DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Elizabeth Elias, Esq.
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500 N. Meridian St., Ste. 400
Indianapolis, IN 46204

RE: ***Denial of Expedited Judicial Review Request***
St. Vincent – Randolph Hospital, Inc.
FYs 2004-2009
Case Nos. 06-1843, 07-1701, 08-1543, 10-0786, 10-1178, 11-0530

Dear Ms. Elias:

The Provider Reimbursement Review Board ("Board" or PRRB) has reviewed the Request for Expedited Judicial Review ("EJR") for Existing Appeals filed by St. Vincent – Randolph Hospital, Inc. ("Provider") in the above-captioned cases.[1] As explained below, the Board hereby denies the Provider's November 11, 2022 EJR Request.

Issue in Dispute in the EJR Request:

On November 11, 2022, the Provider filed a *consolidated* EJR request in all 6 cases where they posed the following legal question in the section of the EJR Request entitled "Issue":

> **I. Issue**
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> The issue presented on these appeals is whether, pursuant to 42 U.S.C. §1395oo(f)(2), St. Vincent Randolph is entitled to an award of litigation interest on the Administrative Resolutions issued by WPS? [2]

Procedural History and Pertinent Facts

The consolidated EJR request covers 6 different cases involving fiscal years ("FYs") 2004 to 2009. The following cases for FYs 2004 to 2008 are on remand from the Administrator – Case Nos. 06-1843, 07-1701, 08-1543, 10-0786, and 10-1178. These cases involved a single issue of whether the Medicare Contractor properly disallowed loan interest expense for fiscal years ("FYs") 2004 to 2008. Case No. 11-0530 is the appeal for FY 2009 and involves the same issue as the other six cases. Set forth below is the procedural history starting with FYs 2004 to 2008.

[1] The same EJR was filed in Case No. 17-0701 twice.
[2] Request for Expedited Judicial Review for Existing Appeals ("EJR Request") at 2 (Nov. 11, 2022).

FYs 2004 to 2008 are covered by Case Nos. 06-1843, 07-1701, 08-1543, 10-0786, and 10-1178. The Board held a hearing on these 5 consolidated cases on February 11, 2014,[3] and issued PRRB Dec. No. 2015-D02 on February 5, 2015.[4] Although the Board found in favor of the Provider, the CMS Acting Deputy Principal Administrator reversed the Board's decision.[5] The Provider then proceeded through the federal courts, and ultimately the case was remanded back to the agency for further proceedings consistent with the decision of the U.S. Court of Appeals for the Seventh Circuit ("Seventh Circuit") in *St. Vincent Randolph Hosp., Inc. v. Price*.[6]

On June 11, 2018, the Board reopened these cases pursuant to an order issued by the CMS Administrator.[7] Upon the reopening, the Board ordered the parties to submit any additional arguments and information to support their respective positions with regard to the interest issue in these cases. The Board further ordered the parties to file position papers within 60 days and, if either party planned to rely on any information or document previously relied upon in PRRB Dec. 2015-D2, to resubmit that information/document as an exhibit in its new position paper.[8]

On June 20, 2018, the Board permitted the Provider to consolidate into the briefing schedule the appeal of its FY 2009 cost report for this same issue under Case No. 11-0530.

In 2018 and 2019, the Board scheduled these cases for a consolidated hearing several times, and the parties requested postponement. The Board held a pre-hearing conference on May 22, 2019.

On December 31, 2019, the Medicare Contractor issued proposed Administrative Resolutions ("ARs") which proposed allowing most of the loan interest expense being sought by the Provider. However, the Provider also was requesting an award of litigation interest pursuant to 42 U.S.C. § 1395oo(f)(2) but the proposed ARs did not include the requested litigation interest.

In 2022, after the passage of a significant amount of time with no ARs executed in these cases, the Board again scheduled the cases for hearing. A second pre-hearing conference was held on August 15, 2022, during which the parties stated that the parties had reached an agreement in principle to tentatively resolve the substance of the appealed matter – the reimbursement of the loan interest expense. However, as the matter is on remand from the Seventh Circuit, the Provider maintains it is also due an award of interest on the amount in controversy pursuant to 42 U.S.C. 1395oo(f)(2). The Medicare Contractor argues it does not have the authority to grant such an award of interest and, as such, has refused to consider such an award as part of the ARs.

On September 8, 2022, the parties filed a Joint Stipulations of Fact and Proposed Disposition which also included a request for a Hearing on the Record. On October 6, 2022, the Board sent a

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[3] The PRRB hearing included PRRB Case No. 04-0953 addressing fiscal year end June 30, 2002, however, the Provider subsequently withdrew this appeal and it was not included in the Board's February 5, 2015 decision.
[4] *St. Vincent – Randolph Hosp. v. WPS/BCBS Assoc.,* PRRB Dec. 2015-D2 (Feb. 5, 2015).
[5] *CMS Administrator Dec.* (Apr. 1, 2015).
[6] 869 F. 3d 510, 514 (7th Cir. 2017).
[7] Medicare Contractor's Final Position Paper (Oct. 9, 2018), Exhibit C-1 at 1-2.
[8] Medicare Contractor's Final Position Paper (Oct. 9, 2018), Exhibit C-1 at 15-16.

Request for Information to the parties asking to clarify the Stipulations and, as appropriate, file updated Stipulations. Specifically, the Board asked the parties to either confirm that it is undisputed that the Provider is only entitled to 95.69 percent of the claimed allocated interest expense for fiscal years 2004 through 2009, or to clarify what remains in dispute regarding the claimed allocated interest expense.

On October 11, 2022, the parties filed an Amended and Updated Joint Stipulation of Fact and Proposed Disposition which reiterates the parties request for a Hearing on the Record. As a result of the update, the Parties have stipulated as follows:

> 1. This Consolidated Appeal was originally brought before the Board on St. Vincent's Request for Hearing on June 9, 2006. The case involved St. Vincent's claim for reimbursement of interest expense on loans incurred by St. Vincent for the construction of a new hospital for fiscal years 2004 through and including 2008.[9] The claim was denied by WPS.
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> 2. Following a hearing held on February 11, 2004, the Board reversed the decision of WPS and issued an order in favor of St. Vincent on February 5, 2015. In its decision, the Board determined that WPS's disallowance of the interest expense for St. Vincent for fiscal years 2004 – 2008 was improper.
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> 3. The Board's decision was reviewed by the Administrator ("Administrator") of the Centers for Medicare and Medicaid Services ("CMS"). In a decision dated April 1, 2015, the Administrator reversed the Board's decision finding that WPS's disallowance of St. Vincent's claimed interest expense for fiscal years 2004 – 2008 was proper. The decision of the Administrator was appealed by St. Vincent to the United States District Court for the Southern District of Indiana on May 14, 2015.
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> 4. Following the briefing by the parties on cross-Motions for Summary Judgment, the District Court entered an order ("District Court Order") upholding the decision of the Administrator for fiscal years 2004 – 2008 and issued judgment pursuant to Rule 58 of the Federal Rules of Civil Procedure on September 26, 2016.
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> 5. St. Vincent appealed the District Court Order to the United States Court of Appeals for the Seventh Circuit on November 18, 2016. Following briefing by the parties, the Seventh Circuit heard oral arguments on April 11, 2017. The Seventh Circuit issued an opinion on August 22, 2017 vacating the District Court Order and remanded the case back to the District Court with instructions to remand the case for fiscal years 2004 –

[9] While the same issue was the basis of the appeal for fiscal year 2009, that appeal for Case No. 11-0530 was not addressed or covered by the hearing, Board Decision 2015-D2, Administrator Review, or the subsequent proceedings before the District Court for the Southern District of Indiana and the United States Circuit Court of Appeals for the Seventh Circuit.

2008 back to the Secretary for proceedings consistent with the Seventh Circuit's opinion.

6. Pursuant to the remand by the District Court, the cases for fiscal years 2004 – 2008 were reopened pursuant to the April 25, 2018 order in which the Principal Deputy Administrator vacated the PRRB's decision 2015-D2 and remanded the cases for fiscal years 2004 – 2008 to the Board ("Administrator's Remand Order"). The Administrator's Remand Order directed the PRRB as follows:

> That the Administrator's Decision in *St. Vincent Randolph Hospital, Inc.,* PRRB Dec. No. 2015-D2, dated February 5, 2015, is hereby vacated and the case is remanded to the PRRB consistent with 42 C.F.R. § 405.1877(g) to allow for the further development of the record; and
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> That the PRRB shall take actions necessary to reinstate the appeal and notify the Provider of the action taken by the Court; and
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> That pursuant to the Circuit Court August 22, 2017 opinion, the PRRB will permit further record development of the record by the parties and reconsider the matter consistent with the August 22, 2017 opinion; and
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> That the PRRB will reconsider St. Vincent Randolph Hospital, Inc.'s claim for reimbursement and allow St. Vincent Randolph the opportunity to submit additional documentation to explain the differences in the principal amounts of the two loans, and
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> That the PRRB will prohibit the Medicare Administrative Contractor from reasserting the "taint" theory as discussed in the August 22, 2017 opinion; and
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> That upon remand to the PRRB and subject to the instructions herein, the PRRB has the authority and discretion to determine how best to proceed with respect to supplemental briefings or whether to conduct of an oral hearing consistent with the procedures set forth at 42 C.F.R., Part 405, Subpart R and consistent with the Seventh Circuit's August 22, 2017 decision; and
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> That the decision of the Board is subject to the provisions of 42 C.F.R. [§] 405.1875.[10]

[10] Medicare Contractor's Final Position Paper (Oct. 9, 2018), Exhibit C-1 at 1-2.

> 7. Following the reopening, while the cases pended before the Board, St. Vincent and WPS reached an agreement on the amount of recoverable interest expense on the loans incurred by St. Vincent for the construction of the new hospital. WPS issued proposed Administrative Resolutions ("AR") for each appeal covering fiscal years 2004 through and including 2009 on December 31, 20019. (*See* Exhibits 1 through 6). The proposed ARs included proposed reimbursement of the loan interest in the amount of 95.69 percent of the amounts claimed by St. Vincent. St. Vincent agreed and accepted the reduction to its claimed interest expense. Thus, the parties reached an agreement on the amount of recoverable claimed interest and *the parties now stipulate that* ***it is undisputed*** *that St. Vincent is owed 95.69 percent of the claimed allocated interest expense for FYs 2004 through 2009* as reflected in the proposed ARs. However, the ARs did not include an award of litigation interest, which had been requested by St. Vincent.
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> 8. *The parties stipulate that* ***there remain no issues in dispute*** *regarding the claimed allocated interest expense* ***outside of the litigation interest issue***. The parties stipulate that the record is complete and there is no additional briefing required on the allocated interest expense for FYs 2004 through 2009 as reflected in the proposed ARs or any other issues.
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> 9. WPS takes the position that Administrator's Remand Order did not include any authority for the Board to consider an award of litigation interest. WPS further posits that neither it nor the Board has the authority to address matters, such as litigation interest pursuant to the statute, which are not raised or addressed in the Notice of Program Reimbursement ("NPR") nor the Administrator's Remand Order.
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> [10.] St. Vincent does not dispute the position of WPS with respect to its lack of authority to address issues such as the litigation interest claimed by St. Vincent. However, St. Vincent will not sign the ARs for any of the appeal covering fiscal years 2004 through and including 2009 that do not address and provide for the recovery of litigation interest it asserts is due and owing on the recoverable amounts pursuant to §1395oo(f)(2).
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> [11.] St. Vincent requests that this matter be placed before the appropriate authority to resolve the current impasse between St. Vincent and WPS. St. Vincent seeks and order granting its request for reimbursement of the litigation interest it asserts is due and owing pursuant to §1395oo(f)(2).[11]

On October 14, 2022, the Board granted the Record Hearing Request for the 6 cases and issued the Notice of Hearing on the Record.

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[11] Amended and Updated Joint Stipulation of Facts and Proposed Disposition (Oct. 11, 2022) (emphasis added).

On November 11, 2022, the Provider filed a Request for EJR. On November 16, 2022, the Medicare Contractor filed a Response to the Provider's Request for EJR.

Provider's Position in its Consolidated EJR Request

The Provider states that EJR is appropriate when the Board has jurisdiction over the matter at issue, and the Board lacks the legal authority to decide the specific legal question presented.

The Provider asserts that there are no jurisdictional challenges for any of these 6 cases before the Board. The Provider contends the Seventh Circuit's Order of Remand, as well as the Administrator's Remand Order, authorize and direct the Board to reinstate the Provider's appeals for further development of the record by the parties and reconsideration of the matter at issue. Thus, the Provider takes the position that the Board has jurisdiction to hear the matter of whether the Provider is entitled to an award of litigation interest on the Administrative Resolutions issued by the Medicare Contractor.

The Provider asserts the parties have agreed that neither the Medicare Contractor nor the Board has authority to decide the question of law as to whether the Provider is entitled to litigation interest pursuant to 42 U.S.C. §1395oo(f)(2). The Provider notes that neither the Seventh Circuit Opinion nor the Administrator's Remand Order include any authority or direction for the Board to consider an award of litigation interest. The parties have stipulated that neither WPS nor the Board has authority to address matters such as litigation interest, which are not raised or addressed in the Notice of Program Reimbursement. The Provider states "[s]ince litigation interest is not a line item on the NPR, [the Medicare Contractor] did not render a final decision on St. Vincent Randolph's request for litigation interest. Without a final determination by [the Medicare Contractor], the Board has nothing to review with respect to the litigation interest issue."[12]

The Provider adds that 42 U.S.C. §1395oo(f)(2) does not give the Board authority to award litigation interest, and refers to the last clause of this statute which states "litigation interest is "to be awarded by the reviewing court in favor of the prevailing party."

Medicare Contractor's Position Regarding the Provider's Consolidated EJR Request

The Medicare Contractor's opposes the Provider's request for EJR of the "litigation interest" issue. The Medicare Contractor argues the "litigation interest issue was not a part of the six appeals which are now back before the Board, and this issue was not heard during the Board's February, 2014 hearing. Additionally, the "litigation interest" issue was not argued before the Administrator, the District Court for the Southern District of Indiana, or the Seventh Circuit. The Medicare Contractor's position is that the Board lacks procedural jurisdiction to hear the issue and EJR is not appropriate.

The Medicare Contractor contends that the Board has approved a hearing on the written record, including the parties' stipulations, and that EJR is appropriate for issues over which the Board cannot issue a decision because it is bound by statute or regulation. Here, the parties have

[12] *Id.* at 7.

acknowledged that there is no statute or regulation giving the Board authority to award "litigation interest," and the Provider is not challenging a statute or regulation. The Medicare Contractor also asserts that Case No. 11-0530 was not previously heard by the Board or remanded by the Court, and that PRRB Dec. 2015-D02 only addresses Case Nos. 06-1843, 07-1701, 08-1543, 10-0786, and 10-1178. The Medicare Contractor states that even if EJR is appropriate for the "litigation interest" issue for fiscal years 2004 through 2008, it would not be appropriate for fiscal year 2009 as this year was never decided by the Board, or litigated before the District Court or U.S. Court of Appeals.

Lastly, the Medicare Contractor claims the "litigation interest" issue was not remanded by the Court and the Board cannot expand the issues before it pursuant to a remand. The Provider has refused to execute the ARs without reimbursement of the "litigation interest" issue which was never before the Board, either as part of the initial appeal or on remand, and the Board lacks procedural jurisdiction to even consider the question of "litigation interest." The Medicare Contractor avers the Provider's contention that "there are no pending jurisdictional challenges" does not *sua sponte*, generate jurisdiction, especially since the MAC has consistently advised that the issue was not part of the initial appeal and was not part of the remand.

Board Determination

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.

As set forth below, the Board denies the *consolidated* EJR request for multiple reasons. However, the facts and the bases for the Board's denial for Case Nos. 06-1843, 07-1701, 08-1543, 10-0786, and 10-1178 differs from that for Case No. 11-0530. Accordingly, the Board discusses each separately.

A. Denial of Consolidated EJR Request for Case Nos. 06-1843, 07-1701, 08-1543, 10-0786, and 10-1178

Five of these cases, Case Nos. 06-1843, 07-1701, 08-1543, 10-0786, and 10-1178, are back before the Board pursuant to the Seventh Circuit's August 22, 2017 opinion, for the specific purpose of further record development by the parties and reconsideration by the Board of the cost item in dispute – allowable loan interest expense. In contrast, as the Provider has noted in its EJR Request, litigation interest is not an item claimed on the cost report and it was neither part of the Provider's original appeal requests, the Board's original decision (PRRB Dec. No. 2015-D02), nor the Remand Orders from the Administrator and Seventh Circuit.[13]

[13] EJR Request at 7 ("As to the Board's authority to address the issue of litigation interest, it should be noted that neither the Seventh Circuit Opinion nor the Administrator's Remand Order included any authority or direction for the Board to consider an award of litigation interest. WPS has stipulated that neither it nor the Board has authority to

42 C.F.R. § 405.1877(g) addresses remands from a federal court:

> (g) *Remand by a court* – (1) *General rule.* Under section 1874 of the Act, and § 421.5(b) of this chapter, the Secretary is the real party in interest in a civil action seeking relief under title XVIII of the Act. The Secretary has delegated to the Administrator the authority under section 1878(f)(1) of the Act to review decisions of the Board and, as applicable, render a final agency decision. If a court, in a civil action brought by a provider against the Secretary as the real party in interest regarding a matter pertaining to Medicare payment to the provider, orders a remand for further action by the Secretary, any component of HHS or CMS, or the contractor, the remand order must be deemed, except as provided in paragraph (g)(3) of this section, to be directed to the Administrator in the first instance, regardless of whether the court's remand order refers to the Secretary, the Administrator, the Board, any other component of HHS or CMS, or the contractor.
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> (2) *Procedures.* (i) Upon receiving notification of a court remand order, the Administrator must prepare an appropriate remand order and, if applicable, file the order in any Board appeal at issue in the civil action.
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> (ii) The Administrator's remand order must -
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> (A) Describe the specific requirements of the court's remand order;
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> (B) Require compliance with those requirements by the pertinent component of HHS or CMS or by the contractor, as applicable; and
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> (C) Remand the matter to the appropriate entity for further action.
>
> (iii) After the entity named in the Administrator's remand order completes its response to that order, the entity's response after remand is subject to further proceedings before the Board or the Administrator, as applicable, in accordance with this subpart. For example -
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> (A) If the contractor issues a revised contractor determination after remand, the provider may request a Board hearing on the revised

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address matters, such as litigation interest, which are not raised or addressed in the Notice of Program Reimbursement. Since litigation interest is not a line item on the NPR, WPS did not render a final decision on St. Vincent Randolph's request for litigation interest. Without a final determination by WPS, the Board has nothing to review with respect to the litigation interest issue."). *See also* Stipulation No. 9.

> determination (as described in §§ 405.1803(d) and 405.1889 of this subpart); or,
>
> (B) If the contractor hearing officer(s) or the Board issues a new decision after remand, a decision may be reviewed by a CMS reviewing official or the Administrator, respectively (as described in §§ 405.1834 and 405.1875(f)(4) of this subpart).
>
> (3) *Exception.* The provisions of paragraphs (g)(1) and (g)(2) of this section do not apply to the extent they may be inconsistent with the court's remand order or any other order of the court regarding the civil action.

While the Board has jurisdiction over the allowable loan interest expense issue, neither the Seventh Circuit's Order or the Administrator's Order permit or direct the Board to decide, on remand, the issue of "litigation interest." Rather, pursuant to 42 U.S.C. § 1395(f)(2), the litigation interest issue is one that may only arise on appeal to federal court and is something that only a federal court has the authority to address. Accordingly, the Board finds that any Board consideration of "litigation interest" is beyond the scope of the remand to the Board and, thus, beyond the scope of its jurisdiction as determined by the Remand Orders. More specifically, under the terms of the Remand Orders, the Board is not able to reach or consider whether that it lacks the authority of decide the "litigation interest" question based upon the criteria required in 42 C.F.R. § 405.1842(f)(2) – that the specific legal question is a challenge either to the constitutionality of a provision of a statute, or to the substantive or procedural validity of a regulation or CMS Ruling. The Provider's Representative acknowledges that Board consideration of litigation interest would be outside the Remand Orders. Indeed, it would not make sense for the Seventh Circuit's remand to encompass litigation interest "for further development" since 42 U.S.C. § 1395(f)(2) only authorizes the reviewing federal court (not the Board) to award litigation interest (*i.e*., it would not make sense for a federal court would not remand an issue that only it has the authority to decide) and there is no evidence it has yet even been considered in federal court.

The fact that the litigation interest issue falls outside the scope of the remand is a sufficient bases alone is to deny the Provider's EJR request for Case Nos. 06-1843, 07-1701, 08-1543, 10-0786, and 10-1178. But there is an additional basis for denial. Even if the litigation interest issue were encompassed within the remand to the Board, the EJR Request would still be improper and fatally flawed here. First, it is clear that the Provider is ***not*** challenging the *validity* of a Medicare statute or regulation. Rather, the Provider merely seeks to have a statute provision *that only may be raised and potentially apply at a subsequent appellate stage* applied at the Board level. However, the Provider is jumping the gun and asking the wrong forum to apply that statue (*i.e*., seeking redress in the wrong forum). Indeed, the Provider readily acknowledges that the Board is the wrong forum and that the federal court is the correct forum.[14] The Board must first

[14] EJR Request at 8 (stating "In addition, 42 U.S.C. §1395oo(f)(2) does not give the Board authority to award litigation interest . . . . The statute specifically provides in the last clause that litigation interest is 'to be awarded by the reviewing court in favor of the prevailing party.'").

complete the tasks directed to it upon remand.[15] Following the Board's completion of those tasks and its issuance of a final decision in these appeals, the Provider may pursue its appeal rights and, once it reaches federal court, may seek to have that statute applied for an award of interest, as relevant and appropriate.

B. Denial of Consolidated EJR Request for Case No. 11-0530

Regarding the last case, Case No. 11-0305, the Board notes that it has never progressed beyond the Board. In particular, this case was not part of the Remand Orders and no civil action in federal court has been commenced for this case. Curiously, the Provider's consolidated EJR request acknowledges in a footnote that this case was not part of the Remand Orders, but then fails to explain why a Board grant of EJR would be appropriate for this case.

Because this case has never reached federal court, any potential consideration of litigation interest for this case would be premature under the clear terms of 42 U.S.C § 1395oo(f)(2). Further, as discussed above, even if that consideration were not premature, it is not an issue suited for EJR. Again, following the Board's completion of the tasks directed to it on remand and its issuance of final decision, the Provider may pursue its appeal rights and, once it reaches federal court, may seek to have that statute applied for an award of interest, as relevant and appropriate. Accordingly, the Board also denies EJR for Case No. 11-0305.

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In summary, the Board denies the Provider's consolidated EJR request for all 6 cases. Review of this decision may be available under 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877 upon final disposition of the appeal.

Board Members Participating:

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

For the Board:

12/1/2022

X Clayton J. Nix

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

cc: Byron Lamprecht, WPS Government Health Administrators (J-8)
Wilson Leong, FSS

[15] While the parties have agreed to certain stipulations, those stipulations are not binding on the Board. Similarly, while the Board has granted the Provider's request for a record hearing, the Board could revoke that grant, upon further review of the record. The Board must complete its review of the record and complete the tasks assigned to it on remand consistent with the Seventh Circuit's decision.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***IRF/LIP Reopening Request – Reconsideration Request Denied***
Montefiore Health CY 2016-2018 Rehab LIP Groups
Case Nos. 19-1808GC, 19-1809GC, 19-1810GC, 20-0577GC, 20-0600GC, 20-0602GC, 21-1415GC, 21-1416GC, 21-1417GC

Dear Ms. Webster and Ms. Decker:

The Provider Reimbursement Review Board ("Board") has reviewed the above-referenced nine (9) common issue related party ("CIRP") group appeals involving Montefiore Health ("Montefiore") in response to the Request for Reopening and Reconsideration ("Reconsideration Request") of the Board's dismissal of these cases that was filed on October 8, 2021 by the Providers' Representative, Ropes & Gray, LLP ("Ropes & Gray"). As explained more fully below, the Board denies the request to reopen and reconsider its dismissal of these cases.

Pertinent Facts

Ropes & Gray filed a number of Montefiore CIRP group appeals with the Board appealing patient days associated with a number of different issues including: Dual Eligible Days, Medicare Advantage/Part C Days, and Post 1498-R Medicare Part A/SSI Percentage, pertaining to fiscal years 2016 through 2018.[1] In all 9 Montefiore CIRP group cases, there is only *one* participating provider. Further, each group issue concerns the Medicare Administrative Contractor's ("MAC") determination of that Provider's[2] low income percentage adjustments under the prospective payment system for inpatient rehabilitation services (hereinafter known as "IRF-LIP"), for the specific days at issue.[3]

[1] Based on the fiscal years under appeal in these groups, the Providers are subject to the substantive claim requirements of 42 C.F.R. §§ 413.24(j) and 405.1873. However, based on the Board's conclusion that the Board's review of the LIP issues in these groups is precluded by statute, the Board did not need to reach the issue of whether the Providers properly made a substantive claim per § 413.24(j) in any instances where a party challenged compliance with the regulation pursuant to § 405.1873(a). *See Request for Hearing*, at Tab 3, Issue Statement (Mar. 8, 2019), Case No. 19-1810GC; *See id.* at Case Nos. 19-1809GC, 19-1808GC, 20-0600GC, 20-0602GC, 20-0577GC, 21-1417GC, 21-1415GC, 21-1416GC.

[2] Each of these cases involved a single provider, Burke Rehabilitation Hospital, Provider No. 33-3030.

[3] *See Request for Hearing*, at Tab 3, Issue Statement (Mar. 8, 2019), PRRB Case No. 19-1810GC; *See id.* at PRRB Case nos. 19-1809GC, 19-1808GC, 20-0600GC, 20-0602GC, 20-0577GC, 21-1417GC, 21-1415GC, 21-1416GC.

On August 10, 2021, the Board reviewed the Providers' documentation in these cases on its own motion in response to the 2018 decision of the U.S. Court of Appeals for the District of Columbia Circuit ("D.C. Circuit") in *Mercy Hospital, Inc. v. Azar* ("*Mercy*").[4] In applying the June 8, 2018 *Mercy* decision, the Board notes that it was well known in that it had been issued 9 months prior to the first 3 CIRP group cases being filed on March 8, 2019 (Case Nos. 19-1808GC, 19-1809GC, 19-1810GC) and more than 3 years prior to the last 3 CIRP groups being filed on June 28, 2021 (Case Nos. 21-1415GC, 21-1416GC, 21-1417GC). Following review of the documentation, the Board found that it did not have jurisdiction to hear the Providers' Inpatient Rehab Facilities – Low Income Payment ("IRF-LIP") related issues and dismissed the instant CIRP group appeals, noting that, pursuant to 42 U.S.C. § 1395ww(j)(8), Congress has prohibited administrative and judicial review of the prospective payment rates for IRFs, including the LIP adjustment.[5] Further, the Board relied on the *Mercy* decision and noted that the D.C. Circuit's decision in *Mercy* is controlling precedent for the interpretation of 42 U.S.C. § 1395ww(j)(8) because the Providers could bring suit in the D.C. Circuit.[6]

On October 8, 2021, the group representative filed a Request for Reopening and Reconsideration with the Board, asserting that the Board improperly issued its *sua sponte* decision without affording an opportunity to be heard as to why jurisdiction is proper over these appeals.[7] Ropes & Gray then sets forth two separate reasons why the Provider's maintain the Board was incorrect in its decision to dismiss these CIRP groups.

First, Ropes & Gray makes the generally argument that the Board is incorrect in asserting that the D.C. Circuit's decision in *Mercy*, which concludes that the Medicare statute precludes review of the LIP adjustment, is dispositive. In support of this position, Ropes & Gray notes that the Provider is located in the Southern District of New York and can, accordingly, bring an action there, instead of in the D.C. District Court. In this instance, the Southern District of New York or the Second Circuit would, in turn, not be bound the D.C. Circuit's *Mercy* decision.[8] Ropes & Gray asserts that the Board itself recognizes this fact in having acknowledged that the Provider could choose to seek review outside of the U.S. District Court for the District of Columbia.[9] In further support of this possibility, Ropes & Gray asserts that the issue of whether the LIP adjustments in dispute are precluded from review is also currently being litigated in other

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[4] *Mercy Hosp., Inc. v. Azar*, 891 F.3d 1062 (D.C. Cir. 2018).
[5] Board's Jurisdictional Determination (Aug. 10, 2021), PRRB Case Nos. 19-1808GC, *et al*.
[6] As noted in footnote 9 of the August 10, 2021 Board dismissal letter, the CMS Administrator generally has applied as controlling precedent the law of the Circuit in which the Provider is located. *See, e.g., QRS CHW DSH Labor room Days Groups v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (Apr. 13, 2009), affirming, PRRB Dec. No. 2009-D11 (Feb. 27, 2009); *St. Vincent Mercy Med. Ctr. v. BlueCross BlueShield Ass'n*, Adm'r Dec. (Nov. 17, 2008), *affirming in part and reversing in part*, PRRB Dec. No. 2008-D35 (Sept. 15, 2008). However, in recognizing that providers may file suit with the appropriate District Court either in the Circuit in which they are located or the D.C. Circuit, the Administrator also applies as controlling precedent the law of the D.C. Circuit. *See, e.g., Jordan Hosp. v. Blue Cross Blue Shield Ass'n.*, Adm'r Dec. (Apr. 30, 2007), *vacating*, PRRB Dec. No. 2007-D23 (Feb. 28, 2007).
[7] Providers' Request for Reopening and Reconsideration (Oct. 8, 2021), PRRB Case Nos. 19-1808GC, *et al*.
[8] Providers' Brief, at 1-2.
[9] Board's Jurisdictional Determination, at 3, n.9 (Aug. 10, 2021), PRRB Case Nos. 19-1808GC, et al.

courts.[10] If that litigation results in another Circuit finding (as the Providers argues here) that the LIP adjustment is subject to administrative and judicial review, there would be a Circuit split that would then ultimately need to be decided by the Supreme Court.[11]

Second, Ropes & Gray argues that *Mercy* got it wrong and that review is available for the retrospectively-calculated LIP adjustment, like other adjustments adopted under the Secretary's authority to create non-statutory adjustments, because the text of the inpatient rehabilitation prospective payment statute provides that only the unadjusted rates and enumerated adjustments to those base rates are precluded from review.[12] Ropes & Gray asserts that this reading of the statute gives effect to every word and results in consistent usage throughout and that any other reading would make surplusage out of Congress's express listing of certain adjustments and create an anomalous usage of the term "prospective payment rates," which is used elsewhere in the statute to refer to unadjusted rates.[13] Ropes & Gray argues that, even if the statute were ambiguous and reasonably susceptible to divergent interpretations, it must be interpreted to allow judicial review, given the strong presumption in favor of review and narrow reading of such statutory bars.

In support of its position, Ropes & Gray asserts that, as part of the August 7, 2001 final rule,[14] the Secretary initially "promulgated a regulation [at 42 C.F.R. § 412.630] interpreting this statutory provision to preclude review of the unadjusted prospective payment rate as well as the adjustments and additional payments enumerated in the statutory provision precluding review, but not to preclude challenges to additional payments made for 'other factors' under section 1395ww(j)(3)(A)(v), including the LIP adjustment." Ropes & Gray acknowledges that as part of the August 6, 2013 final rule, the Secretary revised the 2001 regulation at § 412.630 to delete the word "unadjusted" from the phrase "review . . . . is prohibited with regard to . . . the unadjusted [f]ederal per discharge payment rates" and that the Secretary made that revision because "[a]ccording to the agency, the 2001 regulation was 'at times improperly interpreted to allow review of adjustments authorized under section 1886(j)(3)(v) of the Act,' such as the LIP adjustment. 78 Fed. Reg. at 47,900."[15] However, Ropes & Gray asserts that "[d]espite claiming that is interpretation was 'improper[],' [78 Fed. Reg. at 47,900], a decade of unbroken, uncontested practice indicates otherwise, *see Northeast Hosp.*, 657 F.3d at 15 (concluding that the Secretary's practice 'belies her claim that the revision to [a regulation] codified a longstanding policy' rather than changing it)."[16]

Finally, Ropes & Gray asserts that the agency exceeded its statutory authority in improperly calculating the Provider's LIP adjustments and, as a result, review of its action is not precluded.[17]

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[10] *See, e.g., Bethesda Health, Inc. v. Becerra*, No. 20-cv-62206 (S.D. Fla. 2021), *mot. to dismiss pending* (filed May 6, 2021 and opposed May 21, 2021).
[11] Providers' Brief, at 9.
[12] *Id*. at 2.
[13] *Id*.
[14] 66 Fed. Reg. 41316, 41360 (Aug. 7, 2001).
[15] Reconsideration Request at 5-6.
[16] Reconsideration Request at 18.
[17] *Id*.

Administrative and Judicial Review of LIP Payments:

The Medicare statute at 42 U.S.C. § 1395ww(j)(8) specifically excludes the establishment of some aspects of the inpatient rehabilitation payment system from the administrative and judicial review provided by 42 U.S.C. § 1395oo:

> (8) LIMITATION ON REVIEW. There shall be no administrative or judicial review under section 1395ff of this title, 1395oo of this title, or otherwise of the establishment of—
> (A) case mix groups, of the methodology for the classification of patients within such groups, and of the appropriate weighting factors thereof under paragraph (2) [1395ww(j)(2)],
> (B) the prospective payment rates under paragraph (3) [(1395ww(j)(3)],
> (C) outlier and special payments under paragraph (4) [1395ww(j)(4)], and
> (D) area wage adjustments under paragraph (6) [1395ww(j)(6)].[18]

In 2001, the agency promulgated a regulation interpreting this statutory provision to preclude review of the unadjusted prospective payment rate as well as the adjustments and additional payments enumerated in the statutory provision precluding review, but not to preclude challenges to additional payments made for "other factors" under section 1395ww(j)(3)(A)(v), including the LIP adjustment.[19] More specifically, the clarification expressed the agency's view that "[a]dministrative or judicial review . . . is prohibited with regard to the establishment of the methodology to classify a patient into the case-mix groups and the associated weighting factors, the unadjusted Federal per discharge payment rates, additional payment for outliers and special payments, and the area wage index."[20]

In 2013 (prior to the fiscal years at issue in these group cases), the Secretary "clarify[ied] . . . § 412.630 by deleting the word 'unadjusted' so that the regulation will clearly preclude review of "the Federal per discharge payment rates."[21] Specifically, the Agency gave the following explanation for this "clarification":

> In the original rule establishing a prospective payment system for Medicare payment of inpatient hospital services provided by a rehabilitation hospital or by a rehabilitation unit of a hospital, we stated that that there would be no administrative or judicial review,

[18] Providers' Brief, at 4-5; 42 U.S.C. § 1395ww(j)(8) (emphasis added); *see also* 42 C.F.R. § 412.630 (agency regulation reflecting no administrative or judicial review of "the establishment of," among other items, "the [f]ederal per discharge payment rates").
[19] *See* 42 C.F.R. § 412.630 (2001); 66 Fed. Reg. 41316 (Aug. 7, 2001).
[20] 66 Fed. Reg. at 41369. *See also id*. at 41393; 42 C.F.R. § 412.630 (2001).
[21] 78 Fed. Reg. 47860, 47900 (Aug. 6, 2013).

> under sections 1869 and 1878 of the Act or otherwise, of the establishment of case-mix groups, the methodology for the classification of patients within these groups, the weighting factors, the prospective payment rates, outlier and special payments and area wage adjustments. See FY 2002 IRF PPS final rule (66 FR 41316, 41319). *Our intent* was to honor the full breadth of the preclusion of administrative or judicial review provided by section 1886(j)(8) of the Act. *However, the regulatory text reflecting the preclusion of review has been at times* ***improperly*** *interpreted to allow review of adjustments authorized under section 1886(j)(3)(v) of the Act*. Because we interpret the preclusion of review at § 1886(j)(8) of the Act to apply to ***all*** payments authorized under section 1886(j)(3) of the Act, we do not believe that there should be administrative or judicial review of any part of the prospective rate. Accordingly, we are clarifying our regulation at § 412.630 by deleting the word "unadjusted" so that the regulation will clearly preclude review of "the Federal per discharge payment rates." This clarification will provide for better conformity between the regulation and the statutory language.
>
> As such, in accordance with sections 1886(j)(7)(A), (B), and (C) of the Act, we are revising the regulations at § 412.630 to clarify that administrative or judicial review under sections 1869 or 1878 of the Act, or otherwise, is prohibited with regard to the establishment of the methodology to classify a patient into the case-mix groups and the associated weighting factors, the federal per discharge payment rates, additional payments for outliers and special payments, and the area wage index.

In response to comments, the Secretary confirmed her position that the change is a clarification because "[o]ur proposed change serves to clarify the regulation so that it clearly reflects the preclusion of review found in the statute . . . . [and] removes any doubt as to the conformity of the regulation to the preclusion of review found in the statute, which by its own terms is applicable to all pending cases regardless of whether it is reflected in the regulations or not."[22] The Secretary also explained that the preclusion provision applied to the LIP adjustment to IRF-PPS:

> Section 1886(j)(8) of the statute broadly precludes review of "the prospective payment rates under paragraph (3)," that is, section 1886(j)(3). Within this section, subsection 1886(j)(3)(A) authorizes certain adjustments to the IRF payment rates and, within that, subsection 1886(j)(3)(A)(v) authorizes adjustments to the rates by such other factors as the Secretary determines are necessary to properly reflect variations in necessary costs of treatment among

[22] *Id.* at 47901.

> rehabilitation facilities.'' The LIP adjustment is made under authority of section 1886(j)(3)(A)(v). As that provision is contained within section 1886(j)(3), and the IRF payment rates under section 1886(j)(3) are precluded from review by section 1886(j)(8), the LIP adjustment falls squarely within the statutory preclusion of review. Such preclusion overcomes any presumption of reviewability that might generally apply, and it is not unconstitutional for Congress (which has the power to define the jurisdiction of the federal courts) to preclude review of certain issues as it has done here. Several virtually identical preclusions of review in other sections of the Medicare statute have been repeatedly upheld and applied by federal courts. Finally, as to notice, the proposed rule itself served as notice of our intention to revise the regulation. In addition, as discussed below, the longstanding language of the statute itself provides sufficient notice to apply the preclusion.
>
> ****
>
> In addition, the preclusion applies to all aspects of the IRF PPS payment rates, not just the formulas. Courts have applied nearly identical preclusion provisions in other parts of the Medicare statute to prevent review of all subsidiary aspects of the matter or determination protected from review. Finally, while precluding review of the IRF LIP adjustment may prevent correction of certain errors, we can only conclude that Congress has made the judgment that such a result is an appropriate trade-off for the gains in efficiency and finality that are achieved by precluding review. Similarly, although applying the preclusion here may result in certain questions being reviewable for an IPPS hospital but not an IRF, this is a judgment that Congress has made. We note that there is a preclusion of review provision in the IPPS statute also, at section 1886(d)(7). The precise contours of these preclusive provisions were for Congress to draw.[23]

The rule change became effective on October 1, 2013.[24]

In *Mercy*, the D.C. Circuit held that the statutory preclusion of review provision applied to appeals challenging the LIP payment adjustment for IRFs serving a disproportionate share of low-income patients.[25] The D.C. Circuit was not persuaded that potential agency practice prior to the 2013 clarification revealed anything about the clarity of the text of the statutory preclusion.[26] The D.C. Circuit ultimately "conclude[d] from the statute's plain language that

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[23] *Id.*
[24] *See id*. at 47860.
[25] *Mercy*, 891 F.3d at 1071.
[26] *Id.* at 1070. *See also Mercy Hosp., Inc. v. Burwell*, 206 F. Supp. 3d 93, 101-102 (D.D.C. 2016).

'prospective payment rates' means step-two rates"[27] where the first step takes place before the beginning of the fiscal year when CMS generates a standardized reimbursement rate for each discharged patient and the second step takes place after the fiscal year ends, when CMS adjusts the standardized rates to reflect the particular circumstances of each hospital for that year.[28] The D.C. Circuit further found that "[a]s 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."[29] The D.C. Circuit goes on to explain:

> And realistically, a court cannot review any of those adjustments without also reviewing the step-two rate. A flawed LIP formula would mean that a step-two rate incorporating that formula must be incorrect because that rate depends in part on the flawed formula. A hospital that asks for review of the LIP adjustment used to calculate its reimbursement would be asking the court to remand the step-two rate to be recalculated with a different LIP formula. But remanding the step-two rate would require the court to first find that incorporating a flawed LIP formula made the step-two rate improper. This is the same determination that, if a hospital directly challenged its step-two rate for relying on an improper LIP formula, would be clearly barred by paragraph (8). Designing a pleading so that it circumvents a statutory bar to review will not override Congress's decision to deny jurisdiction. *See Palisades Gen. Hosp. Inc. v. Leavitt*, 426 F.3d 400, 405 (D.C. Cir. 2005). Because reviewing a formula used by the prospective payment rate would effectively review the rate itself, we cannot review the former if we cannot review the latter.[30]

Accordingly, the D.C. Circuit affirmed the D.C. District Court's decision to dismiss the provider's challenge to the Medicare Contractor's LIP adjustments for the years at issue because the preclusion provision bars review of step-two rates and the statutory adjustments.[31]

Board Determination:

Pursuant to 42 C.F.R. § 405.1840(c)(3), as quoted below, the Board's August 10, 2021 dismissal determination became the Agency's final determination. The Provider has requested that the Board reconsider its jurisdictional dismissal and reinstate the Provider's appeal.[32] In considering

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[27] *Id.* at 1071
[28] *Id.* at 1064.
[29] *Id.* at 1067.
[30] *Id*. at 1067.
[31] *Id*. at 1071.
[32] The Provider filed its reconsideration request on October 8, 2021 (59 days after the Board's issuance of its jurisdictional determination on August 10, 2021). It is unclear whether the Provider appealed the Board's jurisdictional determination to the and/or district court. In this regard, the Board notes that 42 C.F.R. § 405.1840(c)(3), a jurisdiction decision to dismiss is in operative for 60 days and becomes the Agency's final decision if the Administrator takes no action to review.

the request, the Board reviewed the following regulations and Board Rules and determined that the Provider's request was a motion for reopening and reinstatement under Board Rule 47.1 which reflects the reopening process in 42 C.F.R. §§ 405.1885 and 405.1889:

1. 42 C.F.R. § 405.1840 which, in pertinent part, states:

> (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 <u>to grant a hearing</u>** 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. **Certain matters at issue <u>are removed</u> from jurisdiction of the Board**. These matters include, but are not necessarily limited to, the following:
>
> (1) A finding in a contractor determination that expenses incurred for certain items or services furnished by a provider to an individual are not payable under title XVIII of the Act because those items or services are excluded from coverage under section 1862 of the Act and part 411 of the regulations. . . .
>
> (2) Certain matters affecting payments to hospitals under the prospective payment system, as provided in section 1886(d)(7) of the Act and § 405.1804 of this subpart.
>
> (c) *Board's jurisdictional findings and jurisdictional dismissal decisions*. . . .
>
> (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

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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 part, no later than 60 days after the date of receipt by the provider of the Board's decision."

