under this subsection as the Secretary deems appropriate."

g. The subsequent amendments that Congress made in 1994[63] and 1997[64] to add subparagraphs (I) and (J) to 42 U.S.C. § 1395ww(d)(5) to recognize and incorporate the concept of transfers into IPPS *in a budget neutral manner*. The Secretary made adjustments to the standardized amounts in order to implement the permanent incorporation of transfers into IPPS.[65]

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[60] *See also* 56 Fed. Reg. 43358, 43373 (Aug. 30, 1991) (stating "Consistent with the prospective payment system for operating costs, the September 1, 1987 capital final rule provided for separate standardized amounts for hospitals located in urban and rural areas. Subsequently, the Omnibus Budget Reconciliation Act of 1987 (Pub. L. 100-203) provided for a higher update factor for hospitals located in large urban areas than in other urban areas and thereby established three standardized amounts under the prospective payment system for operating costs. Large urban areas are defined as those metropolitan statistical areas (MSAs) with a population of more than 1 million (or New England County metropolitan statistical areas (NECMAs) with a population of more than 970,000). Beginning with discharges on or after April 1,1988 and continuing to FY 1995, the Congress has also established higher update factors for rural hospitals than for urban hospitals. The differential updates have had the effect of substantially reducing the differential between the rural and other urban standardized amounts. Section 4002(c) of Public Law 101-508 provides for the elimination of the separate standardized amounts for rural and other urban hospitals in FY 1995 by equating the rural standardized amount to the other urban standardized amount. The separate standardized amount for large urban hospitals would continue. Currently, the large urban standardized amount under the prospective payment system for operating costs is 1.6 percent higher than the standardized amount for hospitals located in other urban areas.").

[61] *See* 42 U.S.C. §§ 1395ww(d)(2)(D), 1395ww(d)(3)(A); *supra* note 26.

[62] Omnibus Reconciliation Act of 1990, Pub. L. 101-508, § 4002(c), 104 Stat. 1388, 1388-33 – 1388-35 (1990).

[63] Social Security Act Amendments of 1994, § 109, Pub. L. 103-432, 108 Stat. 4398, 4408 (1994) placed the then-existing language of 42 U.S.C. § 1395ww(d)(5)(I) into clause (i) and added the following clause (ii): "(ii) In making adjustments under clause (i) for transfer cases (as defined by the Secretary) in a fiscal year, the Secretary may make adjustments to each of the average standardized amounts determined under paragraph (3) to assure that the aggregate payments made under this subsection for such fiscal year are not greater than or lesser than those that would have otherwise been made in such fiscal year."

[64] Balanced Budget Act of 1997, Pub. L. 105-33, § 4407, 111 Stat. 251, 401 (1997), further revised 42 U.S.C. § 1395ww(d)(5)(I) and added § 1395ww(d)(5)(J).

[65] *See* 60 Fed. Reg. 45778, 45854 (Sept. 1, 1995) ("[W]e are revising our payment methodology for transfer cases, so that we will pay double the per diem amount for the first day of a transfer case, and the per diem amount for each day after the first, up to the full DRG amount. For the data that we analyzed, this would result in additional

To illustrate the complex nature of these issues, the Board points to the Secretary's exercise of her discretion under 42 U.S.C. § 1395ww(d)(3)(I)(i) on making recommendations to Congress on whether to make adjustments to the "applicable percentage increases" or update factor for FFY 1986 as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i). In the September 1985 Final Rule,[66] the Secretary asserted that the FFY 1985 Federal rates were "overstated" and cited to the GAO's 1985 report entitled "Report to the Congress of the United States: Use of Unaudited Hospital Cost Data Resulted in Overstatement of Medicare Prospective Payment System Rates" and, pursuant to 42 U.S.C. § 1395ww(e)(4), made a recommendation to Congress that it not provide any increase to FFY 1985 standardized amounts but rather freeze the FFY 1986 amounts at the FFY 1985 levels (*i.e.*, recommended an update factor of 0 percent for FFY 1986).[67] The following excerpts from that rulemaking describe how the Secretary determined that the FFY 1985 standardized amounts were overstated when reviewing whether to recommend that Congress adjust the update factor for the FFY 1986 standardized amounts:

> Since the standardized amounts for FY 1985 are used as the basis for the determination of rates for later years, the level of the FY 1985 standardized amounts must be corrected for any experience that developed since they were published. *We believe that it is necessary, **each year**, to review the appropriateness of the level of the previous year's prospective payment rates for providing reasonable payment for inpatient hospital services furnished to beneficiaries*. Further, we think this review must include assessment of whether the previous year's prospective payment rates have established adequate incentives for the efficient and effective delivery of needed care.
>
> In addition to this general consideration, *the FY 1985 adjusted average standardized amounts* (***Federal rates***) *were required by law **to be adjusted to achieve budget neutrality***; that is, to ensure that aggregate payments for the operating costs of inpatient hospital services would be *neither more **nor** less than* we estimated would have been paid under prior legislation for the costs of the same services. (The technical explanation of how this adjustment was made was published in the August 31, 1984 final rule (49 FR 34791).) *These budget neutrality-adjusted rates for FY 1985 are then to be used as the basis for the determination of rates for later years*.
>
> *Our FY 1985 budget neutrality adjustment factors were based on data and assumptions that resulted in standardized amounts that were **higher** than necessary to achieve budget neutrality*. Therefore, *we have updated the FY 1985 standardized amounts using a factor that*

payments for transfer cases of $159 million. *To implement this change in a budget neutral manner*, we adjusted the standardized amounts by applying a budget neutrality adjustment of 0.997583 in the proposed rule.").

[66] 50 Fed. Reg. 35646, 35704 (Sept. 3, 1985).

[67] U.S. Gov't Accountability Office, GAO/HRD-85-74, Use of Unaudited Hospital Cost Data Resulted in Overstatement of Medicare's Prospective Payment System Rates (1985).

*takes into account the **overstatement** of the FY 1985 amounts to ensure that accuracy of the FY 1986 standardized amounts*. To this end, we have identified several factors, ***discussed in section II.A.3.c.***, below, that contributed to the overstatement of the FY 1985 standardized amounts. *We have determined an appropriate percent value for each of them, and have combined them into **a proposed composite correction factor** for FY 1986 that equals –7.5 percent*.

In addition, we have developed factors representing productivity, technological advances, and the elimination of ineffective practice patterns, which are necessary to ensure the cost-effective delivery of care. Each of these factors interacts with the others, to some extent, and has an impact on the quality of care. Making conservative assumptions, we have determined an appropriate percent value for each of these factors, taking into consideration their potential effect on quality. **We have combined these values into a composite policy target adjustment factor**, **as discussed in section III.3.e., below**. For FY 1986, this factor equals —1.5 percent.

The Secretary is required under section 1886(e)(4) of the Act to make those adjustments in establishing the update factor that are ". . . necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality." *Establishing FY 1986 prospective payment rates based on FY 1985 rates **that have been demonstrated to be overstated**, clearly would not comport with the statutory requirement that the rates represent payment for efficiently delivered care*.

Since the forecasted hospital market basket increase for FY 1986 is +4.27 percent, and the adjustment for Part B costs and FICA taxes is +.31 percent, it is clear that there is a potential justification of a –4.42 percent decrease in the FY 1986 standardized amounts as compared to those for FY 1985 as described below:

	Percent
Forecasted market basket increase..	+4.27
Part B costs and FICA taxes.....	+.31
Composite correction factor.....	–7.5
Composite policy target adjustment factor.....	–1.5

However, for the reasons discussed in section II.A.3.f., below, we have decided that such a decrease is undesirable. Therefore, we are

maintaining the FY 1986 standardized amounts at the same average level as FY 1985, in effect applying a zero percent update factor.[68]

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(3) *Additional causes for the overstatement of FY 1985 Federal rates.* In addition to the factors above, which we believe we must correct, **other considerations also contributed significantly to the overstatement of the FY 1985 standardized amounts**.

When we set the standardized amounts for FY 1985, we made assumptions on hospital cost per case increases in order to estimate, for purposes of budget neutrality, the payments that would have been made had prior payment rules continued in effect. These assumed rates of increase in cost per case were 10.9 percent for 1983, 9.8 percent for 1984, and 9.8 percent for 1985. These assumptions were significantly higher than the actuarial estimates. The actuarially estimated rates of increase in cost per case (which ignore any effects of the prospective payment system such as shorter lengths of stay) are 9.8 percent for 1983, 8.1 percent for 1984, and 8.5 percent for 1985. After application of the revised market basket, discussed previously, use of these actuarial estimates would reduce the standardized amounts by an additional 1.2 percent.

For FY 1985, we also used 1981 unaudited, as-submitted cost reports (to get recent data as quickly as possible) to set the Federal rates. The hospital specific rates were set using later (1982 or 1983) cost reports that were fully audited. The audits adjusted the total cost for these reports downward by $2.2 billion, of which Medicare realized about $900 million in inpatient recoveries. **Since the cost data used to set the Federal rates do not reflect audit recoveries, it is likely that they are overstated by a similar amount**. We do not know precisely what proportion of this amount applies to capital-related costs and other costs that would not affect the Federal rates. However, approximately 90 percent of hospitals" total inpatient costs are operating costs, and if only 40 percent of the $900 million in audit recoveries is related to Federal payments for inpatient operating costs, there would have been, conservatively estimated, at least a one percent overstatement of allowable costs incorporated into the cost data to determine the FY 1985 standardized amounts.