> 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**.[33]

2. Board Rule 7.2

> **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

[33] (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)).

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).

Example: Revised NPR workpapers and applicable cost report worksheets to document that the issue under appeal was specifically adjusted.[34]

3. Board Rule 47.1

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.[35]

The Board makes the following observations:

- The Provider's group appeal requests for these cases do not address the Board's substantive jurisdiction over the LIP-LIP issues in these CIRP groups *notwithstanding* guidance in Board Rule 7.2 and 42 C.F.R. § 405.1835(b)(1) and 405.1840, and the fact that certain aspects of the IRF IPPS, including "outlier and other special payments under

[34] (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).
[35] (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).")

paragraph (4),"[36] are excluded from administrative and judicial review pursuant to 42 U.S.C. § 1395ww(j)(8).[37]

- At least 9 months prior to the filing of these group appeals (in some cases more than 3 years), the D.C. Circuit Court of Appeals *broadly* applied this statutory provision in the June 8, 2018 *Mercy* decision which the Board discussed (and relied on) in its dismissal. Following the issuance of *Mercy*, over 200 cases involving the IRF IPPS adjustment factor known as LIP (that was the subject of *Mercy Hospital*) were either withdrawn by Provider representatives or dismissed by the Board based on the *Mercy* decision's broad application of 42 U.S.C. § 1395ww(j)(8).[38]

- Stephanie Webster is the Group Representative and filed all of these CIRP group appeals. The Board takes administrative notice that she is listed in the *Mercy* decisions as having argued the cause for the appellee provider both at the D.C. District Court and at the D.C. Circuit.[39]

In the cover letter to its motion for reopening and reinstatement, the Providers' Representative alleged that "the Board improperly issued its *sua sponte* decision without affording the Provider an opportunity to be heard as to why jurisdiction is proper over these appeals." However, the Providers' Representative did not address or explain the basis for its allegation in its briefing. Notwithstanding the lack of any explanation or citation to supporting authorities, the Board disagrees and notes that the above observations and findings in conjunction with the above regulations and Board Rules confirm that the Board did ***not*** err procedurally in issuing its jurisdictional determination dated August 10, 2021 that dismissed these 9 CIRP group cases pursuant to 42 U.S.C. § 1395ww(j)(8) and 42 C.F.R. § 412.630 as explained in *Mercy*.

The Provider has filed for reinstatement within the three-year time frame and included the documents required by Board Rules. As discussed below, the Board declines to exercise its discretion to reopen and reconsider its dismissal.

In essence, the Provider disagrees with *Mercy*. The Provider does not dispute that the *Mercy* decision is on point or that the Board's application of the *Mercy* holdings were incorrect. Rather, the Provider simply desires the Board not to apply *Mercy* at all because another Circuit could

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[36] 42 U.S.C. § 1395ww(j)(8)(C).

[37] The Provider's appeal request contains a detailed issue statements that includes references to Medicare statutory provisions and certain case law affecting disproportionate share adjustment under the inpatient prospective payment system. However, they do not discuss 42 U.S.C. § 1395ww(j)(8) notwithstanding the requirement in 42 C.F.R. § 405.1835(b)(1) that its appeal request must "demonstrat[e] that the provider satisfies the requirements for a Board hearing as specified in paragraph (a) of this section . . . ." and in § 405.1837(c)(1) that the group appeal request must "deomonstrat[e] that the request satisfies the requirements for a Board hearing as a group appeal, as specified in paragraph (a) of this section . . . ." In this regard, 42 C.F.R. § 405.1840(b) notes that a right to hearing is dependent upon substantive jurisdiction and 42 C.F.R. §§ 405.1835(b) and 405.1837(c) each allow the Board to dismiss for failure to meet the content requirement therein.

[38] The Board takes administrative notice that Providers' Representative was the designated representative in some of these dismissed cases.

[39] 891 F.3d at 1063; 206 F. Supp. 3d at 94.

potentially agree with the Provider's reading of 42 U.S.C. § 1395ww(j)(8). While the Provider could pursue the issue in an alternative Circuit, that does not mean that the *Mercy* decision does not apply to the instant appeals or is any less relevant.[40] Indeed, the Board already addressed the Provider's main point of contention in footnote 9 of the August 10, 2021 dismissal, explaining that the CMS Administrator generally has applied as controlling precedent the law of the Circuit in which the Provider is located[41] ***or*** the D.C. Circuit because, pursuant to 42 U.S.C. § 1395oo(f)(1), providers may file suit with the appropriate District Court either in the Circuit in which they are located or the D.C. Circuit.[42] As the D.C. Circuit is the only Circuit to interpret and apply the preclusion provisions at issue in these cases, the Board applied it as controlling precedent for the Board proceedings consistent with the Administrator's practice in applying Circuit decisions. The Administrator's application of the D.C. Circuit decisions as controlling precedent for Board adjudications presumably reflects that the fact that D.C. Circuit case law may impact the whole Medicare program since all U.S. providers have the right to pursue appeals from the Administrator in the D.C. Circuit.

Based on the above, the Board finds it made no error in issuing the August 10, 2021 dismissal determination; declines to exercise its discretion to reopen and reconsider that dismissal determination; and affirms that that dismissal determination remains the correct and final decision of the Board in these cases.[43] While the Board denies the Provider's Reconsideration Request, the Board notes that all supporting documentation filed along with the Reconsideration Request, as well as the Request itself, will be included in the record for these cases.

Board Members Participating:

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

For the Board:

12/1/2022

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services

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[40] Moreover, while the Board's August 10, 2021 decision did not explicitly rely on 42 C.F.R. § 412.630 (2013), the Board notes that it is otherwise bound by the Medicare regulation, and its applicability (as was explained and discussed in the *Mercy* decisions) would remain regardless of whether the Board relied on *Mercy* relative to the scope of the statutory preclusion.

[41] *See, e.g.*, *QRS CHW DSH Labor room Days Groups v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (Apr. 13, 2009), *affirming*, PRRB Dec. No. 2009-D11 (Feb. 27, 2009); *St. Vincent Mercy Med. Ctr. v. BlueCross BlueShield Ass'n*, Adm'r Dec. (Nov. 17, 2008), *affirming in part and reversing in part*, PRRB Dec. No. 2008-D35 (Sept. 15, 2008).

[42] *See, e.g., Jordan Hosp. v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (Apr. 30, 2007), *vacating*, PRRB Dec. No. 2007-D23 (Feb. 28, 2007).

[43] *See* 42 C.F.R. § 405.1840(c)(3).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Jurisdictional Decision***
Ascension Health 2011 DSH Medicare/Medicaid Medicare Advantage Days CIRP
Case No. 14-2029GC

Dear Ms. Elias and Mr. Lamprecht:

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the jurisdictional documentation in the common issue related party ("CIRP") group under Case No. 14-2029GC. The Board's decision is set forth below.

Background

The group appeal request was filed on January 27, 2014. On June 1, 2018, the Group Representative requested that CIRP group cases under Case No. 14-2029GC (entitled "Ascension Health 2011 DSH Medicare/Medicaid Medicare Advantage Days CIRP Group)[1] and Case No. 14-2033GC (entitled "Ascension Health 2011 DSH Medicaid Fraction Medicare Advantage Days CIRP Group) be consolidated into a single group, with Case No. 14-2029GC surviving.[2] On June 5, 2018, the Board granted the request, and changed the group name of Case No. 14-2029GC to "Ascension Health 2011 DSH Medicare/Medicaid Medicare Advantage Days CIRP Group."[3]

Board's Analysis and Decision

As set forth below, the Board finds that it does not have jurisdiction over the following three (3) participants in this group appeal that have appealed from revised Notices of Program Reimbursement ("NPR"):

- Seton Southwest Healthcare Center, Prov. No. 45-0865;

[1] Case No. 14-2029GC was originally entitled, "Ascension Heal, th 2011 DSH SSI Fraction Medicare Advantage Days CIRP Group," before consolidation.
[2] Providers' Request Bifurcation of Rehab Providers from Mandatory Groups into Newly Formed Mandatory Group Appeal (Jun. 1, 2018), (The request also bifurcated all Inpatient Rehabilitation Facility units from these cases into a newly formed group).
[3] Board's Bifurcation and Consolidation Letter (Jun. 5, 2018).

- Seton Medical Center Hays, Prov. No. 67-0056; and
- St. Vincent's East, Prov. No. 01-0011.

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2017), a provider has a right to a hearing before the Board with respect to specific items claimed on a timely filed cost report if: (1) it is dissatisfied with the final determination of the Medicare contractor; (2) the amount in controversy is $10,000 or more ($50,000 for a group); and (3) the request for a hearing is filed within 180 days of the date of receipt of the final determination.

The Code of Federal Regulations provides for an opportunity for a reopening and revised NPR at 42 C.F.R. § 405.1885 (2017), which provides in relevant part:

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

Additionally, 42 C.F.R. § 405.1889 (2017)[4] explains the effect of a cost report revision:

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

42 C.F.R. § 405.1835(a) explains a provider's right to appeal to the Board and specifically references § 405.1889:

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

> (a) *Right to hearing on final contractor determination*. A provider . . . has a right to a Board hearing, as a single provider appeal, with respect to a final contractor or Secretary determination for the provider's cost reporting period, if -
>
> (1) The provider is dissatisfied with the contractor's final determination of the total amount of reimbursement due the provider, as set forth in the contractor's written notice specified under § 405.1803. **Exception**: If a final contractor determination is reopened under § 405.1885, **any review by the Board must be limited solely to those matters that are specifically revised in the contractor's revised final determination** (§§ 405.1887(d), 405.1889(b), and the "Exception" in § 405.1873(c)(2)(i)).[5]

A. St. Vincent's East, Prov. No. 01-0011, FYE 6/30/2011

On July 14, 2014, the MAC issued a Notice of Intent to Reopen Cost Report:

> ln accordance with this Regulation, in the event of an unfavorable final non -appealable decision in Allina Health Services v. Sebelius, the cost report will be reopened to adjust the Disproportionate Share payment calculation.

On August 11, 2014, the Provider submitted a reopening for additional bad debts that include crossover bad debts and "[a]dditional DSH days."

Subsequently, on November 18, 2015, the Medicare Contractor issued a "Corrected NOR" captioned as a Notice of Reopening of Cost Report – REVISED. The caption of this letter indicated that the previous notice of reopening was corrected or revised to pertain to the following:

> [W]e are hereby reopening your cost report for the following reasons:
>
> - To include additional Medicaid days not originally included in the cost report.
> - To include Part A and Part B crossover bad debts not originally included in the cost report.
> - To include FTE's previously disallowed for improper support of offsite rotations.
> - To adjust the DSH% based upon the allowance of additional Medicaid days.

On December 31, 2015, the Medicare Contractor concluded the reopening by issuing the Provider's revised NPR. The audit adjustment report included in the record was one page and

[5] (Emphasis added.)

included 5 adjustments. Two adjustments pertain to allowable FTEs related to graduate medical education and another related to bad debts. The remaining two were DSH related. Audit Adjustment No. 1 was made "[t]o include additional Medicaid days on the cost report" (specifically it added 33 Medicaid days); and Audit Adjustment No. 5 increased the DSH percentage by 0.03 and was described as follows: "We have adjusted the allowable DSH % to the audited amounts in accordance with PRM-2, Section 4030.1 and 42 CFR 412.106(d)." Thus, the DSH percentage was adjusted to reflect the addition of 33 Medicaid days to the Medicaid fraction, as used in the DSH percentage.

Based on these documents, the Board finds that it does not have jurisdiction over the Part C Days issue for Provider No. 01-0011. Although the first Notice of Reopening indicates that the MAC may reopen the Provider's cost report for *Allina*, neither the revised Notice of Reopening nor the audit adjustment report reference *Allina* or Part C days. More importantly, if there had been any adjustment for Part C Days, then there would have been an adjustment to the SSI percentage; however, there was no adjustment to the SSI fraction reflected in the Audit Adjustment Report. Rather, there the adjustment to DSH reflect the addition of 33 Medicaid eligible days as addressed in the revised Notice of Reopening.

As Part C days were not adjusted in the revised NPR as required by 42 C.F.R. § 405.1889, the Board finds that it does not have jurisdiction over St. Vincent's East, because, pursuant to § 405.1889(b), the Provider did not have a right to appeal the revised NPR for the Part C days issue. In making this ruling, the Board notes that its application of 42 C.F.R. § 405.1889(b) has been upheld by courts on review.[6] Accordingly, the Board dismisses St. Vincent's East from Case No. 14-2029GC.

B. Seton Medical Center Hays, Prov. No. 67-0056, FYE 6/30/2011

On February 2, 2017, the Provider requested reopening: (1) "to recalculate the SSI percentage based on the Hospital's fiscal year rather than the federal fiscal year"; and (2) for "the inclusion of an additional 99 Medicaid labor and delivery (L&D) days" as "[t]hese days were filed on Worksheet S-3 Part I line 32, column 7 and erroneously omitted from Worksheet S-2 Part I line 24, column 6."

On April 11, 2017, the Medicare Contractor issued a Notice of Reopening:

- To include an additional 99 Medicaid (L&D) Eligible Days on WS S-2 Part 1 that was not included on the original NPR, and to update E Part A to the correct DPP percentage.
- To incorporate settlement amounts from the previous cost report settlement to ensure proper determination of payments, as necessary.

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

- To address cost report software updates and edits and correct cost report mathematical and flow errors, as necessary.

On May 3, 2017, the Medicare Contractor issued a Notice of Reopening:

- To update the SSI percentage and DSH payment percentage per Provider's request to recalculate the SSI percentage using their cost report Fiscal Year. A request will be submitted to CMS.
- To incorporate settlement amounts from the previous cost report settlement to ensure proper determination of payments, as necessary.
- To address cost report software updates and edits and correct cost report mathematical and flow errors, as necessary.

On August 18, 2017, the Medicare Contractor issued the Revised NPR to reflect the adjustments referenced in the May 3, 2017 Notice of Reopening. The Audit Adjustment Report is one page and, of 5 adjustments listed thereon, only one pertains to DSH. Specifically, Audit Adjustment No. 4 was "[t]o incorporate the Recalculated SSI Percentage based on Provider's Fiscal Year."

The Board has consistently found that it does not have jurisdiction over revised NPRs that were issued as a result of a provider's request for realignment of its SSI percentage. As noted in 42 C.F.R. § 412.106(b)(2), CMS gathers data to be used in the SSI fraction on a month-by-month basis:

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

> (A) Are associated with discharges that occur during that period; and
>
> (B) Are furnished to patients entitled to Medicare Part A (including Medicare Advantage (Part C)).[7]

The data matching process by which CMS gathers this *monthly* data is described in the FY 2011 IPPS Final Rule.[8] As described in the Federal Register, under the realignment process, CMS calculates the SSI fraction using the *previously-gathered* data for the months included in the published SSI fractions for 2 Federal fiscal years that encompass the hospital's cost reporting period:

1. *75 Fed. Reg. 50042, 50279 (Aug. 16, 2010)*.—"[W]e publish these [SSI fraction] data for every hospital based on the Federal fiscal year but, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived *from the data match process* ***for the two Federal fiscal years that spanned the hospital's cost reporting period***."[9]

2. *70 Fed. Reg. 47278, 47439 (Aug. 12, 2005)*.—"Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period, and *the hospital* ***must accept*** *the resulting DSH percentage for that year, whether or not it is a more favorable number than the DSH percentage based on the Federal fiscal year*. . . .

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

[7] (Emphasis added.)
[8] 75 Fed. Reg. 50042, 50275-85 (Aug. 16, 2010).
[9] (Emphasis added.)

> *fraction determined on the basis of its fiscal year rather than a Federal fiscal year*. The data set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year."[10]

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

In other words, the determination was only being reopened to include realigned SSI percentages. Since the only matters specifically revised in the revised NPR was the adjustment to realign the SSI percentage from the federal fiscal year to the provider's fiscal year, the Board does not have jurisdiction over the revised NPR appeal of the DSH Part C days issue. In making this ruling, the Board notes that its application of 42 C.F.R. § 405.1889(b) has been upheld by courts on review.[11]

As Part C days were not adjusted in the revised NPR as required by 42 C.F.R. § 405.1889, the Board finds that it does not have jurisdiction over Seton Medical Center Hays because, pursuant to § 405.1889(b), the Provider did not have a right to appeal the revised NPR for the Part C days issue. Accordingly, the Board dismisses Seton Medical Center Hays from Case No. 14-2029GC.

C. Seton Southwest Healthcare, Prov. No. 45-0865, FYE 6/30/2011

On October 5, 2016, the Medicare Contractor issued a Notice of Reopening:

- To update the SSI percentage and DSH payment percentage per Provider's request to recalculate the SSI percentage using their cost report Fiscal Year. A request will be submitted to CMS.
- To incorporate settlement amounts from the previous cost report settlement to ensure proper determination of payments, as necessary.
- To address cost report software updates and edits and correct cost report mathematical and flow errors, as necessary.

On July 11, 2017, the Medicare Contractor issued the Revised NPR to reflect the adjustments referenced in the October 5, 2016 Notice of Reopening. The Audit Adjustment Report is two pages and, of 8 adjustments listed thereon, three pertain to DSH. Specifically, Audit Adjustment

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

No. 4 was "[t]o update the eligibility for DSH;" No. 6 was "[t]o update the SSI percentage per CMS release;" and, No. 7 was "[t]o update the allowable Percentage."

It appears as if the request for realignment may have pushed the provider over the threshold for DSH qualification.

The Board has consistently found that it does not have jurisdiction over revised NPRs that were issued as a result of a provider's request for realignment of its SSI percentage. As noted in 42 C.F.R. § 412.106(b)(2), CMS gathers data to be used in the SSI fraction on a month-by-month basis:

> (2) *First computation: Federal fiscal year*. **For each month** of the Federal fiscal year in which the hospital's cost reporting period begins, CMS -
>
> (i) Determines the number of patient days that -
>
> (A) Are associated with discharges occurring **during each month**; and
>
> (B) Are furnished to patients who **during that month** were entitled to both Medicare Part A (including Medicare Advantage (Part C)) and SSI, excluding those patients who received only State supplementation;
>
> (ii) Adds the results for the whole period; and
>
> (iii) Divides the number determined under paragraph (b)(2)(ii) of this section by the total number of days that -
>
> (A) Are associated with discharges that occur during that period; and
>
> (B) Are furnished to patients entitled to Medicare Part A (including Medicare Advantage (Part C)).[12]

The data matching process by which CMS gathers this *monthly* data is described in the FY 2011 IPPS Final Rule.[13] As described in the Federal Register, under the realignment process, CMS calculates the SSI fraction using the *previously-gathered* data for the months included in the published SSI fractions for 2 Federal fiscal years that encompass the hospital's cost reporting period:

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[12] (Emphasis added.)
[13] 75 Fed. Reg. 50042, 50275-85 (Aug. 16, 2010).

3. *75 Fed. Reg. 50042, 50279 (Aug. 16, 2010)*.—"[W]e publish these [SSI fraction] data for every hospital based on the Federal fiscal year but, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived *from the data match process* ***for the two Federal fiscal years that spanned the hospital's cost reporting period***."[14]

4. *70 Fed. Reg. 47278, 47439 (Aug. 12, 2005)*.—"Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period, and *the hospital* ***must accept*** *the resulting DSH percentage for that year, whether or not it is a more favorable number than the DSH percentage based on the Federal fiscal year*. . . .

   Beginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108–173), we will arrange to furnish, consistent with the Privacy Act, MedPAR LDS data for a hospital's patients eligible for both SSI and Medicare at the hospital's request, regardless of whether there is a properly pending appeal relating to DSH payments. *We will make the information available for either the Federal fiscal year or, if the hospital's fiscal year differs from the Federal fiscal year, for the* ***months*** ***included in the 2 Federal fiscal years that encompass the hospital's cost reporting period***. Under this provision, *the hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year*. The data set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year."[15]

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

[14] (Emphasis added.)
[15] (Emphasis added.)

In other words, the determination was only being reopened to include realigned SSI percentages. Since the only matters specifically revised in the revised NPR was the adjustment to realign the SSI percentage from the federal fiscal year to the provider's fiscal year, the Board does not have jurisdiction over the revised NPR appeal of the DSH Part C days issue. In making this ruling, the Board notes that its application of 42 C.F.R. § 405.1889(b) has been upheld by courts on review.[16]

As Part C days were not adjusted in the revised NPR as required by 42 C.F.R. § 405.1889, the Board finds that it does not have jurisdiction over Seton Medical Center Hays because, pursuant to § 405.1889(b), the Provider did not have a right to appeal the revised NPR for the Part C days issue. Accordingly, the Board dismisses Seton Southwest Healthcare, Prov. No. 45-0865, from Case No. 14-2029GC.

Conclusion

The Board finds that it does not have jurisdiction over the revised NPR appeals of St. Vincent's East (Prov. No. 01-0011, FYE 6/30/2011), Seton Medical Center Hays (Prov. No. 67-0056, FYE 6/30/2011), and Seton Southwest Healthcare Center (Prov. No. 45-0865, FYE 6/30/2011) because, pursuant to 42 C.F.R. § 405.1889, each of these providers they did not have a right to appeal the group issue from the relevant revised NPR. Accordingly, the Board hereby dismisses the revised NPR appeal of these Providers from Case No. 14-2029GC. The remaining providers in the case will be remanded pursuant to CMS Ruling 1739-R under separate cover.

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

Board Members Participating:

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

For the Board:

12/2/2022

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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410-786-2671

Via Electronic Delivery

Nan Chi
Houston Methodist Hospital System
8100 Greenbriar, GB 240
Houston, TX 77054

RE: ***Jurisdictional Decision***
Houston Methodist San Jacinto Hospital (Prov. No. 45-0424)
FYE 12/31/2005
Case No. 16-2019

Dear Ms. Chi,

The Provider Reimbursement Review Board ("Board") has reviewed the jurisdictional documents in the above referenced appeal pursuant to a jurisdictional challenge filed by the Medicare Contractor ("MAC"). The jurisdictional decision of the Board is set forth below.

Background:

A. Procedural History for Case No. 16-2019

On July 12, 2016, Houston Methodist San Jacinto Hospital, appealed a Revised Notice of Program Reimbursement ("RNPR") dated January 12, 2016, for its fiscal year ending December 31, 2005 ("FY 2005"). The appeal request contained the following issues:

- 1) DSH SSI-Provider Specific
- 2) DSN SSI-Systemic Errors
- 3) DSH SSI-Medicare Managed Care Part C Days
- 4) DSH SSI Fraction/Dual Eligible Days
- 5) DSH Medicaid Fraction/Part C Days
- 6) DSH Medicaid Fraction/Dual Eligible Days
- 7) Capital IME and DSH[1]

However, the appeal request did not the reopening notice associated with the RNPR. The appeal request did include a copy of the audit adjustment report which revises the SSI percentage, and updates the DSH %, based on the SSI percentage change (1498-R table attached to the adjustment report reduces the SSI % from 9.61 to 9.60)

[1] Provider's Request for Hearing, Tab 3, at Issue Statement (Jul. 12, 2016).

On May 9, 2018, the Medicare Contractor filed a Jurisdictional Challenge regarding Issue Nos. 1, 2, 5, and 6, addressing the DSH Supplemental Security Income ("SSI") Percentage related issues.[2] The Provider transferred Issues 2 through 6 to other groups, and in particularly transferred Issue 2 (the DSH Systemic Errors) to Case No. 17-1077GC. After the transfers, Issues 1 and 7 are the sole remaining issues. Significantly, the Provider did ***not*** file a response to the Jurisdictional Challenge within the 30 days allotted under Board Rule 44.4.3 which specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

The Board, on its own motion, is reviewing jurisdiction over Issue 7. This determination will not address the challenge to Issues 5 and 6, as those issues were previously transferred to group appeals, and will be handled in those group appeals.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 17-1077GC

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

> The Provider contends that the MAC did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the MAC's calculation of how the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations.
>
> The provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both 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).[3]

[2] MAC's Jurisdictional Challenge, at 1 (May 9, 2018).
[3] Provider's Request for Hearing, Issue Statement (Sep. 14, 2021).

As the Provider is commonly owned by Houston Methodist, the Provider also appealed the DSH SSI System Errors issue, and transferred that issue to the common issue related party ("CIRP") group under Case No. 17-1077GC entitled "QRS Houston Methodist 2005 DSH SSI Percentage CIRP Group." Issue #2, Systemic Errors has the following issue statement:

> **Statement of the Issue:**
>
> Whether the Secretary properly calculated the Provider's [DSH]/[SSI] percentage, and whether CMS should be required to recalculate the SSI percentage.
>
> **Statement of the Legal Basis**
>
> The Provider(s) contend(s) that the MAC's determination for their DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww(d)(5)(F)(vi). The Provider(s) further contend(s) that the SSI percentages calculated by [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. 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.[4]

The amount in controversy listed for both issues 1 and 2 are $45,475.

The group issue statement for 17-1077GC, the issue statement is as follows:

> **Statement of the Issue:**
>
> Whether the Medicare/SSI fraction used in the Medicare DSH 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. 1395(d)(5)(F)(vi).
>
> **Statement of the Legal Basis**

[4] Group Issue Statement, Case No. 21-1724GC.

> The Provider(s) contend(s) that the Lead MAC's determination for their DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww(d)(5)(F)(vi). The Provider(s) further contend(s) that the SSI percentages calculated by [CMS] and used by the MAC to settle their Cost Reports incorporates a new methodology inconsistent with the Medicare statute.
>
> 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.
>
> Providers in this case are also seeking resolution of the following additional aspects of the Medicare fraction that were not addressed in the Baystate case:
>
> 1. Availability of MEDPAR and SSA records,
> 2. Failure to adhere to required notice and comment rulemaking procedures,
> 3. Fundamental problems in the SSI percentage calculation,
> 4. Not in agreement with provider's records,
> 5. Paid days vs. Eligible Days, and
> 6. Covered days vs. Total days.[5]

MAC's Contentions:

The MAC contends that issues 1 and 2 are duplicative issue, as both refer to the MedPar data. concerning SSI data accuracy should be dismissed because it is duplicative of Issue 2.

Provider's Response:

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

[5] Group Issue Statement, Case No. 21-1724GC.

Board Decision:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2014), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

A. SSI 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 (Systemic Errors) issue transferred to Group case no. 17-1077GC, "*QRS Houston Methodist 2005 DSH SSI Percentage CIRP Group"*.[6]

The Board finds that the first aspect of Issue 1 (the DSH/SSI (Provider Specific) issue) in this appeal is duplicative of Issue 2 (the DSH/SSI (Systemic Errors) issue) that was transferred to Case No. 17-1077GC. The first aspect of Issue 1 in the present appeal concerns "whether the Medicare Administrative Contractor used the correct [SSI] percentage in the [DSH] Calculation."[7] The Provider's legal basis for this aspect of Issue 1 is simply that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[8] Similarly, the Provider argues that "it[s] SSI percentage published by [CMS] was incorrectly computed . . ." and it ". . . [s]pecifically . . . disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[9] Issue 2, transferred to the group under Case No. 17-1077GC, similarly alleges that the Medicare Contractor and CMS improperly calculated the DSH/SSI Percentage, the DSH/SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F)(i). Indeed, the Provider has the ***same*** amount in controversy for both Issue 1 and 2, that was transferred to 17-1077GC, namely $45,475.

Thus, the Board finds that the first aspect of Issue 1 in this appeal is duplicative of Issue 2 in Case No. 17-1077GC. Because the issue is duplicative, and duplicative issues appealed from the

[6] *See* Request to Transfer Issue, Model Form D (Feb. 23, 2017), PRRB Case No. 16-2019.
[7] Individual Appeal Request, Issue 2.
[8] *Id.*
[9] *Id.*

same final determination are prohibited by Board Rule 4.5 (Mar. 1, 2013), the Board dismisses this aspect of the DSH/SSI (Provider Specific) issue.

In making this finding, the Board further notes that CMS regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, is pursuing that issue as part of the group under Case No. 17-1077GC. 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 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. 17-1077GC. Moreover, the Provider failed to respond to the Jurisdictional Challenge to otherwise make this clarification.[11]

Accordingly, the Board must find that Issue 1 is the same issue as (and, thus, duplicative of) Issue 2, which was transferred to the CIRP group under Case No. 17-1077GC. Because Issue 1 is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (2015), the Board dismisses this component of Issue 1, the DSH/SSI (Provider Specific) issue.

Even outside of that, there is additional bases upon which to dismiss this aspect of Issue 1. The Board notes that the Provider appealed from an RNPR. While the Provider submitted a copy of the audit adjustment report, the Provider failed to include a copy of the notice of reopening. As a result, the record is unclear why the cost report was reopened. Without that additional information, the Board cannot determine whether the SSI fraction was adjusted for Issue 1 as required by 42 C.F.R. § 405.1889 and must dismiss because the Provider has failed to establish Board jurisdiction under 42 C.F.R. § 405.1889. Indeed, the fact that the adjustment ***decreased*** the SSI percentage by 0.1 suggests that there was minimal adjustment or change and suggests that the SSI percentage was likely realigned from the federal fiscal year to the Provider's fiscal year. In those situations, the Board has consistently found that it does not have jurisdiction over RNPRs that were issued as a result of a provider's request for realignment of its SSI percentage. As noted in 42 C.F.R. § 412.106(b)(2), CMS gathers data to be used in the SSI fraction on a month-by-month basis:

> (2) *First computation: Federal fiscal year*. **For each month** of the Federal fiscal year in which the hospital's cost reporting period begins, CMS -

[10] 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).

[11] At this time, no Final Position Paper has yet been submitted, and the filing of the Preliminary Position Paper was limited to the cover page consistent with Board Rules then in effect.

> (i) Determines the number of patient days that -
>
> (A) Are associated with discharges occurring **during each month**; and
>
> (B) Are furnished to patients who **during that month** were entitled to both Medicare Part A (including Medicare Advantage (Part C)) and SSI, excluding those patients who received only State supplementation;
>
> (ii) Adds the results for the whole period; and
>
> (iii) Divides the number determined under paragraph (b)(2)(ii) of this section by the total number of days that -
>
> (A) Are associated with discharges that occur during that period; and
>
> (B) Are furnished to patients entitled to Medicare Part A (including Medicare Advantage (Part C)).[12]

The data matching process by which CMS gathers this *monthly* data is described in the FY 2011 IPPS Final Rule.[13] As described in the Federal Register, under the realignment process, CMS calculates the SSI fraction using the *previously-gathered* data for the months included in the published SSI fractions for 2 Federal fiscal years that encompass the hospital's cost reporting period:

1. *75 Fed. Reg. 50042, 50279 (Aug. 16, 2010)*.—"[W]e publish these [SSI fraction] data for every hospital based on the Federal fiscal year but, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived *from the data match process* ***for the two Federal fiscal years that spanned the hospital's cost reporting period***."[14]

2. *70 Fed. Reg. 47278, 47439 (Aug. 12, 2005)*.—"Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period, and *the hospital* ***must accept*** *the resulting DSH percentage for that year, whether or not it is a more favorable number than the DSH percentage based on the Federal fiscal year. . . .*

[12] (Emphasis added.)
[13] 75 Fed. Reg. 50042, 50275-85 (Aug. 16, 2010).
[14] (Emphasis added.)

> Beginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108–173), we will arrange to furnish, consistent with the Privacy Act, MedPAR LDS data for a hospital's patients eligible for both SSI and Medicare at the hospital's request, regardless of whether there is a properly pending appeal relating to DSH payments. *We will make the information available for either the Federal fiscal year or, if the hospital's fiscal year differs from the Federal fiscal year, for the* ***months*** ***included in the 2 Federal fiscal years that encompass the hospital's cost reporting period***. Under this provision, *the hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year*. The data set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year."[15]

Accordingly, the realignment process does not change any of the data underlying the realigned SSI fraction (*e.g*., Part C days or Part A days) because that data had been previously gathered on a month-by-month basis and *there is no need for CMS to rerun the data matching process* in order to effectuate a realignment (*i.e*., realigning the SSI fraction from the federal fiscal year to the provider's fiscal year). Indeed, as noted in the second Federal Register excerpt, CMS' stated realignment policy is that the provider "must accept" the realigned SSI percentage. Accordingly, had the provider wanted to appeal issues such as this it should have appealed the issue from its original RNPR.[16]

In summary, there are 2 separate bases by which the Board may dismiss Issue 1, one is procedural (a prohibited duplicate) and the other is jurisdictional (failure to establish that the requirements of an RNPR appeal § 405.1889 had been met).

2. Second Aspect of Issue 1

The second aspect of the DSH SSI Percentage (Provider Specific) issue—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—must be dismissed for lack of jurisdiction and as premature. Under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request…" Without this written request, the Medicare Contractor cannot issue a final determination from which the Provider can be dissatisfied with for appealing purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding the Provider's DSH SSI Percentage realignment as such there is no "determination" to appeal and the appeal of this issue is otherwise premature.

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[15] (Emphasis added.)

[16] The Board will conduct a similar review of its jurisdiction over Issue 2 in the context of the group to which it was transferred, Case No. 17-1077GC.

B. Capital IME and DSH

The Board dismisses the Capital IME and DSH IME as a "flow-through issue" in Issue 7 as being in violation of the Board Rules. In the appeal request, the Provider simply describes the issue as "ask[ing] the MAC to incorporate the resolution of the DSH issues (1 thru 6 above) to the determination of the Capital reimbursement amount" and estimated the reimbursement impact as $1,546.

A provider is entitled to a hearing before the Board if (1) such provider is dissatisfied with a final determination of the Medicare Contractor as to its amount of total program reimbursement due the provider; (2) the amount in controversy is $10,000 or more; and, (3) such provider files a request for a hearing within 180 days after notice of the final determination.[17] The related regulations and Board rules describe in more detail what is required in order to file a hearing request with the Board. 42 C.F.R. § 1841 states in pertinent part:

> Such request for Board hearing must identify the aspects of the determination with which the provider is dissatisfied, explain why the provider believes the determination is incorrect in such particulars, and be accompanied by any documenting evidence the provider considers necessary to support its position.

The Board Rules state, "[f]or each issue under appeal, give a brief summary of the determination being appealed and the basis for dissatisfaction."[18] Board Rule 7.1(A) requires a concise issue statement describing the adjustment, including the adjustment number; why the adjustment is incorrect; and, how the payment should be determined differently.[19] Alternatively, if the Provider does not have access to the underlying information, it is to describe why that information is not available.[20] These requirements are reiterated in Model Form A, the Individual Appeal Request form, which was utilized by the Provider to file its appeal.[21] Model Form A provides that:

> The statement of the issue(s) must conform to the requirements of the regulations found at 42 C.F.R. § 405.1835 et seq. and the Board's Rules and must include: (1) a description of the issue; (2) the audit adjustment number(s), if applicable, or other evidence required by 42 C.F.R. § 405.1835 (a)(1)(ii); (3) the amount in controversy; and (4) a statement identifying the legal basis for the appeal (with citation to statutes, regulations and/or manual provisions).[22]

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[17] 42 U.S.C. § 1395oo(a).
[18] PRRB Board Rules, Rule 7 (Mar. 1, 2013).
[19] *Id.* at 7.1A.
[20] *Id*. at 7.1B.
[21] *See* Model Form A, PRRB Board Rules, at 48-51.
[22] *Id*. at 50. (Section 8 of Model Form A describes the requirements for appealed issues).

The Provider did not appeal a specific issue, but rather a "flow-through effect" from any DSH adjustments. The Provider did not cite to any audit adjustments or even describe how it determined the $1546 amount in controversy for this issue.[23] Because the appeal is from an RNPR, it is imperative that an audit adjustment occur since Board jurisdiction over RNPR appeals is limited to those issues specifically adjusted in the RNPR as explained at 42 C.F.R. § 405.1889(b) (2016):

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

Moreover, the Provider failed to sufficiently identify the issue that is in dispute, in violation of the appeal content requirements at 42 C.F.R. § 405.1835(b) and the Board Rules 7 and 8.[24] Accordingly, the Board dismisses Issue 7 both for failure to establish Board jurisdiction under 42 C.F.R. § 405.1889[25] as well as the for the failure of the Provider's appeal request to comply with the appeal content requirements for this issue as set forth at 42 C.F.R. § 405.1835(b) and the Board Rules 7 and 8.

Conclusion:

The Board dismisses Issue 1, the DSH/SSI (Provider Specific) issue, and Issue 7, the Capital IME and DSH "recalculation" issue, in their entirety from this appeal. As there are no remaining issues in the appeal, Case No. 16-2019 will be closed and removed from the Board's docket.

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

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[23] This issue appears to be an amalgamation of multiple flow through items and there is no demarcation of any of them except for Capital IME which showed ***no*** change (i.e., did not list an amount in controversy for Capital IME flow through). Moreover, IME is not listed anywhere else in the appeal request and, as such, it is unclear what is in dispute in this issue. *See also supra* note 25.

[24] In particular, Board Rule 7 states that "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. *See* subsections below and Rule 8 for special instructions regarding multi-component disputes." (Emphasis in original.) Similarly, Board Rule 7.2.1 states that *each* issue raised in the appeal request must describe "the relevant adjustment(s), including the audit adjustment number(s), . . . why the adjustment is incorrect, how the payment should be determined differently, the reimbursement effect, and the basis for jurisdiction before the Board." Finally Board Rule 8 states: "Some issues may have multiple components. To comply with the requirements of 42 C.F.R. § 405.1835, appeal requests must specifically identify the items in dispute, and each contested component must be appealed as a separate issue and described as narrowly as possible using the applicable format outlined in Rule 7."

[25] The Board anticipates that it will deny jurisdiction over all issues in this appeal (Issues 1 through 7) for lack of jurisdiction under 42 C.F.R. § 405.1889. As Issues 2, 3, 4, 5, and 6 were transferred to groups, the Board will address its jurisdiction over those issues as part of the group appeals.

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For the Board:

12/2/2022

X Clayton J. Nix

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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RE: ***Board Decision to Dismiss***
Ashford Hall, Inc. (Prov. No. 45-5748)
Appealed Period: 5/01/2020 to 5/31/2020
Cost Reporting Periods Affected: 10/01/2019, 9/30/2020
Case No. 21-0223

Dear Mr. Daucher,

The Provider Reimbursement Review Board ("Board") has reviewed the documents in the above referenced appeal and finds that it does not have jurisdiction over the Coronavirus Aid, Relief, and Economic Security ("CARES") Act and the Paycheck Protection Program and Health Care Enhancement Act ("PPPHCE") Relief Fund Distribution payment. The decision of the Board to **dismiss** this case is set forth below.

Pertinent Facts:

The Board received the Provider's Request for Hearing dated November 18, 2020. The Provider filed a preliminary position paper on July 14, 2021 and the MAC filed a preliminary position paper on October 19, 2021.

The Provider's Preliminary Position Paper describes the issue as: "Whether the U.S. Department of Health & Human Services ("HHS") erred in its original Skill Nursing Facility Relief Fund Distribution, by materially underpaying provider Ashford Hall, Inc."[1] The Provider received a payment on May 22, 2020, under the CARES Act and the PPPHCE Act.[2] The federal government enacted the CARES Act specifically "to mitigate the negative economic impact of COVID-19 on providers."[3]

The Provider is appealing an underpayment of its original relief fund distribution amount, specifically, the number of its licensed bed was incorrectly reported due to a "clerical error" which resulted in the underpayment.[4] The Provider argues it is entitled to "$2,500.00 on each of

[1] Provider's Preliminary Position Paper (hereinafter "Provider's PPP") at 1
[2] MAC Jurisdictional Challenge at 1.
[3] Provider's PPP at 3.
[4] MAC Jurisdictional Challenge at 1.

232 additional beds (undercounted due to CMS data error), for a total further payment of $580,000.00"[5]

On October 12, 2021, the Medicare Administrative Contractor ("MAC") filed a jurisdictional challenge on October 12, 2021, stating that the Relief Fund Distribution payment on appeal is not a Medicare Payment as set forth in 42 U.S.C. § 1395oo(a) and 42 C.F.R. § 405.1835(b)(2). The MAC requests that the Board dismiss the issue.

On November 11, 2021, Ashford Hall ("Ashford" or "Provider") timely filed a response to the MAC's jurisdictional challenge.

The MAC also filed substantive claim letter on October 12, 2021, arguing the Provider's cost report does not include an appropriate claim for the specific item on appeal.

MAC's Jurisdictional Challenge:

The MAC argues that funds derived from the CARES and PPPHCE Act are administered and distributed by the Health Resources Services Administration ("HRSA") through the Provider Relief Fund ("PRF").[6] The Provider Relief Fund "provides direct payments for "eligible providers who diagnose, test or care for individuals with possible or actual cases of COVID19 and have health care related expenses and lost revenues attributable to COVID-19"[7]

The sole issue in the Provider's appeal is an underpayment of its Provider Relief Fund Distribution Payment. However, the MAC argues that PRF payments are not considered Medicare program reimbursement. The MAC is challenging jurisdiction over this issue as it is not a Medicare Payment as defined by 42 U.S.C. § 1395oo(a) and 42 C.F.R. § 405.1835(b)(2).

The MAC explains that PRF payments are separate and distinct from Medicare payments and the Board's jurisdiction is limited to Medicare Program Payments:

> 42 C.F.R. § 405.1835(b)(2) requires:
>
> (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).

[5] Provider's PPP at 2.
[6] MAC Jurisdictional Challenge at 4.
[7] *Id* at 4.

> (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 § 413.240) 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.[8]

According to the MAC, because the PRF payments at issue do not qualify as a "Medicare payment," the Provider cannot satisfy the requirements for a Board hearing according to 42 C.F.R. 405-1835(b)(2).[9] The MAC argues:

> In order to trigger the provider's right to a Board hearing, the regulations expressly require a provider to include an account of: (1) why "Medicare payment is incorrect for each disputed item"; and (2) how and why "Medicare payment must be determined differently for each disputed item.[10]

Additionally, the FAQ section of the HHS website, outlines an established process to appeal a dispute of PRF payments. The MAC concludes that the Board is not an appropriate venue for PRF payment disputes and the Provider should seek a remedy through the HHS appeals process.

Provider's Response to Jurisdictional Challenge:

On November 11, 2021, the Provider filed a response to the MAC's Jurisdictional Challenge. The Providers argue that, "due to nothing more than a data entry error by CMS in 2019, CMS relied upon erroneous data (reported beds of 98 instead of the correct, longstanding number of 330) in calculating Provider's payment, paying provider only $295,000.00 instead of $875,000.00, shorting provider by $580,000.00."[11]

42 U.S.C. § 1395oo allows the Board to review appeals of final determinations of provider payments as long as the jurisdictional prerequisites are met. The Provider argues the Phase 1 payments were a final determination because "it was (1) made by HHS, (2) to a Medicare provider, resulting in (3) a distribution dependent on CMS methodology"[12] The Provider maintains these jurisdictional requirements have been met and this matter is properly within the jurisdiction of the Board.

The Provider maintains nothing in 42 U.S.C. § 1395oo(a) uses the words "Medicare Payment" as a jurisdictional limitation. "The MAC suggests that PRRB review under section 1395oo(a) is limited to "Medicare Payments," but that language is notably absent from the statute. Instead,

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[8] 42 C.F.R. § 405.1835(b)(2).
[9] Provider's Jurisdictional Response at 5.
[10] *Id.*
[11] *Id.* at 3.
[12] *Id.* at 7.

section 1395oo allows for review of a final determination of any organization serving, with respect to such payment."[13]

The MAC fails to specify any other viable relief despite knowing the underpayment was a result from CMS' "own proximate data entry error on the Provider's bed count"[14] The Provider explains it made several attempts to contact "various divisions of CMS/HHS, United Healthcare, HRSA, Texas Nursing Home Association, and AHCA, and the CARES Act assistance number (managed by CMS) to remedy its error."[15]

The Provider concludes that the MAC is suggesting to pursue a Phase 3 appeal process, however, it only applies to incorrect payment calculations under "phase 3" and the Provider's appeal involves an error to phase 1 payments.

Board Decision:

Congress established Board appeals by codifying 42 U.S.C. § 1395oo as part of the Social Security Amendments of 1972. Significantly, the Board's governing statue is located in 42 U.S.C. Ch. 7, Subch. XVIII which governs the Medicare program. Under subsection (a) of the Board's governing statute, Board appeals are limited to providers of services appealing Medicare cost reports or to hospitals appealing "payments in amounts computed under subsection (b) or (d) of section 1395ww of this title" both of which pertain to Medicare program payments to hospitals.[16] Here, the Provider is a SNF and its appeal rights under § 1395oo only pertain to Medicare cost report as discussed in 42 C.F.R. Part 413. Accordingly, it is clear that, as a general matter, Board appeals under § 1395oo are limited to certain Medicare program reimbursement.[17]

More specifically, pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835(b)(2), a provider has a right to a hearing before the Board with respect to "a final contractor or Secretary determination" if 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 contractor or Secretary determination***.[18] 42 C.F.R. § 405.1801 defines final contractor determination as:

> *Contractor determination* means the following:
>
> (1) With respect to a provider of services that has filed a cost report under §§ 413.20 and 413.24 of this chapter, the term means a final

[13] *Id.* at 5.
[14] *Id.* at 1.
[15] *Id*. at 3.
[16] 42 U.S.C. § 1395oo(a) states in pertinent part: "Any provider of services which has filed a required cost report within the time specified in regulations *may obtain a hearing with respect to* ***such cost report*** by a Provider Reimbursement Review Board . . . ***and*** (except as provided in subsection (g)(2)) any hospital which receives payments in amounts computed under subsection (b) or (d) of section 1395ww of this title and which has submitted such 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 . . . ."
[17] *See* 73 Fed. Reg. 30190 (May 23, 2008) (discussing the nature of Board appeals).
[18] Board Rule 4.4.1 (Aug. 29, 2018); 42 CFR §405.1835.

> determination of the amount of total reimbursement due the provider, pursuant to § 405.1803 following the close of the provider's cost reporting period, for items and services furnished to beneficiaries for which reimbursement may be made on a reasonable cost basis under Medicare for the period covered by the cost report.
>
> (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.
>
> (4) For purposes of § 405.376 concerning claims collection activities, the term does not include an action by CMS with respect to a compromise of a Medicare overpayment claim, or termination or suspension of collection action on an overpayment claim, against a provider or physician or other supplier.

In this case, the amount exceeds $10,000 and the Provider appears to have timely filed its appeal.[19] However, the Provider did ***not*** appeal from an appealable final determination as that term is used in 42 U.S.C. 1395oo(a) or in 42 C.F.R. § 405.1835(a) and defined at 42 C.F.R. § 405.1801 and has cited no other regulation or authority that gives the Board the authority to conduct a hearing on the determination at issue. Further, on a separate independent basis for dismissal, the Board finds that the Provider failed to include with its appeal request a copy of the determination at issue as required by 42 C.F.R. § 405.1835(b)(3).

First, the Board has determined the Provider's Relief Fund Distribution payments are not a "final determination" under appealable under applicable Medicare rules and regulations. In particular, the Relief Fund Distribution payments are clearly not handled through the Medicare cost report and are not Medicare program payments. As such, the Board lacks substantive jurisdiction to hear this matter.

[19] The Provider indicates the Phase 1 payment was distributed on May 22, 2020, the Provider "exhausted all options" from May 26, 2020 until the appeal was filed on November 18, 2020 which is exactly 180 days from May 22, 2020. *See* Provider response at 4

The Provider argues, "CMS controlled these payments and, at least as to Phase 1 payments under the CARES Act, failed to allow or refused to provide for any prospect of adjustment or correction, rendering them final determinations subject to PRRB review."[20] The Board finds the Provider's argument misplaced as to jurisdictional review. The Provider Relief Fund Distribution payments are administered through a division of CMS identified as the Health Resources & Services Administration which is *not* associated with the Provider Reimbursement Review Board. CMS is a large agency the Medicare program is just one of the numerous programs that it oversees. The Provider's Exhibit P-5 contains a letterhead document sourced from the Health Resources and Services Administration as the managing agency for Provider Relief Fund Distribution payments. The CARES Act and the Paycheck Protection Program was created in response to provide "relief to hospitals and other healthcare providers on the front lines of the coronavirus response…This funding will be used to support healthcare-related expenses or lost revenue attributable to COVID-19 and to ensure uninsured Americans can get treatment for COVID-19."[21] Additionally, Provider's Exhibit P-10, acknowledges the Provider Relief Fund Distribution payments are governed by 45 C.F.R. Part 75, which is separate from the regulations governing cost report audits. Specifically, Volume 45 pertains to Public Welfare and Part 75 "establishes uniform administrative requirements, cost principles, and audit requirements for Federal awards to non-Federal entities, as described in §75.101."[22] In contrast, the regulations governing the Medicare program are located in 42 C.F.R. Ch. IV and, in particular, the regulations governing Board appeals are located at 42 C.F.R. Part 405, Subpart R.[23]

The Terms and Conditions for the use of the funds is clearly not limited to Medicare beneficiaries and contains no reference to the Medicare program. In order to receive Provider Relief Fund Distribution payments, a provider must accept the Terms and Conditions and sign an attestation. Under the terms and conditions for Skilled Nursing Facility Relief Fund Payments, "[t]he Recipient certifies that the Payment will **only** be used to prevent, prepare for, and respond to coronavirus, and that the Payment shall reimburse the Recipient **only** for health care related expenses or lost revenues that are attributable to coronavirus."[24] Additionally, providers are required to accept or reject the funds and confirm the specified payment amount. An opportunity to reject the payment if it was incorrect is provided on the HRSA Provider Relief Fund Payment Portal:

> Within 90 days of receiving this payment, you must sign an attestation confirming receipt of the funds and agreeing to the Terms and Conditions of payment. Should you choose to reject the funds, you must also complete the attestation to indicate this. The

[20] Provider's Response to Medicare Administrative Contractor's Jurisdictional Challenge at 1.
[21] *See* Provider's Exhibit P-2.
[22] 45 C.F.R. § 75.100(a)(1).
[23] Provider's Exhibit P-10 at 6 states, "Recipients (both non-federal entities and commercial organizations) of the General and Targeted Distributions of the Provider Relief Fund are subject to 45 CFR 75 Subpart A (Acronyms and Definitions) and B (General Provisions), subsections §§75.303 (Internal Controls), and 75.351-.353 (Subrecipient Monitoring and Management), and Subpart F (Audit Requirements). In addition, the terms and conditions of the PRF payments incorporate by reference the obligation of recipients to comply with the requirements to maintain appropriate financial systems at 75.302 (Financial management and standards for financial management systems) and the requirements for record retention and access at 75.361 through 75.365 (Record Retention and Access)."
[24] https://www.hrsa.gov/sites/default/files/hrsa/provider-relief/terms-conditions-skilled-nursing-facility-relief-fund.pdf.

> HRSA Provider Relief Fund Payment Portal will guide you through the attestation process to accept or reject the funds. Not returning the payment within 90 days of receipt will be viewed as acceptance of the Terms and Conditions.[25]

In its preliminary position paper, the Provider acknowledges that it received a payment of $295,000 and argues that, "As a result, on May 22, 2020, Provider received the baseline payment of $50,00 as well as a further $245,000 covering just 98 of its 330 beds."[26] In this regard, Exhibit P-3 attached to the Provider's Preliminary Position Paper is a copy of the confirmation that the Provider signed on the HERSA Provider Relief Fund Payment Portal. Based on the above documents, it appears that the Provider should have noticed the incorrect amount when signing that attestation confirming receipt of the funds.

Finally, the Board notes that 42 C.F.R. § 405.1835(b)(2) reinforces the fact that appeals to the Board are limited to the Medicare program. The regulation specifies that the following content must be included in an appeal request:

> (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).[27]

The Provider Relief Fund Distribution payments are plainly not direct *Medicare* reimbursements, but rather payments made to providers in response to the coronavirus pandemic generally as such payments were not issued for use only with Medicare beneficiaries and such payments were not even administered by CMS, the agency charged with overseeing the Medicare program. The Board's jurisdiction is statutorily limited to Medicare reimbursement payments. The Board has determined the Provider's Relief Fund Distribution payments cannot be considered a "final determination" under applicable Medicare rules and regulations and for the purposes of establishing jurisdiction with the Board.

Based on the above, it is clear that the Provider is appealing a determination on which the Board has no authority to conduct a hearing. It is the Providers responsibility to establish its right to a hearing before the Board as explained at 42 C.F.R. § 405.1835(b). Similarly, 42 C.F.R. § 405.1853(b)(2) specifies that position papers must brief the Board's jurisdiction over each item in dispute in the appeal. However, the Provider has failed to comply with those requirements to

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[25] HRSA Provider Relief Fund Payment Portal User Guide, Attest to Payment. https://chameleoncloud.io/review/3016-5ec704315a620/prod.
[26] Provider's PPP at 4.
[27] (Emphasis added.)

establish Board jurisdiction over the sole dispute in this appeal and, in particular, has cited no regulation or other authority granting Board jurisdiction over the dispute.[28] Accordingly the Board dismisses the sole issue in this appeal for lack of substantive jurisdiction.

An alternative and independent basis for dismissal concerns the Provider's failure to comply with the content requirements for Board appeal requests. Specifically, the Provider failed to include with its appeal request the determination that it was appealing as required by 42 C.F.R. § 405.1835(b) in paragraph (3) which states, in pertinent part:

> *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. . . .
>
> (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.[29]

A copy of the final determination is critical for the Board's determination of its jurisdiction over the appeal (e.g., substantive jurisdiction, timeliness) as well as its assessment of the nature of the dispute (*e.g.*, what the Medicare Contractor stated about the item in dispute or how it determined payment or the authorities it relied on in making the determination).

Here, the appeal request only identifies May 22, 2022 as the date of the "determination" and then included a copy of email exchanges it had with the HRSA regarding the Provider Relief Fund regarding payments already made. In particular, the email from HRSA dated September 3, 2020 (which identifies itself as a response to an "inquiry" as opposed to as a "determination") describes the 4 separate payments that the Provider received on April 17, 2020 ($136,239.64), April 24, 2020 ($24,731.63), May 22, 2020 ($295,000.00), and August 27, 2020 ($488,500.00). However, the appeal request only identifies the May 22, 2020 payment of $295,000.00 as being in dispute. Moreover, the appeal request did not include a copy of any correspondence or issuance associated with the alleged May 22, 2020 payment of $295,000 to establish when the determination to pay $295,000 was determined/made (*i.e.*, date of issuance for purposes of

---

[28] Board Rule 7.1.2.5 direct a provider filing an appeal to provide the following information on determination that are not one of the enumerated typical Medicare program appeals: "For any other final determination not listed above, identify the specific final determination being appealed and the authority granting the Board's jurisdiction over the dispute." In this regard, the Board *by regulation* has the authority to hear certain appeals not encompassed by 42 U.S.C. § 1395oo. For example, 42 C.F.R. § 413.30 specifies that SNFs may appeal the Board a denial of a SNF's request for an adjustment to, or an exemption from, the routine cost limits that were in effect prior to SNF PPS. *See* 73 Fed. Reg. at 30191.

[29] (Emphasis added.) The Board incorporated this requirement into its Rules at Board Rule 7.1.

confirming timeliness of the appeal) and the nature of the determination including how that payment was calculated and a description of any appeal rights (which clearly are not to the Board).[30] Indeed, even at this late date, there is nothing in the record dated May 22, 2020, the date claimed as the "determination" date. Unfortunately, the Provider's appeal request failed to satisfy § 405.1835(b)(3) since a payment of $295,000.00 is not a determination but merely reflects the execution of a determination, and the appeal request Board only contains circumstantial evidence of both that payment and the presumed underlying determination.

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In summary, while understanding of the Provider's dilemma, the Board is not the appropriate forum for the type of relief the Provider is seeking. Accordingly, for the reasons outlined above, the Board does not have substantive jurisdiction over the sole dispute in this appeal. Further, the Provider's appeal request is fatally flawed as it did not include a copy of the determination which is necessary for basic jurisdictional review purposes. Accordingly, the Board has a separate and independent basis to dismiss this case. Specifically, even if there were jurisdiction, the Board would dismiss the case by exercising its authority under 42 C.F.R. § 405.1835(b) for failure to include a copy of the final determination being appealed.

The Board dismisses the issue in its entirety from this appeal.[31] As no additional issues remain pending, the Board hereby closes the case and removes it from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

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12/2/2022

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Chair
Signed by: PIV

cc: Wilson C. Leong, Esq., Federal Specialized Services
Bill Tisdale, Novitas Solutions, Inc. (J-H)

[30] For example, the Medicare program gives the following instructions in 42 C.F.R. § 405.1803(b) on what is required to be included in a Medicare Contractor notice of program reimbursement: "The contractor must include in each notice appropriate references to law, regulations, CMS Rulings, or program instructions to explain why the contractor's determination of the amount of program reimbursement for the period differs from the amount the provider claimed. ***The notice must also inform the provider of its right to contractor or Board hearing*** (see §§ 405.1809, 405.1811, 405.1815, 405.1835, and 405.1843) and that the provider must request the hearing within 180 days after the date of receipt of the notice." (Emphasis added.)

[31] The Board notes that the MAC has filed a substantive claim letter on October 12, 2021, which the Board need not reach as the issue has been dismissed from the appeal. In this regard, 42 C.F.R. § 405.1873(e)(1) specifically prohibits the Board from including any findings of fact or conclusions of law on substantive claim challenges questioning whether the provider's cost report included an appropriate claim for the specific item under appeal. If this case were to be reinstated, the Board would need to address those substantive claim issues raised by the MAC.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Board Decision to Dismiss***
Tampa General Hospital (Prov. No. 10-0128)
FYE 09/30/2006
Case No. 13-1831

Dear Ms. Webster and Mr. Pike:

The above-captioned individual appeal involves the Provider's appeal of its fiscal year ending September 30, 2006 ("FY 2006"). The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Provider's documentation pursuant to a pending jurisdictional challenge filed by the Medicare Contractor ("MAC") on May 30, 2014. As set forth below, the Board finds that it does not have jurisdiction to hear the Provider's Inpatient Rehab Facilities – Low Income Payment ("IRF-LIP") related issue and dismisses that issue from the instant appeal.

Pertinent Facts:

On April 30, 2013, the Provider filed its appeal of a Revised Notice of Program Reimbursement ("RNPR") dated November 2, 2012, for FY 2006. The Provider appealed the following issues:[1]

- Issue 1: DSH – Dual Eligible Days/SSI Fraction
- Issue 2: DSH – Dual Eligible Days/Medicaid Fraction
- Issue 3: DSH – Medicare Advantage Days/SSI Fraction
- Issue 4: DSH – Medicare Advantage Days/Medicaid Fraction
- Issue 5: LIP – Adjustment Issue

Four of the issues were transferred to *optional* group appeals. As a result, only one issue remains pending in the appeal, namely Issue 5, the LIP – Adjustment Issue. The appeal request describes Issue 5 as follows:

> The issue in this case concerns the Medicare Administrative Contractor's ("MAC") improper determination of the Provider's

[1] Provider's Request for Hearing, Tab 3, at Issue Statement (Apr. 30, 2013).

> low income percentage adjustment ("LIP adjustment") to payments for inpatient rehabilitation services due to the improper treatment of part C and part A non-covered days in the Medicaid and Medicare part A/SSI fractions used for the LIP adjustment, and potential errors in the data matching process used to calculate the Medicare part A/SSI fraction that may persist even after the agency's purported correction of those errors?[2]

MAC Jurisdictional Challenge:

On May 30, 2014, the Medicare Contractor filed a Jurisdictional Challenge regarding Issue 5, the LIP – Adjustment Issue.[3] The MAC challenges Issue 5 (as identified above) for the SSI percentage used for the rehab LIP payment. The MAC contends that the Board does not have subject matter jurisdiction over the LIP calculation. The Inpatient Rehab Facility ("IRF") low income patient ("LIP") adjustment is a component of the IRF prospective payment rate established under 42 U.S.C. § 1395ww(j)(3)(A)(v). In accordance with § 1395ww(j)(8), there is no administrative or judicial review of the IRF LIP adjustment.

The MAC argues that in this appeal, the Provider challenges the accuracy of the IRF LIP adjustment. The IRF LIP adjustment is a facility-level adjustment for low income patients that takes into account both the percentage of Medicare patients who are receiving Supplemental Security Income and the percentage of Medicaid patients who are not entitled to Medicare. The purpose of the LIP adjustment is to pay IRFs more accurately for the incremental increase in Medicare costs associated with the facility's percentage of low-income patients. 42 U.S.C. § 1395ww(8) specifically prohibits and precludes administrative and judicial review of prospective payment rates established under § 1395ww(j)(3).[4]

They add, that in responding to comments made in response to the Secretary's final rule in the Federal Register regarding IRF LIP adjustments, the Secretary specifically noted that the LIP adjustment was an adjustment under § 1395ww(j)(3)(A)(v). Because the LIP adjustment is a component of the IRF prospective payment rate established under § 1395ww(j)(3), administrative and judicial review of the LIP adjustment are statutorily precluded by § 1395ww(j)(8). 42 C.F.R. § 405.1867 mandates that the Board must comply with all of the provisions of the Medicare Act and the regulations issued thereunder. Accordingly, § 1395ww(j)(8)(B) precludes administrative review of the IRF-LIP adjustment, and thereby divests the Board of jurisdiction to hear issue 5 of the Provider's appeal.[5]

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[2] Provider's Final Position Paper, at 3.
[3] MAC's Jurisdictional Challenge, at 1 (May 30, 2014).
[4] *Id*. at 2.
[5] *Id*.

Provider Response:

The Provider did not timely file a response to the May 30, 2014 Jurisdictional Challenge within 30 days as required by Board Rule 44.3. To date, the Provider still has not filed a response. Rather, 6+ years later, on July 30, 2020, the Provider has asked for postponement of the hearing date and associated final position paper filing deadlines due to pending litigation in the case identified as *Naples Community Hosp., Inc. v. Azar*, No. 8:18-cv-01398 ("*Naples*") which involved the issue of whether patient days associate with Florida's Low Income Pool may be included in the rehabilitation provider's low income payment adjustment. In that request, the Provider also noted that the *Naples* case had been stayed pending a final decision from the D.C. Circuit in *Bethesda Health, Inc. v. Azar*, No. 19-5260 ("*Bethesda*"). Significantly, the postponement request did not mention or identify: (a) the jurisdictional challenge pending in the instant case; (b) 42 U.S.C. § 1395ww(j)(8)(B); or (c) the D.C. Circuit Court's 2018 decision in *Mercy Hospital, Inc. v. Azar* ("*Mercy*")which addresses the sole issue in this case.[6]

The Provider has not filed any updates to its postponement request. Rather, on August 19, 2021, October 18, 2021, and February 15, 2022, August 19, 2022, the Provider simply filed notices of its understanding that *position paper deadlines* have been suspended in this case pursuant to Board Alert 19 and that it would file *its position papers* once the general suspension under Board Alert 19 has been lifted.

The Board never specifically ruled on the postponement request, and multiple new notices of hearing setting new hearing and position paper filing deadlines were issued.

Board's Analysis and Decision:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1840 (2012), a provider has a right to a Board hearing with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more ($50,000 for a group), and the request for hearing is filed within 180 days of the date of receipt of the final determination. Under 42 C.F.R. § 405.1835(a)(1) (2012), a provider has preserved its right to claim dissatisfaction with the amount of Medicare payment for a specific item at issue by either (i) including a claim for the specific item on its cost report for the period where the provider seeks payment that it believes to be in accordance with Medicare policy; or (ii) effective with cost reporting periods that end on or after December 31, 2008, self-disallowing the specific item by following the applicable procedures for filing a cost report under protest where the provider seeks payment that it believes may not be in accordance with Medicare policy.

Under 42 U.S.C. § 1395ww(j)(8)(B), Congress specifically precludes administrative or judicial review of the prospective payment rates ("PPS") for inpatient rehabilitation facilities ("IRFs"). Although providers have attempted to dispute exactly what rate-setting "steps" Congress

[6] 891 F.3d 1062 (D.C. Cir. 2018).

intended to shield from review under the statute, the D.C. Circuit's 2018 decision in *Mercy* answers this question and clarifies what is shielded from review in its analysis of this issue.[7]

In *Mercy*, the D.C. Circuit describes CMS' two-step rate-setting process for Medicare reimbursement for IRFs. The first step takes place prior to the beginning of the fiscal year and involves CMS' establishment of a standardized reimbursement rate, while the second step involves CMS' adjustments (calculated by the Medicare contractor) to "the standardized rates to reflect the particular circumstances of each hospital for that year."[8] One of the ways in which CMS adjusts a hospital's IRF Medicare payment is by taking into account the number of low income patients ("LIP") served by the hospital, also known as the LIP adjustment. The D.C. Circuit in *Mercy* affirmed the D.C District Court, wherein the D.C. District Court concluded that 42 U.S.C. § 1395ww(j)(8) prohibits administrative or judicial review of the Medicare Contractor's determination of the LIP adjustment, because such review amounts to review of the establishment of the hospital's prospective payment rates.[9] The D.C. Circuit concluded that the Statute's plain language prohibits administrative and judicial review of not only the statutory adjustments, but also the "step two rates" utilized by the Medicare Contractor when adjusting the standardized reimbursement rate and then calculating a hospital's final payment.[10]

In the instant appeal, the Provider seeks Board review of a number of the components utilized by the Medicare Contractor to determine the Providers' LIP adjustments. Because, pursuant to 42 U.S.C. § 1395ww(j)(8)(B), Congress has prohibited administrative and judicial review of the prospective payment rates for IRFs, including the LIP adjustment, the Board lacks the jurisdiction to hear the Provider's appeal of the LIP adjustment and dismisses the issue in the instant appeal that challenge this adjustment. In making this finding, the Board relied on the *Mercy* decision in determining the scope and applicability of the preclusion provisions in42 U.S.C. § 1395ww(j)(8) and notes that, consistent with the Administrator's practice, the D.C. Circuit's decision in *Mercy* is controlling precedent for the interpretation of 42 U.S.C. § 1395ww(j)(8) because the Provider could bring suit in the D.C. Circuit.[11] Accordingly, the Board hereby dismisses Issue 5, the LIP Adjustment issue. As there are no other issues that remain pending in the case, Case No. 18-1831 is hereby closed and removed from the Board's docket.

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[7] *Id*.
[8] *Id.* at 1064.
[9] *Mercy Hosp., Inc. v. Burwell,* 206 F. Supp. 3d 93, 102 (D.D.C. 2016).
[10] *Mercy*, 891 F.3d at 1068.
[11] The CMS Administrator generally has applied as controlling precedent the law of the Circuit in which the Provider is located. *See, e.g., QRS CHW DSH Labor room Days Groups v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (Apr. 13, 2009), affirming, PRRB Dec. No. 2009-D11 (Feb. 27, 2009); *St. Vincent Mercy Med. Ctr. v. BlueCross BlueShield Ass'n*, Adm'r Dec. (Nov. 17, 2008), *affirming in part and reversing in part*, PRRB Dec. No. 2008-D35 (Sept. 15, 2008). Further, in recognizing that providers may file suit with the appropriate District Court either in the Circuit in which they are located or the D.C. Circuit, the Administrator also applies as controlling precedent the law of the D.C. Circuit. *See, e.g., Jordan Hosp. v. Blue Cross Blue Shield Ass'n.*, Adm'r Dec. (Apr. 30, 2007), *vacating*, PRRB Dec. No. 2007-D23 (Feb. 28, 2007).

In making this ruling, the Board notes that the Provider never responded to the May 2014 Jurisdictional Challenge.[12] While the Provider failed to respond, the Board recognizes that, 6+ years later on July 20, 2020, the Provider notified the Board that there was the *Naples* litigation pending in Florida concerning the same issue but that *Naples* litigation had been stayed pending the outcome of the *Bethesda* litigation in the D.C. Circuit. However, more than 2 years has passed and, during that intervening period, the Provider has failed to update the Board on the status of that pending litigation in any of its multiple subsequent filings with the Board. The Board takes administrative notice that the docket for the *Naples* litigation reflects that the Florida Middle District Court stayed the *Naples* litigation with the condition that the parties file a joint status report regarding the necessity of further proceedings within 14 days of the final decision in the *Bethesda* litigation. On November 13, 2020, the D.C. Circuit issued its final decision in the *Besthesda* litigation on November 13, 2020 (930 F.3d 121 (D.C. Cir. 2020)). There is no further activity listed in the docket for the *Naples* litigation and the Florida Middle District Court closed the case on August 25, 2021. As such, it is clear that any potential basis for the Provider's initial request for postponement in July 2020 is no longer present.

Finally, the fact that a Circuit other than the D.C. Circuit could *potentially* reach a different outcome does not alter the relevance or import of D.C. Circuit's decision in *Mercy* and the Board's decision to apply *Mercy*. As the D.C. Circuit is the only Circuit to interpret and apply the preclusion provisions at issue in these cases, the Board applied it as controlling precedent for the Board proceedings consistent with the Administrator's practice in applying Circuit decisions.[13] The Administrator's application of the D.C. Circuit decisions as controlling precedent for Board adjudications under 42 U.S.C. § 1395oo presumably reflects that the fact that D.C. Circuit case law may impact the whole Medicare program since *all* U.S. providers have the right to pursue § 1395oo appeals from the Administrator in the D.C. Circuit by filing in the D.C. District Court pursuant to 42 U.S.C. § 1395oo(f)(1).[14]

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[12] The Board also notes that the Provider's appeal request did not address jurisdiction over the IRF LIP issue including whether 42 U.S.C. § 1395ww(j)(8) precludes Board jurisdiction. Under Board Rule 7.2, the provider's appeal request is required to include the basis for the Board's jurisdiction before the Board. 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). *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)).

[13] *See supra* note 11.

[14] 42 U.S.C. § 1395oo(f)(1) states, in pertinent part: "Such action shall be brought *in the district court of the United States for the judicial district in which the provider is located* (or, in an action brought jointly by several providers, the judicial district in which the greatest number of such providers are located) ***or*** *in the District Court for the District of Columbia* and shall be tried pursuant to the applicable provisions under chapter 7 of title 5 notwithstanding any other provisions in section 405 of this title." (Emphasis added.)

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:

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RE: ***Jurisdictional Decision & Order to Cure Record***
SRI Summa FY 2007 Unmatched Medicaid CIRP
Case No. 14-1552GC

Dear Mr. Putnam:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above-referenced common issue related party ("CIRP") group appeal in response to the Medicare Contractor's Jurisdictional Challenge. Set forth below, is the Board's decision on the Jurisdictional Challenge as well as an order to cure the record.

Procedural History

On December 5, 2013, the Providers' representative established the group appeal with the following two Providers:

- Summa Akron City and St. Thomas Hospitals (Prov. No. 36-0020); and
- Summa Western Reserve Hospital (Prov. No. 36-0150).

Significantly, none of the participants as identified by their provider number are IRFs. All IRFs can be identified by a "T" in the third position of the provider number.[1] However, none of the participants have a provider number with such a "T". Rather each of the 2 participants in this case are subsection (d) hospitals subject to the IPPS as identified by their provider numbers shown above.

In the Statement of Group Issues, the Providers' representative summarizes its DSH Unmatched Medicaid Eligible Days issue as follows:

> The provider contends that the Medicaid fraction of its Operating Disproportionate Share Hospital, Low Income Payment, and Capital Disproportionate Share Hospital adjustment calculations (collectively "Calculations") has not been calculated in accordance with Medicare regulations and manual provisions as described in 42 CFR 412.106.

[1] *See* State Operations Provider Certification Manual, CMS Pub. 100-07.

> The provider requests that patient days pertaining to additional patient stays that were not paid by Medicaid, but related to patients with Medicaid coverage during the stay be included in the Medicaid fraction of the Calculations.[2]

The group issue statement references both the disproportionate share hospital payment adjustment under the inpatient prospective payment system that is made to subsection (d) hospitals as well as the low income payment ("LIP") adjustment under the inpatient rehabilitation hospital prospective payments system ("IRF-PPS) that is made to IRFs.

On December 10, 2021, the Providers' representative certified that the group was fully formed. Accordingly, pursuant to Board Rules 20 to 20.1, the Providers' representative had 60 days following that date (*i.e.*, by Tuesday. February 8, 2022) to make the appropriate Schedule of Providers filing required by those Rules. However, the Providers' representative failed to make this filing.

On March 3, 2022, the Board notified the parties that the electronic docket for this case is fully-populated in OH CDMS with the complete record for this case. The Notice also stated that, ***at the latest***, "prior to submitting a request for EJR or within thirty (30) days of hearing, the Board expects [each party] to compare the electronic record in OH CDMS for this case with [its] records and notify the Board of any discrepancies."

On April 14, 2022, the Providers' representative filed its Preliminary Position Paper ("PPP"). Pursuant to 42 C.F.R. § 405.1853(b)(2), "[e]ach 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." While the PPP had a jurisdictional section, it did not address whether 42 U.S.C. § 1395ww(j)(8)(B) precludes administrative review of the LIP adjustment.

On July 8, 2022, the Board received a Jurisdictional Challenge filed on behalf of the Medicare Administrative Contractor ("MAC") which argued that the Board lacks jurisdiction over the Inpatient Rehabilitation Facility ("IRF") Low income payment ("LIP") sub-issue because 42 U.S.C. § 1395ww(j)(8)(B) precludes administrative review of this adjustment.[3]

On July 15, 2022, the MAC filed its PPP.

The Providers' representative did ***not*** file a response to the Jurisdictional Challenge. Under Board Rule 44.4.3, "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."

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[2] Statement of Group Issues (Dec. 6, 2013).
[3] Jurisdictional Challenge at 3 (July 8, 2022).

The Board Rules require that Provider Responses to the MAC's Jurisdictional Challenge must filed within thirty (30) days of the filing of the Jurisdictional Challenge.[4] The Provider has not filed a response in this case and the time for doing so has elapsed.

Board Decision

A. Dismissal of LIP Issue

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.

Additionally, 42 C.F.R. §§ 405.1837 provides for the creation of Group appeals, 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.[5]

Under 42 U.S.C. § 1395ww(j)(8)(B), Congress specifically precludes administrative or judicial review of the prospective payment rates under the IRF-PPS. Although providers have attempted to dispute exactly what rate-setting "steps" Congress intended to shield from review under the statute, the D.C. Circuit's decision in *Mercy Hosp., Inc. v. Azar,* 891 F. 3d 1062 (June 8, 2018) ("*Mercy*") answers this question and clarifies what is shielded from review in its analysis of this issue.

In *Mercy*, the Court describes CMS' two-step rate-setting process for Medicare reimbursement for IRFs. The first step takes place prior to the beginning of the fiscal year and involves CMS' establishment of a standardized reimbursement rate, while the second step involves CMS' adjustments (calculated by the Medicare contractor) to "the standardized rates to reflect the particular circumstances of each hospital for that year." One of the ways in which CMS adjusts a hospital's IRF Medicare payment is by taking into account the number of low-income patients served by the hospital, also known as the LIP adjustment. The D.C. Circuit in *Mercy* affirmed the

[4] Board Rule 44.3, v. 3.1. (Nov. 2021).
[5] (Emphasis added.)

District Court's decision, wherein the District Court concluded that 42 U.S.C. § 1395ww(j)(8) prohibits administrative or judicial review of the Medicare Contractor's determination of the LIP adjustment, because such review amounts to review of the establishment of the hospital's prospective payment rates.[6] The D.C. Circuit concluded that the Statute's plain language prohibits administrative and judicial review of not only the statutory adjustments, but also the "step two rates" utilized by the Medicare Contractor when adjusting thestandardized reimbursement rate and then calculating a hospital's final payment.[7]

The Board finds that the group appeal *improperly* contains multiple issues that do not involve a single question of factor or interpretation, as the issue statement challenges both the Medicaid fraction of its Operating Disproportionate Share Hospital ("DSH") calculation and the LIP calculation. As described above, administrative review of the LIP payment is prohibited by 42 U.S.C. § 1395ww(j)(8), and therefore the Board is precluded from rendering a determination over the issue. The LIP sub-issue relative to Medicaid eligible day is hereby dismissed. In making this finding, the Board relied on the *Mercy* decision in determining the scope and applicability of the preclusion provisions in42 U.S.C. § 1395ww(j)(8) and notes that, consistent with the Administrator's practice, the D.C. Circuit's decision in *Mercy* is controlling precedent for the interpretation of 42 U.S.C. § 1395ww(j)(8) because the Provider could bring suit in the D.C. Circuit.[8]

Based on this dismissal, the single remaining issue in the appeal is the Medicaid days relative to the DSH payment.

B. Order To Cure the Record

Upon review of the record in this case, the Board has identified the following 2 deficiencies that the Provider must cure ***within fifteen (15) days of this letter's signature date***:

[6] *Mercy Hosp., Inc. v. Burwell*, 206 F. Supp. 3d 93, 102 (D.D.C. 2016).
[7] *Mercy*, 891 F.3d at 1068.
[8] The CMS Administrator generally has applied as controlling precedent the law of the Circuit in which the Provider is located. *See, e.g., QRS CHW DSH Labor room Days Groups v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (Apr. 13, 2009), affirming, PRRB Dec. No. 2009-D11 (Feb. 27, 2009); *St. Vincent Mercy Med. Ctr. v. BlueCross BlueShield Ass'n*, Adm'r Dec. (Nov. 17, 2008), *affirming in part and reversing in part*, PRRB Dec. No. 2008-D35 (Sept. 15, 2008). Further, in recognizing that providers may file suit with the appropriate District Court either in the Circuit in which they are located or the D.C. Circuit, the Administrator also applies as controlling precedent the law of the D.C. Circuit. *See, e.g., Jordan Hosp. v. Blue Cross Blue Shield Ass'n.*, Adm'r Dec. (Apr. 30, 2007), *vacating*, PRRB Dec. No. 2007-D23 (Feb. 28, 2007). The fact that a Circuit other than the D.C. Circuit could *potentially* reach a different outcome does not alter the relevance or import of D.C. Circuit's decision in *Mercy* and the Board's decision to apply *Mercy*. As the D.C. Circuit is the only Circuit to interpret and apply the preclusion provisions at issue in these cases, the Board applies it as controlling precedent for the Board proceedings consistent with the Administrator's practice in applying Circuit decisions. The Administrator's application of the D.C. Circuit decisions as controlling precedent for Board adjudications under 42 U.S.C. § 1395oo presumably reflects that the fact that D.C. Circuit case law may impact the whole Medicare program since *all* U.S. providers have the right to pursue § 1395oo appeals from the Administrator in the D.C. Circuit by filing in the D.C. District Court pursuant to 42 U.S.C. § 1395oo(f)(1).

1. *File Exhibits P-3 and P-4*.—The Provider's preliminary position paper filed on April 14, 2022 references exhibits through Exhibit P-4 where Exhibit P-4 is described as "each hospital's additional Medicaid days listing containing the days that were incorrectly omitted from the original filing." The filing must comply with Board Rule 1.4 addressing the redaction of protected health information ("PHI") or other personally identifiable information ("PII"). However, the Provider only filed Exhibits P-1 and P-2 and it must cure the record.

2. *File the Schedule of Providers Filing Per Board Rules 20 to 20.1*.—Pursuant to Board Rules 20 to 20.1, once a group is fully formed, then *within 60 days of that full formation*, the group representative must take one of the following actions:

   - For a group that is fully populated in OH CDMS, 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)" as explained at Board Rule 20; ***or***

   - For a group that is *not* fully populated in OH CDMS, the group representative must file both a hard copy and electronic copy of the Schedule of Providers ("SoP").

   Here, the Group Representative *on his own initiative* certified on December 10, 2021 that the group was complete. Accordingly, the Group Representative had 60 days from that date (*i.e.*, by Tuesday. February 8, 2022) to make the appropriate SoP filing required under Board Rules 20 to 20.1. However, the Group Representative failed to make that filing and instead proceeded to file its preliminary position paper. As the case was not fully populated in OH CDMS as of February 8, 2022, the Group Representative was required to file both the hard copy and electronic copy of the SoP. However, since that time the case became fully populated on March 3, 2022. Accordingly, the Board is exercising its discretion to permit the Group Representative to cure the record by "fil[ing] 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)" as explained at Board Rule 20.

The Board ***directs*** *the Group Representative to Review Board Rules 20 and 201 and to come into compliance with those Rules*. Regardless of whether it is addressed in the Notice of Critical Due Dates, the 60-day deadline to file the requisite SoP filing required under those Rules immediately applies when the Group Representative certifies that the group is fully formed. ***Be advised that failure to come into compliance with these Board Rules may result in dismissal of any group case in which the Group Representative fails to timely file the requisite SoP filing.***

Be advised that the above filing deadline is firm and, to the extent there is any question about its applicability, the Board exempts it from the Alert 19 suspension of Board-set deadlines.

Conclusion

In summary, the Board finds that the group appeal was *improperly* filed with more than one legal issue and that the LIP adjustment sub-issue is ***precluded*** from administrative review under 42 U.S.C. § 1395ww(j)(8)(B) and *Mercy*. Accordingly, the Board finds it lacks jurisdiction over this LIP sub-issue and dismisses it from the group appeal. The case will remain open for the DSH Medicaid eligible days issue.

Further, the Board gives the Group Representative ***15 days from this letter's signature date*** to cure the record for Exhibits associate with the preliminary position paper and to make the SoP filing required under Board Rules 20 to 20.1.

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

Board Members:

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

For the Board:

12/5/2022

X Clayton J. Nix

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

cc: Wilson C. Leong, Esq. Federal Specialized Services
Judith Cummings, CGS Administrators (J-15)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

James Ravindran
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RE: ***Board Decision* – SSI Percentage (Provider Specific)**
Danbury Hospital (Provider Number: 07-0033)
FYE: 9/30/2011
Case Number: 16-0078

Dear Mr. Ravindran,

The Provider Reimbursement Review Board ("Board") has reviewed the documentation in the above referenced appeal. The decision of the Board with regard to the SSI Percentage (Provider Specific) issue is set forth below.

Background:

A. *Procedural History for Case No. 16-0078*

On October 19, 2015, the Board received Provider's Individual Appeal Request appealing from its Notice of Program Reimbursement ("NPR") dated April 22, 2015 for fiscal year ending September 30, 2011. The initial appeal contained the ten (10) following issues:

- DSH/SSI Percentage (Provider Specific)
- DSH/SSI Percentage (Systemic Errors)
- DSH – SSI Fraction/Medicare Managed Care Part C Days
- DSH – SSI Fraction/Dual Eligible Days
- DSH – Medicaid Fraction/Medicare Managed Care Part C Days
- DSH – Medicaid Fraction/Dual Eligible Days
- DSH – Medicaid Eligible Days
- DSH – Medicare Managed Care Part C Days
- DSH – Dual Eligible Days
- DSH – Medicaid Eligible – Connecticut State Administered General Assistance Days

On May 31, 2016, Issues 2, 3, 4, 5, 6, 8, 9 and 10 were transferred to group appeals. The two remaining issues are Issue 1- DSH/SSI Percentage (Provider Specific) and Issue 7 – DSH – Medicaid Eligible Days.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 15-3037G

The Provider's appeal request described Issue 1: DSH/SSI – Provider Specific issue as follows:

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

The Provider's appeal request described Issue 2: DSH/SSI – Systemic Errors issue as follows:

> The Provider contends that the Lead 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)(i). The Providers [*sic*] further contend that the SSI percentages calculated by [CMS] and used by the Lead MAC to settle their Cost Reports does not address all the deficiencies as described in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37, 44 (D.D.C. 2008) and incorporates a new methodology inconsistent with the Medicare statute.
>
> The Providers [*sic*] 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]

The Provider also transferred its Issue 2 – DSH/SSI Percentage – Systemic Errors to the optional group under Case Number 15-3037G, *QRS 2011 DSH SSI Percentage Group 2*, on May 31, 2016. The Group Issue Statement for that case is identical to the DSH/SSI – Systemic Errors issue in case 16-0078.