[68] 50 Fed. Reg. at 35695 (bold, italics, and underline emphasis added).

> In addition, the General Accounting Office (GAO) recently conducted a study to evaluate the adequacy of the Standardized amounts. In its report to Congress dated July 18, 1985 (GAO/HRD-85-74), **GAO reported findings that the standardized amounts, as originally calculated, are overstated by as much as 4.3 percent because they were based on unaudited cost data and include elements of capital costs.** GAO recommended that the rates be adjusted accordingly.
>
> We believe that these causes for the overstatement of the standardized amounts are related to our own procedures and decisions. Thus, they are unlike both the market basket index, which is a technical measure of input prices, and the increases in case-mix, which would not have been passed through beyond the extent to which they affected the estimates of cost per case. Further, as discussed below, even without making these corrections, we could justify a negative update factor for FY 1986, although we are not establishing one. **Since we have decided to set FY 1986 standardized amounts at the same level as those for FY 1985, making corrections now to reflect the cost per case assumptions and the audit data would have no practical effect. Therefore, we have decided <u>at this time not</u> to correct the standardized amounts for these factors.**
>
> We received no comments on this issue.
>
> (4) ***Composite Correction Factor.*** We are adjusting the standardized amounts as follows to take into consideration the overstatement of the prior years, amounts:
>
> | | *Percent* |
> |---|---|
> | Case mix..... ..... | –6.3 |
> | Market basket..... | –1.2 |
> | Composite correction factor..... | –7.5[69] |

Congress did immediately act on the Secretary's September 3, 1985 recommendation because, shortly thereafter on September 30, 1985, it enacted § 5(a) of the Emergency Extension Act of 1985 ("EEA-85") to maintain existing IPPS payment rates for FFY 1986 at the FFY 1985 Rates (*i.e.*, provide a 0 percent update factor) until November 14, 1985 as specified in EEA-85 § 5(c).[70] Congress subsequently modified this freeze on several different occasions as explained in the interim final rule published on May 6, 1986:

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[69] *Id.* at 35703-04 (bold and underline emphasis added).

[70] Pub. L. 99-107, § 5(a), 99 Stat. 479, 479 (1985). In July 1984, Congress had *already* reduced the 1 percent update factor planned for FFY 1986 to ¼ of a percentage point. Deficit Reduction Act of 1984, Pub. L. 98-369, § 2310(a), 98 Stat. 494, 1075 (1984). As part of the Emergency Extension Act of 1985, Congress further reduced the update factor for FFY 1986, presumably in response to the Secretary's recommendation.

> - Pub. L. 99-155, enacted December 14, 1985, extended the [EEA-85] delay through December 14, 1985.
>
> - Pub. L. 99-181, enacted December 13, 1985, extended the [EEA-85] delay through December 18, 1985.
>
> - Pub. L. 99-189, enacted December 18, 1985, extended the [EEA-85] delay through December 19, 1985.
>
> - Pub. L. 99-201 enacted December 23, 1985, extended the [EEA-85] delay through March 14, 1986.[71]

Second, on April 7, 1986, Congress further revised EEA-85 § 5(c) by extending the 0 percent update factor through April 30, 1986 and then specified that, for discharges on or after May 1, 1986, the update factor would be ½ of a percentage point.[72]

The examples highlight concerns about how certain future actions and decisions by the Secretary and Congress build upon prior decisions. Here, the Secretary's recommendation to Congress regard the FFY 1986 update factor were based on its analysis of the FFY 1984 and 1985 standardized amounts that had already been adjusted for budget neutrality. To the extent the 1984 standardized amounts had been *further* adjusted (*as **now** proposed by the Providers*), it could have potentially impacted the Secretary's recommendation to Congress for the FFY 1986 update factor as well as Congress' subsequent revisions to the updated factor. Accordingly, this highlights how revisiting and otherwise adjusting the FY 1984 standardized amounts can have ripple effects with the update factor and other adjustments that were made for subsequent years *based on analysis of the prior year(s) and other information*.

[71] 51 Fed. Reg. 16772, 16772 (May 6, 1986).
[72] *See Id.* at 16773. *See also* Medicare and Medicaid Budget Reconciliation Amendments of 1985, Pub. L. 99-272, § 9101(a), 100 Stat. 151, 153 (1986).