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[1] Individual Appeal Request at Tab 3.
[2] *Id.* at Issue 2.

The Provider submitted its Final Position Paper on May 27, 2022. 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. This is based on certain data from the State of Connecticut and the Provider that does not support the SSI percentage issued by CMS.
>
> The Provider has worked with the State of Connecticut and has learned that similar to *Loma Linda Community Hospital v. Dept of Health* and Human Services, No. CVT94- 0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records.
>
> The Provider is seeking the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR"), HHS/HCFAIOIS, 09-07-009, which was published in the Federal Register on August 18, 2000, from CMS in order to reconcile its record 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.

MAC'S Contentions:

The Medicare Contractor filed a Jurisdictional Challenge on May 30, 2018 arguing the DSH Provider Specific and DSH/SSI Systemic Errors issues are identical. It also noted that Issue 2 – DSH/SSI Percentage (Systemic Errors) was transferred to group case 15-3037G. Since the issues are identical the Medicare Contractor requests that the Board DSH/SSI Percentage (Provider Specific) Issue be dismissed.

Provider's Response:

The Provider filed a response on June 20, 2018, arguing that these two issues represent different components of the SSI issue. It contends that the Systemic Errors issue involves inaccurate MedPAR data, specifically several categories of ***days being omitted from the SSI percentage***.

It claims that the Provider Specific issue "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, but specifically argues that "the SSI percentage determined by CMS is incorrect due to the ***understated days in the SSI ratio***."

Board Analysis and Decision:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2013), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

A. SSI 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 issue that was appealed in Group Case No. 15-3037G.

The Board finds that the first aspect of Issue 1 (the DSH/SSI (Provider Specific) issue) in this appeal is duplicative of Issue 2 (the DSH/SSI issue) that was appealed in Case No. 15-3037G. The first aspect of Issue 1 in the present appeal concerns "whether the Medicare Administrative Contractor used the correct [SSI] percentage in the [DSH] Calculation."[3] The Provider's legal basis for this aspect of Issue 1 is simply that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[4] Similarly, the Provider argues that "it[s] SSI percentage published by [CMS] was incorrectly computed . . ." and it ". . . [s]pecifically . . . disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[5] Issue 2, transferred to group Case No. 15-3037G, similarly alleges that the Medicare Contractor and CMS improperly calculated the DSH/SSI Percentage, the DSH/SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F)(i).

Thus, the Board finds that the first aspect of Issue 1 in this appeal is duplicative of the appealed issue in Case No. 15-3037G. In making this finding, the Board further notes that CMS'

[3] Individual Appeal Request, Issue 1.
[4] *Id.*
[5] *Id.*

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. 15-3037G. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[6] 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. 15-3037G.

Furthermore, the Board notes that Provider's Final Position Paper did not did not provide any basis upon which to distinguish the two SSI issues. Accordingly, the Board finds that the DSH/SSI Provider Specific Issue failed to comply with Board Rule 25 governing the content of position papers, which requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions."[7] 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, 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.

[6] 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).
[7] (Emphasis added.)

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.[8] 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."[9]

Accordingly, the Board must find that Issues 1 and the group issue in Group Case 15-3037G, are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (2015), the Board dismisses this component of the DSH/SSI (Provider Specific) issue. As an alternative basis the Board dismisses Issue 1 for failure of the Provider to properly brief the issue in its position paper in compliance with Board Rules.

2. Second Aspect of Issue 1

The second aspect of the DSH SSI Percentage (Provider Specific) issue—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—must be dismissed for lack of jurisdiction and as premature. Under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request…" Without this written request, the Medicare Contractor cannot issue a final determination from which the Provider can be dissatisfied with for appealing purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding the Provider's DSH SSI Percentage realignment as such there is no

[8] (Last accessed Nov. 21, 2022.)
[9] (Emphasis added.)

"determination" to appeal and the appeal of this issue is otherwise premature. Further, the Provider's cost reporting period ends on 9/30, which is the same as the fiscal year end. Thus, any realignment of the SSI percentage would have no effect for this provider.

Conclusion:

The Board dismisses Issue 1, the DSH/SSI (Provider Specific) issue, in its entirety from this appeal. Since the Medicaid Eligible Days issue remains open in the appeal, Case No. 16-0078 will remain open on the Board's docket.

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

Board Members Participating:

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

For the Board:

12/5/2022

X Kevin D. Smith, CPA

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

cc: Wilson C. Leong, Esq., Federal Specialized Services
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DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

James Ravindran
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RE: ***Notice of Dismissal***
Novant 1998 DSH Medicare Managed Care/Medicaid Elig Days Grp
Case No. 08-2558GC

Dear Ravindran:

The above-captioned common issue related party ("CIRP") group case is currently scheduled for a live hearing on December 15, 2022. In a letter dated November 17, 2022, the Medicare Contractor objected to the Providers' Supplemental Position Paper that the Providers' representative, Quality Reimbursement Services, Inc. ("QRS"), filed with the Board on November 15, 2022. The Medicare Contractor requests the Board to strike the Providers' Supplemental Position Paper from the record **and** to dismiss this appeal.

Recent Procedural History:

On September 3, 2020, the Board issued a Notice of Hearing in this case, setting a hearing date of June 24, 2021 and requiring final position papers ("FPPs") to be filed by the Providers on March 26, 2021 and the Medicare Contractor on April 25, 2021. QRS filed the Providers' FPP on March 26, 2021, and the Medicare Contractor filed its FPP on April 23, 2021.[1]

On June 17, 2021, QRS submitted a request to postpone the June 24, 2021 hearing date. On June 21, 2021, the Board issued a Notice of Hearing – Rescheduled setting a new hearing date of January 11, 2022.

[1] The Providers had previously filed a final position paper in this case on October 13, 2015 and included as Exhibit 2 and a redacted eligibility listing for the 2 participants in this case, showing that Participant #1 had 351 HMO days at issue and that Participant #2 had 263 days at issue. This is significantly less that what was alleged in the amount in controversy calculations included in the final Schedule of Providers filed several months earlier on July 1, 2013, namely 1110 HMO days for Participant #1 (representing $339,411 in controversy) and 888 HMO days for Participant #2 (representing $260,470 in controversy). The resulting proportional reduction in the AiCs suggests that the aggregate amount in controversy, here, has been reduced to $184,471 (*i.e.*, $107,327 for Participant #1 + $77,144 for Participant #2). Note that the Providers' second final position paper filed on March 26, 2021 did ***not*** include an eligibility listing at Exhibit 2 thereto and noted that it was "not included, being sent under separate cover." However, no such updated listing was *ever* sent. Accordingly, the listing attached to the October 13, 2015 final position paper remains the current and final listing of HMO days at issue and only entails 614 HMO days in the aggregate. To the extent, the Providers had any intent to update the list with additional days, the Providers forewent that opportunity by not filing it with the second final position paper and not explaining why it was not available under Board Rule 25.2.2. *See* 42 C.F.R. § 405.1842(b)(2)-(3) (requiring full briefing in position papers and exhibits).

On December 29, 2021, QRS submitted a second postponement request, stating that the Providers were awaiting CMS's rulemaking implementing the U.S. Supreme Court decision in *Azar v. Allina Health Services*.

In a letter issued January 7, 2022, the Board denied the request and noted that the issue in this appeal concerns the treatment of ***pre*** – 1/1/1999 Medicare HMO days in the Medicare DSH calculation and, as a result, does *not* involve Medicare Part C (also known as Medicare Advantage) since Medicare Part C was established by § 4000 of the Balanced Budget Act and was effective January 1, 1999. Thus, the U.S. Supreme Court decision in *Allina,* which concerns Medicare Advantage days, is *not* applicable to the law and regulations in effect for the cost reporting under appeal.

In the January 7, 2022 letter, the Board also determined that supplemental briefing was necessary in this appeal and proposed a briefing schedule. Significantly, the Board set forth the specific areas that the Board wished the parties to address. In light of the need for supplemental briefing, the Board postponed the January 11, 2022 hearing and asked the parties to review the additional briefing required as well as the proposed briefing schedule and to propose an alternative schedule if the parties were not in agreement with the Board's proposed briefing schedule. The parties' response was due 30 days later.

On February 7, 2022, the Medicare Contractor timely filed a response agreeing to the Board's proposed supplemental briefing schedule. Similarly, on February 8, 2022, QRS timely filed the Providers' response agreeing to the Board's proposed supplemental briefing schedule. *Significantly,* ***neither party objected*** *to the specific areas on which the Board requested additional supplemental documentation.*

Subsequently, *as agreed to by* ***each*** *of the parties*, the Board issued a Scheduling Order on February 9, 2022, requiring the parties to file supplemental parties addressing the substantive areas outlined in the Board January 7, 2022 letter and establishing the following deadlines for that supplemental briefing consistent with that proposed supplemental briefing schedule:

- The Providers' supplemental brief with any supporting exhibits shall be filed no later than June 1, 2022;

- The Medicare Contractor's supplemental brief with any supporting exhibits shall be filed no later than October 1, 2022;

- The Providers' optional response brief with any supporting exhibits shall be filed no later than November 1, 2022.

The Board's Scheduling Order stated the following:

> No additional evidence will be accepted outside of the timeline and procedures outlined above without express leave from the Board. *Be advised that the above deadlines are* ***firm*** *and, given the length of the briefing schedule, the Board has determined to* ***exempt*** *them from the*

> *Board Alert 19 suspension of Board filing deadlines.* Accordingly, failure of the Providers' Representative to comply with the timeline and filing deadlines outlined above may result in dismissal or other remedial action it considers appropriate in accordance with 42 C.F.R. § 405.1868(b)(3). Similarly, failure of the Medicare Contractor to comply with the timeline and filing deadlines outlined above will result in the Board issuing a written notice to CMS, pursuant to 42 C.F.R. § 405.1868(c), describing the contractor's actions and requesting that CMS take action, as appropriate.[2]

However, QRS did not file the Provider' supplemental brief by the June 1, 2022 filing deadline even though QRS had specifically agreed, *in writing*, to that deadline. Further, QRS did not even seek to extend this deadline by filing an extension request with the Board. On September 26, 2022, the Medicare Contractor timely filed its supplemental brief. Similarly, QRS did not file any response to the Medicare Contractor's supplemental brief by the November 1, 2022 deadline.

As noted previously, QRS did eventually file the Providers' required supplemental brief on November 15, 2022 but this was 5 ½ months after the filing deadline has passed and exactly 2 weeks after the Providers' optional responsive brief, if any, was due from QRS. Significantly, QRS' filing neither recognized that it was untimely nor explained why it was not timely filed.

Accordingly, on November 17, 2022, the Medicare Contractor filed a motion to dismiss, asserting that the Providers' supplemental briefing was filed ***outside*** the time deadline requirements of the Board's Scheduling Order *without leave of the Board* and, therefore, should be rejected by the Board and stricken from the record. Specifically, the Medicare Contractor maintains that the Providers' ***flagrant*** *failure to comply* with the clearly set forth directives and timelines is grounds for dismissal or, at a minimum, grounds to have the untimely briefing stricken from the record.

Board's Decision

The regulations at 42 C.F.R. § 405.1868 state the following:

> (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-*

[2] (Emphasis in original.)

> (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.

Board 41.2 reflects the regulation and states the following:

> The Board may dismiss a case or an issue on its own motion:
>
> - if it has a reasonable basis to believe 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 finds that the Providers failed to comply with the Board's Scheduling Order and, instead, filed their supplemental brief in this appeal on November 15, 2022, exactly 5 ½ months after the June 1, 2022 filing deadline established in the Board's February 9, 2022 Scheduling Order and only 1 month prior to the December 15, 2022 scheduled hearing date.[3] The Board notes that its February 9, 2002 Scheduling Order specifically exempted the filing deadlines from the Board Alert 19 suspension of Board filing deadlines and importantly advised QRS that failure to comply with the Providers' filing deadline and to timely file (without a Board approved extension) could result in dismissal of the Providers case. Significantly, prior to establishing these filing deadlines, the Board requested comment from both parties and *QRS **specifically** agreed, in writing, to the Providers' filing deadline*. QRS even failed to file an extension request with the Board to extend the agreed-to filing line. Indeed, QRS' November 15, 2022 filing fails to recognize that it filed 5 ½ months late, much less explain why it filed 5 ½ months late. Moreover, QRS' untimely-filing of the supplemental briefing occurred exactly 1 month prior to the December 15, 2022 hearing date and, thus, clearly prejudiced the opposing party in preparation for that hearing.[4] Similarly, the untimely filing was

[3] Indeed, the extent of the untimeliness of the filing is further highlighted by the fact that the Board's Scheduling Order included a deadline for QRS to file an optional response brief by November 1, 2022 to permit the Providers with an opportunity to respond to the Medicare Contractor's Supplemental Brief. However, QRS filed the supplemental briefing 14 days after this deadline. Indeed, this untimely filing even failed to otherwise respond to, discuss or recognize the Medicare Contractor's supplemental briefing which had been filed 1½ months earlier.

[4] Unless good cause is established and advance notice is provided to all parties, the Board generally does ***not*** permit briefing of this substantive and factual nature to occur 30 day prior to a hearing. To highlight the prejudicial nature of this untimely filing, the Board notes that, pursuant to Board Rule 28, parties are required to make decisions about whether to present witnesses and must file its witness list ***at least** 30 days prior to the hearing*. Thus, the late filing of the supplemental position paper 30 days prior to hearing prejudiced the Medicare Contractor by not giving the

also prejudicial to the Board and interfered with the speedy, orderly and fair conduct of the Board proceedings as highlighted by the untimely objections and concerns raised in that filing.[5]

Finally, QRS has not, to date, directly responded to the Medicare Contractor's November 17, 2022 request that the Board dismiss this case. Rather, 24 hours later, on November 18, 2022, QRS filed a request for postponement of the December 15, 2022 hearing date in this case. In making this request, QRS recognizes that the Medicare Contractor "does not support this request." However, QRS failed to address the nature of the Medicare Contractor's opposition, namely that Medicare Contractor had a pending request that the Board either dismiss this case or strike the Providers' supplemental briefing from the record due to QRS' failure to comply with the Board's February 9, 2022 Scheduling Order for Supplemental Briefs. Since QRS conferred with the Medicare Contractor prior to filing the record hearing request in lieu of the December 15, 2022 hearing and it is now within 9 days of that hearing date, the Board must assume that QRS has filed its response to the Medicare Contractor's motion to dismiss or in the alternative strike.

Based on the above, it is clear that: (1) the June 1, 2022 deadline for the Providers' supplemental brief was firm since the Providers *specifically* agreed to that deadline and since the Board established it in a Scheduling Order which notified the Providers that the Board could dismiss the case if they failed to timely file; and (2) QRS blatantly disregarded for the Providers' firm filing deadline and failed to meet it. Accordingly, given the nature, extent, and effect of QRS' failure to timely file the Providers' supplemental brief, the Board finds that dismissal of the Providers' appeal is warranted, pursuant to its authority under 42 C.F.R. § 405.1868(a)-(b), and hereby dismisses that appeal and pursuant to that authority and removes it from the Board's docket.[6]

Finally, if the Board were not dismissing this case, the Board would strike the supplemental briefing from the record for the reasons stated herein. Similarly, the Board would deny the Providers' record hearing request and proceed with the hearing currently scheduled for December 15, 2022. Board Rule 32.4 provides the following guidance on when a record hearing may be appropriate:

> *In cases involving only legal interpretation* **or** ***very limited*** *fact disputes*, ***and*** *where both parties agree that the case is appropriate for a record hearing*, the Board may approve the parties' request to submit their case only on the existing written record. Generally, record hearings are *inappropriate when material facts are in dispute* and/or the

Medicare Contractor to assess the filing and its potential impact on its case presentation and its decision on whether to call any witnesses and, if so, to identify those witnesses and their availability for the December 15, 2022 hearing.

[5] The Providers untimely supplemental briefing appears to raise objections to relevance of the Board's questions that it had posed over 11 months earlier on January 7, 2022. However, the Provider never previously raised any such objections, including in particular, when it agreed to the briefing schedule. To include objections in an untimely-filed supplemental filing 30 days prior to the hearing (as opposed 8 months earlier when it filed its response to the Board's proposed scheduling order) is prejudicial both to the Board and the opposing party because it did not permit the Board an opportunity review those objections/concerns and then, as appropriate, potentially revise its proposed scheduling order for purpose of developing the record prior to the December 15, 2022 hearing date.

[6] If the Board were not dismissing the case, the Board would strike the supplemental briefing from the record for the reasons stated herein, including those in *supra* notes 3-5.

> credibility of witnesses may be at issue. After approving the request, if the Board concludes that a case is not suitable for a record hearing, the Board will reset the case for an in-person, video, or telephonic hearing.
>
> *To be approved for a record hearing, the record must be* ***substantially complete*** *and well organized*. Position papers must be filed by both parties and clearly reference specific evidence on which the parties rely, including the exhibit number and page. The *Board generally will deny the parties' request for a record hearing if stipulations regarding all undisputed facts and principles of law are not submitted with the parties' request*.
>
> Upon approval of a record hearing, the Board will issue a Notice of Record Hearing to notify the parties of a date for the final closure of the record. No additional evidence or arguments may be presented after such time, except on written motion demonstrating good cause for the late filing.

Here, there are material factual and legal disputes and gaps in the administrative record *for this case* as highlighted by the Board's request for supplemental briefing and the parties' responses.[7, 8] Further, a condition for a record hearing is that both parties agree to a record hearing. However, there is no such agreement here as the Medicare Contractor opposes a record hearing and QRS failed to explain why it maintains a record hearing is appropriate notwithstanding the Medicare Contractor's opposition. Similarly, QRS did not include Stipulations with its request,

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[7] The Providers' supplemental briefing as filed by QRS was also inadequate and failed to fully respond to the Board's request for information. For example, QRS cites to PRRB Dec. No. 2011-D20 and the underlying cases which, according to QRS, were appealed to the U.S. District Court and then remanded back to the Board for further proceedings. Case No. 08-2558GC is ***neither*** part of PRRB Dec. No. 2011-D20 ***nor*** part of the remand associated with the cases underlying that decision. As a result, the Board is not bound or restricted by the remand (or findings) made in those *unrelated* cases (which is *unreported* decision). Significantly, the Board is charged with developing the administrative record for this case (*i.e.*, Case No. 08-2558GC) and none of the record for those unrelated cases (*e.g.*, testimony) has been made part of the Board's administrative record for Case No. 08-2558GC (outside of the PRRB Dec. No. 2011-D20 as Exhibit C-7). *See, e.g.*, Board Rules 35.8, 35.9 (addressing the admission of testimony from prior Board proceedings in other cases and transcripts from prior hearings in other cases). The inadequacy of the supplemental briefing is further highlighted by the fact that, even though the Board's questions are clearly centered around availability of MedPAR data on the aggregate 614 HMO days at issue (*see supra* note 1), they failed to discuss the availability of MedPAR data for those days and, if so, what information is contained in that data, notwithstanding the fact that the Medicare Contractor had in its response filed 1½ months earlier stated: "*The Providers requested* ***and received MedPAR data*** *from CMS for the fiscal year ends at issue*. The MAC cannot attest to if the MedPAR data had a field relating to HMO days, as the MAC does not have access to this information. The Providers can best respond to any questions relating to if the days were already included in the numerator and/or denominator of the Medicare fraction and how this figure compares to the dual eligible HMOs that the providers are requesting in the Medicaid fraction. The Providers clearly have the burden of proof. The MAC cannot address and determine whether discovery under 42 C.F.R. § 405.1853 or FOIA is needed, as this is the Provider's prerogative." (Emphasis added.)

[8] As the D.C. District Court noted in *Baptist Med. Ctr. v. Burwell*, No. 1:11-cv-0899, 2015WL13808477 at *5 (D.D.C. Aug. 24, 2015): "Under the APA, it is the agency's role to resolve factual issues and to arrive at a decision that is supported ***by the administrative record***, whereas "the function of the district court is to determine whether or not as a matter of law the evidence in the administrative record permitted the agency to make the decision it did." (Emphasis added.)

notwithstanding the fact that the Board generally denies record hearing requests when the parties have not filed stipulations.[9]

In sum, the untimely filing of the supplemental briefing is one part of a larger picture that shows QRS' mismanaging this case and failing to comply with multiple filing obligations and requirements under Board Rules and the Board's Scheduling Order. This larger picture reinforces the Board's decision to exercise its discretionary authority under 42 C.F.R. § 405.1868(a)-(b) to dismiss this case.

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:

12/6/2022

X Clayton J. Nix

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

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

[9] QRS also has not filed the Providers' witness list for the December 15, 2022 hearing even though one must be filed due 30 days prior to hearing. Thus, if the hearing were to proceed on December 15, 2022, QRS would not be permitted to present any witnesses on behalf of the Providers.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Expedited Judicial Review Determination***
K&L Gates LLP CYs 2016 - 2017 Capital DSH Group
Case No. 21-1359G

Dear Mr. Ruskin:

The Provider Reimbursement Review Board ("Board") has reviewed the Provider's October 17, 2022 request for expedited judicial review ("EJR") in the above-referenced optional group appeal. The decision with respect to EJR is set forth below.

Issue under Dispute

In this case, the Providers are

> [C]hallenging the application of 42 C.F.R. § 412.320(a)(1)(iii), which states that urban hospitals may qualify for Capital [disproportionate share hospital] payments unless, on or after October 1, 2006, the urban hospital is reclassified as rural. [The Provider Group contends that] [t]his regulation is inconsistent with Social Security Act Section 1886(d)(8)(E)[1], which specifically concerns rural status. Section 1886(d)(8)(E) specifically notes that the hospitals that have undergone a rural reclassification are rural only for "purposes of this subsection [1886(d)]."[2]

Background:

Under the inpatient prospective payment system ("IPPS"), Medicare pays hospitals predetermined rates for patient discharges and this system is comprised of two parts, one for operating costs ("operating IPPS") as set forth at § 1395ww(d); and one for capital costs ("capital IPPS") as set forth at 42 U.S.C. § 1395ww(g). The primary objective of IPPS is to

[1] Codified at 42 U.S.C. § 1395ww(d)(8)(E).
[2] Request for Expedited Judicial Review at 3 (Oct. 17, 2022) ("EJR Request"). *See also* Issue Statement – Capital DSH.

create incentives for hospitals to operate efficiently, while providing adequate compensation to hospitals.[3] This case focuses on the capital IPPS.

1. 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.

2. Operating DSH Adjustment Under Operating IPPS

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

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

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

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[3] Daniel R. Levinson, Department of Health and Human Services, Office of the Inspector General, *Significant Vulnerabilities Exist in the Hospital Wage Index System for Medicare Payments*, 1 (Nov. 2018), *available at* https://oig.hhs.gov/oas/reports/region1/11700500.pdf (last visited Oct. 20, 2022) ("*Significant Vulnerabilities*").
[4] *See* https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/wageindex.html (42 U.S.C. § 1395ww(d)(3)(E) requires that, as part of the methodology for determining prospective payments to hospitals, the Secretary must adjust the standardized amounts "for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level." This adjustment factor is the wage index. The Secretary currently defines hospital geographic areas (labor market areas) based on the definitions of Core-Based Statistical Areas ("CBSAs") established by the Office of Management and Budget and announced in December 2003. The wage index also reflects the geographic reclassification of hospitals to another labor market area, such as rural to urban or vice versa, in accordance with sections 1395ww(d)(8)(B) and 1395ww(d)(10).).
[5] Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, 103 Stat. 2106, 2154 (1989). *See also Significant Vulnerabilities* at 4-5.
[6] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[7] *Id.*
[8] *See* 42 U.S.C. § 1395ww(d)(5).
[9] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[10] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[11] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).

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

3. 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 <u>an adjustment</u> to take into account variations in the relative costs of capital and construction for the different types of facilities or areas in which they are located*;
>
> (iii) may provide for such exceptions (including appropriate exceptions to reflect capital obligations) as the Secretary determines to be appropriate, and
>
> (iv) may provide for suitable adjustment to reflect hospital occupancy rate.
>
> (C) In this paragraph, the term ''capital-related costs'' has the meaning given such term by the Secretary under subsection (a)(4) as of September 30, 1987, and does not include a return on equity capital.[13]

[12] Pub. L. 100-203, § 4006(b), 101 Stat. 1330, 1330-52 (1987).
[13] (Underline and italics emphasis added.)

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

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

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

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:

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[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 Oct. 20, 2022).
[15] 56 Fed. Reg. 43356 (Aug. 30, 1991).
[16] *Id.* at 43369-70 (emphasis added).

> In the proposed rule, our regression results indicated that for urban hospitals with more than 100 beds, the disproportionate share percentage of low income patients has an effect on capital costs per case. We proposed that urban hospitals with 100 or more beds would receive an additional payment equal to ({1 +DSHP)$^{0-4176}$ - 1)), where DSHP is the disproportionate share patient percentage. There would be no minimum disproportionate share patient percentage required to qualify for the payment adjustment. A hospital would receive approximately a 4.2 percent increase in payments for each 10 percent increase in its disproportionate share percentage. This formula is similar to the one used for the indirect medical education adjustment under the operating prospective payment system.
>
> Since we did not find a disproportionate share effect on the capital costs of urban hospitals with fewer than 100 beds or on rural hospitals, we did not propose to make a disproportionate share adjustment to the capital payment to these hospitals.[17]

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

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

[17] *Id* at 43377.

> patients either because of their smaller size (i.e., under 100 beds) or lower disproportionate share patient percentage. **In rural areas, we believe the more relevant criteria for determining whether a hospital should receive special payment protection is whether the hospital represents the sole source of care reasonably available to Medicare beneficiaries**.[18]

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

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

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

> 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

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

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

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

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

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

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

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

> *Comment*: Many commenters sought clarification of the effect of reclassification by the Medicare Geographic Classification Review Board (MGCRB) on eligibility for capital disproportionate share payments.

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

> *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) If a hospital meets the criteria in paragraph (a) of this section for a disproportionate share hospital for purposes of capital prospective payments, the disproportionate share payment adjustment factor equals [e raised to the power of (.2025 X the hospital's disproportionate patient percentage as determined under § 412.106(b)(5)), —1], where e is the natural antilog of 1.
>
> (2) If a hospital meets the criteria in § 412.106(c)(2) for purposes of inpatient hospital operating prospective payments, the disproportionate share adjustment factor equals 14.16 percent.[24]

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

On November 29, 1999, Congress enacted the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 ("BBRA") and BBRA § 401 amended 42 U.S.C. § 1395ww(d)(8) to require that certain urban IPPS hospitals be reclassified as rural *for purposes of operating IPPS* if

[23] (Bold and underline emphasis added.)
[24] *Id*. at 43452-53.

an application is submitted to the MGCRB and certain criteria are met.[25] IPPS hospitals are reclassified per BBRA § 401 are often referred to as "§ 401 hospitals."

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

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

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

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

[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.)

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 Health and Human Services, Health Resources and Services Administration, Office of Rural Health Policy, 5600 Fishers Lane, Room 9–05, Rockville, MD 20857.

[27] 65 Fed. Reg. 47054, 47088-89 (Aug. 1, 2000).

> (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]

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.

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

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.
>
> (ii) The term *urban area* means—

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

> (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]

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

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 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.

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

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>
> 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.
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>
> As previously discussed, we proposed and adopted as final our policy that, beginning in FY 2005 and thereafter, only those hospitals geographically located in a large urban area (as defined in revised § 412.63(c)(6)) will be eligible for the large urban add-on payment adjustment provided under § 412.312(b)(2)(ii) and § 412.316(b). *Similarly, beginning in FY 2005 and thereafter, to receive capital IPPS DSH payments under § 412.320, a hospital will need to be geographically located in an urban area (as defined in new § 412.64) and meet all other requirements of § 412.320.* Accordingly, we are adopting our proposed revisions as final without change.[37]

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

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

[37] 69 Fed. Reg. 48916, 49187-88 (Aug. 11, 2004) (italics emphasis added).
[38] of the Department of Health and Human Services.

the capital IPPS in FY 1992, the same geographic classifications used under the operating IPPS also have been used under the capital IPPS.[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 2006rulemaking is arbitrary and capricious and thus unreasonable for two principal reasons. First, it charges the Secretary with misrepresenting the regulatory history in claiming that the 2006 Rule merely restored a previously implemented policy. Second, the hospital argues that the Secretary failed to "take into account" relative costs of capital

[42] *Id.*
[43] (Bold emphasis added.)
[44] 2021 WL 4502052 (D.D.C. 2021).

> for various hospital types and areas of location, as subsection (g) requires.[45]

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

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

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

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

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

The Providers state that EJR is appropriate because the they are challenging the regulation that governs capital DSH payments to urban hospitals that have been reclassified under 42 U.S.C. § 1395ww(d)(8)(E) and 42 C.F.R. § 412.103 (hospitals located in urban areas and that apply for reclassification as rural).[60]

The Providers are challenging the application 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 42 U.S.C. § 1395ww(d)(8)(E) 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), not § 1395ww(d), and, accordingly, the literal wording of the rural reclassification statutory provision identifies that rural status does not reach the capital DSH calculation. The Providers 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.

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[54] *Id.*
[55] *Id.*
[56] *Id.*
[57] *Id.* at *11-12.
[58] *Id.* at *12.
[59] *Id.*
[60] Request for EJR at 2.

§§ 1395ww(d)(8)(E) and 1395ww(g), and the regulation must be found invalid.[61] 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*.

Since the Board is bound by the regulations being challenged,[62] 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.

Board Decision

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.

A. Jurisdiction

*1. Participant with Cost Reporting Period Beginning **Prior to** January 1, 2016*

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending on or after December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming it as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen* ("*Bethesda*").[63] In that case, the Supreme Court concluded that a cost report submitted in full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.[64]

On August 21, 2008, new regulations governing the Board were effective.[65] Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hospital v. Burwell* ("*Banner*").[66] In *Banner*, the provider filed its cost report in accordance with the applicable

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[61] *Id.* at 3.
[62] *See* 42 C.F.R. § 405.1867.
[63] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).
[64] *Bethesda*, 108 S. Ct. at 1258-59.
[65] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[66] 201 F. Supp. 3d 131 (D.D.C. 2016).

outlier regulations and did not protest the additional outlier payment it was seeking. The provider's request for EJR was denied because the Board found that it lacked jurisdiction over the issue. The District Court concluded that, under *Bethesda,* the 2008 self-disallowance regulation could not be applied to appeals raising a legal challenge to a regulation or other policy that the Medicare Contractor could not address.[67]

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

One of the participants that comprise this optional group appeal has filed an appeal involving its fiscal year ending September 30, 2016 (Cape Fear Valley Medical Center, FYE September 30, 2016, hereinafter "Cape Fear FY 2016"). The Board has determined that, for Cape Fear FY 2016, the challenge involving the capital DSH payment in this case is governed by CMS Ruling CMS-1727-R since the Provider is challenging the validity of 42 C.F.R. § 412.320(a)(1)(iii) for a fiscal year ending prior to December 31, 2016. The four remaining participants have filed appeals involving fiscal years ending September 30, 2017 and December 31, 2017. As further discussed below, these participants are subject to the regulations at 42 C.F.R. §§ 413.24(j) and 405.1873.

2. Jurisdiction Over the Remaining Participants

In the November 13, 2015 Final Outpatient Prospective Payment Rule,[68] the Secretary finalized new cost reporting regulations related to the substantive reimbursement requirement of an appropriate cost report claim.[69] 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, again, for cost reports beginning on or after January 1, 2016 (hereinafter the "claim-specific dissatisfaction

[67] *Id.* at 142.
[68] 80 Fed. Reg. 70298, 70551-70580 (Nov. 13, 2015).
[69] *Id.* at 70555.

requirement"). As all of the remaining participants in this case have fiscal years that began on or after January 1, 2016, the claim-specific dissatisfaction requirement is not applicable.

All of the remaining participants in this optional group have appealed from original NPRs. Based on its review of the record, the Board finds that each of the participants timely filed their appeals within 180 days of the issuance of their respective final determinations as required by 42 C.F.R. § 405.1835, that the providers each appealed the issue in this appeal, and that the Board is not precluded by regulation or statute from reviewing the issue in this appeal.

3. Jurisdiction Over the Group

The Board finds the group issue is appropriate for a group and that the EJR request reflects the group 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). The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount.

B. Board review of compliance with the reimbursement requirement of an appropriate cost report claim pursuant to 42 C.F.R. § 405.1873 (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.[70]

These regulations are applicable to the cost reporting periods under appeal for four (4) of the participants in this group, which all have cost reporting periods ending on or 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 Medicare Contractor filed a Substantive Claim Challenge on October 18, 2022 regarding only one of the four participants that are subject to compliance with § 413.24(j). Specifically, the Medicare Contractor argues that St. Barnabas Hospital (FYE December 31, 2017, hereinafter

[70] (Bold emphasis added.)

"St. Barnabas") did not include an appropriate claim for the Capital DSH issue. On October 31, 2022, pursuant to Board Rule 44.6 (Nov. 2021), the Board issued a Scheduling Order requiring the Provider to file any response to the challenge no later than November 21, 2022. The Provider filed its response on November 21, 2022.

1. Medicare Contractor's Argument

The Medicare Contractor claims that St. Barnabas did not claim reimbursement for an amount stemming from the purported understated Capital DSH Payment Amount and, thus, has not claimed reimbursement for this specific issue in its December 31, 2017 cost report. While St. Barnabas did identify $1,583,693 in Part A protested amounts, the summary of protested amounts did not establish a self-disallowed item specifically for the purported understated Capital DSH issue. As a result, the Medicare Contractor contends that St. Barnabas did ***not*** include an appropriate claim for the specific item under appeal, and that none of the exceptions in 42 C.F.R. § 413.24(j)(3)(i)-(iii) apply.

2. Group Representative's Argument

The Group Representative's response to the Substantive Claim Challenge first restates the merits of its position on the validity of the regulation governing Capital DSH payments and the related *Toledo* litigation. It notes that it would have been impossible to know that CMS relied on false information and misstatements of policy at the time the Capital DSH regulation was promulgated.

The Group Representative then points to the notice and the comments raised when the substantive claim regulations were promulgated. Commenters were concerned about this scenario, namely whether there would be redress or agency errors unknown or unknowable by a provider. The Group Representative summarizes CMS' response as that a provider could appeal the issue even if not protested, but that no relief (reimbursement) would ultimately be available upon a successful appeal. It claims that, in this scenario, equitable remedies are appropriate such as the tolling of any substantive claim requirement until the filing of a Request for Hearing, "which is exactly what happened here." Accordingly, the Group Representative admits that St. Barnabas did not comply with § 413.24(j).

The Group Representative concludes its response by arguing that the substantive claim challenge regulations are invalid based on the rationale in *Bethesda Hosp. Ass'n v. Bowen*, 485 U.S. 399, 402 (1988) and *Banner Heart Hospital v. Burwell*, 201 F. Supp. 3d 131, 140 (D.D.C. 2016). It requests the Board deny the Substantive Claim Challenge or, in the alternative, grant EJR over the validity of 42 C.F.R. §§ 413.24(j) and 405.1873, in addition to the Capital DSH issue.

3. Appropriate Cost Report Claim: Findings of Fact and Conclusions of Law

The regulation at 42 C.F.R. § 405.1873 dictates that, for fiscal years beginning January 1, 2016 and later, the Board's findings with regard to whether or not a provider "include[d] in its cost report an appropriate claim for the ***specific*** item [under appeal] (as prescribed in § 413.24(j))"[71] may not be invoked or relied on by the Board to decline jurisdiction. *Instead, 42 C.F.R.*

[71] (Emphasis added.)

§ 413.24(j) makes this a requirement for reimbursement, rather than a jurisdictional one. Nevertheless, when granting EJR, 42 C.F.R. § 405.1873(d)(2) requires the Board to include its specific findings of fact and conclusions of law findings as to whether an appropriate claim was included.

Here the Board only has obligations to make findings on one Provider, namely St. Barnabas, since the Medicare Contractor only filed a challenge against that Provider. The Board finds that St. Barnabas failed to make an appropriate claim for the Capital DSH issue. St. Barnabas admits this fact, but argues that it is inequitable to apply the substantive claim regulations given the facts of this case. The Board does not have the power to provide equitable remedies[72] and is bound by the substantive claim regulations as written.[73] However, as it is undisputed that St. Barnabus failed to comply with § 413.24(j), the Board finds it appropriate to grant St. Barnabas' EJR request challenging the validity of 42 C.F.R. §§ 413.24(j) and 405.1873 in addition to the Capital DSH regulation.[74]

C. Board's Decision Regarding the EJR Request

The Board finds that:

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

2) St. Barnabas Hospital (Prov. No. 33-0399, FYE 12/31/2017) appealed a cost reporting period beginning after January 1, 2016 and it is undisputed that it failed to include "an appropriate claim for the specific item" that is the subject of the group appeal as required under 42 C.F.R. § 413.24(j)(1);

3) Based upon the participants' assertions regarding 42 C.F.R. § 412.320(a)(1)(iii), there are no findings of fact for resolution by the Board;

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

5) It is without the authority to decide the legal questions of: (a) whether 42 C.F.R. § 412.320(a)(1)(iii), as promulgated in the FY 2007 IPPS Final Rule, is substantively or

---

[72] *Sebelius v. Auburn Regional Medical Center*, 133 S. Ct. 817 (2013).
[73] 42 C.F.R. § 405.1867.
[74] The Board recognizes that this question relates only to St. Barnabas and does not apply to the full group and that, as a result, it would appear to run afoul of 42 C.F.R. § 405.1837(g) and potentially require bifurcation. However, the Board finds that this is not so in this case. Compliance with 42 C.F.R. § 413.24(j) is substantive in nature (*i.e.*, directly impacts potential reimbursement), but does not affect the issue that is the subject of the appeal. Similar to jurisdictional review, a provider's compliance with § 413.24(j) relates to the nature of the provider's participation in the group (as set forth in 42 C.F.R. § 405.1873) and is only triggered when, pursuant to § 405.1873(a) as a procedural matter in the proceedings before the Board, a party raises their hand and questions the provider's compliance with § 413.24(j). As a result, the Board finds that potential bifurcation has not been triggered under § 405.1837(f). This situation is akin to the Board denying jurisdiction over one participant in a group but granting EJR relative to the rest of the group. Accordingly, judicial review is available to St. Barnabas.

procedurally valid; ***and*** (b) as it relates to St. Barnabas Hospital, whether the regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 are valid.

Accordingly, the Board finds that the question of the validity of 42 C.F.R. § 412.320(a)(1)(iii) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for EJR for the issue and 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 St. Barnabas Hospital's (Provider No. 33-0399, FYE 12/31/2017) request for EJR for the issue and the subject year.[75] The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in this case, the Board hereby closes the case.

Board Members Participating:

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

FOR THE BOARD:

12/7/2022

X Clayton J. Nix

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

Enclosure: Schedule of Providers

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

[75] *See supra* note 74.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Board Decision*** **– SSI Percentage (Provider Specific) and Medicaid Eligible Days**
Berwick Hospital Center (Prov. No. 39-0072)
FYE 06/30/2018
Case No. 22-0076

Dear Messrs. Summar and Lamprecht:

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the documentation in Case No. 22-0076 in response to a jurisdictional challenge filed by the Medicare Contractor ("MAC"). The Board's decision is set forth below.

Background

A. Procedural History for Case No. 22-0001

On October 26, 2021, Berwick Hospital Center, appealed a Notice of Program Reimbursement (NPR) dated May 14, 2021, for its fiscal year dating June 30, 2018 ("FY 2018"). The Provider appealed the following 3 issues:[1]

- Issue 1: Supplemental Security Income (SSI) Percentage (Provider Specific)
- Issue 2: SSI Percentage (Systemic Errors)[2]
- Issue 3: Medicaid Eligible Days

On May 9, 2022, Issues 2 was transferred to the common issue related party("CIRP") group under Case No. 21-1206GC. As a result, only 2 issues remain pending: Issue 1, DSH SSI Percentage (Provider Specific) and Issue 3, DSH Medicaid Eligible Days.[3]

On May 24, 2022, the Provider filed its preliminary position paper ("PPP").

[1] Provider's Request for Hearing, Tab 3, at Issue Statement (Oct. 1, 2021).
[2] The Provider transferred this issue to Group Case No. 21-1206GC on May 9, 2022.
[3] MAC's Jurisdictional Challenge, at 1 (Jul. 13, 2022).

On July 13, 2022, the Medicare Contractor filed a Jurisdictional Challenge regarding ***both*** Issues 1 and 3, addressing the DSH Supplemental Security Income ("SSI") Percentage related issue and the DSH Medicaid Eligible Days issue.[4]

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

On September 28, 2022, the Medicare Contractor filed its PPP.

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

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

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

As the Provider is commonly owned by Community Health Systems, Inc. ("CHS"), the Provider was also directly added to the CHS common issue related party ("CIRP") group under Case No.

---

[4] *Id*.
[5] Provider's Request for Hearing, Issue Statement (Oct. 26, 2021).

21-1206GC entitled "CHS CY 2018 DSH SSI Percentage CIRP Group." This CHS CIRP group has the following issue statement:

> **Statement of the Issue:**
>
> Whether the Secretary properly calculated the Provider's [DSH]/[SSI] percentage, and whether CMS should be required to recalculate the SSI percentages using a denominator based solely upon covered and paid for Medicare Part A days, or alternatively, expand the numerator of the SSI percentage to include paid/covered/entitled as well as unpaid/con-covered/eligible SSI days?
>
> **Statement of the Legal Basis**
>
> The Provider(s) contend(s) that the MAC's determination for their DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww(d)(5)(F)(vi). The Provider(s) further contend(s) that the SSI percentages calculated by [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. 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 the Provider as a participant in Case No. 21-1206GC is $6,257.

As noted above, on May 25, 2022, the Provider filed its PPP. 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

[6] Group Issue Statement, Case No. 21-1466GC.

> 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. 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 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).

The only exhibit included with the PPP that relates to Issue 1 was Exhibit 1, which was listed as an Eligibility Listing, but noted that it would be sent under separate cover. Exhibit 2 shows the amount in controversy as $6,257. This is the ***same*** *amount* that is listed as the amount in controversy for this Provider as a participant in Case No. 21-1466GC.

MAC's Contentions

Issue 1 – DSH SSI Percentage (Provider Specific)

The MAC contends that the portion of Issue 1 concerning SSI data accuracy should be dismissed because it is duplicative of Issue 2, which was transferred into Group Case No. 21-1206GC, *CHS CY 2018 DSH SSI Percentage CIRP Group*. The Portion of Issue 1 concerning realignment should be dismissed because there was no final determination over SSI realignment and the Provider's appeal is premature as the Provider has not exhausted all available remedies.[7]

Lastly, Issue 1 should be dismissed because the Provider failed to file a complete PPP including all supporting exhibits to document the merits of its argument in accordance with 42 C.F.R. § 405.1853(b)(2) and Board Rule 25.

[7] *Id*. at 2.

Issue 3 – DSH Medicaid Eligible Days

The MAC also argues that the Provider has abandoned the DSH – Medicaid Eligible Days issue. Pursuant to Board Rule 25.3, parties should file a complete PPP with a fully developed narrative, all exhibits, a listing of exhibits, and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853, which the Provider did not do with respect to the Medicaid eligible days issue.[8]

Provider's Response

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

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.

A. SSI 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 directly filed into Group Case No. 21-1206GC, CHS CY 2018 DSH SSI Percentage CIRP Group.

The Board finds that the first aspect of Issue 1 (the DSH/SSI (Provider Specific) issue) in this appeal is duplicative of Issue 2 (the DSH/SSI (Systemic Errors) issue) that was directly filed into Case No. 21-1206GC. The first aspect of Issue 1 in the present appeal concerns "whether the Medicare Administrative Contractor used the correct [SSI] percentage in the [DSH] Calculation."[9]

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

The Provider's legal basis for this aspect of Issue 1 is simply that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[10] Similarly, the Provider argues that "it[s] SSI percentage published by [CMS] was incorrectly computed . . ." and it ". . . [s]pecifically . . . disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[11] The DSH systemic issues filed into Case No. 21-1466GC, similarly alleges that the Medicare Contractor and CMS improperly calculated the DSH/SSI Percentage, the DSH/SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F)(i). Indeed, the Provider has the ***same*** amount in controversy for both Issue 1 and for its participation in the CIRP group, namely $4,777.

Thus, the Board finds that the first aspect of Issue 1 in this appeal is duplicative of the group issue in Case No. 21-1206GC, for this same provider and fiscal year. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (Mar. 1, 2013), the Board dismisses this aspect of the DSH/SSI (Provider Specific) issue.

In making this finding, the Board further notes that CMS regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, is pursuing that issue as part of the group under Case 21-1206GC. 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.[12] 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. 21-1206GC.

To this end, the Board also reviewed the Provider's PPP 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 PPP 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 PPP and include *all* exhibits. The Provider has failed to establish, describe

[10] *Id.*
[11] *Id.*
[12] 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).

or explain any of the alleged "provider-specific" errors.[13] As a result, neither the Board nor the opposing party has a thorough understanding of the merits of the Provider's case on this issue.

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

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

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

[13] If it is not provider specific issue but rather systemic, then it is an issue that would be common to all CHS providers and would be required to be transferred to a CHS CIRP. Indeed, this is what CHS did by transferring Issue 2 to a CHS CIRP Group.

> https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH.[14] 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."[15]

Accordingly, the Board must find that Issues 1 and the group issue in the CHS CIRP group under Case No. 21-1206GC, are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (2015), the Board dismisses this component of the DSH/SSI (Provider Specific) issue. As an alternative basis the Board dismisses Issue 1 for failure of the Provider to properly brief the issue in its position paper in compliance with Board Rules.

2. *Second Aspect of Issue 1*

The second aspect of the DSH SSI Percentage (Provider Specific) issue—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—must be dismissed for lack of jurisdiction and as premature. Under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request…" Without this written request, the Medicare Contractor cannot issue a final determination from which the Provider can be dissatisfied with for appealing purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding the Provider's DSH SSI Percentage realignment as such there is no "determination" to appeal and the appeal of this issue is otherwise premature.

B. DSH Medicaid Eligible Days

According to its Appeal Request, the Provider asserts that all Medicaid eligible days were not included in the calculations of the DSH calculations. The Provider states Issue 2 as:

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

[14] (Last accessed Nov. 21, 2022.)
[15] (Emphasis added.)

> 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.[16]

The amount in controversy calculation and protested item documentation for this issue suggests the number of Medicaid eligible days at issue. However, the Provider's appeal request did not include a list of the specific additional Medicaid eligible days that are in dispute in this appeal and desire to be included in their Medicaid percentage and DSH computations, with their appeal request. Rather, it simply represented in the amount in controversy calculation that there were 50 Medicaid eligible days at issue.

On May 25, 2022, the Provider filed their PPP in which it indicated that it would be sending the eligibility listing under separate cover.[17] Indeed, the position paper did not even identify how many Medicaid eligible days remained in dispute in this case (*e.g.*, whether there remained the same number of days as suggested in the appeal request or more or less). Specifically, the Provider's complete briefing of this issue in its position paper is as follows:

> **Calculation of Medicaid Eligible Days**
>
> Specifically, the Provider disagrees with the MAC's determination of the computation of the disproportionate patient percentage set forth at 42 C.F.R. § 412.106(b)(4) of the Secretary's Regulations.
>
> The Sixth Circuit Court of Appeals, in *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.*, 19 F.3d 270 (6th Cir. 1994), held that all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage when the DSH adjustment is calculated. Similar decisions were rendered by the Fourth, Eighth and Ninth Circuits: *Cabell Huntington Hospital, Inc. v. Shalala*, 101 F.3d 984 (4th Cir. 1996); *Deaconess Health Services Corp. v. Shalala*, 83 F.3d 1041 (8th Cir. 1996), *aff'g* 912 F. Supp. 478 (E.D. Mo. 1995); and *Legacy Emanuel Hospital and Health Center v. Shalala*, 97 F.3d 1261 (9th Cir. 1996).

[16] *Id*.
[17] Provider's Preliminary Position Paper at 8 (May 25, 2022).

> The Centers for Medicare and Medicaid Services ("CMS", formerly HCFA) acquiesced in the above decisions and issued HCFA Ruling 97-2, which in pertinent part reads as follows:
>
> > [T]he Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to include all inpatient hospital days of service for patients who were eligible on that day for medical assistance under a state Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for these inpatient hospital services.
>
> Based on the Listing of Medicaid Eligible Days being sent under separate cover, the Provider contends that the total number of days reflected in its' [*sic*] 2018 cost report does not reflect an accurate number of Medicaid eligible days, as required by HCFA Ruling 97-2 and the pertinent Federal Court decisions.

In its jurisdictional challenge, the MAC asserts that the Provider has failed to submit a list of additional Medicaid eligible days. While the Calculation Support filed with their appeal notes a net impact of $39,728, with an increase in days, it is unclear whether this amount continues to be in dispute as of the Provider's filing of the position paper.

Board Rule 7.3.1.2 (Nov. 2021) 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 MAC asserts that the Provider neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2.

Notably, the Provider has not included a list of additional Medicaid eligible days with its preliminary position paper or submitted such list under separate cover. The MAC thus asserts that the Provider has essentially abandoned the issue by failing to properly develop its arguments

and to provide supporting documents or to explain why it cannot produce those documents, as required by the regulations and the Board Rules.[18]

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*.[19]

With regard to the filing of an individual appeal, Board Rule 7 (Support for Appealed Final Determination, Issue-Related Information and Claim of Dissatisfaction) (Jul. 2015) states:

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

Similarly, with regard to position papers,[20] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[21] 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:

---

[18] *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.

[19] (Emphasis added.)

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

[21] (Emphasis added.)

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.[22]

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,

[22] (Emphasis added.)

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" [23] 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 with its PPP 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.

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's PPP has failed to satisfy the requirements of Board Rules 25.2.1 and 25.2.2 related to identifying the days in dispute and the submission of documentary evidence required to support its claims or describe why said evidence is unavailable, which the Provider has failed to do.[24] The Board takes administrative notice that it has made similar dismissal in other cases in which CHS was the designated representative and, notwithstanding, CHS failed to provide the Medicaid eligible days listing with its preliminary position paper.

****

In summary, the Board hereby dismisses the SSI 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. As an alternative basis, the Board would dismiss the SSI Provider Specific Issue for failure to meet the Board requirements for position papers. In addition, the Board dismisses the Medicaid eligible days issue as the Provider also failed to meet the Board requirements for position papers for this issue. As no issues remain pending, the Board hereby closes Case No. 22-0076 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:

12/7/2022

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services

[23] (Emphasis added.)
[24] Board Rule 25, of which 25.2.1 and 25.2.2 are a part, is applicable to final position papers via Board Rule 27.2.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Board Decision*** **– SSI Percentage (Provider Specific)**
Bailey Medical Center (Prov. No. 37-0228)
FYE: 12/31/2010
Case Number: 15-2347

Dear Messrs. Ravindran and Tisdale:

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the documentation in Case No. 15-2347 in response to a jurisdictional challenge filed by the Medicare Contractor ("MAC"). The Board's decision is set forth below.

Background

A. Procedural History for Case No. 15-2347

Bailey Medical Center's ("Bailey" or "Provider"), appealed a Notice of Program Reimbursement (NPR) dated October 22, 2014, for its fiscal year end (FYE) December 31, 2010 cost reporting period. On April 21, 2015, the Provider filed an individual appeal request which contained the following issues including those challenged by the MAC below.[1]

- Issue 1: Disproportionate Share Hospital (DSH) Supplemental Security Income (SSI) Percentage (Provider Specific)
- Issue 2: DSH SSI Percentage (Systemic Errors)
- Issue 3: DSH Medicare Managed Care Part C Days
- Issue 4: DSH Dual Eligible Days – SSI Fraction
- Issue 5: DSH – Medicaid Eligible Days
- Issue 6: DSH Medicare Part C Days – Medicaid Fraction
- Issue 7: DSH Dual Eligible Days – Medicaid Fraction
- Issue 8: Outlier Payments

[1] Provider's Request for Hearing, Tab 3, at Issue Statement (Apr. 21, 2015).

All but two of the group issues were transferred to Group Cases. After all transfers, two issues remain: Issue 1, DSH SSI Percentage (Provider Specific), and Issue 5, DSH – Medicaid Eligible Days.[2]

The Medicare Contractor filed a Jurisdictional Challenge on August 25, 2015, regarding Issue 5, DSH – Medicaid Eligible Days, and Issue 8, Outlier Payments. The Provider filed a response on September 18, 2015. The outlier issue was then transferred to a group appeal on July 15, 2016.

On October 21, 2022, the Board issued a letter to FSS and the MAC, inquiring if a Board decision is necessary for the resolution of the Medicaid Eligible days issue, as the Board had yet to respond to the initial challenge.[3] In response, the MAC filed a new jurisdictional challenge, filed on October 26, 2022, supplanting and withdrawing the original challenge from 2015. This new challenge withdraws the challenge to issue 5, and solely challenges Issue 1, the DSH SSI Percentage (Provider Specific) issue.[4]

The Provider failed to respond to the jurisdictional challenge filed October 26, 2022.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 14-2877GC

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

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

[2] MAC's Jurisdictional Challenge, at 1 (Aug. 25, 2015).
[3] Board's Inquiry Letter (Oct. 21, 2022).
[4] MAC's Jurisdictional Response and Challenge (Oct. 26, 2022).

> CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[5]

As the Provider is commonly owned, the Provider was also directly added to the common issue related party ("CIRP") group under Case No. 14-2877GC entitled "Ardent Health Services 2010 Post 1498-R SSI% Data Match Process CIRP Group." This CIRP group has the following issue statement:

> **Statement of the Issue:**
>
> Whether the Secretary properly calculated the Provider's [DSH]/[SSI] percentage, and whether CMS should be required to recalculate the SSI percentages using a denominator based solely upon covered and paid for Medicare Part A days, or alternatively, expand the numerator of the SSI percentage to include paid/covered/entitled as well as unpaid/con-covered/eligible SSI days?
>
> **Statement of the Legal Basis**
>
> The Provider(s) contend(s) that the MAC's determination for their DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww(d)(5)(F)(vi). The Provider(s) further contend(s) that the SSI percentages calculated by [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. 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]

On December 23, 2015, the Provider filed its preliminary position paper. The original appeal documentation shows the amount in controversy as $3,621. This is the same amount that is listed as the amount in controversy for this Provider as a participant in 14-2877GC.

MAC's Jurisdictional Challenge

Issue 1 – DSH SSI Percentage (Provider Specific)

[5] Provider's Request for Hearing, Issue Statement (Oct. 26, 2021).
[6] Group Issue Statement, Case No. 14-2877GC.

The MAC contends that the portion of Issue 1 concerning SSI data accuracy should be dismissed because it is duplicative of Issue 2, which was transferred into Group Case No. 14-2877GC, *QRS Ardent Health 2010 DSH SSI Percentage CIRP Group*. The Portion of Issue 1 concerning realignment should be dismissed because there was no final determination over SSI realignment and the Provider's appeal is premature as the Provider has not exhausted all available remedies.[7]

Lastly, Issue 1 should be dismissed because the Provider failed to file a complete preliminary position paper including all supporting exhibits to document the merits of its argument in accordance with 42 C.F.R. § 405.1853(b)(2) and Board Rule 25.

Provider's Response

The Provider did not file a response to the jurisdictional challenge over the SSI Provider Specific. As previously noted, 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

A. SSI 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 directly filed into Group Case No. 14-2877GC, Ardent Health Services 2010 Post 1498-R SSI% Data Match Process CIRP Group.

The Board finds that the first aspect of Issue 1 (the DSH/SSI (Provider Specific) issue) in this appeal is duplicative of Issue 2 (the DSH/SSI (Systemic Errors) issue) that was directly filed into Case No. 14-2877GC. The first aspect of Issue 1 in the present appeal concerns "whether the Medicare Administrative Contractor used the correct [SSI] percentage in the [DSH] Calculation."[8] The Provider's legal basis for this aspect of Issue 1 is simply that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[9] Similarly, the Provider argues that "it[s] SSI percentage published by [CMS] was incorrectly computed . . ." and it ". . . [s]pecifically . . .

[7] *Id*. at 2.
[8] Individual Appeal Request, Issue 1.
[9] *Id.*

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."[10] The DSH systemic issues filed into Case No. 14-2877GC, similarly alleges that the Medicare Contractor and CMS improperly calculated the DSH/SSI Percentage, the DSH/SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F)(i). Indeed, the Provider has the same amount in controversy for both Issue 1 and for its participation in the CIRP group, namely $3,621.

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 14-2877GC. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[11] 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. 14-2877GC.

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. 14-2877GC, 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;

[10] *Id.*
[11] 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).

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

Accordingly, the Board finds that the first aspect of Issue 1 and the group issue in Group Case 14-2877GC, are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (2015), the Board dismisses this component of the DSH/SSI (Provider Specific) issue. As an alternative basis the Board dismisses Issue 1 for failure of the Provider to properly brief the issue in its position paper in compliance with Board Rules.

2. Second Aspect of Issue 1

[12] (Last accessed Nov. 21, 2022.)
[13] (Emphasis added.)

The second aspect of the DSH SSI Percentage (Provider Specific) issue—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—must be dismissed for lack of jurisdiction and as premature. Under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request…" Without this written request, the Medicare Contractor cannot issue a final determination from which the Provider can be dissatisfied with for appealing purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding the Provider's DSH SSI Percentage realignment as such there is no "determination" to appeal and the appeal of this issue is therefore premature.

****

In summary, the Board hereby dismisses the SSI Provider Specific issue from this appeal as it is duplicative of the issue in Case No. 14-2877GC, 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. Medicaid Eligible Days is the sole issue that remains pending.

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

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For the Board:

12/8/2022

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cc: Wilson Leong, Federal Specialized Services

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RE: ***Expedited Judicial Review Determination***
Montefiore Health CY 2017 Capital DSH CIRP Group
Case No. 21-1419GC

Dear Mr. Ruskin:

The Provider Reimbursement Review Board ("Board") has reviewed the Provider's December 1, 2022 request for expedited judicial review ("EJR") in the above-referenced common issue related party ("CIRP") group appeal.[1] The decision with respect to EJR is set forth below.

Issue under Dispute

In this case, the Providers are

> [C]hallenging the application of 42 C.F.R. § 412.320(a)(1)(iii), which states that urban hospitals may qualify for Capital [disproportionate share hospital] payments unless, on or after October 1, 2006, the urban hospital is reclassified as rural. [The Provider Group contends that] [t]his regulation is inconsistent with Social Security Act Section 1886(d)(8)(E)[2], which specifically concerns rural status. Section 1886(d)(8)(E) specifically notes that the hospitals that have undergone a rural reclassification are rural only for "purposes of this subsection [1886(d)]."[3]

[1] Montefiore Health System is a health system with multiple hospitals and is subject to the mandatory CIRP group regulations at 42 C.F.R. § 405.1837(b)(1) as it relates to the common issue in Case No. 21-1419GC for the year 2017. As Montefiore Health System designated the CIRP group fully formed, the health system is 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."

[2] Codified at 42 U.S.C. § 1395ww(d)(8)(E).

[3] Request for Expedited Judicial Review at 2-3 (Dec. 1, 2022) ("EJR Request"). *See also* Issue Statement – Capital DSH.

Background:

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

A. Geographic Reclassification

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

B. Operating DSH Adjustment Under Operating IPPS

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

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

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[4] Daniel R. Levinson, Department of Health and Human Services, Office of the Inspector General, *Significant Vulnerabilities Exist in the Hospital Wage Index System for Medicare Payments*, 1 (Nov. 2018), *available at* https://oig.hhs.gov/oas/reports/region1/11700500.pdf (last visited Oct. 20, 2022) ("*Significant Vulnerabilities*").
[5] *See* https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/wageindex.html (42 U.S.C. § 1395ww(d)(3)(E) requires that, as part of the methodology for determining prospective payments to hospitals, the Secretary must adjust the standardized amounts "for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level." This adjustment factor is the wage index. The Secretary currently defines hospital geographic areas (labor market areas) based on the definitions of Core-Based Statistical Areas ("CBSAs") established by the Office of Management and Budget and announced in December 2003. The wage index also reflects the geographic reclassification of hospitals to another labor market area, such as rural to urban or vice versa, in accordance with sections 1395ww(d)(8)(B) and 1395ww(d)(10).).
[6] Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, 103 Stat. 2106, 2154 (1989). *See also Significant Vulnerabilities* at 4-5.
[7] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[8] *Id.*
[9] *See* 42 U.S.C. § 1395ww(d)(5).
[10] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.

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

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

C. Capital DSH Adjustment Under Capital IPPS

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

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

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

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

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

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

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

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

[14] (Underline and italics emphasis added.)
[15] 42 C.F.R. § 412.320(a)(1). *See also* MedPAC, *Hospital Acute Inpatient Services Payment System: Payment Basics*, 2 (rev. Nov. 2021), *available at* https://www.medpac.gov/wp-content/uploads/2021/11/medpac_payment_basics_21_hospital_final_sec.pdf (last visited Oct. 20, 2022).
[16] 56 Fed. Reg. 43356 (Aug. 30, 1991).

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

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

> In the proposed rule, our regression results indicated that for urban hospitals with more than 100 beds, the disproportionate share percentage of low income patients has an effect on capital costs per case. We proposed that urban hospitals with 100 or more beds would receive an additional payment equal to ({1 +DSHP)$^{0-4176}$ - 1)), where DSHP is the disproportionate share patient percentage. There would be no minimum disproportionate share patient percentage required to qualify for the payment adjustment. A hospital would receive approximately a 4.2 percent increase in payments for each 10 percent increase in its disproportionate share percentage. This formula is similar to the one used for the indirect medical education adjustment under the operating prospective payment system.
>
> Since we did not find a disproportionate share effect on the capital costs of urban hospitals with fewer than 100 beds or on rural hospitals, we did not propose to make a disproportionate share adjustment to the capital payment to these hospitals.[18]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[24] (Bold and underline emphasis added.)
[25] *Id*. at 43452-53.

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

On November 29, 1999, Congress enacted the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 ("BBRA") and BBRA § 401 amended 42 U.S.C. § 1395ww(d)(8) to require that certain urban IPPS hospitals be reclassified as rural *for purposes of operating IPPS* if an application is submitted to the MGCRB and certain criteria are met.[26] IPPS hospitals 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.[27]

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

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

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

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

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

This policy is consistent not only with the statutory language but also with the policy considerations underlying the MGCRB process. The MGCRB process permits a hospital to be reclassified from one geographic area to another if it is significantly disadvantaged by its geographic location and would be paid more appropriately if it were reclassified to another area. We believe that it would be illogical to permit a hospital that applied to be reclassified from urban to rural under section 1886(d)(8)(E) of the Act because it was disadvantaged as an urban hospital to then utilize a process that was established to enable hospitals significantly disadvantaged by their rural or small urban location to reclassify to another urban location. *If an urban hospital applies under section 1886(d)(8)(E) of the Act in order to be treated as being located in a rural area, then it would be anomalous at best for the urban hospital to subsequently claim that it is significantly disadvantaged by the rural status for which it applied and should be reclassified to an urban area. Furthermore, permitting hospitals the option of seeking rural reclassification under section 1886(d)(8)(E) of the Act for certain payment advantages, coupled with the ability to pursue a subsequent MGCRB reclassification back to an urban area, could have implications beyond those originally envisioned under Public Law 106–113*. In particular, we are concerned about the potential interface between rural reclassifications under section 401 and section 407(b)(2) of Public Law 106– 113, which authorizes a 30-percent expansion in a rural hospital's resident full-time equivalent count for purposes of Medicare payment for the indirect costs of medical education (IME) under section 1886(d)(5)(B) of the Act. (Reclassification from urban to rural under section 1886(d)(8)(E) of the Act can affect IME payments to a hospital, which are made under section 1886(d)(5)(B) of the Act, but not payments for the direct costs of GME, which are made under section 1886(h) of the Act.)

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

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

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

[28] 65 Fed. Reg. 47054, 47088-89 (Aug. 1, 2000).

> Services Administration which is available via the ORHP website at http:// www.nal.usda.gov/orph or from the U.S. Department of Health and Human Services, Health Resources and Services Administration, Office of Rural Health Policy, 5600 Fishers Lane, Room 9–05, Rockville, MD 20857.
>
> (2) The hospital is located in an area designated by any law or regulation of the State in which it is located as a rural area, or the hospital is designated as a rural hospital by State law or regulation.
>
> (3) The hospital would qualify as a rural referral center as set forth in § 412.96, or as a sole community hospital as set forth in § 412.92, if the hospital were located in a rural area.[29]

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

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

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

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

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

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

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

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

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

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

(ii) The term *urban area* means—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[38] 69 Fed. Reg. 48916, 49187-88 (Aug. 11, 2004) (italics emphasis added).

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

In the FY 2007 Proposed IPPS Rule, the Secretary[39] announced that he was proposing technical changes to 42 C.F.R. §§ 412.316(b) and 412.320(a)(1) to clarify that hospitals reclassified as rural under § 412.103 are not eligible for the large urban add-on payment or for the capital DSH adjustment. These proposed changes reflected the historic policy that hospitals reclassified as rural under § 412.103 also would be considered rural under the capital IPPS. Since the genesis of the capital IPPS in FY 1992, the same geographic classifications used under the operating IPPS also have been used under the capital IPPS.[40]

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

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

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

[39] of the Department of Health and Human Services.
[40] 71 Fed. Reg. 23995, 24122 (Apr. 25, 2006).
[41] *Id.*

> reclassifications under the operating PPS the same for purposes of the capital PPS. Therefore, we proposed to specify under §§ 412.316(b)(2) and (b)(3) and 412.320(a)(1)(ii) and (a)(1)(iii) that, for discharges on or after October 1, 2006, hospitals that are reclassified from urban to rural under § 412.103 would be considered rural.[42]

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

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

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

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

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

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[42] *Id.*
[43] *Id.*
[44] (Bold emphasis added.)
[45] 2021 WL 4502052 (D.D.C. 2021).

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

In *Toledo*, U.S. District Court for the District of Columbia ("D.C. District Court") outlined the legislative history surrounding the creation of the MGCRB in 1989 which, as noted above, can redesignate IPPS hospitals to different labor market areas in order to receive a different wage reimbursement rate.[47] The Court also noted how Congress enacted legislation in 1999[48] allowing IPPS hospitals to reclassify from an urban labor market area to a rural one for various reasons. Thus, a geographically urban hospital can be classified as rural, but then redesignate itself back into an urban labor market area for the purposes of fixing its wage index.[49] The Court also noted the separate IPPS payment for a hospital's *capital* costs at 42 U.S.C. § 1395ww(g) (compared to the IPPS payment for *operating* costs), as well as the capital IPPS adjustments found at 42 C.F.R. § 412.320 for large urban hospitals (the capital DSH payment).[50] The Court explained that, following the 2006 rulemaking, a geographically urban hospital which reclassifies as rural under § 401 loses its eligibility for the capital DSH adjustment.[51]

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

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

---

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

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

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

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

   - "[T]he record does not show that the Secretary articulated a consistent policy of treating these reclassified hospitals as rural for capital DSH adjustment purposes, he cannot fall back on any purported general policy of using operating PPS geographic classifications for capital PPS reimbursements."[56]

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

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

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

Providers' Request for EJR

The Providers state that EJR is appropriate because the they are challenging the regulation that governs capital DSH payments to urban hospitals that have been reclassified under 42 U.S.C. § 1395ww(d)(8)(E) and 42 C.F.R. § 412.103 (hospitals located in urban areas and that apply for reclassification as rural).[61]

The Providers are challenging the application 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

[54] *Id.* at *11.
[55] *Id.*
[56] *Id.*
[57] *Id.*
[58] *Id.* at *11-12.
[59] *Id.* at *12.
[60] *Id.*
[61] EJR Request at 2.

with 42 U.S.C. § 1395ww(d)(8)(E) 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), not § 1395ww(d), and, accordingly, the literal wording of the rural reclassification statutory provision identifies that rural status does not reach the capital DSH calculation. The Providers 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)(E) and 1395ww(g), and the regulation must be found invalid.[62] 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*.

Since the Board is bound by the regulations being challenged,[63] 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' EJR Request. Since the additional criteria for EJR have also been met, the Providers request the Board grant the request.

Board Decision

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.

A. Jurisdiction

In the November 13, 2015 Final Outpatient Prospective Payment Rule,[64] the Secretary finalized new cost reporting regulations related to the substantive reimbursement requirement of an appropriate cost report claim.[65] 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, again, for cost reports beginning on or after January 1, 2016 (hereinafter the "claim-specific dissatisfaction requirement"). As all of the participants in this case have fiscal years that began on or after January 1, 2016, the claim-specific dissatisfaction requirement is not applicable.

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[62] *Id.* at 3.
[63] *See* 42 C.F.R. § 405.1867.
[64] 80 Fed. Reg. 70298, 70551-70580 (Nov. 13, 2015).
[65] *Id.* at 70555.

The participants that comprise this CIRP group appeal have filed appeals involving fiscal years ending December 31, 2016 and 2017. Three Providers have appealed from an original NPR and one Provider has appealed from a revised NPR. For any participant that files an appeal from a revised NPR issued after August 21, 2008, the Board only has jurisdiction to hear that participant's appeal of matters that the Medicare contractor specifically revised within the revised NPR.[66] The Board notes that the Provider's revised NPR appeal included within this EJR request was issued after August 21, 2008. The Provider which filed an appeal from revised NPR cited audit adjustments which removed Capital DSH payments, as required for jurisdiction under the provisions of 42 C.F.R. § 405.1889.

Based on its review of the record, the Board finds that all four participants in this CIRP group filed their appeals within 180 days of the issuance of their respective final determinations as required by 42 C.F.R. § 405.1835, that the providers each appealed the issue in this appeal, and that the Board is not precluded by regulation or statute from reviewing the issue in this appeal. 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). The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount.

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

[66] *See* 42 C.F.R. § 405.1889(b)(1) (2008).

> 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.[67]

These regulations are applicable to the cost reporting periods under appeal for all four of the participants in this group, which all have cost reporting periods ending on or 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).

[67] (Bold emphasis added.)

On December 8, the Medicare Contractor filed a response to the EJR Request which stated, in its entirety:

> The MAC has reviewed the EJR request and the various providers in the Group. The MAC has neither substantive claim nor jurisdictional challenges for these providers.

The Board interprets the regulation at 42 C.F.R. § 405.1873 to only require the Board to review a provider's "compliance"[68] 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.[69] In this CIRP group case, the Medicare Contractor has failed to file a Substantive Claim Challenge[70] consistent with § 405.1873(a) within the time frame specified by Board Rule 44.5.1 (2021) for any of the Providers in the case.

As such, since no party to the appeal has questioned, pursuant to § 405.1873(a), whether an appropriate claim was made,[71] the Board finds there was no regulatory obligation for the Board to affirmatively, on its own, review the appeal documents to determine whether an appropriate claim was made. As a result, Board review under 42 C.F.R. § 405.1873(b) has not been triggered. Accordingly, the Board need not include any findings regarding compliance with the substantive claim requirements and may proceed to rule on the EJR request pursuant to 42 C.F.R. § 405.1873(d).

C. Board's Decision Regarding the EJR Request

The Board finds that:

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

2) Based upon the participants' assertions regarding 42 C.F.R. § 412.320(a)(1)(iii), there are no findings of fact for resolution by the Board;

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

4) It is without the authority to decide the legal question of whether 42 C.F.R. § 412.320(a)(1)(iii), as promulgated in the FY 2007 IPPS Final Rule, is substantively or procedurally valid.

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[68] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."
[69] *See* 42 C.F.R. § 405.1873(a).
[70] Board Rule 44.5 states: "The Board adoption of the term 'Substantive Claim Challenge' simply refers to any question raised by a party concerning whether the cost report at issue included an appropriate claim for one or more of the specific items being appealed in order to receive or potentially qualify for reimbursement for those specific items."
[71] 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."

Accordingly, the Board finds that the question of the validity of 42 C.F.R. § 412.320(a)(1)(iii) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' EJR Request for the issue and the subject years. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in this case, the Board hereby closes the case.

Board Members Participating:

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

FOR THE BOARD:

12/15/2022

X Clayton J. Nix

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

Enclosure: Schedule of Providers

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Andrew Ruskin, Esq.
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RE: ***Expedited Judicial Review Determination***
Lake Charles Memorial Hospital (Prov. No. 19-0060)
FYE December 31, 2017
Case No. 23-0331

Dear Mr. Ruskin:

The Provider Reimbursement Review Board ("Board") has reviewed the Provider's December 1, 2022 request for expedited judicial review ("EJR") in the above-referenced individual appeal. The decision with respect to EJR is set forth below.

Issue under Dispute

In this case, the Provider is

> [C]hallenging the application of 42 C.F.R. § 412.320(a)(1)(iii), which states that urban hospitals may qualify for Capital [disproportionate share hospital] payments unless, on or after October 1, 2006, the urban hospital is reclassified as rural. [The Provider Group contends that] [t]his regulation is inconsistent with Social Security Act Section 1886(d)(8)(E)[1], which specifically concerns rural status. Section 1886(d)(8)(E) specifically notes that the hospitals that have undergone a rural reclassification are rural only for "purposes of this subsection [1886(d)]."[2]

Background:

Under the inpatient prospective payment system ("IPPS"), Medicare pays hospitals predetermined rates for patient discharges and this system is comprised of two parts, one for operating costs ("operating IPPS") as set forth at § 1395ww(d); and one for capital costs ("capital IPPS") as set forth at 42 U.S.C. § 1395ww(g). The primary objective of IPPS is to

[1] Codified at 42 U.S.C. § 1395ww(d)(8)(E).
[2] Request for Expedited Judicial Review at 2-3 (Dec. 1, 2022) ("EJR Request"). *See also* Issue Statement – Capital DSH.

create incentives for hospitals to operate efficiently, while providing adequate compensation to hospitals.[3] This case focuses on the capital IPPS.

A. Geographic Reclassification

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

B. Operating DSH Adjustment Under Operating IPPS

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

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

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

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[3] Daniel R. Levinson, Department of Health and Human Services, Office of the Inspector General, *Significant Vulnerabilities Exist in the Hospital Wage Index System for Medicare Payments*, 1 (Nov. 2018), *available at* https://oig.hhs.gov/oas/reports/region1/11700500.pdf (last visited Oct. 20, 2022) ("*Significant Vulnerabilities*").
[4] *See* https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/wageindex.html (42 U.S.C. § 1395ww(d)(3)(E) requires that, as part of the methodology for determining prospective payments to hospitals, the Secretary must adjust the standardized amounts "for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level." This adjustment factor is the wage index. The Secretary currently defines hospital geographic areas (labor market areas) based on the definitions of Core-Based Statistical Areas ("CBSAs") established by the Office of Management and Budget and announced in December 2003. The wage index also reflects the geographic reclassification of hospitals to another labor market area, such as rural to urban or vice versa, in accordance with sections 1395ww(d)(8)(B) and 1395ww(d)(10).).
[5] Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, 103 Stat. 2106, 2154 (1989). *See also Significant Vulnerabilities* at 4-5.
[6] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[7] *Id.*
[8] *See* 42 U.S.C. § 1395ww(d)(5).
[9] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[10] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[11] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).

The DSH adjustment provided under operating IPPS is ***not*** at issue in this case. The DSH adjustment is relevant because certain standards set forth in 42 U.S.C. § 1395ww(d)(5)(F) for the DSH adjustment that 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 <u>an adjustment</u> to take into account variations in the relative costs of capital and construction for the different types of facilities or areas in which they are located*;
>
> (iii) may provide for such exceptions (including appropriate exceptions to reflect capital obligations) as the Secretary determines to be appropriate, and
>
> (iv) may provide for suitable adjustment to reflect hospital occupancy rate.
>
> (C) In this paragraph, the term ''capital-related costs'' has the meaning given such term by the Secretary under subsection (a)(4) as of September 30, 1987, and does not include a return on equity capital.[13]

[12] Pub. L. 100-203, § 4006(b), 101 Stat. 1330, 1330-52 (1987).
[13] (Underline and italics emphasis added.)

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

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

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

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:

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[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 Oct. 20, 2022).
[15] 56 Fed. Reg. 43356 (Aug. 30, 1991).
[16] *Id.* at 43369-70 (emphasis added).

> 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)$^{0\text{-}4176}$ - 1)), where DSHP is the disproportionate share patient percentage. There would be no minimum disproportionate share patient percentage required to qualify for the payment adjustment. A hospital would receive approximately a 4.2 percent increase in payments for each 10 percent increase in its disproportionate share percentage. This formula is similar to the one used for the indirect medical education adjustment under the operating prospective payment system.
>
> Since we did not find a disproportionate share effect on the capital costs of urban hospitals with fewer than 100 beds or on rural hospitals, we did not propose to make a disproportionate share adjustment to the capital payment to these hospitals.[17]

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

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

[17] *Id* at 43377.

> patients either because of their smaller size (i.e., under 100 beds) or lower disproportionate share patient percentage. **In rural areas, we believe the more relevant criteria for determining whether a hospital should receive special payment protection is whether the hospital represents the sole source of care reasonably available to Medicare beneficiaries**.[18]

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

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

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

> 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

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

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

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

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

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

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

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

> *Comment*: Many commenters sought clarification of the effect of reclassification by the Medicare Geographic Classification Review Board (MGCRB) on eligibility for capital disproportionate share payments.

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

> *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) If a hospital meets the criteria in paragraph (a) of this section for a disproportionate share hospital for purposes of capital prospective payments, the disproportionate share payment adjustment factor equals [e raised to the power of (.2025 X the hospital's disproportionate patient percentage as determined under § 412.106(b)(5)), —1], where e is the natural antilog of 1.
>
> (2) If a hospital meets the criteria in § 412.106(c)(2) for purposes of inpatient hospital operating prospective payments, the disproportionate share adjustment factor equals 14.16 percent.[24]

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

On November 29, 1999, Congress enacted the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 ("BBRA") and BBRA § 401 amended 42 U.S.C. § 1395ww(d)(8) to require that certain urban IPPS hospitals be reclassified as rural *for purposes of operating IPPS* if

[23] (Bold and underline emphasis added.)
[24] *Id*. at 43452-53.

an application is submitted to the MGCRB and certain criteria are met.[25] IPPS hospitals are reclassified per BBRA § 401 are often referred to as "§ 401 hospitals."

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

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

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

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

[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.)

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 Health and Human Services, Health Resources and Services Administration, Office of Rural Health Policy, 5600 Fishers Lane, Room 9–05, Rockville, MD 20857.

[27] 65 Fed. Reg. 47054, 47088-89 (Aug. 1, 2000).

> (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]

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.

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

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.
>
> (ii) The term *urban area* means—

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

> (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]

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

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 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.

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

> ****
>
> 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 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

[37] 69 Fed. Reg. 48916, 49187-88 (Aug. 11, 2004) (italics emphasis added).
[38] of the Department of Health and Human Services.

the capital IPPS in FY 1992, the same geographic classifications used under the operating IPPS also have been used under the capital IPPS.[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 2006rulemaking is arbitrary and capricious and thus unreasonable for two principal reasons. First, it charges the Secretary with misrepresenting the regulatory history in claiming that the 2006 Rule merely restored a previously implemented policy. Second, the hospital argues that the Secretary failed to "take into account" relative costs of capital

[42] *Id.*
[43] (Bold emphasis added.)
[44] 2021 WL 4502052 (D.D.C. 2021).

> for various hospital types and areas of location, as subsection (g) requires.[45]

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

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

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

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

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

Provider's EJR Request

The Provider states that EJR is appropriate because the it is challenging the regulation that governs capital DSH payments to urban hospitals that have been reclassified under 42 U.S.C. § 1395ww(d)(8)(E) and 42 C.F.R. § 412.103 (hospitals located in urban areas and that apply for reclassification as rural).[60]

The Provider is challenging the application 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 Provider asserts that this regulation is inconsistent with 42 U.S.C. § 1395ww(d)(8)(E) 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), not § 1395ww(d), and, accordingly, the literal wording of the rural reclassification statutory provision identifies that rural status does not reach the capital DSH calculation. The Provider believes that the promulgation of 42 C.F.R. § 412.320(a)(1)(iii) is, therefore, beyond the authority granted under 42 U.S.C.

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[54] *Id.*
[55] *Id.*
[56] *Id.*
[57] *Id.* at *11-12.
[58] *Id.* at *12.
[59] *Id.*
[60] EJR Request at 2.

§§ 1395ww(d)(8)(E) and 1395ww(g), and the regulation must be found invalid.[61] Though 42 C.F.R. § 412.320(a)(1)(iii) has not been vacated, the Provider argues that the merits of their position were adopted by the D.C. District Court in *Toledo*.

Since the Board is bound by the regulations being challenged,[62] 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 Provider's EJR Request. Since the additional criteria for EJR have also been met, the Provider is asking the Board to grant the request.

Medicare Contractor's Position

On December 8, 2022, the Medicare Contractor filed a response to the EJR Request. It disagrees with the merits of the Provider's position, but agrees that its arguments are beyond the scope of the Board's authority to determine. As a result, it believes EJR is appropriate and has not identified any jurisdictional or substantive claim impediments that would otherwise prevent the grant of EJR.

Board Decision

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.

A. Jurisdiction

In the November 13, 2015 Final Outpatient Prospective Payment Rule,[63] the Secretary finalized new cost reporting regulations related to the substantive reimbursement requirement of an appropriate cost report claim.[64] 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, again, for cost reports beginning on or after January 1, 2016 (hereinafter the "claim-specific dissatisfaction

[61] *Id.* at 3.
[62] *See* 42 C.F.R. § 405.1867.
[63] 80 Fed. Reg. 70298, 70551-70580 (Nov. 13, 2015).
[64] *Id.* at 70555.

requirement"). Since the Provider in this case has a fiscal year that began on or after January 1, 2016, the claim-specific dissatisfaction requirement is not applicable.

The Provider in this appeal involves a fiscal year ending December 31, 2017. The Board notes that the Provider has appealed from a revised NPR. For any provider that files an appeal from a revised NPR issued after August 21, 2008, the Board only has jurisdiction to hear that provider's appeal of matters that the Medicare contractor specifically revised within the revised NPR.[65] The Board notes that the Provider's revised NPR appeal included within this EJR request was issued after August 21, 2008. The Provider's revised NPR also contained an audit adjustment that removed Capital DSH payments, as required for jurisdiction under the provisions of 42 C.F.R. § 405.1889.

Based on its review of the record, the Board finds that the Provider filed its appeal within 180 days of the issuance its final determination as required by 42 C.F.R. § 405.1835, that it appealed the Capital DSH issue in its appeal, and that the Board is not precluded by regulation or statute from reviewing the issue in this appeal. Finally, the amount in controversy meets the $10,000 amount in controversy requirement for an individual appeal pursuant to 42 C.F.R. § 405.1835(a)(2). The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount.

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

[65] *See* 42 C.F.R. § 405.1889(b)(1) (2008).

> (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.[66]

These regulations are applicable the Provider in this individual appeal, which has a cost reporting period ending on December 31, 2017. 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

[66] (Bold emphasis added.)

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"[67] 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.[68] As noted above, the Medicare Contractor filed a response to the EJR Request noting that it has not identified any jurisdictional or substantive claim impediments.

As such, since no party to the appeal has questioned, pursuant to § 405.1873(a), whether an appropriate claim was made,[69] the Board finds there was no regulatory obligation for the Board to affirmatively, on its own, review the appeal documents to determine whether an appropriate claim was made. As a result, Board review under 42 C.F.R. § 405.1873(b) has not been triggered. Accordingly, the Board need not include any findings regarding compliance with the substantive claim requirements and may proceed to rule on the EJR request pursuant to 42 C.F.R. § 405.1873(d).

C. Board's Decision Regarding the EJR Request

The Board finds that:

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

2) Based upon the Provider's assertions regarding 42 C.F.R. § 412.320(a)(1)(iii), there are no findings of fact for resolution by the Board;

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

4) It is without the authority to decide the legal question of whether 42 C.F.R. § 412.320(a)(1)(iii), as promulgated in the FY 2007 IPPS Final Rule, is substantively or procedurally valid.

Accordingly, the Board finds that the question of the validity of 42 C.F.R. § 412.320(a)(1)(iii) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Provider's EJR Request for the issue and the subject year. The Provider has 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in this case, the Board hereby closes the case.

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[67] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."
[68] *See* 42 C.F.R. § 405.1873(a).
[69] 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."

Board Members Participating:

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

FOR THE BOARD:

12/15/2022

X Clayton J. Nix

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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RE: ***Expedited Judicial Review Determination***
Lake Charles Memorial Hospital (Prov. No. 19-0060)
FYE December 31, 2018
Case No. 23-0332

Dear Mr. Ruskin:

The Provider Reimbursement Review Board ("Board") has reviewed the Provider's December 1, 2022 request for expedited judicial review ("EJR") in the above-referenced individual appeal. The decision with respect to EJR is set forth below.

Issue under Dispute

In this case, the Provider is

> [C]hallenging the application of 42 C.F.R. § 412.320(a)(1)(iii), which states that urban hospitals may qualify for Capital [disproportionate share hospital] payments unless, on or after October 1, 2006, the urban hospital is reclassified as rural. [The Provider Group contends that] [t]his regulation is inconsistent with Social Security Act Section 1886(d)(8)(E)[1], which specifically concerns rural status. Section 1886(d)(8)(E) specifically notes that the hospitals that have undergone a rural reclassification are rural only for "purposes of this subsection [1886(d)]."[2]

Background:

Under the inpatient prospective payment system ("IPPS"), Medicare pays hospitals predetermined rates for patient discharges and this system is comprised of two parts, one for operating costs ("operating IPPS") as set forth at § 1395ww(d); and one for capital costs ("capital IPPS") as set forth at 42 U.S.C. § 1395ww(g). The primary objective of IPPS is to

[1] Codified at 42 U.S.C. § 1395ww(d)(8)(E).
[2] Request for Expedited Judicial Review at 2-3 (Dec. 1, 2022) ("EJR Request"). *See also* Issue Statement – Capital DSH.

create incentives for hospitals to operate efficiently, while providing adequate compensation to hospitals.[3] This case focuses on the capital IPPS.

A. Geographic Reclassification

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

B. Operating DSH Adjustment Under Operating IPPS

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

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

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

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[3] Daniel R. Levinson, Department of Health and Human Services, Office of the Inspector General, *Significant Vulnerabilities Exist in the Hospital Wage Index System for Medicare Payments*, 1 (Nov. 2018), *available at* https://oig.hhs.gov/oas/reports/region1/11700500.pdf (last visited Oct. 20, 2022) ("*Significant Vulnerabilities*").
[4] *See* https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/wageindex.html (42 U.S.C. § 1395ww(d)(3)(E) requires that, as part of the methodology for determining prospective payments to hospitals, the Secretary must adjust the standardized amounts "for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level." This adjustment factor is the wage index. The Secretary currently defines hospital geographic areas (labor market areas) based on the definitions of Core-Based Statistical Areas ("CBSAs") established by the Office of Management and Budget and announced in December 2003. The wage index also reflects the geographic reclassification of hospitals to another labor market area, such as rural to urban or vice versa, in accordance with sections 1395ww(d)(8)(B) and 1395ww(d)(10).).
[5] Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, 103 Stat. 2106, 2154 (1989). *See also Significant Vulnerabilities* at 4-5.
[6] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[7] *Id.*
[8] *See* 42 U.S.C. § 1395ww(d)(5).
[9] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[10] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[11] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).

The DSH adjustment provided under operating IPPS is ***not*** at issue in this case. The DSH adjustment is relevant because certain standards set forth in 42 U.S.C. § 1395ww(d)(5)(F) for the DSH adjustment that 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 <u>an adjustment</u> to take into account variations in the relative costs of capital and construction for the different types of facilities or areas in which they are located*;
>
> (iii) may provide for such exceptions (including appropriate exceptions to reflect capital obligations) as the Secretary determines to be appropriate, and
>
> (iv) may provide for suitable adjustment to reflect hospital occupancy rate.
>
> (C) In this paragraph, the term ''capital-related costs'' has the meaning given such term by the Secretary under subsection (a)(4) as of September 30, 1987, and does not include a return on equity capital.[13]

[12] Pub. L. 100-203, § 4006(b), 101 Stat. 1330, 1330-52 (1987).
[13] (Underline and italics emphasis added.)

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

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

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

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:

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[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 Oct. 20, 2022).
[15] 56 Fed. Reg. 43356 (Aug. 30, 1991).
[16] *Id.* at 43369-70 (emphasis added).

> In the proposed rule, our regression results indicated that for urban hospitals with more than 100 beds, the disproportionate share percentage of low income patients has an effect on capital costs per case. We proposed that urban hospitals with 100 or more beds would receive an additional payment equal to ({1 +DSHP)$^{0-4176}$ - 1)), where DSHP is the disproportionate share patient percentage. There would be no minimum disproportionate share patient percentage required to qualify for the payment adjustment. A hospital would receive approximately a 4.2 percent increase in payments for each 10 percent increase in its disproportionate share percentage. This formula is similar to the one used for the indirect medical education adjustment under the operating prospective payment system.
>
> Since we did not find a disproportionate share effect on the capital costs of urban hospitals with fewer than 100 beds or on rural hospitals, we did not propose to make a disproportionate share adjustment to the capital payment to these hospitals.[17]

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

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

[17] *Id* at 43377.

> patients either because of their smaller size (i.e., under 100 beds) or lower disproportionate share patient percentage. **In rural areas, we believe the more relevant criteria for determining whether a hospital should receive special payment protection is whether the hospital represents the sole source of care reasonably available to Medicare beneficiaries**.[18]

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

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

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

> 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

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

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

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

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

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

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

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

> *Comment*: Many commenters sought clarification of the effect of reclassification by the Medicare Geographic Classification Review Board (MGCRB) on eligibility for capital disproportionate share payments.

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

> *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) If a hospital meets the criteria in paragraph (a) of this section for a disproportionate share hospital for purposes of capital prospective payments, the disproportionate share payment adjustment factor equals [e raised to the power of (.2025 X the hospital's disproportionate patient percentage as determined under § 412.106(b)(5)), —1], where e is the natural antilog of 1.
>
> (2) If a hospital meets the criteria in § 412.106(c)(2) for purposes of inpatient hospital operating prospective payments, the disproportionate share adjustment factor equals 14.16 percent.[24]

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

On November 29, 1999, Congress enacted the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 ("BBRA") and BBRA § 401 amended 42 U.S.C. § 1395ww(d)(8) to require that certain urban IPPS hospitals be reclassified as rural *for purposes of operating IPPS* if

[23] (Bold and underline emphasis added.)
[24] *Id*. at 43452-53.

an application is submitted to the MGCRB and certain criteria are met.[25] IPPS hospitals are reclassified per BBRA § 401 are often referred to as "§ 401 hospitals."

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

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

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

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

[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.)

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 Health and Human Services, Health Resources and Services Administration, Office of Rural Health Policy, 5600 Fishers Lane, Room 9–05, Rockville, MD 20857.

[27] 65 Fed. Reg. 47054, 47088-89 (Aug. 1, 2000).

> (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]

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.

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

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.
>
> (ii) The term *urban area* means—

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

> (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]

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

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 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.

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

> ****
>
> 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 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

[37] 69 Fed. Reg. 48916, 49187-88 (Aug. 11, 2004) (italics emphasis added).
[38] of the Department of Health and Human Services.

the capital IPPS in FY 1992, the same geographic classifications used under the operating IPPS also have been used under the capital IPPS.[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 2006rulemaking is arbitrary and capricious and thus unreasonable for two principal reasons. First, it charges the Secretary with misrepresenting the regulatory history in claiming that the 2006 Rule merely restored a previously implemented policy. Second, the hospital argues that the Secretary failed to "take into account" relative costs of capital

[42] *Id.*
[43] (Bold emphasis added.)
[44] 2021 WL 4502052 (D.D.C. 2021).

> for various hospital types and areas of location, as subsection (g) requires.[45]

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

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

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

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

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

Provider's EJR Request

The Provider states that EJR is appropriate because the it is challenging the regulation that governs capital DSH payments to urban hospitals that have been reclassified under 42 U.S.C. § 1395ww(d)(8)(E) and 42 C.F.R. § 412.103 (hospitals located in urban areas and that apply for reclassification as rural).[60]

The Provider is challenging the application 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 Provider asserts that this regulation is inconsistent with 42 U.S.C. § 1395ww(d)(8)(E) 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), not § 1395ww(d), and, accordingly, the literal wording of the rural reclassification statutory provision identifies that rural status does not reach the capital DSH calculation. The Provider believes that the promulgation of 42 C.F.R. § 412.320(a)(1)(iii) is, therefore, beyond the authority granted under 42 U.S.C.

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[54] *Id.*
[55] *Id.*
[56] *Id.*
[57] *Id.* at *11-12.
[58] *Id.* at *12.
[59] *Id.*
[60] EJR Request at 2.

§§ 1395ww(d)(8)(E) and 1395ww(g), and the regulation must be found invalid.[61] Though 42 C.F.R. § 412.320(a)(1)(iii) has not been vacated, the Provider argues that the merits of their position were adopted by the D.C. District Court in *Toledo*.

Since the Board is bound by the regulations being challenged,[62] 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 Provider's EJR Request. Since the additional criteria for EJR have also been met, the Provider is asking the Board to grant the request.

Medicare Contractor's Position

On December 8, 2022, the Medicare Contractor filed a response to the EJR Request. It disagrees with the merits of the Provider's position, but agrees that its arguments are beyond the scope of the Board's authority to determine. As a result, it believes EJR is appropriate and has not identified any jurisdictional or substantive claim impediments that would otherwise prevent the grant of EJR.

Board Decision

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.

A. Jurisdiction

In the November 13, 2015 Final Outpatient Prospective Payment Rule,[63] the Secretary finalized new cost reporting regulations related to the substantive reimbursement requirement of an appropriate cost report claim.[64] 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, again, for cost reports beginning on or after January 1, 2016 (hereinafter the "claim-specific dissatisfaction

[61] *Id.* at 3.
[62] *See* 42 C.F.R. § 405.1867.
[63] 80 Fed. Reg. 70298, 70551-70580 (Nov. 13, 2015).
[64] *Id.* at 70555.

requirement"). Since the Provider in this case has a fiscal year that began on or after January 1, 2016, the claim-specific dissatisfaction requirement is not applicable.

The Provider in this appeal involves a fiscal year ending December 31, 2018 from an original NPR. Based on its review of the record, the Board finds that the Provider filed its appeal within 180 days of the issuance its final determination as required by 42 C.F.R. § 405.1835, that it appealed the Capital DSH issue in its appeal, and that the Board is not precluded by regulation or statute from reviewing the issue in this appeal. Finally, the amount in controversy meets the $10,000 amount in controversy requirement for an individual appeal pursuant to 42 C.F.R. § 405.1835(a)(2). The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount.

B. Board review of compliance with the reimbursement requirement of an appropriate cost report claim pursuant to 42 C.F.R. § 405.1873 (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.[65]

These regulations are applicable the Provider in this individual appeal, which has a cost reporting period ending on December 31, 2018. 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"[66] 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.[67] As noted above, the Medicare Contractor filed a response to the EJR Request noting that it has not identified any jurisdictional or substantive claim impediments.

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[65] (Bold emphasis added.)
[66] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."
[67] *See* 42 C.F.R. § 405.1873(a).

As such, since no party to the appeal has questioned, pursuant to § 405.1873(a), whether an appropriate claim was made,[68] the Board finds there was no regulatory obligation for the Board to affirmatively, on its own, review the appeal documents to determine whether an appropriate claim was made. As a result, Board review under 42 C.F.R. § 405.1873(b) has not been triggered. Accordingly, the Board need not include any findings regarding compliance with the substantive claim requirements and may proceed to rule on the EJR request pursuant to 42 C.F.R. § 405.1873(d).

C. Board's Decision Regarding the EJR Request

The Board finds that:

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

2) Based upon the Provider's assertions regarding 42 C.F.R. § 412.320(a)(1)(iii), there are no findings of fact for resolution by the Board;

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

4) It is without the authority to decide the legal question of whether 42 C.F.R. § 412.320(a)(1)(iii), as promulgated in the FY 2007 IPPS Final Rule, is substantively or procedurally valid.

Accordingly, the Board finds that the question of the validity of 42 C.F.R. § 412.320(a)(1)(iii) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Provider's EJR Request for the issue and the subject year. The Provider has 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in this case, the Board hereby closes the case.

Board Members Participating:

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

For the Board:

12/15/2022

X Clayton J. Nix

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

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

[68] 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."

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Transfer Requests from Closed Case***
St. Charles Hospital (Prov. No. 33-0246; FYE 12/31/2009)
Case No. 14-2681

Dear Mr. Blumberg and Ms. Decker:

The Provider Reimbursement Review Board ("PRRB") received 3 hard copy Transfer Requests from St. Charles Hospital (Prov. No. 33-0246) on December 17, 2018. St. Charles Hospital requested that issues from individual Case No. 14-2681 be transferred to the following group cases:

(1) Medicare HMO Part C Days – Medicaid Fraction to Case No. 18-0024GC
(2) Medicare HMO Part C Days – Medicare Fraction to Case No. 18-0074GC
(3) SSI Percentage to Case No. 18-0079GC

The Board finds that Case No. 14-2681 was previously closed, ***more than 3 years prior***, for lack of jurisdiction on February 10, 2015. Therefore, the Board denies these 3 Transfer Requests because these requests were ***improperly*** made from a closed case and were, therefore, ***void*** in the first instance. Indeed, the 3-year period in which the Board could have considered reinstatement of Case No. 14-2681 expired prior to these transfer requests even being filed. Accordingly, Case No. 14-2681 remains closed.

*The Board further **admonishes** the Representative for its failure to comply with Board Rules*. In this regard, the Board notes it dismissed this case because the Representative filed with case without included a letter of representation or a final determination in compliance with 42 C.F.R. § 405.1835(b) and Board Rule 6.4 and and because the Representative failed to cure that defect. Yet, again in this case, the Representative failed to follow Board Rules and has ***improperly*** filed transfer requests from a case that had been closed more than 3 years prior.

Board Members Participating:

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

12/20/2022

X Clayton J. Nix

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

cc: Wilson C. Leong, Federal Specialized Services

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RE: ***Motion for Partial Reinstatement***
Borgess Medical Center (Prov. No. 23-0117)
FYE 6/30/2008
Case No. 13-1947

Dear Mr. Ravindran,

The Provider Reimbursement Review Board ("Board") has reviewed the Motion for Reinstatement of Issues 4 and 6 ("Motion for Partial Reinstatement") filed on May 24, 2022 by Quality Reimbursement Services, Inc. ("QRS") as the designated representative for Borgess Medical Center ("Borgess" or "Provider"). Issues 4 and 6 relate to treatment of Medicare Part C and Dual Eligible days respectively in the disproportionate share hospital ("DSH") adjustment calculation. Borgess is commonly owned or controlled by Ascension Health. As set forth below, the Board denies the Motion for Partial Reinstatement. Further, upon further review of the record, *the Board* ***reprimands QRS*** *for its blatant disregard of the CIRP group requirements;* ***and****, given QRS' multiple CIRP group compliance issues with representing Borgess,*[1] *has included the corporate contact for Ascension Health, Dawn Davidson, as an addressee to* ***admonish Ascension Health and remind it of its responsibility to oversee*** *its designated agents that pursue the claims of Ascension Health and its providers, such as Borgess, for additional Medicare reimbursement before the Board.*[2]

Pertinent Facts:

On May 8, 2013, QRS established Case No. 13-1947 by filing an appeal request for Borgess, which contained the following issues:

1. DSH SSI Provider Specific[3]
2. DSH SSI Systemic Errors[4]
3. Medicaid Eligible Days[5]

[1] The Board has identified similar CIRP issues in Borgess' individual appeals for FYs 2009 and 2010 under Case Nos. 14-0641 and 14-0848. QRS is also Borgess' designated representative in these other 2 cases and the Board concurrently issued a letter in those cases to reprimand QRS and include Ascension Health as an addressee with similar reminders.
[2] *See infra* note 34.
[3] The Board dismissed this issue on November 17, 2021.
[4] This issue was presumed abandoned in Board's Notice of Dismissal (March 31, 2022).
[5] In the Provider's Final Position Paper, QRS states that it would submit a listing to the MAC for review. According to the MAC's Final Position Paper, no documentation on additional eligible days has been received.

4. Medicare Managed Care Part C Days[6]
5. Labor Room Days[7]
6. Dual Eligible Days Exhausted Part A Days
7. Outlier Payments[8]

Significantly, Borgess' appeal request acknowledged that it was commonly owned or controlled by Ascension Health and specifically listed both an address and corporate contact for Ascension Health.[9] Consistent with this acknowledgement, QRS gave the following certification confirming that it would be transferring common issues to Ascension Health CIRP groups:

> There may be other providers to which this provider is related by common ownership or control that have a pending request for a Board hearing on the same issues now being appealed for the cost reporting period that ends in the same calendar year covered in this request. Accordingly, **the Provider <u>intends</u> to transfer this Provider to an appropriate CIRP group appeal once this appeal of the NPR is established**. *See* 42 C.F.R. § 405.1835(b)(4)(i).[10]

However, no such transfers were ever made.

On December 26, 2013, QRS filed Borgess' preliminary position paper ("PPP"). On May 1, 2014, the Medicare Contractor filed its PPP.

On April 23, 2020, the Board issued a Notice of Hearing and Critical Due Dates setting a hearing date of December 18, 2020 as well as deadlines for final position papers ("FPPs"). On September 17, 2020, QRS timely filed Borgess' FPP. Similarly, on October 19, 2020, the Medicare Contractor timely filed its FPP.

On November 20, 2020, QRS requested postponement of the December 18, 2020 hearing due to pending litigation that affected Issues 4 and 6. The litigation impacting Issue 4 (Medicare Part C days) was *Azar v. Allina Health Services* (which had already been resolved by the Supreme Court on June 3, 2019[11]) and the litigation impacting Issue 6 was *Empire Health Foundation v. Azar* (which was resolved by the Supreme Court on June 24, 2022[12]). QRS proposed a new hearing date of June 16, 2021.

The Board did not specifically rule on the request for postponement but, on November 30, 2020, did issue a new Notice of Hearing setting a new hearing date of June 16, 2021 consistent with that request.

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[6] The Board dismissed this issue on November 17, 2021.
[7] The Provider withdrew this issue on February 25, 2022.
[8] The Provider withdrew this issue on February 25, 2022.
[9] *See infra* note 34.
[10] (Bold and underline emphasis added.)
[11] 139 S. Ct. 1804 (2019).
[12] 142 S. Ct. 2354 (2022).

On June 14, 2021, QRS filed its second request for postponement again citing the same litigation impacting both Issus 4 and 6. The litigation cited for Issue 4 continued to be the *Allina* case, notwithstanding the fact that that litigation had already been resolved in 2019 as previously noted. QRS proposed a new hearing date of December 13, 2021.

The Board did not specifically rule on the request for postponement but, on October 20, 2021, did issue a new Notice of Hearing setting a new hearing date of April 19, 2022.

On November 17, 2021, the Board issued a Jurisdictional Decision which dismissed Issue 1 (SSI Provider Specific) as a prohibited duplicate of Issue 2 (DSH SSI Systemic). This determination further notified QRS that "[i]t has come to the Board's attention that this Provider is commonly owned by Ascension Health and, as a result it is clear that the remaining issues should be pursued in [CIRP] Groups as required by 42 C.F.R. § 405.1837(b)(1). Indeed, the Board notes that the Model Form A – Individual Appeal Request filed to establish this case specifically identifies Ascension Health as the corporate owner of Borgess and the Representation Letter attached thereto was on Ascension Health letterhead." The Board then dismissed Issue 4 pertaining to Part C Days because "there was a 2008 CIRP group for Ascension Health for this same issue (Case No. 13-1517GC, Ascension 2008 Medicare/Medicaid Medicare Advantage Days CIRP Group) in which the Board granted EJR and closed the appeal on May 3, 2019." Essentially, Ascension Health had already fully adjudicated the Part C days issue for all Ascension Health providers, thereby precluding any individual appeals of the Part C Days issue by Borgess or any other Ascension Health providers that were not part of that CIRP group.

Finally, as part of the November 17, 2021 determination, the Board required that, "***within sixty (60) days of this letter's signature date*,** the Provider confer with Ascension Health and, following that consultation, either: (1) transfer the remaining common DSH issues to CIRP groups; or (2) attest that there are no other related providers for this fiscal year, that either are, or could be pursuing the four issues remaining (*e.g*., if there is a 2008 Ascension Health CIRP group to which the provider should have been transferred but has now been closed, this must be identified)."[13] The Board confirmed that "***this filing deadline is firm and . . . specifically exempt . . . from the Alert 19 suspension of Board-set filing deadlines***. Accordingly, <u>failure to respond by the filing deadline may result in dismissal of the remaining issues</u>."[14]

QRS failed to timely respond to the Board's request by the deadline of Tuesday, January 18, 2022 (*i.e*., 60 days from November 17, 2021[15]). Rather, QRS filed a response 38 days late, on Friday, February 25, 2022. Significantly, QRS did not recognize that it was filed late nor did it include information that could be construed as "good cause" for the late filing. In its response, QRS recognized that only Issues 3, 5, 6 and 7 remained pending in the appeal and then concurrently withdrew Issues 5 and 7. In doing so, QRS recognized that only Issues 3 and 6 remained in the appeal since the Board had dismissed Issue 4 concerning Part C days. Significantly, in its February 25, 2022 filing, QRS did ***not*** contest the Board's dismissal of Issue

[13] Board's Determination (Nov. 17, 2021)
[14] *Id.* (underline emphasis added).
[15] As the 60-day deadline fell on a Sunday and Monday, January 17 was a holiday, the filing deadline was the next business day, *i.e.*, Tuesday, January 18, 2022.

4. Moreover, QRS did ***not*** respond to the Board's request for information even at this late date but simply stated the following:

> The Provider intends to purse the Medicaid Eligible day issue [*i.e.*, Issue 3], based on the 9th circuit court decision in [*sic*] Empire court case which invalidated the underlying dual eligible day regulation. The Provider believes that the Dual Eligible Days should be treated as Medicaid Eligible Days [*i.e.*, Issue 6]. Additionally, once the United States Supreme court [*sic*] rules on the Empire case, the dual eligible days in the instant case [*i.e.*, Issue 6] will be resolvable along with the Medicaid Eligible Days [*i.e.*, Issue 3].
>
> As the Dual Eligible Days issue [*i.e.*, Issue 6] and the Medicaid eligible day issue [*i.e.*, Issue 3] will either proceed to a live hearing or be resolved based on the specific days in question, this provider should not be transferred to a group appeal.
>
> As such, the Provider hereby requests a postponement of the ruling pending the ruling of the United States Supreme court [*sic*]. Provider [*sic*] hereby requests a 180-day postponement of case number 13-1947 based on the Empire court case.

On March 31, 2022, the Board issued a Notice of Dismissal that dismissed all the remaining issues since QRS failed to timely respond to the Board's November 17, 2021 RFI and the belated response failed to address the CIRP issues raised in that RFI. Specifically, the Board dismissed Issues 2, 3, 5, 6 and 7 since the Board had already dismissed Issues 1 and 4 as part of its November 17, 2021 determination. The Board explained the basis for these findings as follows, in pertinent part:

> The Board finds that the Provider has failed to comply with the Board's procedures, specifically the filing deadlines set in this case. Furthermore, the belated Response to the Board's CIRP RFI was deficient in numerous respects, since it failed to give any reason for the late filing, did not give a sufficient explanation as to why the 2 remaining issues should not be transferred to CIRP groups, nor did it actually attest that there are no other related providers for the fiscal year with either of the 2 remaining issues. In this regard, the Board notes that the Provider's Representative does not dispute that the Provider is part of Ascension Health and, thereby, subject to the Mandatory CIRP rules; nor is there any indication that the Representative discussed the Board's RFI with the Provider's parent corporation, Ascension Health, to determine if there were other CIRP groups to which the Provider should be transferred. Finally, it is clear that the Provider abandoned the

> DSH/SSI Percentage (Systemic Errors) issue since its belated response failed to list the issue or otherwise address that issue in compliance with the Board's RFI.[16]
>
> Moreover, a wholly separate and independent basis for dismissal of the dual eligible days issue is the Provider's failure to comply with the CIRP group regulations as that was the reason underlying the RFI with which the Provider failed to comply, namely that the *Empire* dual eligible day issue is one that is common to Ascension Health and must be brought as part of a CIRP group per 42 C.F.R. § 405.1837(b)(1)).
>
> ****
>
> Finally, as discussed above in the procedural background section, the Provider's belated response to the Board's RFI not only failed to address the Board's RFI but appears to abandon it as a separate and distinct issue and subsume it into the dual eligible days issue.[17] Indeed, without information in the record to identify the Medicaid eligible days at issue (*e.g.*, how many, what type of day, and supporting documentation) notwithstanding the fact such information was required to be provided as part of the Provider's FPP, the Board necessarily must find that it has been subsumed into the dual eligible days issue.
>
> Accordingly, based on the untimely and deficient response and the failure to comply with the CIRP group regulations, the Board hereby dismisses the case *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.[18]

On May 24, 2022, the Provider filed the Motion for Partial Reinstatement of Issue 4 (which the Board had dismissed on November 17, 2021) and Issue 6 (which the Board had dismissed on March 31, 2022). The Medicare Contractor did not file a response to the Motion.

Provider's Motion for Partial Reinstatement:

On May 24, 2022, the Provider requested that the Board reinstate Case No. 13-1947 for Issue 4 (the DSH Part C issue) and Issue 6 (the DSH Part A issue) which the Board had dismissed

[16] Even if the Provider had not abandoned the DSH/SSI Percentage (Systemic Errors) issue, it would be dismissed for the same reasons as the Board is dismissing the dual eligible days issue.
[17] The Provider's motion for postponement filed shortly thereafter on June 14, 2021 similarly does not identify Medicaid eligible days as a separate issue pending in the case but rather only identifies the Part C days issue (that the Board later dismissed) and the no-pay dual eligible days issue.
[18] (Footnote in original.)

previously on November 17, 2021 and March 31, 2022 respectively. The Provider begins by arguing that there is good cause for the Board to reinstate these two issues. The Provider points out that the Board specifically exempted from Alert 19 its response to the Board's request for information, but argues that its "business and affairs has not been immune to the ongoing COVID 19 pandemic" and that due to this challenge and "reduced staffing", the Provider "in good faith responded as quickly as practicable."[19] Significantly, QRS gives no further detail about how it was specifically impacted or why it needed 38 days in addition to the 60 days originally given by the Board for it to respond.

Next, the Provider argues that, "there is absolutely no need for the Board to conduct proceedings regarding [the DSH Part A and Part C issues]" because the DSH Part A issue will be determined by the Supreme Court decision in *Empire v. Becerra* and the Board is required to remand the Part C issue pursuant to CMS Ruling 1739-R.[20] However, QRS failed to recognize that the Board had dismissed the Part C days issue *more than 6 months earlier* on November 17, 2021, nor did it address the applicability of the mandatory CIRP group regulations to Borgess as detailed in the Board's letter dated November 17, 2021.

Finally, QRS contends that QRS is not in a position to determine the compliance of its client, Borgess, with the CIRP group requirements and requested that the Board reinstate the Part C Days issue and transfer it to the applicable Ascension Health CIRP group:

> The Board apparently possesses knowledge that other Ascension Health providers have appealed these issues for FYE 6/30/2008 in a CIRP group. ***The undersigned is not in a position to, and therefore does not, possess this knowledge.*** Other than alleged failure to comply with the CIRP regulation, the Board has not found any jurisdictional defects. In the interest of justice, rather than deprive this Provider of its right to appeal the DSH Part A and Part C issues, the undersigned respectfully suggests that the Board should reinstate this case, permit the Provider to transfer its appeal to the applicable CIRP Groups appealing the DSH Part A and Part C issues, and then to close this case.[21]

Significantly, QRS' above contention again fails to recognize that the November 17, 2021 determination had already dismissed Issue 4 (the Part C days issue) because Ascension Health ***already*** had had a 2008 Part C Days CIRP group:

> [W]ith regard to Issue 4 (DSH Payment – Medicare Managed Care Part C Days), there was a CIRP group for Ascension Health for this issue (Case No. 13-1517GC, Ascension 2008 Medicare/Medicaid Medicare Advantage Days CIRP Group) in which the Board granted EJR and closed on May 3, 2019.

[19] Provider's Motion for Partial Reinstatement at 1 (May 24, 2022).
[20] *Id.* at 1-2.
[21] *Id.* at 2 (emphasis added).

> Therefore, the Board dismisses the Part C days issue from the instant appeal since it must have been brought as part of the CIRP group for that issue.[22]

Board's Decision:

PRRB Rule 47.1 explains that a Provider may request reinstatement of an issue and also states that the Board will not reinstate an issue or case if the provider was at fault:

> A provider may request reinstatement of an issue(s) or case within three years from the date of the Board's decision to dismiss the issue(s)/case or, if no dismissal was issued, within three years of the Board's receipt of the provider's withdrawal of the issue(s) (*see* 42 C.F.R. § 405.1885 addressing reopening of Board decisions). The request for reinstatement is a motion and must be in writing setting out the reasons for reinstatement (*see* Rule 44 governing motions). *The Board will not reinstate an issue(s)/case if the provider was at fault.*[23]

Additionally, Board Rule 47.3 states:

> Upon written motion *demonstrating good cause*, the Board may reinstate a case dismissed for failure to comply with Board procedures. Generally, administrative oversight, settlement negotiations or a change in representative will not be considered good cause to reinstate. If the dismissal was for failure to file with the Board a required position paper, Schedule of Providers, or other filing, then the motion for reinstatement must, as a prerequisite, include the required filing before the Board will consider the motion.[24]

As set forth below, the Board denies QRS' motion for reinstatement of Issues 4 and 6.

A. CIRP Requirements

Pursuant to 42 C.F.R. § 405.1837(b)(1)(i) implements the requirement in 42 U.S.C. § 1395oo(f)(1) that providers under common ownership or control must bring common issues as part of a group which the Board refers to as common issue related party ("CIRP") groups:

> *Two or more providers under common ownership or control* that wish to appeal to the Board a specific matter at issue that involved a question of fact or interpretation of law, regulations, or CMS Rulings that is common to the providers, and that arises in cost

[22] Board Determination at 5 (Nov. 17, 2021) (footnote omitted).
[23] PRRB Board Rule 47.1 (Sept, 30, 2021). (emphasis added)
[24] PRRB Board Rule 47.3 (Sept, 30, 2021). (emphasis added)

> 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*.

Additionally, 42 C.F.R. § 405.1837(e)(1) specifies how a group is designated as fully formed and the effect of a group being fully formed:

> (e) *Group appeal procedures pending full formation of the group and issuance of a Board decision*. (1) A provider (or providers) may file a group appeal hearing request with the Board under this section before each provider member of the group identifies or complies with paragraphs (a)(1) and (a)(2) of this section, or before the group satisfies the $50,000 amount in controversy requirement under paragraph (a)(3) of this section. . . . The Board will determine that a group appeal brought under paragraph (b)(1) of this section is fully formed **upon a notice in writing from the group that it is fully formed**. Absent such a notice from the group, the Board may issue an order, requiring the group to demonstrate (within a period of not less than 15 days) that at least one commonly owned or controlled provider has preserved the issue for appeal by claiming the relevant item on its cost report or by self-disallowing the item, but has not yet received its final determination with respect to the item for a cost year that is within the same calendar year as that covered by the group appeal (or that it has received its final determination with respect to the item for that period, and is still within the time to request a hearing on the issue). The Board determines that a group appeal brought under paragraph (b)(2) of this section is fully formed **upon a notice in writing from the group that it is fully formed**, or following an order from the Board that in its judgment, that the group is fully formed, or through general instructions that set forth a schedule for the closing of group appeals brought under paragraph (b)(2) of this section. **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.[25]

Board Rules 12.3 and 19 (2018) reflect the above regulations and state, in pertinent part:

> **12.3 Types of Groups**

[25] (Bold and underline emphasis added.)

> **12.3.1 Mandatory Common Issue Related Part ("CIRP") Group**
>
> Providers under common ownership or control that wish to appeal a specific matter that is common to the providers must bring the appeal as a group appeal. *See* 42 C.F.R. § 405.1837(b).
>
> ****
>
> **Rule 19 – Full Formation of Groups**
>
> Reference 42 C.F.R. § 405.1837(e) regarding group appeal procedures pending full formation of the group and issuance of a Board decision.
>
> ****
>
> **19.2 – Mandatory (CIRP) Groups**
>
> Mandatory CIRP group appeals must contain all Providers eligible to join the group which intend to appeal the disputed common issue. The Board will determine that a CIRP group appeal is fully formed upon:
>
> • Written notice from the Group Representative that the group is fully formed, or
> • A Board order issued after the Group Representative has the opportunity to present evidence regarding whether any CIRP providers who have not received final determinations could potentially join the group. . . .[26]

B. Failure to Establish Good Cause for the QRS' Untimely Response to the November 17, 2021 Request for Information

QRS suggests that both Issue 4 and 6 should be reinstated because QRS had good cause to not timely respond to the Board's November 17, 2021 request for information. As described below, the Board finds, for multiple reasons, that QRS has ***not*** established good cause for its failure to timely respond to the Board's November 17, 2022 request for information.

First, the request for information did ***not*** pertain to Issue 4 because the November 17, 2021 letter dismissed Issue 4 and the request for information only pertained to the "remaining issues." As such, the Board's dismissal of Issue 4, as stated in its November 17, 2021 determination, remains in effect.

Regardless, QRS has failed to establish good cause for its failure to timely respond to the Board's November 17, 2021 request for information (whether in relation to Issue 4 or 6). The

[26] (Underline emphasis added.)

Board gave QRS 60 days to respond to the Board's request for information and that 60-day period expired on Tuesday, January 18, 2022. Significantly, QRS neither timely responded *nor filed a request for an extension on the 60 days allotted in the November 17, 2021 determination*. Rather, QRS' response was filed 38 days late on February 25, 2022 (exactly 100 days after the Board issued its November 17, 2022 determination). To explain the late filing, QRS makes generic assertions that QRS "has not been immune to the ongoing COVID 19 pandemic" and "[f]aced with this challenge, which reduced available staffing, the undersigned in good faith responded as quickly as practicable."[27] However, QRS' response gives no detail on its staffing or why QRS could not request an extension of time within the 60 days allotted by the Board for a response or even why it took *38 days beyond the deadline* to file its response (*i.e.*, 100 days beyond the November 17 2021 request for information). Indeed, the Board is aware that, during the 60-day period from November 17, 2021 to January 18, 2022, QRS was making numerous filings, including requesting changes in the lead Medicare Contractor, Schedules of Providers and consolidated requests for expedited judicial review.[28] Accordingly, it is clear that QRS was capable of performing significant Board-related work during that time period and the Board suspects that QRS did not sufficiently manage and/or prioritize its work, such as simply filing an extension request in this case. Accordingly, the Board finds that QRS has failed to establish good cause for its failure to timely respond to the Board's November 17, 2021 request for information and reaffirms that the Board properly exercised its discretion under 42 C.F.R. § 405.1868(a)-(b) to dismiss Issue 6 for QRS' failure to meet the Board filing deadline.

Even if the Board were to find good cause for QRS' failure to timely respond to the November 17, 2021 request for information, it would not negate the Board's *alternative and wholly independent bases* for dismissing Issues 4 and 6 as described below.

---

[27] QRS further states that "the Board has occasion to extend deadlines to which the Board is subject, notably the 30-day deadline to decide an expedited judicial review request." QRS is misplaced in stating that the Board has granted itself an "extension" to the 30-day deadline related to EJR requests. Rather, the Board has simply applied the following regulation at 42 C.F.R. § 405.1842(b)(2) which makes clear that that 30-day clock does not begin until the Board finds jurisdiction and the EJR request is complete:

> Under paragraphs (d) and (e) of this section, a provider may request a determination of the Board's authority to decide a legal question, but the 30-day period for the Board to make a determination under section 1878(f)(1) of the Act does not begin to run until the Board finds jurisdiction to conduct a hearing on the specific matter at issue in the EJR request and notifies the provider that the provider's request is complete.

[28] The Board takes administrative notice that, during the 60-day period from November 17, 2021 to January 18, 2022, QRS was making many filings in other cases. For example, on January 12, 2022, Philip Payne at QRS filed a consolidated EJR request ***in 80 different cases*** where the lead case was Case No. 09-1903GC and concurrent with that filing Philip Payne of QRS filed Schedules of Providers ("SoPs") in many of those 80 cases as well as filings in other cases (*e.g.*, change-in-MAC requests were filed in Case Nos. 21-0237G, 21-0239G on December 1, 2021, Case Nos. 21-0273G on December 22, 2021; ***a hearing postponement request*** was filed in Case No. 15-2294 on December 29, 2021; SoPs were filed in Case Nos. 21-0132G, 21-0134G on December 2, 2021, Case No. 21 0258 on December 28, 2021, Case Nos. 21-0237G, 21-0239G on January 4, 2022, Case No. 09-1903GC on January 7, 2022, Case Nos. 13-1419G, 13-1440G, 13-1720GC, 13-1722GC on January 10, 2022, Case Nos. 13-2678G, 13-2693G, 13-2901GC, 13-2903GC, 18-1405G, 18-1408G, 20-0211G on January 11, 2022). Similarly, in the 38-day period from January 18 to February 25, 2022, QRS was similarly actively filing documents in Board cases. For example, Philip Payne of QRS filed a consolidated EJR request on February 11, 2022 for 10 cases (lead case is Case No. 21-0008GC) and a consolidated EJR request for 17 cases on February 27, 2022 (lead case is Case No. 15-0007GC).

C. In the Alternative, the Board Would Deny the Motion to Reinstate Issue 4 Because QRS' Motion is Fatally Flawed.

QRS' Motion to Reinstate Issue 4 (the DSH Part C days issue) is fatally flawed. First, QRS fails to recognize that the Board dismissed the Part C days issue in its November 17, 2021 determination rather than its March 31, 2022 determination. Moreover, QRS fails to recognize that Ascension Health already had a 2008 Part C days CIRP group for which the Board had already granted EJR as specifically recounted by the Board in its November 17, 2021 dismissal of Issue 4:

> [W]ith regard to Issue 4 (DSH Payment – Medicare Managed Care Part C Days), there was a 2008 CIRP group for Ascension Health for this same issue (Case No. 13-1517GC, Ascension 2008 Medicare/Medicaid Medicare Advantage Days CIRP Group) in which the Board granted EJR and closed on May 3, 2019. As this CIRP was fully formed on April 9, 2019, 42 C.F.R. § 405.1837(e)(1) prohibited Ascension Health providers from pursuing the common issue for 2008 inside or outside of the CIRP group absent a Board order . . . . Therefore, ***the Board dismisses the Part C days issue from the instant appeal*** since: (a) the CIRP group was fully formed and has been fully adjudicated and closed; and (b) the Provider should have been brought as part of the CIRP group for that issue.[29]

On February 25, 2022, QRS *belatedly* filed a response to the Board's November 17, 2021 Determination to dismiss Issues 1 and 4 and request information on the remaining issues, namely Issues 2, 3, 5, 6 and 7. Specifically, QRS' response was not timely filed because a response was due within 60 days (*i.e.*, by January 18, 2022) and QRS' response was filed 38 days late on February 25, 2022. Significantly, the February 25, 2022 response recognized the dismissal of Issue 4 since QRS did not claim it was still pending in the case. However, QRS' February 25, 2022 response did not challenge or otherwise dispute the Board's dismissal of Issue 4.

As a result, it is unclear why QRS waited until May 24, 2022 to request reinstatement of Issue 4. Moreover, QRS has failed to establish good cause, consistent with Board Rule 47.1, on why the Board should reinstate Issue 4. In this regard, QRS has failed to acknowledge (as it previously had in its February 24, 2022 filing) that the Board had previously dismissed Issue 4. Rather, its response *incorrectly* suggests that the Board's request for information encompassed Issue 4.

From a substantive standpoint, the record is clear that the Board's November 17, 2021 dismissal of Issue 4 clearly lays out the fact that Ascension Health already had fully adjudicated before the Board the Part C days issue as part of Case No. 13-1517GC. Indeed, based on the certification made in the appeal request that Borgess intended to transfer common issues to CIRP group appeals, it is unclear why Borgess did not immediately transfer the Part C days issue from the instant appeal to Case No. 13-1517GC which was filed on April 10, 2013, roughly a month prior to the instant appeal being filed on May 8, 2013. Borgess had almost 6 years in which to transfer

[29] (Emphasis added.)

the Part C days issue to Case No. 13-1517GC before Ascension Health designated that CIRP group fully formed on April 9, 2019. As discussed below, QRS has blatantly disregarded the CIRP group regulations and Board Rules. Moreover, QRS has no basis to request that the Board reinstate Borgess' Part C issue to allow transfer to an Ascension Health CIRP group for that issue because the Board closed the 2008 Ascension Health CIRP group for that issue under Case No. 13-1517GC on May 3, 2019 (upon granting Ascension Health's request for EJR) and the 3-year period allowed for the Board to reopen a case lapsed on May 3, 2022. As a result, the Board has no authority to otherwise consider any potential request for reopening of that case to allow Borgess to properly pursue the Part C days issue as a participant in Case No. 13-1517GC.

Accordingly, for the above reasons, the Board finds that QRS' Motion to Reinstate Issue 4 is fatally flawed because it has not presented good cause, as required by Board Rule 47.3, for the Board to otherwise revisit or overturn its November 17, 2021 dismissal of Issue 4.

D. In the Alternative, the Board Would Deny the Motion to Reinstate Issue 6 Because QRS' Motion is Fatally Flawed.

The Board finds that the Provider failed to comply with the CIRP regulations and Board procedures, specifically failing to respond to a Board Request for Information and the CIRP Group regulations, therefore the Board ***denies*** the Provider's Motion for Reinstatement.

Rule 47.3, as quoted above, is clear in its requirement that the reinstatement request must demonstrate good cause. The Provider's Motion for Reinstatement did not state a *specific reason* for their failure to comply with the Board's inquiry, but rather refers nebulously to being impacted by the COVID-19 pandemic and gives no details or dates. The Board finds that this explanation does not establish good cause for the reinstatement of the appeal.

Furthermore, it is clear that QRS has a fundamental misunderstanding of its responsibilities ***as Borgess' representative***. Specifically, QRS improperly suggests in the following statement that QRS, ***as the representative of Borgess,*** is not in a position to act on Borgess' CIRP group responsibilities:

> The Board apparently possesses knowledge that other Ascension Health providers have appealed these issues for FYE 6/30/2008 in a CIRP group. ***The undersigned is <u>not</u> in a position to, and therefore does not, possess this knowledge***. Other than alleged failure to comply with the CIRP regulation, the Board has not found any jurisdictional defects. In the interest of justice, rather than deprive this Provider of its right to appeal the DSH Part A and Part C issues, the undersigned respectfully suggests that the Board should reinstate this case, permit the Provider to transfer its appeal to the applicable CIRP Groups appealing the DSH Part A and Part C issues, and then to close this case.[30]

[30] QRS Motion for Partial Reinstatement at 2 (emphasis added).

For QRS to assert that it is not in a position to possess knowledge of Ascension Health's CIRP group appeals raises ***serious concerns*** *regarding potential negligence and dereliction of QRS' responsibilities as Borgess' representative before the Board. Upon further review of this case as filed,* ***the Board reprimands QRS for its blatant disregard of the CIRP group regulations and Board Rules. This case has been pending for over 9 years without Borgess making the requisite CIRP group transfer of Issue 6, notwithstanding the following facts:***

1. *Prior to QRS filing this individual appeal on May 8, 2013,* Ascension Health had ***already*** established the 2008 Ascension Health CIRP group under Case No. 13-1515GC (entitled "Ascension 2008 SSI Fraction Dual Eligible Days CIRP Group") for the Part A days issue, roughly 1 month earlier on April 10, 2013 and the Board closed the case on March 27, 2017 with the issuance of PRRB Dec. No. 2017-D11;

2. In the May 8, 2013 appeal request, QRS recognized Borgess is part of Ascension Health.

3. In the May 8, 2013 appeal request, QRS certified that "There may be other providers to which this provider is related by common ownership or control that have a pending request for a Board hearing on the same issues now being appealed for the cost reporting period that ends in the same calendar year covered in this request" and "[a]ccordingly, the Provider intends to transfer this Provider to an appropriate CIRP group appeal once this appeal of the NPR is established. See 42 C.F.R. § 405.1835(b)(4)(i)."

4. QRS filed Borgess' PPP on December 26, 2013 and Borgess' FPP on September 17, 2020 but failed to address the fact that there were potential CIRP issues.[31]

The Board reminds QRS of its responsibilities as the representative of a CIRP Provider, specifically that when an appeal is filed the representative must comply with the following appeal content requirement at 42 C.F.R. § 405.1835(b)(4):

> 42 C.F.R. § 405.1835(b) *Contents of request for a Board hearing on final contractor determination.*
>
> ****
>
> (4) With respect to a provider under common ownership or control, the name and address of its parent corporation, and a statement that –
>
> (i) To the best of the provider's knowledge, no other provider to which it is related by common ownership or control, **has pending a request for a Board hearing** pursuant to this section or pursuant to § 405.1837(b)(1) **on any of the same issues** contained in the provider's hearing request for a cost reporting period that ends within the same calendar year as the calendar year covered by the provider's hearing request; or

[31] *See infra* note 33 and accompanying text.

> (ii) Such a pending appeal(s) exist(s), and the provider name(s), provider number(s), and the case number(s) (if assigned), for such appeal(s).

***As part of its reprimand of QRS**, the Board further reminds QRS that, consistent with the above regulation, it has a responsibility as the representative of Borgess, to work with Borgess and Ascension Health to identify and comply with Borgess' CIRP group obligations which necessarily impact Ascension Health as a whole.[32] For example, under the operation of 42 C.F.R. § 405.1837(b)(1) and (e)(1), an Ascension Health provider cannot pursue an issue common to other Ascension Health providers for the same year outside of the Ascension Health CIRP group established for that issue and year. Similarly, Ascension Health may not seek to establish a CIRP group for an issue that an Ascension Health provider has already adjudicated before the Board for the same year (e.g., as part of an individual appeal where the Board granted EJR for that provider). Accordingly, QRS is not only the agent of Borgess but also of Ascension Health's CIRP interests through that Provider. The fact that QRS was not the group representative on an Ascension Health CIRP group in no way diminishes QRS' responsibilities **as the agent** of the Provider (and of Ascension Health, through that Provider):*

(a) To actively screen this case to identify potential common issues that should be part of Ascension Health CIRP groups;[33]

(b) To consult, as needed, with both the individual Provider and Ascension Health regarding potential common issues and the existence of relevant Ascension Health CIRP Groups and obtain, as relevant, assurances from the Provider and Ascension Health about their compliance with CIRP group obligations; and

(c) To take actions to ensure compliance, such as coordinating with Ascension Health and Borgess for the transfer of identified common issues to the appropriate Ascension Health CIRP group.

The Provider's Appeal Request, received on May 8, 2013, lists Ascension Health as the Provider's common owner, with both a contact name and phone number. *As Borgess'*

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[32] Indeed, to this end, the Board requires in the Model A Form that the representative of a commonly owned Providers include not just contact information for the Provider but also contact information for the corporate owner.

[33] The Board reminds QRS that, at the position paper stage, 42 C.F.R. § 405.1853(b)(2) requires that "[e]ach 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) . . . ." One aspect of jurisdiction is compliance with the mandatory CIRP group regulation (*i.e.*, there are instances where a provider does not have a right to pursue an issue in individual provider appeal but "must bring" that issue as part of a CIRP group per 42 C.F.R. § 405.1837(b)(1)). Accordingly, consistent with § 405.1853(b)(2), when preparing position papers, QRS should be screening its cases for potential jurisdiction issues, including screening of individual appeals for potential CIRP group issues. To this end, Board Rule 4.7.3 and 12.11 (2018) set forth the Board's expectation that transfers from individual appeals to group appeals will be effectuated prior to submission of the PPPs. As previously noted, QRS filed Borgess' PPP and FPP in this case on December 26, 2013 and September 17, 2020 respectively.

representative, it is QRS' responsibility to consult with Borgess and Ascension Health regarding other Ascension Health appeals, as required in 42 C.F.R. § 405.1835(b)(4).

*Accordingly, **the Board also admonishes Ascension Health and reminds it** that it retained QRS as its agent in this Medicare reimbursement appeal and Ascension Health has responsibilities to oversee its agents, track and monitor its Board cases, **and** to ensure it (through its agents) complies with the CIRP group requirements and does not pursue **improper** claims/appeals*.[34]

*****

In conclusion, the Board ***denies*** the Motion for Reinstatement of Issue 6 because the Board finds QRS failed to establish good cause for its late filing. As such, the Board affirms the exercise of its authority to dismiss Issue 6 pursuant to 42 C.F.R. § 405.1868(a)-(b). Regardless, on separate and independent basis, the Board would deny reinstatement of Issue 6 because Issue 6 was required to be part of a CIRP group and it is Ascension Health's responsibility to ensure such issues get transferred to an appropriate CIRP group.

The Board further denies the Motion for Reinstatement of Issue 4 because the Board notified QRS in its November 17, 2021 dismissal of Issue 4 that Borgess failed to comply with the CIRP group requirements because Borgess should have transferred Issue 4 to the 2008 Ascension Health Part C Days CIRP group under Case No. 13-1517GC. *Finally, upon further review of the record, the Board **reprimands QRS** for its blatant disregard of the CIRP group regulations and related Board Rules. Similarly, **the Board admonishes Ascension Health and reminds it** that it retained QRS as its agent in this Medicare reimbursement appeal and Ascension Health has responsibilities to oversee its agents, track and monitor its Board cases, **and** to ensure it (through its agents) complies with the CIRP group requirements and does not pursue **improper** claims/appeals*. Accordingly, Case No. 13-1947 remains closed.

Board Members Participating:

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

For the Board:

12/20/2022

X Clayton J. Nix

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

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

[34] The appeal request filed on November 6, 2013 identifies Richard L. Felbinger as the Senior Vice President and Chief Financial Officer for ***both*** Ascension Health and Borgess where Ascension Health is listed as the corporate owner of Borgess. The appointment of designated representative was signed by Mr. Felbinger. Based on recently-filed CIRP group appeals for Ascension Health CIRP groups, the Board identified Ms. Davidson as the current Ascension Health contact for Board appeals.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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RE: ***Motion for Partial Reinstatement***
Borgess Medical Center (Prov. No. 23-0117)
FYE 6/30/2009
Case No. 14-0641

Dear Mr. Ravindran,

The Provider Reimbursement Review Board ("Board") has reviewed the Motion for Reinstatement of Issues 4 and 5 ("Motion for Partial Reinstatement") filed on May 24, 2022 by Quality Reimbursement Services, Inc. ("QRS") as the designated representative for Borgess Medical Center ("Borgess" or "Provider"). Issues 4 and 5 relate to treatment of Medicare Part C days in the disproportionate share hospital ("DSH") adjustment calculation ("Part C days issue").[1] Borgess is commonly owned or controlled by Ascension Health. As set forth below, the Board denies the Motion for Reinstatement. Further, as described below, upon further review of the record, *the Board* ***reprimands QRS*** *for its blatant disregard of the CIRP group requirements;* ***and****, given QRS' multiple CIRP group compliance issues with representing Borgess,*[2] *has included the corporate contact for Ascension Health, Dawn Davidson, as an addressee to* ***admonish Ascension Health and remind it of its responsibility to oversee*** *its designated agents that pursue the claims of Ascension Health and its providers, such as Borgess, for additional Medicare reimbursement before the Board*.[3]

Pertinent Facts:

On November 6, 2013, QRS filed an appeal request on behalf of Borgess to establish the instant case for the fiscal year ending June 30, 2009 ("FY 2009") with the following issues:

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[1] Since Issue 4 relates to treatment of Medicare Part C days in the Medicare or SSI fraction and Issue 5 relates to treatment of Medicare Part C days in the Medicaid fraction, the Board treats Issues 4 and 5 as one issue based on the D.C. Circuit's decision in *Allina Health Servs. v. Sebelius* ("*Allina*"), 746 F.3d 1102, 1108 (D.C. Cir. 2014). In *Allina*, the D.C. Circuit reviewed how the whole class of patients who were enrolled in Medicare Part C should be treated under the DSH statute and found that: "*the* ***statute*** *unambiguously requires* that Part C days be counted in one fraction or the other (a Part C-enrolled individual is either eligible for Medicare Part A, or not)." (Emphasis added.) Accordingly, there are no separate Medicare or Medicaid fraction issues since Part C days must be counted in one fraction or the other (*i.e*., excluding them from one means they must be counted in the other).

[2] The Board has identified similar CIRP issues in Borgess' individual appeals for FYs 2008 and 2010 under Case Nos. 13-1947 and 14-0848. QRS is also Borgess' designated representative in these other 2 cases and the Board concurrently issued a letter in those cases to reprimand QRS and include Ascension Health as an addressee with similar reminders.

[3] *See infra* note 33.

1. DSH SSI Provider Specific[4]
2. DSH SSI Systemic Errors
3. Medicaid Eligible Days [5]
4. SSI Fraction/Part C Days[6]
5. Medicaid Fraction/Part C Days[7]
6. Labor Room Days[8]
7. SSI Fraction/Dual Eligible Days
8. Medicaid Fraction/Dual Eligible Days
9. Outlier Payments

As part of the appeal request, QRS identified Borgess as being commonly owned or controlled by Ascension Health and included the following certification:

> There may be other providers to which this provider is related by common ownership or control that have a pending request for a Board hearing on the same issues now being appealed for the cost reporting period that ends in the same calendar year covered in this request. Accordingly, **the Provider <u>intends</u> to transfer this Provider to an appropriate CIPR group appeal once this appeal of the NPR is established**. *See* 42 C.F.R. § 405.1835(b)(4)(i).[9]

However, no such transfers were ever effectuated.

On July 31, 2014, QRS filed Borgess' preliminary position paper ("PPP") and, in the cover letter for this filing, withdrew Issue 6. On December 1, 2014, the Medicare Contractor filed its PPP. Subsequently, on March 25, 2015, the Medicare Contractor filed a revised PPP.

On July 16, 2015, QRS withdrew Issue 2 and stated that the issue was being withdrawn "pursuant to the attached Administrative Resolution"; however, no attachment was included. Accordingly, on July 21, 2015, the Board requested a clarification from QRS regarding the case status and a copy of the Administrative Resolution. QRS did not respond.

On June 4, 2020, the Board issued a Notice of Hearing and Critical Due Dates setting a hearing date of January 20, 2021 and setting deadlines for final position papers ("FPP"). Consistent with this Notice, QRS timely filed Borgess' FPP on October 19, 2020, and the Medicare Contractor filed its FPP on November 18, 2020.

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[4] The Board dismissed this issue on March 17, 2021.
[5] The Provider withdrew this issue on July 16, 2015.
[6] The Board remanded this issue on January 7, 2021 pursuant to CMS Ruling 1739-R.
[7] The Board remanded this issue on January 7, 2021 pursuant to CMS Ruling 1739-R.
[8] The Provider withdrew this issue on July 31, 2014.
[9] (Bold and underline emphasis added.)

On January 7, 2021, pursuant to CMS Ruling 1739-R, the Board issued a determination to remand to the Medicare Contractor Issues 4 and 5 concerning treatment of Medicare Part C days in the DSH adjustment calculation.

On January 19, 2021, the Board issued a new Notice of Hearing rescheduling the hearing for July 20, 2021.

On March 17, 2021, the Board issued a determination to dismiss Issue 1 (DSH SSI Provider Specific) as a prohibited duplicate of Issue 2 (DSH SSI Systemic). This determination further notified QRS that "[i]t has come to the Board's attention that this Provider is commonly owned by Ascension Health (*as admitted in the appeal request*)" and that "[a]s a result it is clear that the[] four remaining issues [DSH issues] should be pursued in [CIRP] group for Ascension Health as required by 42 C.F.R. 405.1837(b)(1)." Accordingly, the Board required that, **within sixty (60) days,** "the Provider confer with Ascension Health and, following that conference, either: (1) transfer the remaining common DSH issues to CIRP groups; or (2) attest that there are no other related providers for this fiscal year, that either are, or could be pursuing the four issues remaining."[10] The Board confirmed that "*this filing deadline is **firm** and . . . specifically **exempt** . . . from the Alert 19 suspension of Board-set filing deadlines. Accordingly, <u>failure to respond by the filing deadline may result in dismissal of the remaining issues</u>*."[11]

QRS ***failed*** to file a response to the Board's Order within 60 days, *i.e.*, by Monday, May 17, 2021. Accordingly, on March 11, 2022, the Board issued a Notice of Dismissal of the remaining issues, Issues 2, 7, 8, and 9 based on 2 different and independent bases, namely failure to comply with the mandatory CIRP group requirements and failure to timely file a response to the Board's March 17, 2021 Order. The Board also reopened its January 7, 2021 determination to remand the Part C days and rescinded that remand based on its finding that the Part C days issue was not properly pending before the Board since it was required to be part of the 2009 Ascension Health CIRP group under Case No. 13-2615GC and, as a result, did not qualify for remand under CMS Ruling 1739-R since it failed to meet the prerequisites for remand under Ruling 1739-R. Specifically, the Board made the following findings:

> In its Appeal Request, the Provider's representative confirmed that Borgess Medical Center was part of the Ascension Health Chain during FY 2009, the year at issue in this case. Therefore, pursuant to the regulations and Board Rules discussed above, Borgess Medical Center was required to be a participant in the group with the other CIRP providers appealing the Part C days issue for 2009, which has since been closed. **To the extent Borgess Medical Center wished to pursue the Part C Days issue, QRS should have transferred the issue to Case No. 13-2615GC** (Ascension Health 2009 DSH Medicare/Medicaid Fraction Part C Days Group) which remained opened from August 5, 2013 until June 18, 2019.

[10] Board Determination (Mar. 17, 2021).
[11] *Id.* (underline emphasis added).

> The Board notes this CIRP group was certified complete by the Providers Representative and, accordingly, per Board Rule 19.2, the Board deemed the 2009 Ascension Health DSH Medicare/Medicaid Fraction Part C Days CIRP group complete.
>
> **The Board finds that: (1) 42 C.F.R. § 405.1837(b)(1)(i) and Board Rule 19.2 required Borgess Medical Center to be in the CIRP group referenced above as Borgess Medical Center was part of Ascension Health in 2009; and (2) as the 2009 CIRP group has since fully formed and closed, Borgess Medical Center forfeited its right to appeal the Part C Days issue for 2009**. The Board's decision is consistent with the mandate in 42 C.F.R. § 405.1837(e)(1) that "[w]hen the Board has determined that a [CIRP] group appeal . . . 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."[12] As it has come to the Board's attention that the Provider is prohibited from pursuing appealing the Part C Days issue in this appeal as it was pursued in group Case No. 13-2615GC, the Board is reopening the decision to remand the Part C Days issue pursuant to 42 C.F.R. § 405.1885.[13]

On May 24, 2022, QRS filed a Motion for Partial Reinstatement with respect to the DSH Part C days issue only. The Medicare Contractor did not file a response.

Provider's Motion for Reinstatement

On May 24, 2022, QRS requested that the Board reinstate Case No. 14-0641 ***solely*** with respect to the DSH Part C issue. QRS argues that there are several bases upon which the Board could find good cause for reinstatement of this issue. Significantly, QRS does not dispute the Board findings that: "(1) 42 C.F.R. § 405.1837(b)(1)(i) and Board Rule 19.2 required Borgess Medical Center to be in the CIRP group referenced above as Borgess Medical Center was part of Ascension Health in 2009; and (2) as the 2009 CIRP group has since fully formed and closed, Borgess Medical Center forfeited its right to appeal the Part C Days issue for 2009."[14] Rather, QRS only presents procedural arguments.

At the outset, QRS acknowledges that the Board has the authority to reopen a determination or decision pursuant to 42 C.F.R. § 405.1885(a)(1). However, it asserts that, consistent with the findings of the U.S. District Court for the District of Columbia ("D.C. District Court") in *Empire*

[12] The Board added emphasis in its quotation.
[13] (Bold emphasis added.)
[14] Board Determination at 5 (Mar. 11, 2022).

Health Found. v. Burwell, 209 F Supp. 3d 261 (D.D.C. 2016) ("*Empire*"), the remand of the DSH Part C issue is not a "decision" and, as a result, the Board lacks the authority to reopen and rescind the remand.[15] QRS further contends that, even if the Board had the authority to reopen the remand, it failed to comply with the procedural requirements for reopening because it is required to issue a notice of reopening, which must be sent to the Administrator, and which must give the Provider reasonable opportunity to respond. Similarly, QRS contends that the Board's reopening of its remand order is at odds with the provision in CMS Ruling 1739-R specifying that "it is not a basis for reopening regarding a DSH Part C appeal."

Finally, QRS contends that QRS is not in a position to determine the compliance of its client, Borgess, with the CIRP group requirements and requested the Board reinstate the Part C Days issue and transfer it to the applicable Ascension Health CIRP group:

> The Board apparently possesses knowledge that other Ascension Health providers have appealed the DSH Part C issue for FYE 6/30/2009 in a CIRP group. ***The undersigned is not in a position to, and therefore does not, possess this knowledge***. Other than alleged failure to comply with the CIRP regulation, the Board has not found any jurisdictional defects. In the interest of justice, rather than deprive this Provider of its right to appeal the DSH Part C issue, the undersigned respectfully suggests that the Board should reinstate this case, permit the Provider to transfer its appeal to the applicable CIRP Groups appealing the Part C issues (which presumably are subject to remand under CMS Ruling 1739-R, and which presumably Board believes that it possesses authority to reopen and to add this Provider to the CIRP group), and then to close this case.[16]

Significantly, QRS' above contention fails to recognize that the March 11, 2022 determination confirmed that Ascension Health ***already*** had had a 2009 Part C Days CIRP group: "Importantly, the Board notes there was an Ascension Health CIRP Group for the Part C Days issue, which was closed on June 18, 2019, in response to the Providers' requests for EJR: 13-2615GC Ascension Health 2009 DSH Medicare/Medicaid Fraction Part C Days Group."[17]

Board's Decision:

Board Rule 47.1 (2021) explains that a Provider may request reinstatement of an issue and also states that the Board will not reinstate an issue or case if the provider was at fault:

> A provider may request reinstatement of an issue(s) or case within three years from the date of the Board's decision to dismiss the issue(s)/case or, if no dismissal was issued, within three years of the

[15] QRS Motion for Partial Reinstatement at 1-2 (May 24, 2022).
[16] *Id.* at 2 (emphasis added).
[17] Board letter at 5 (Mar. 11, 2022).

> Board's receipt of the provider's withdrawal of the issue(s) (*see* 42 C.F.R. § 405.1885 addressing reopening of Board decisions). The request for reinstatement is a motion and must be in writing setting out the reasons for reinstatement (*see* Rule 44 governing motions). **The Board will not reinstate an issue(s)/case if the provider was at fault**. If an issue(s)/case was remanded pursuant to a CMS ruling (e.g., CMS Ruling 1498-R), the provider must address whether the CMS ruling permits reinstatement of such issue(s)/case. If the Board reinstates an issue(s) or case, the provider will have the same rights (no greater and no less) that it had in its initial appeal. These requirements also apply to Rule 47.2 below.[18]

Additionally, Board Rule 47.3 states:

> Upon written motion **demonstrating good cause**, the Board may reinstate a case dismissed for failure to comply with Board procedures. Generally, administrative oversight, settlement negotiations or a change in representative will not be considered good cause to reinstate. If the dismissal was for failure to file with the Board a required position paper, Schedule of Providers, or other filing, then the motion for reinstatement must, *as a prerequisite*, include the required filing before the Board will consider the motion.[19]

As set forth below, the Board denies QRS' motion for reinstatement and affirms its authority to reopen and rescind the January 7, 2021 remand determination.

A. The Board Had the Authority to Reopen and Rescind the January 7, 2021 1739-R Remand Determination

CMS Ruling 1739-R provides:

> First, it is CMS's Ruling that the agency and the Medicare contractors will resolve each ***properly*** *pending* claim in a DSH appeal in which a provider alleges that its DSH payment adjustment for years prior to FY 2014 is invalid because the Secretary did not undertake notice-and-comment rulemaking before including days for patients enrolled in Part C in the SSI fraction of the DSH formula. The agency and the Medicare contractors will calculate or recalculate the provider's DSH payment adjustment in accordance with CMS's forthcoming rule. CMS's action eliminates any actual case or controversy regarding the hospital's previously calculated SSI and Medicaid fractions and

[18] Board Rule 47.1 (Nov. 1, 2021) (bold emphasis added).
[19] Board Rule 47.3 (Nov. 1, 2021) (bold emphasis added).

> its DSH payment adjustment and thereby renders moot each ***properly*** *pending* claim in a DSH appeal involving the issue resolved by the Supreme Court in Allina, ***provided such claim otherwise satisfies the applicable jurisdictional and procedural requirements*** *of section 1878 of the Act, the Medicare regulations, and other agency rules and guidelines for appeal*.
>
> Second, it is also CMS's Ruling that pursuant to 42 CFR 405.1801(a) and 405.1885(c)(1) and (2), this Ruling is not an appropriate basis for a new reopening of any final determination of the Secretary or a Medicare contractor or of any decision by a reviewing entity with respect to the Part C day DSH issue.
>
> Any reopening notice previously issued by CMS, with respect to the Part C days DSH issue, should be processed according to the instructions included in this Ruling.[20]

By its terms, the remand under CMS Ruling 1739-R only applies to "properly pending" claims relative to the Medicare Part C days issue and such claims must "satisf[y] the applicable jurisdictional and procedural requirements of section 1878 of the Act, the Medicare regulations, and other agency rules and guidelines for appeal."[21] Here, the Board's January 7, 2021 remand determination was in clear error because, as explained in the March 11, 2022 reopening and rescission, the Part C days issue was not properly pending in Borgess' individual appeal since it was required to be part of the CIRP group under Case No. 13-2615GC, *which had been closed for almost 3 years*, since June 18, 2019 when the Board granted Ascension Health's request for EJR.

The Board recognizes that the above excerpt from CMS Ruling 1739-R does not permit "this Ruling" to be a basis for a new reopening. Here, the Board did not reopen its January 7, 2021 remand determination *on the basis of Ruling 1739-R*.[22] Rather, the Board reopened the January 7, 2022 determination because it incorrectly found that Borgess' Part C days issue had met the 1739-R prerequisite that Borgess' claim "satisfy[y] the applicable jurisdictional and procedural requirements of section 1878 of the Act, the Medicare regulations, and other agency rules and guidelines for appeal." As explained in the March 11, 2022 determination, additional facts and information came to the Board's attention and, based on those additional facts/information, it is clear that Borgess did not "satisf[y] applicable jurisdictional and procedural requirements of section 1878 of the Act, the Medicare regulations, and other agency rules and guidelines for

[20] CMS Ruling 1739-R at 8-9 (Aug. 17, 2020) (emphasis added).
[21] CMS Ruling at 8-9 (Aug. 17, 2020).
[22] An example of an improper reopening covered by the prohibition under CMS Ruling 1739-R is where the Board were to reopen a Part C days issue dismissed prior to the issuance of 1739-R (*i.e*., dismissed prior to 1739-R) solely to then remand that Part C days issue per 1739-R. That is not what occurred here. Rather, the Board reopened to the remand determination to correct its findings on jurisdiction (and related claims filing requirements) which are a prerequisite to any action under 1739-R.

appeal." Indeed, as discussed more fully below, it is clear that QRS blatantly disregarded the CIRP group regulations and Board Rules.

Similarly, the Board finds that the holdings of the D.C. District Court in the *Empire* decision cited by QRS are not applicable. The *Empire* decision addresses whether a determination or decision is "final" and, as such, reviewable by a federal district court per 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. § 405.1877. That is an entirely different question that the one here, namely whether the Board may reopen a determination. The fact that the determination that the Board reopened is not "final" *for purposes of review by a federal district court* has no direct bearing on whether the Board itself may reopen its determination that the jurisdictional and procedural prerequisites for application of Ruling 1739-R had been met. Here, it is clear that the Board had the authority to reopen its determination that the 1739-R prerequisites had been met.[23]

QRS further complains that the Board did not give QRS an opportunity to file in opposition to the reopening and rescission of the January 7, 2021 remand determination. Here, as discussed more fully below, it is clear that Borgess was subject to the CIRP group requirements for FY 2009, that Ascension Health had a 2009 CIRP group for the Part C days issue under Case No. 13-2615GC that had already been closed on June 18, 2019, and that Borgess was required to be part of that CIRP group to the extent it wished to pursue its Medicare Part C days issue. In the Board's letter dated March 17, 2021, the Board notified QRS of Borgess' CIRP group obligations and required action from QRS relative to those obligations. However, QRS ***failed*** to respond. *QRS' failure to respond* resulted in both the Board's March 11, 2022 dismissal of Issues 2, 7, 8, and 9 as well as the Board's reopening and rescission of its earlier January 7, 2021 remand of the Part C days issue and dismissal of the Part C days issue. Accordingly, the Board finds that QRS did have an opportunity to substantively respond to the basis for the Board's reopening but failed to do so.[24] Indeed, QRS' Motion for Reinstatement does not dispute the Board's basis for reopening, namely that Borgess was required to be part of the Ascension Health CIRP group under Case No. 13-2615GC.

Moreover, any potential procedural error associated with the reopening has been cured by QRS' filing of the request for reinstatement. Per Board Rules 47.1 and 47.3, a motion for reinstatement must set forth the basis for reinstatement and must demonstrate good cause. Thus, QRS' motion for reinstatement cured any deficiency in that it allowed QRS to fully respond. Significantly, QRS' response would not have changed the Board's March 11, 2022 determination because, importantly, *QRS does **not** dispute the facts* that Borgess was subject to the CIRP group requirements for FY 2009, that Ascension Health had a 2009 CIRP group for the Part C days issue under Case No. 13-2615GC that had already been closed on June 18, 2019, and that Borgess was required to be part of that CIRP group to the extent it wished to pursue its Medicare Part C days issue. Indeed, when QRS filed the instant appeal, Case No. 13-2615GC had already been established 5 months earlier and it is unclear why Borgess did not immediately transfer the Part C days issue to Case No. 13-2615GC consistent with the certification that QRS made in its

[23] *See* 42 C.F.R. § 405.1840(a)(3) ("The Board may revise a preliminary determination of jurisdiction at any subsequent stage of the proceedings in a Board appeal, and must promptly notify the parties of any revised determination."). QRS also should have addressed the CIRP group deficiency at the position paper stage. *See infra* note 32.
[24] *See also infra* note 32.

appeal request. The Board discusses Borgess' CIRP group obligations more fully *infra*. Finally, all the alleged procedural errors regarding 1739-R have no basis as explained above.

For the reasons stated above, the Board rejects QRS' claims that the Board's March 11, 2022 determination to rescind the January 7, 2021 remand of the Part C days issue and then dismiss the Part C days issue was improper or fatally flawed. To the extent it is later determined that the Board is required to reopen and reinstate the Part C days issue due to the alleged procedural deficiencies under 42 C.F.R. § 405.1885, the Board would in the alternative do so, but it would again immediately issue a determination to both affirm the January 7, 2021 rescission of the remand order and dismiss the Part C days issue for the reasons stated herein. Again, the Board would note that the motion for reinstatement would cure any alleged procedural defect and serve as Borgess' response to the reopening.

B. It Is Undisputed that Borgess Failed to Comply with the Mandatory CIRP Group Requirements.

42 C.F.R. § 405.1837(b)(1)(i) implements the requirement in 42 U.S.C. § 1395oo(f)(1) that providers under common ownership or control must bring common issues as part of a group which the Board refers to as common issue related party ("CIRP") groups:

> (b) *Usage and filing of group appeals* – (1) ***Mandatory*** *use of group appeals.* (i) **Two or more providers under common ownership or control** that wish to appeal to the Board a specific matter at issue that involved 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**.[25]

Additionally, 42 C.F.R. § 405.1837(e)(1) specifies how a group is designated as fully formed and the effect of a group being fully formed:

> (e) *Group appeal procedures pending full formation of the group and issuance of a Board decision*. (1) A provider (or providers) may file a group appeal hearing request with the Board under this section before each provider member of the group identifies or complies with paragraphs (a)(1) and (a)(2) of this section, or before the group satisfies the $50,000 amount in controversy requirement under paragraph (a)(3) of this section. . . . The Board will determine that a group appeal brought under paragraph (b)(1) of this section is fully formed **upon a notice in writing from the group that it is fully formed**. Absent such a notice from the group, the Board may issue an order, requiring the group to

[25] (Bold and underline emphasis added.)

> demonstrate (within a period of not less than 15 days) that at least one commonly owned or controlled provider has preserved the issue for appeal by claiming the relevant item on its cost report or by self-disallowing the item, but has not yet received its final determination with respect to the item for a cost year that is within the same calendar year as that covered by the group appeal (or that it has received its final determination with respect to the item for that period, and is still within the time to request a hearing on the issue). The Board determines that a group appeal brought under paragraph (b)(2) of this section is fully formed **upon a notice in writing from the group that it is fully formed**, or following an order from the Board that in its judgment, that the group is fully formed, or through general instructions that set forth a schedule for the closing of group appeals brought under paragraph (b)(2) of this section. **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.[26]

Board Rules 12.3 and 19 (2018) reflect the above regulations and state, in pertinent part:

> **12.3 Types of Groups**
>
> **12.3.1 Mandatory Common Issue Related Part ("CIRP") Group**
>
> Providers under common ownership or control that with to appeal a specific matter that is common to the providers must bring the appeals a group appeal. *See* 42 C.F.R. § 405.1837(b).
>
> ****
>
> **Rule 19 – Full Formation of Groups**
>
> Reference 42 C.F.R. § 405.1837(e) regarding group appeal procedures pending full formation of the group and issuance of a Board decision.
>
> ****
>
> **19.2 – Mandatory (CIRP) Groups**

[26] (Bold and underline emphasis added.)

> Mandatory CIRP group appeals must contain all Providers eligible to join the group which intend to appeal the disputed common issue. The Board will determine that a CIRP group appeal is fully formed upon:
>
> • written notice from the Group Representative that the group is fully formed, or
> • a Board order issued after the Group Representative has the opportunity to present evidence regarding whether any CIRP providers who have not received final determinations could potentially join the group. . . .[27]

In its March 11, 2022 determination, the Board found that Borgess failed to comply with the CIRP regulations and Board procedures. Further review of the file reaffirms this finding.

In filing Borgess' November 6, 2013 appeal request, QRS specifically acknowledged that Borgess is owned by Ascension Health and is subject to the mandatory CIPR Group requirements. Moreover, *as part of that appeal request*, QRS specifically certified that, consistent with those requirements, Borgess intended to transfer issues to Ascension Health CIRP Groups:

> There may be other providers to which this provider is related by common ownership or control that have a pending request for a Board hearing on the same issues now being appealed for the cost reporting period that ends in the same calendar year covered in this request. Accordingly, **the Provider intends to transfer this Provider to an appropriate CIPR group appeal once this appeal of the NPR is established**. *See* 42 C.F.R. § 405.1835(b)(4)(i).[28]

In the Board's letter dated March 17, 2021, the Board notified QRS of Borgess' CIRP group obligations and required action from QRS relative to those obligations. However, QRS ***failed*** to respond. *QRS' failure to respond* resulted in both the Board's March 11, 2022 dismissal of Issues 2, 7, 8, and 9 as well as the Board's reopening and rescission of its earlier January 7, 2021 remand of the Part C days issue and dismissal of the Part C days issue.

Furthermore, it is clear that QRS has a fundamental misunderstanding of its responsibilities ***as Borgess' representative***. Specifically, QRS improperly suggests in the following statement that QRS, ***as the representative of the Borgess,*** is not in a position to act on Borgess' CIRP group responsibilities:

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[27] (Underline emphasis added.)
[28] (Bold emphasis added.)

> The Board apparently possesses knowledge that other Ascension Health providers have appealed the DSH Part C issue for FYE 6/30/2009 in a CIRP group. ***The undersigned is <u>not</u> in a position to, and therefore does not, possess this knowledge***. Other than alleged failure to comply with the CIRP regulation, the Board has not found any jurisdictional defects. In the interest of justice, rather than deprive this Provider of its right to appeal the DSH Part C issue, the undersigned respectfully suggests that the Board should reinstate this case, permit the Provider to transfer its appeal to the applicable CIRP Groups appealing the Part C issues (which presumably are subject to remand under CMS Ruling 1739-R, and which presumably Board believes that it possesses authority to reopen and to add this Provider to the CIRP group), and then to close this case.[29]

For QRS to assert that it is not in a position to possess knowledge of Ascension Health's CIRP group appeals raises ***<u>serious concerns</u>*** *regarding potential negligence and dereliction of QRS' responsibilities as Borgess' representative before the Board. Upon further review of this case as filed,* ***the Board <u>reprimands</u> <u>QRS for its blatant disregard of the CIRP group regulations and Board Rules. This case has been pending for over 9 years</u> without Borgess making the requisite CIRP group transfer of the Part C days issue, notwithstanding the following facts:***

1. *Prior to QRS filing this individual appeal on November 6, 2013,* Ascension Health had ***already*** established the 2009 Ascension Health CIRP group under Case No. 13-2615GC for the Part C days issue, roughly 5 months earlier on June 18, 2019;

2. In the November 6, 2013 appeal request, QRS recognized that Borgess was part of Ascension Health.

3. In the November 6, 2013 appeal request, QRS certified that "There may be other providers to which this provider is related by common ownership or control that have a pending request for a Board hearing on the same issues now being appealed for the cost reporting period that ends in the same calendar year covered in this request" and "[a]ccordingly, the Provider intends to transfer this Provider to an appropriate CIRP group appeal once this appeal of the NPR is established. See 42 C.F.R. § 405.1835(b)(4)(i)."

4. QRS filed Borgess' PPP on July 31, 2014 and Borgess' FPP on October 19, 2020 but failed to address the fact that there were potential CIRP issues.[30]

Indeed, since the 2009 Ascension Health Part C Days CIRP group under Case No. 13-2615GC had already been established 5 months prior to the instant case, it is unclear why Borgess did not

[29] QRS Motion for Reinstatement at 2 (emphasis added).
[30] *See infra* note 32 and accompanying text.

immediately transfer the Part C days issue to Case No. 13-2615GC consistent with the certification that QRS made in its appeal request.

The Board reminds QRS of its responsibilities as the representative of a CIRP Provider, specifically that when an appeal is filed the representative must comply with the following appeal content requirement at 42 C.F.R. § 405.1835(b)(4):

> 42 C.F.R. § 405.1835(b) *Contents of request for a Board hearing on final contractor determination.*
>
> ****
>
> (4) With respect to a provider under common ownership or control, the name and address of its parent corporation, and a statement that –
>
> (i) To the best of the provider's knowledge, no other provider to which it is related by common ownership or control, **has pending a request for a Board hearing** pursuant to this section or pursuant to § 405.1837(b)(1) **on <u>any</u> of the same issues** contained in the provider's hearing request for a cost reporting period that ends within the same calendar year as the calendar year covered by the provider's hearing request; or
>
> (ii) Such a pending appeal(s) exist(s), and the provider name(s), provider number(s), and the case number(s) (if assigned), for such appeal(s).

As part of its reprimand of QRS*, the Board further reminds QRS that, consistent with the above regulation, QRS it has a responsibility as the Representative of Borgess to work with Borgess and Ascension Health to identify and comply with Borgess' CIRP group obligations which necessarily impact Ascension Health as a whole.*[31] *For example, under the operation of 42 C.F.R. § 405.1837(b)(1) and (e)(1), an Ascension Health provider cannot pursue an issue common to other Ascension Health providers for the same year outside of the Ascension Health CIRP group established for that issue and year. Similarly, Ascension Health may not seek to establish a CIRP group for an issue that an Ascension Health provider has already adjudicated before the Board for the same year (e.g., as part of an individual appeal where the Board granted EJR for that provider). Accordingly, QRS is not only the agent of Borgess but also of Ascension Health's CIRP interests through that Provider. The fact that QRS was not the group representative on the 2009 Ascension Health CIRP group for the Part C days issue under Case No. 13-2615GC in no way diminishes QRS' responsibilities* ***as the agent*** *of the Provider (and of Ascension Health, through that Provider):*

[31] Indeed, to this end, the Board requires in the Model A Form that the representative of a commonly owned Providers include not just contact information for the Provider but also contact information for the corporate owner.

(a) To actively screen this case to identify potential common issues that should be part of Ascension Health CIRP groups;[32]

(b) To consult, as needed, with both the individual Provider and Ascension Health regarding potential common issues and the existence of relevant Ascension Health CIRP Groups and obtain, as relevant, assurances from the Provider and Ascension Health about their compliance with CIRP group obligations; and

(c) To take actions to ensure compliance, such as coordinating with Ascension Health and Borgess for the transfer of identified common issues to the appropriate Ascension Health CIRP group.

The Provider's Appeal Request, received on November 6, 2013, lists Ascension Health as the Provider's common owner, with both a contact name and phone number. *As Borgess' representative, it is QRS' responsibility to consult with Borgess and Ascension Health regarding other Ascension Health appeals, as required in 42 C.F.R. § 405.1835(b)(4).*

*Accordingly, **the Board also admonishes Ascension Health and reminds it** that it retained QRS as its agent in this Medicare reimbursement appeal and Ascension Health has responsibilities to oversee its agents, track and monitor its Board cases, **and** to ensure it (through its agents) complies with the CIRP group requirements and does not pursue **improper** claims/appeals*.[33] As noted above, the Board's records show that Ascension Health had a 2009 Part C Days CIRP group under Case No. 13-2615GC that had been established 5 months prior to the instant appeal. As a result, Borgess and Ascension Health had over 5 ½ years until May 10, 2019 (when Ascension Health certified that Case No. 13-2615GC was fully formed) to transfer the Part C days issue from the instant case to Case No. 13-2615GC.[34] As such, it is clear that the Board improperly remanded Borgess on January 7, 2021 because Ruling 1739-R only applies to properly pending appeals before the Board. Here, the Part C days issue was not properly pending

[32] The Board reminds QRS that, at the position paper stage, 42 C.F.R. § 405.1853(b)(2) requires that "[e]ach 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) . . . ." One aspect of jurisdiction is compliance with the mandatory CIRP group regulation (*i.e*., there are instances where a provider does not have a right to pursue an issue in individual provider appeal but "must bring" that issue as part of a CIRP group per 42 C.F.R. § 405.1837(b)(1)). Accordingly, consistent with § 405.1853(b)(2), when preparing position papers, QRS should be screening its cases for potential jurisdiction issues, including screening of individual appeals for potential CIRP group issues. To this end, Board Rule 4.7.3 and 12.11 (2018) set forth the Board's expectation that transfers from individual appeals to group appeals will be effectuated prior to submission of the PPPs. As previously noted, QRS filed Borgess' PPP and FPP in this case on August 28, 2014 and May 1, 2020 respectively.

[33] The appeal request filed on November 6, 2013 identifies Richard L. Felbinger as the Senior Vice President and Chief Financial Officer for ***both*** Ascension Health and Borgess where Ascension Health is listed as the corporate owner of Borgess. The appointment of designated representative was signed by Mr. Felbinger. Based on recently-filed CIRP group appeals for Ascension Health CIRP groups, the Board identified Ms. Davidson as the current Ascension Health contact for Board appeals.

[34] The Board further notes that it has now been more than 3 years since the Board closed Case No. 13-2615GC on June 6, 2018 when it granted Ascension Health's request for EJR and, as such, any potential reopening of Case No. 13-2615GC has passed. Even if it had not passed, there is no indication in the record that there would have been any "good cause" as required under Board Rule 47 for the Board to consider such a reopening.

before the Board in the instant case because it was subject to the mandatory CIRP group rules and was required to have been part of Case No. 13-2615GC prior to the Board's closing of that case.[35]

*****

In conclusion, the Board ***denies*** the Motion for Partial Reinstatement because the Board finds it properly reopened the case, any potential procedural defects have been cured, and QRS does not dispute the basis for the Board's dismissal of the Part C days, namely that Borgess was required to have been part of Case No 13-2615GC. To the extent it is later determined that the Board is required to reopen and reinstate the Part C days issue due to the alleged procedural deficiencies under 42 C.F.R. § 405.1885, the Board would in the alternative do so, but it would immediately issue a determination to affirm its rescission of the January 7, 2021 remand order and dismiss the Part C days issue for the reasons stated herein. *Indeed, upon further review of the record, the Board **reprimands QRS** for its blatant disregard of the CIRP group regulations and related Board Rules. Similarly, **the Board admonishes Ascension Health and reminds it** that it retained QRS as its agent in this Medicare reimbursement appeal and Ascension Health has responsibilities to oversee its agents, track and monitor its Board cases, **and** to ensure it (through its agents) complies with the CIRP group requirements and does not pursue **improper** claims/appeals*. Accordingly, Case No. 14-0641 remains closed.

Board Members Participating:

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

For the Board:

12/20/2022

X Clayton J. Nix

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

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

[35] The other issues that the Board dismissed for failure to comply with the mandatory CIRP group rules were Issues 1, 7, 8, and 9. While QRS has not requested reinstatement of these issues, the Board notes that it has identified 2009 Ascension Health CIRP groups that appear to cover Issues 1, 7, and 8 under Case Nos. 13-2614GC (Issue 1) and 13-2611GC (Issues 7 and 8). These cases were closed in 2017 or 2018.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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RE: ***Notice of Dismissal of Issues 4 & 7 and Denial of EJR for Issues 4 & 7***
Borgess Medical Center (Prov. No. 23-0117)
FYE 6/30/ 2010
Case No. 14-0848

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the record in the above referenced appeal involving Borgess Medical Center ("Borgess") which is owned or controlled by Ascension Health. Quality Reimbursement Services, Inc. ("QRS") is Borgess' designated representative. The Board's decisions to dismiss both Issue 4 – DSH SSI Fraction/Medicare Part C Days and Issue 7 DSH SSI Fraction/Dual Eligible Days, as well as deny the EJR requests for Issues 4 and 7, is set forth below. Further, as described below, *the Board* ***reprimands QRS*** *for its disregard of the CIRP group requirements and the Board's Order in its November 2, 2022 request for information;* ***and****, given QRS' multiple CIRP group compliance issues with representing Borgess,*[1] *has included the corporate contact for Ascension Health, Dawn Davidson, as an addressee to* ***admonish Ascension Health and remind it of its responsibility to oversee*** *its designated agents that pursue its claims for additional Medicare reimbursement before the Board*.[2]

Background:

On November 18, 2013, QRS established Case No. 14-0848 by filing an appeal request for Borgess which contained the following issues:

- Issue 1 – DSH Supplemental Security Income ("SSI") Percentage (Provider Specific)
- Issue 2 – DSH SSI Percentage (Systemic Errors)
- Issue 3 – DSH Medicaid Eligible Days
- Issue 4 – DSH SSI Fraction/Medicare Part C Days
- Issue 5 – DSH Medicaid Fraction/Medicare Part C Days
- Issue 6 – DSH Medicaid Eligible Labor Room Days
- Issue 7 - DSH SSI Fraction/Dual Eligible Days
- Issue 8 – DSH Medicaid Fraction/Dual Eligible Days
- Issue 9 – Outlier Payments – Fixed Loss Threshold

[1] The Board has identified similar CIRP issues in Borgess' individual appeals for FYs 2008 and 2009 under Case Nos. 13-1947 and 14-0641. QRS is also Borgess' designated representative in these 2 other cases and the Board concurrently issued a letter in those cases to reprimand QRS and include Ascension Health as an addressee with similar reminders.
[2] *See infra* note 33.

Significantly, Borgess' appeal request acknowledged that it was commonly owned or controlled by Ascension Health and specifically listed both an address and corporate contact for Ascension Health.[3] Consistent with this acknowledgement, QRS gave the following certification confirming that it would be transferring common issues to Ascension Health CIRP groups:

> There may be other providers to which this provider is related by common ownership or control that have a pending request for a Board hearing on the same issues now being appealed for the cost reporting period that ends in the same calendar year covered in this request. Accordingly, **the Provider <u>intends</u> to transfer this Provider to an appropriate CIRP group appeal once this appeal of the NPR is established**. *See* 42 C.F.R. § 405.1835(b)(4)(i).[4]

However, only one such transfer was made and, as described below, that transfer was not made until roughly 9 years later and was made only because the Board required it.

On August 28, 2014, QRS withdrew the Medicaid Eligible Labor Room Days issue (Issue 6). Similarly, on July 23, 2020, QRS withdrew the Outlier Payments – Fixed Loss Threshold issue (Issue 9).

On April 17, 2020, the Board dismissed the DSH SSI Percentage (Provider Specific) issue (Issue 1) from the appeal. Following this dismissal, there were 6 issues remaining in this appeal:

- Issue 2 – DSH SSI Percentage (Systemic Errors)
- Issue 3 – DSH Medicaid Eligible Days
- Issue 4 – DSH SSI Fraction/Medicare Part C Days
- Issue 5 – DSH Medicaid Fraction/Medicare Part C Days
- Issue 7 - DSH SSI Fraction/Dual Eligible Days
- Issue 8 – DSH Medicaid Fraction/Dual Eligible Days

On November 2, 2022, the Board issued a Request for Information to QRS because it had come to the Board's attention that Borgess is commonly owned by Ascension Health and, as such, is subject to the *mandatory* statutory and regulatory requirements governing commonly owned related party ("CIRP") group appeals. The Board noted that Ascension Health already had pending 2010 CIRP groups for four of the remaining issues:

> Case No. 13-3062GC – Ascension Health 2010 DSH Medicare Fraction Part C Days
> Case No. 13-3066GC – Ascension Health 2010 DSH Medicaid Fraction Part C Days
> Case No. 13-3067GC – Ascension Health 2010 DSH Medicare Fraction Dual Eligible Days
> Case No. 13-3068GC – Ascension Health 2010 DSH SSI Post 1498R Data Match

[3] *See infra* note 33.
[4] (Bold and underline emphasis added.)

The Board also noted that 3 of these 4 cases were already ***closed*** and, as such, the Provider would be precluded from pursuing the same issues (Issues 4, 5, and 7) for 2010 (whether as part of an individual appeal or a group). The Board directed QRS to confer with Borgess and Ascension Health regarding whether Borgess was, in fact, owned or controlled by Ascension Health for 2010 and, if so, to either withdraw Issues 4, 5, and 7 or show cause why the Board should not dismiss them. The Board also required QRS to transfer Issue 2 to the Ascension Health CIRP group under Case No. 13-3068GC (Ascension Health 2010 DSH SSI Post 1498R Data Match). Finally, the Board required QRS to determine whether Issue 8 should be transferred to an Ascension CIRP group, since Issue 8 is an issue that could be common to other Ascension Health providers and, thereby, subject to the CIRP group requirements. A response was due from QRS within 21 days, *i.e.*, by Friday, November 23, 2022.

On November 21, 2022, QRS filed withdrawal of Issue 3 and Borgess transferred Issue 2 to the Ascension Health CIRP group under Case No. 13-3068GC. On November 22, QRS filed withdrawal Issues 5 and 8 and filed its Response to the Board's Request for Information. In its Response, QRS affirmed that Borgess was part of Ascension during FY 2010; however, it is unclear whether QRS conferred with Borgess and Ascension Health as directed by the Board. Moreover, *QRS **failed** to address whether Issue 4 should have been included in Case No. 13-3066GC or whether Issue 7 should have been in Case No. 13-3067GC*. Rather, QRS gave the following responses and did not address how their continued pursuit of these issues, even if distinguishable, would not be subject to the mandatory CIRP group requirements (*i.e.*, whether other Ascension Health providers had, would have, or should have had these issues):

Issue 4 – DSH SSI Fraction/Medicare Part C Days

- "Although this issue, on its surface, may appear to be similar to the Ascension Part C CIRP group appeal, the issue addressed is in fact ***distinctly different*** from that group appeal. The Provider's challenge to the DSH Part C Rule implicates and, therefore, challenges Centers for Medicare & Medicaid Services ("CMS") Ruling 1739-R as well as a proposed rule promulgated by CMS, 85 Fed. Reg. 47723-47728 (Aug. 6, 2020) (the "Proposed Rule"). Accordingly, the issues on appeal in this case would not have properly been included in the Ascension Part C CIRP group appeal. As the Board has no authority to address or modify rule 1739-R, the Provider concurrent with this letter is filing its request for expedited judicial review regarding its challenge to Ruling 1739-R and the Proposed Rule."

Issue 7 – DSH SSI Fraction/Dual Eligible Days

- QRS simply stated that "QRS will be requesting an EJR Request" for this issue.

Concurrently, on November 22, 2022, QRS filed a request for Expedited Judicial Review ("EJR") over Issue 4 – SSI Fraction/Medicare Part C Days. Further, on November 30, 2022, QRS filed an EJR request over Issue 7 – DSH SSI Fraction/Dual Eligible Days.

On December 5, 2022, the Medicare Contractor filed a response to the EJR Requests for Issues 4 and 7, though the time for doing so, in the case of Issue 4, had elapsed.[5] The Medicare Contractor simply requests the Board deny the EJR requests because Issues 4 and 7 were identical to the issues in

[5] Board Rule 42.4 states: "If the Medicare contractor opposes an EJR request filed by a provider or group of providers, then it must file its response within five (5) business days of the filing of the EJR Request." Thus, any response to the instant EJR Request for Issue 4 would have been due no later than 11:59 p.m. (EST), November 30, 2022.

Ascension Health CIRP groups under Case Nos. 13-2062GC and 13-3067GC respectively. Further, with respect to Issue 7, the Medicare Contractor maintains that QRS did not attempt to comply with the Board's directive to explain good cause for not complying with 42 C.F.R. § 405.1837(b)(1). Thus, the Medicare Contractor concludes that the Provider has failed to comply with the CIRP group appeal regulation and that the EJR should be denied and that Issue 4 and 7 should be dismissed.

Rules on Mandatory Common Issue Party Related (CIRP) Groups:

By way of background, chain provider organizations are subject to the following requirement in 42 U.S.C. § 1395oo(f)(1):

> Any appeal to the Board or action for judicial review by providers which are under common ownership or control or which have obtained a hearing under subsection (b) ***must*** *be brought* by such providers *as a group* with respect to any matter involving an issue common to such providers.[6]

This statutory provision was implemented at 42 C.F.R. § 405.1837(b)(1)(i) and this regulation mandates the use of a CIRP group appeal where:

> *Two or more providers under common ownership or control* that wish to appeal to the Board a specific matter at issue that involved 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.*

Further, 42 C.F.R. § 405.1835(b) address the "Contents of request for a Board hearing" and requires the following in paragraph (4) *when a provider is under common ownership or control*:

> (b) *Contents of request for a Board hearing on final contractor determination.* The provider's request for a Board hearing under paragraph (1) of this section **must be submitted in writing** to the Board, and the request **must include the elements described in paragraphs (b)(1) through (b)(4)** of this section. If the provider submits a hearing request that does not meet the requirements of paragraph (b)(1), (b)(2), or (b)(3) of this section, **the Board may dismiss** with prejudice the appeal or take any other remedial action it considers appropriate.
>
> * * * *
>
> (4) **With respect to a provider under common ownership or control**, the name and address of its parent corporation, and a statement that –

[6] (Emphasis added).

> (i) To the best of the provider's knowledge, no other provider to which it is related by common ownership or control, has pending a request for a Board hearing pursuant to this section or pursuant to § 405.1837(b)(1) on any of the same issues contained in the provider's hearing request for a cost reporting period that ends within the same calendar year as the calendar year covered by the provider's hearing request; or
>
> Such a pending appeal(s) exists(s), and the provider name(s), provider number(s), and the case number(s) (if assigned), for such appeal(s).[7]

42 C.F.R. § 405.1837(e)(1) and Board Rules further address the mandatory use of CIRP groups. First, 42 C.F.R. § 405.1837(e)(1) addresses full formation of groups:

> 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.[8]

Further, the current Board Rules issued on August 29, 2018 states:

> **12.3 Types of Groups**
>
> **12.3.1 Mandatory Common Issue Related Part ("CIRP") Group**
>
> Providers under common ownership or control that with to appeal a specific matter that is common to the providers must bring the appeals a group appeal. *See* 42 C.F.R. § 405.1837(b).
>
> ****
>
> **Rule 19 – Full Formation of Groups**
>
> Reference 42 C.F.R. § 405.1837(e) regarding group appeal procedures pending full formation of the group and issuance of a Board decision.
>
> **19.2 – Mandatory (CIRP) Groups**
>
> Mandatory CIRP group appeals must contain all Providers eligible to join the group which intend to appeal the disputed common issue. The Board will determine that a CIRP group appeal is fully formed upon:

[7] (Bold and underline emphasis added.)
[8] (Emphasis added.)

> • Written notice from the Group Representative that the group is fully formed, or
>
> • A Board order issued after the Group Representative has the opportunity to present evidence regarding whether any CIRP providers who have not received final determinations could potentially join the group. . . .[9]

Relevant Facts:

A. Issue 4 – DSH – SSI Fraction/Medicare Managed Care Part C Days

As previously noted, Borgess' appeal request notes that it is commonly owned by Ascension Health. Issues 4 and 5 relate to treatment of Medicare Part C days in the disproportionate share hospital ("DSH") adjustment calculation ("Part C days issue") where one focuses on the Medicare fraction and the other on the Medicaid fraction. The Board considers them one issue based on the D.C. Circuit's decision in *Allina Health Servs. v. Sebelius* ("*Allina*").[10] In *Allina*, the D.C. Circuit reviewed how the whole class of patients who were enrolled in Medicare Part C should be treated under the DSH statute and found that: "*the **statute** unambiguously requires* that Part C days be counted in one fraction or the other (a Part C-enrolled individual is either eligible for Medicare Part A, or not)."[11] Accordingly, there are no separate Medicare or Medicaid fraction issues since Part C days must be counted in one fraction or the other (*i.e*., excluding them from one means they must be counted in the other). QRS withdrew Issue 5 *without any explanation and without any conditions.*[12] As such, the withdrawal of Issue 5 is also applicable to Issue 4 since they are the same issue, meaning it is an effective withdrawal of Issue 4. The Board suspects that the withdrawal of Issue 5 is premised on the fact that Issue 5 duplicates Issue 4 and the fact that this is not explained further highlights QRS' mishandling of this appeal. However, this issue is moot because, as set forth below, the Board has bases to dismiss Issue 4 for other reasons.

In its initial appeal request for Case No. 14-0848, Borgess described its Issue 4: DSH – SSI Fraction/Medicare Managed Care Part C Days Issue as follows:

> **Statement of Issue**
>
> Whether HMO / Medicare Plus Choice / Medicare Managed Care / Medicare Part C / Medicare Advantage ("MA") Days were properly accounted for in the Disproportionate Share Hospital ("DSH") calculation.

[9] (Underline Emphasis added.)
[10] 746 F.3d 1102, 1108 (D.C. Cir. 2014). The Board has been consolidating separate Medicare Part C appeals based on the Medicare and Medicaid fractions and, indeed, did this for Ascension Health in 2018 relative to its 2009 Part C days CIRP groups as discussed *infra*.
[11] *Id.* (emphasis added).
[12] The November 22, 2022 response to the Board's RFI simply states that Issue 5 "has been withdrawn" and provides no explanation of why Issue 5 was withdrawn and, notwithstanding this withdrawal, Issue 4 continues to be pursued.

Statement of the Legal Basis

The Provider contends that the MAC's treatment of the MA days is not in accordance with the DSH statute at 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II). The MAC failed to include patient days applicable to MA patients who were also eligible for Medicaid in the Medicaid fraction of the Medicare DSH payment adjustment, but instead included those days in the SSI or Medicare fraction.

The key legal issue to be determined is whether dual eligible MA patients are "entitled to benefits under Part A." If the answer to this question is in the affirmative, then these patient days should be included in both the numerator and the denominator of the SSI or Medicare fraction. On the other hand, if these patients are not entitled to benefits under Part A, then these patients should be excluded from both the numerator and denominator of the SSI or Medicare fraction.

It is clear from the statute that MA patients are not "entitled to benefits under Part A." Under the Medicare statute, "entitlement of an individual to [Medicare part A] benefits for a month shall consist of entitlement to have payment made under, and subject to the limitations in, [Medicare] part A . . . on his behalf for [certain] services." *See* 42 U.S.C § 426(c)(l). A person may only enroll in a MA plan if he is entitled to benefits under Medicare Part A. *See* 42 U.S.C. § 1395w-21(a)(3)(A). However, upon enrollment in a MA plan, an individual is no longer "entitle[d] to have payments made under, and subject to the limitations in, [Medicare] part A." Rather, "payments under a contract with a Medicare+Choice organization...with respect to an individual electing a Medicare+Choice plan offered by the organization shall be ***instead*** of the amounts which (in the absence of the contract) would otherwise be payable under [Medicare] parts A and B." *See* 42 U.S.C. § 1395w -21(i)(1) (emphasis added). *See also* 42 U.S.C. § 1395w-21(a)(l) ("Each [MA] eligible individual . . . is entitled to receive benefits . . . (A) through the original Medicare fee-for-service program under parts A and B . . . , (B) through enrollment in a Medicare+Choice plan under [MA]." (Emphasis added).

The use of the language "**instead**" and "**or**" in the statute clearly indicates that a patient is entitled to benefits under a MA plan or Part A, but not both. Thus, a patient receiving benefits under an MA plan is not also entitled to benefits under Part A. Accordingly, the plain language of the statute requires that MA patients be excluded from the Medicare fraction and included in the Medicaid fraction.

Moreover, applying the interpretation reached in *Jewish Hospital*, the term "entitled to benefits under Part A" would refer to the right to a payment

> under Part A. However, the statutory language states that MA patients are paid under Part C instead of Part A. *See e.g.* 42 U.S.C. § 1395w-23(a)(1)(A) ("[T]he Secretary shall make monthly payments under this section in advance to each Medicare+Choice organization, *with respect to coverage of an individual under this part* [*i.e.*, part C] ...." (Emphasis added)).
>
> In addition, just as the D.C. Court of Appeals ruled in *Northeast Hospital Corporation v. Sebelius* (D.C. Cir. September 13, 2011) ("*Northeast*") MA days must be included in the Medicaid fraction for periods prior to October 1, 2004. The D.C. District Court ruled in *Allina Health Services, et al. v. Sebelius* (Case No. 1:10-cv-01463 (RMC)) ("*Allina*") that MA days should be included in the Medicaid fraction for periods after October 1, 2004. The D.C. District Court in *Allina* also found that the 2004 Final Rule, et. al., which applies to the fiscal year under appeal, were procedurally defective and, therefore, infirm *ab initio*. The Providers request the Board incorporate the entire administrative and judicial records of *Northeast* and *Allina* into the record of this appeal.
>
> Accordingly, MA days are not days for which patients are "entitled to benefits under Part A." As a result, these days should be excluded from the numerator and denominator of the Providers' SSI or Medicare fractions.

The group issue statement in the Ascension Health CIRP group under Case No. 13-3062GC entitled "*Ascension Health 2010 DSH Medicare Fraction Part C Days.*" which reads as follows:

> Issue Description for DSH SSI Ratio Part C (Medicare Advantage) Days Issue
>
> The failure of the Fiscal Intermediary and the Centers for Medicare & Medicaid Services (CMS) to properly determine the ratio of Supplemental Security Income (SSI) recipient patient days for patients who, for such days, were entitled to benefits under both Medicare Part A and SSI (excluding any State supplementation), to Medicare Part A patient days (the Medicare Proxy or Fraction) for the Participating Providers in their Disproportionate Share Hospital (DSH) eligibility determinations and payment calculations. The Participating Providers assert that the Medicare Proxy is improperly understated due to CMS's erroneous inclusion of inpatient days attributable to Medicare Advantage (MA) patients in both the numerator and the denominator of the DSH fraction and/or low income patient (LIP) fraction for Inpatient Rehabilitation Facilities (IRFFs) and/or IRF units, as applicable.
>
> The authority upon which CMS relied to collect this MA days information is the DSH regulation at 42 C.F.R. § 412.106, which includes MA days in the description of days included in the Medicare fraction. However, the

enabling statute for this regulation, 42 U.S.C. § 1395ww(d)(5)(F), makes no mention of the inclusion of MA days in the Medicare Fraction only traditional Part A days. MA beneficiaries are not entitled to benefits under Part A, but instead are entitled to benefits under Part C. Thus, the Participating Providers challenge the validity of the regulation to the extent that 42 C.F.R. § 412.106 contradicts the enabling statute at 42 U.S.C. § 1395ww(d)(5)(F).

Providers also challenge the validity of the regulation and assert that it was adopted in violation of the Administrative Procedures Act (APA). CMS violated the APA when it deprived the public the opportunity to comment on the regulation. The District Court for the District of Columbia recently held that the FFY 2004 Rulemaking shall be vacated for violations of the APA in Allina Health Services v. Sebelius. (D.D.C. Nov. 15, 2012).

In addition to challenging to challenging the validity of the regulation at issue, the Participating Providers assert that CMS failed to comply with the Paperwork Reduction Act, 44 U.S.C. §§ 3501-3549 ("PRA"). Under the PRA, "no person shall be subject to any penalty for failing to comply with a collection of information … if the collection of information does not display a valid control number assigned by the Director in accordance with this subchapter." 44 U.S.C. § 3512(a). The claims forms CMS required the Participating Providers to use to report MA days, Form UB-92, bear a control number indicating approval by the Office of Management and Budget, but the claims filing requirement at issue here was a new use of such form. CMS failed to conduct the necessary extensive review, or seek public comment, as necessary to extend the use of a previously-approved collection of information. 44 U.S.C. § 3507(h). See generally, Cottage Health System v. Sebelius, 631 F.Supp.2d 80 (D.D.C. 2009).

Providers also assert that any Medicare Advantage (MA or Medicare Part C) Days that are also Dual Eligible (DE) Days cannot be counted in the Medicare ratio for the same reasons as set forth above, primarily because the CMS regulation requiring such inclusion in the Medicare ratio is invalid therefore these DE-MA Days must be counted in the Medicaid numerator.

This improper treatment resulted in an underpayment to the Participating Providers as DSH program eligible providers of services to indigent patients, and includes any other related adverse impact to DSH payments, such as reduced capital DSH payments. Also, this treatment is not consistent with congressional intend to reimburse hospitals for treatment of indigent patients when determining DSH program eligibility and payment pursuant to 42 U.S.C. § 1395ww(d)(5)(F), 42 C.F.R. § 412.106,

> Medicare Intermediary Manual § 3610.15, or any other applicable statues, regulations, program guidelines, or case law.

Similar to Borgess, Ascension Health had two separate 2010 CIRP groups for the Part C Days issue, one for the Medicare fraction (Case No. 13-3062GC) and the other for the Medicaid fraction (Case No. 13-3066GC). On July 16, 2018, the Board consolidated Case No. 13-3066GC into Case No. 13-3062GC because, consistent with the holding in *Allina* noted above, the Board treats the treatment of Part C days in the DSH calculation as a single issue. On June 18, 2019, the Board granted EJR for Case No. 13-3062GC.

In response to the Board's RFI, QRS affirmed that Borgess was part of Ascension Health for FY 2010 and, thus, subject to the mandatory CIRP group requirements. QRS attempted to summarily distinguish the Part C Days issue in Borgess' individual appeal from the Part C Days issue in the Ascension Health CIRP group under Case No. 13-3062GC:

> Although this issue, on its surface, may appear to be similar to the Ascension Part C CIRP group appeal, the issue addressed is in fact distinctly different from that group appeal. The Provider's challenge to the DSH Part C Rule implicates and, therefore, challenges Centers for Medicare & Medicaid Services ("CMS") Ruling 1739-R as well as a proposed rule promulgated by CMS, 85 Fed. Reg. 47723-47728 (Aug. 6, 2020) (the "Proposed Rule").

In Borgess' EJR Request, QRS gives a similarly cursory explanation as to how these issues differ:

> Although the Provider is related to other Providers that formed a common issue related party ("CIRP") group appealing the DSH Part C Policy, those Providers did not challenge either the Proposed Rule or the Ruling. Accordingly, the CIRP rule does not apply to the Provider's challenge to the Proposed Rule and the Ruling.

The Medicare Contractor filed a response to the EJR Request on December 5, 2022, though the time for doing so had elapsed.[13] The Medicare Contractor simply requests the Board deny the EJR request because Issue 4 is identical to the issue in CIRP Group 13-2062GC and, thus, the Provider has failed to comply with the CIRP group appeal regulation.

B. Issue 7 – DSH SSI Fraction/Dual Eligible Days

On August 19, 2013, Ascension Health established the 2010 Ascension Health CIRP group under Case No. 13-3067GC entitled "Ascension Health 2010 DSH Medicare Fraction Dual Eligible Days."

Shortly thereafter, on November 18, 2013, QRS filed an appeal on behalf of Borgess and noted therein that Borgess was part of Ascension Health. Borgess' appeal request included Issue 7 entitled "Disproportionate

[13] Board Rule 42.4 states: "If the Medicare contractor opposes an EJR request filed by a provider or group of providers, then it must file its response within five (5) business days of the filing of the EJR Request." Thus, any response to the instant EJR Request would have been due no later than 11:59 p.m. (EST), November 30, 2022.

Share Hospital Payment – SSI Fraction/Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No Pay Part A Days)." The issue is described as follows in its entirety:

> **Statement of Issue**
>
> Whether patient days associated with Medicare Part A and Title XIX eligible patients should be excluded from SSI or Medicare fraction of the Disproportionate Share Hospital ("DSH") calculation. Further whether the MAC should have excluded from the SSI or Medicare fraction of the DSH calculation patient days applicable to patients who were eligible for Medicare and Medicaid where Medicare Part A did not make payment.
>
> **Statement of the Legal Basis**
>
> The Provider contends that the MAC did not allow patient days associated with certain Medicare Part A and Title XIX dual eligible patients to be included in the numerator of either the SSI percentage or the Medicaid Percentage of the Medicare DSH calculation. These patients were eligible for Medicare Part A benefits, however, no payments were made by Medicare Part A for these patients. The MAC did not allow the days to be included in the Medicaid Proxy and CMS did not include the days in the calculation of the SSI percentage. In some instances, such days were included in the denominator of the SSI percentage.
>
> CMS has represented to several courts that the Medicare/SSI fraction only counts Medicare paid days. See, e.g., Legacy Emanuel Hospital & Health Center v. Shalala, 976 F.3d 1261, 1265 (9th Cir. 1996).
>
> While CMS has stated that the SSI fraction would only include patient days paid by Medicare Part A, intermediaries have refused to recognize these dual eligible patient days, which lack Medicare Part A payments, in the Medicaid percentage of the Medicare DSH payment calculation. Since CMS has stated that only "paid" days will be used in the SSI percentage, the Provider contends that the terms **paid** and **entitled** must be consistent with one another due to the usage of the two terms in 42 C.F.R. § 412.106(b) and CMS testimony. The numerator of the SSI percentage requires SSI payment to have been made, *thus the denominator should also require Part A payment*.
>
> *It is the Provider's contention that these days must be excluded from both the numerator and the denominator of the SSI percentage factor in the Medicare DSH formula*.[14]

[14] (Italics emphasis added.)

The estimated reimbursement amount for Issue 7 per the appeal request is $41,209. Further, the calculation included at Tab 5 for Issue 7 shows that, consistent with the issue statement, this calculation was based on the removal of 50 no-pay dual eligible days from the SSI fraction (followed, in turn, by the addition of those 50 no-pay dual eligible days to the Medicaid fraction under Issue 8).

On June 1, 2018, the Board granted Ascension Health's request for EJR. 42 C.F.R. §§ 405.1837(b)(1) and 405.1837(e)(1) make clear that Borgess was required to be part of that Ascension Health CIRP group if it wished to pursue the group issue. On May 4, 2018, Ascension Health requested EJR for Case No. 13-3067GC. Shortly thereafter, on June 1, 2018, the Board granted EJR for Case No. 13-3067GC and closed it.

In its November 2, 2022 letter to QRS, the Board noted that Ascension Health had filed Case No. 13-3067GC but that it had been closed and, as a result, that Borgess is precluded from pursuing Issue 7 for 2010. Accordingly, the Board directed QRS to confer with Borgess and Ascension Health regarding whether Borgess was, in fact, owned or controlled by Ascension Health for 2010 and, if so, to either withdraw Issue 7 ***or*** *show cause why the Board should not dismiss it*.

As previously noted, QRS timely filed a response to the Board's November 2, 2022 letter and confirmed Borgess was owned and controlled by Ascension Health for 2010. However, contrary to the Board's directive, QRS failed to *either* withdraw Issue 7 *or* show cause why the Board should not dismiss it as being precluded by Case No. 13-3067GC.

Decision of the Board:

A. Issue 4 – DSH – SSI Fraction/Medicare Managed Care Part C Days

The Board finds that Issue 4, as presented in the instant appeal, and the group issue in the Ascension Health CIRP Group Case 13-3062GC are identical. The Part C Days issue presented in Case No. 14-0848 argues that Part C Days were improperly accounted for in its DSH calculation. Specifically, the Provider claims Part C Days were improperly left out of the Medicaid fraction, and improperly included in the Medicare Fraction.

Likewise, the issue presented in 2010 Ascension Health CIRP group under Case No. 13-3062GC (entitled "*Ascension Health 2010 DSH Medicare Fraction Part C Days*") argues that the Medicare Proxy is improperly understated due to the erroneous inclusion of Part C Days in the DSH calculation. Specifically, it argues that the DSH statute does not permit Part C Days to be included in the Medicare fraction, but that the DSH regulation contradicts the statute by including Part C Days in the Medicare Fraction.

QRS does not dispute that Borgess was commonly owned by Ascension Health during the fiscal year at issue. However, it has attempted to summarily distinguish Issue 4 from the CIRP group issue arguing that the individual appeal presents a "challenge to the DSH Part C Rule implicates and, therefore, challenges [CMS] Ruling 1739-R as well as a proposed rule promulgated by CMS . . . ."[15] The Board finds there is no distinction. The *appealed issues* are identical and, therefore, the Provider was ***required***

[15] Response to Board's RFI.

by statute and regulation to pursue the SSI Fraction Part C Days issue, if at all, as a member of the applicable CIRP group. Since it was not permitted to pursue the issue individually, and since Ascension Health has already sought (and been granted) EJR on this exact issue for the fiscal year under appeal, the Board hereby dismisses Issue 4 – DSH SSI Fraction/Medicare Part C Days from case 14-0848. Since the issue has been dismissed, the request for EJR over this issue is moot and hereby denied.

In finding that there is no distinction, the Board notes that Ascension Health filed its EJR request for Case No. 13-3062GC on May 20, 2019. ***At that point in time***, Borgess was required to be part of that CIRP group to the extent Borgess wished to pursue the Part C days issue. With respect to CMS Ruling 1739-R, the Board notes that the Ruling was not issued until August 17, 2020 and that the Ruling was issued to bring resolution to properly pending Part C days appeals. As Ascension Health was granted EJR more than a year prior to the Ruling being issued, it is clear that Borgess' Issue 4 is *not* ***properly*** pending before the Board because Borgess was required to be part of the CIRP group under Case No. 13-3062GC *at the time the EJR request was filed and granted back in 2019*. Moreover, the very issues that Borgess raises regarding CMS Ruling 1739-R are procedural (not the substantive merits which are indistinguishable from those in Case No. 13-3062GC when the issue statements are compared) and this 1739-R procedural issue would otherwise be common to Ascension Health and would itself be subject to the CIRP group requirements to the extent Ascension Health had not already pursued and been granted EJR.[16] Similarly, to the extent that the Provider seeks to pursue this issue as a challenge to the Proposed Rule published on August 6, 2020, it is clear that this is not yet ripe since proposed rules are subject to change and, thus, are not "final" determinations under 42 U.S.C. § 1395oo(a) subject to appeal before the Board and, importantly, was not included as part of this appeal (*i.e*., was not a determination appealed as part of this appeal request).[17] Since Borgess' Issue 4 was required to be part of the Ascension Health CIRP group under Case No. 13-3062GC in the first instance, Issue 4 is not *properly* part of Borgess' individual appeal and Ruling 1739-R is not even applicable. Indeed, QRS' contention that Issue 4 differs from the group case, simply because it is ***now*** challenging Ruling 1739-R, is nonsensical, given that the initial appeal of Issue 4 was filed in 2013, *over 6 years before CMS Ruling 1739-R was issued in 2020,* and clearly did not (and could not have) included a challenge to CMS Ruling 1739-R.[18]

Finally, the Board ***admonishes*** QRS for *prematurely* filing the EJR request concurrent with its November 22, 2022 response to the Board's November 2, 2022 request for information. As noted in 42 C.F.R. § 405.1842(b)(2) (as well as Board Rule 42), a Board finding of jurisdiction is a prerequisite to any Board consideration of an EJR request:

---

[16] Ascension Health's EJR of Case No. 13-3062GC is just one of several hundred EJRs that the Board granted for the Part C days issue and it is this volume of litigation on the Part C days that drove the Agency to issue CMS Ruling 1739-R to resolve all remaining ***properly*** pending appeals of this issue pursuant to a forthcoming rulemaking. *See* CMS Ruling 1739-R at 7 (stating "In order to resolve in an orderly manner pending administrative appeals of the Part C days SSI fraction issue, as previously described, for qualifying patient discharge dates and cost reporting periods, the administrative appeals tribunals will use the following procedure to begin the overall process of implementing the Ruling."); *id.* at 8 (stating "First, it is CMS's Ruling that the agency and the Medicare contractors will resolve each ***properly*** pending claim in a DSH appeal in which a provider alleges that its DSH payment adjustment for years prior to FY 2014 is invalid because the Secretary did not undertake notice-and-comment rulemaking before including days for patients enrolled in Part C in the SSI fraction of the DSH formula." (emphasis added.)).

[17] Ascension Health may have appeal rights from the final rule once it is issued, to the extent that final rule is applicable to it and it is found to be is a final determination for purposes 42 U.S.C. § 1395oo(a).

[18] *See supra* note 17 and accompanying text.

> Under paragraphs (d) and (e) of this section, a provider may request a determination of the Board's authority to decide a legal question, but the 30-day period for the Board to make a determination under section 1878(f)(1) of the Act does not begin to run *until the Board finds jurisdiction to conduct a hearing on the specific matter at issue in the EJR request* and notifies the provider that the provider's request is complete.[19]

Here, the Board had a pending question requiring QRS to show cause as to why the Board should not dismiss Issue 4 for failure to transfer to the 2010 Ascension Part C Days CIRP group and any potential EJR request was clearly premature. Indeed, the Board's dismissal of Issue 4 confirms the EJR request was premature and had no basis as Borgess clearly was required to be part of the Ascension Health CIRP group for the merits of the Part C Days issue when that CIRP group was fully formed and when the Board granted Ascension Health's EJR request.

B. Issue 7 – DSH SSI Fraction/Dual Eligible Days

On August 19, 2013, Ascension Health established the CIRP group under Case No. 13-3067GC entitled "Ascension Health 2010 DSH Medicare Fraction Dual Eligible Days." On June 1, 2018, the Board granted Ascension Health's request for EJR.

In its November 2, 2022 letter to QRS, the Board noted that Ascension Health had filed Case No. 13-3067GC but that it had been closed and, as a result, that Borgess is precluded from pursuing Issue 7 for 2010. Accordingly, the Board directed QRS to confer with Borgess and Ascension Health regarding whether Borgess was, in fact, owned or controlled by Ascension Health for 2010 and, if so, to either withdraw Issue 7 or show cause why the Board should not dismiss it. QRS did not respond or otherwise contest the Board preliminary finding that Borgess is precluded from pursuing Issue 7 because Borgess was required to transfer Issue 7 to Case No. 13-3067GC. Instead, QRS simply stated it would be filing an EJR request even though the Board's Order did not ask for an EJR request and any EJR request would otherwise be premature until the Board first resolved the CIRP group issues raised in its November 2, 2022 letter. Accordingly, based on the record before it, the Board finalizes its finding that, pursuant to 42 C.F.R. §§ 405.1837(b)(1) and 405.1837(e)(1), Borgess is precluded from pursuing Issue 7 because Borgess was required to transfer Issue 7 to Case No. 13-3067GC and dismisses Issue 7 because Case No. 13-3067GC was fully formed and then closed following the Board's grant of EJR ***over 4 years ago***, in 2018.

As an alternative basis for dismissal, the Board notes that QRS *wholly* failed to respond to the Board's directive that QRS *show cause* as to why the Board should not dismiss Issue 7 based on its preliminary findings. Rather, QRS stated it was going to file an EJR request at a future date.[20] Indeed, QRS' November 22, 2022 response failed to lay ***any*** foundation for its subsequent filing of the EJR request for Issue 7 on November 30, 2022. Based on this *blatant* disregard for the Board's Order (and premature

[19] (Emphasis added.)

[20] QRS did not request (nor did the Board grant) an extension to the deadline specified in the Board's November 2, 2022 letter. Moreover, any future EJR request that QRS planned to file in Borgess' individual appeal for Issue 7 would immediately raise CIRP group issues since Issue 7 is a legal issue *that would be **common** to all Ascension Health providers*. Thus, even to the extent QRS may have had a colorable claim that Issue 7 was distinct and separate from the group issue in Case No. 13-3062GC, QRS would still have to address whether Ascension Health had, currently has, or will have a 2010 CIRP group for that alleged distinguishable common issue.

filing of the EJR request for Issue 7, as discussed *infra*), the Board ***admonishes*** QRS and exercises its discretion under 42 C.F.R. § 405.1868(a)-(b) to dismiss Issue 7.

Finally, Board denies the November 30, 2022 EJR request for Issue 7 for multiple reasons, as set forth below.

The November 30, 2022 EJR request only pertains to Issue 7. At the time this EJR request was filed, only Issues 4 and 7 remained in the appeal and, as noted in QRS' November 22, 2022, this EJR request was for Issue 7. As the Board has dismissed Issue 7, the Board must deny the EJR request for Issue 7.

Moreover, even if the Board had not dismissed Issue 7, the Board would still deny the November 30, 2022 EJR request because it is fatally flawed and includes an issue that was never part of Issue 7, as stated in the appeal request. The EJR request states the issue as follows:

> Whether patient days associated with patients entitled to Medicare Part A for whom no Medicare Part A payment is made and who are eligible to Title XIX should be excluded from the Medicare fraction and included in the numerator of the Medicaid fraction of the Medicare [DSH] calculation? *Alternatively, if "entitled" to Medicare Part A includes patients for whom no payment is made, whether the numerator of the Medicare fraction of the Medicare DSH percentage should include all of the Provider's patients entitled to supplemental security income ("SSI"), as required by 42 U.S.C. § 1395ww(d)(5)(F)(vi).*[21]

Regarding the alternative argument italicized above, "[t]he Provider concludes that CMS violates the language of the Medicare DSH statute and the intent of Congress by only using SSI codes C01, M01 and M02 to determine entitlement to SSI benefits."[22] However, this alternative argument was never part of Issue 7, as stated in the appeal request, and issues may not be added at this late stage.[23] In this regard, Issue 7 is "the Provider's contention [is] that these days must be ***excluded*** from both the numerator and the denominator of the SSI percentage factor in the Medicare DSH formula." Thus, Issue 7 only sought to exclude dual eligible days from the SSI fraction and Borgess did not include, in Issue 7, a separate alternative legal argument to include additional SSI days by expanding the definition what of "entitled to SSI benefits" means, specifically to expand it from "paid" SSI days to SSI "eligible" days. 42 C.F.R. § 405.1835(b) (2013) and Board Rules 7 and 8 (2013) require certain basic information for each issue being appealed. 42 C.F.R. § 405.1835(b) (2013) states in pertinent part:

> (b) *Content of request for a Board hearing.* The provider's request for a Board hearing must be submitted in writing to the Board, and the request **must include the elements described in paragraphs (b)(1) through (b)(4)** of this section. If the provider submits a hearing request that does not meet the requirements of paragraphs (b)(1), (b)(2), or (b)(3) of this

[21] (Italics emphasis added.)
[22] EJR Request at 19 (Nov. 30, 2022).
[23] 42 C.F.R. § 405.1835 specifies that no issues may added to a properly pending Board appeal once 60 days from the close of the 180-day period to file that Board appeal has passed.

> 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 intermediary's or Secretary's determination under appeal.
>
> (2) **An explanation (for <u>each</u> specific item at issue**, see paragraph (a)(1) of this section) of the provider's dissatisfaction with the intermediary's or Secretary's determination under appeal, including an account of all of the following:
>
> (i) **Why** the provider believes Medicare **payment is incorrect for <u>each</u> 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 <u>each</u> disputed item**.
>
> (iii) If the provider self-disallows a specific item, **a description of the nature and amount of each self-disallowed item and the reimbursement or payment sought for the item**.

Similarly, Board Rules 7 and 8 (2013) state in pertinent part:

> **Rule 7 – Issue Statement and Claim of Dissatisfaction**
>
> For <u>each</u> 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.
>
> ****
>
> **7.2 – Self-Disallowed Items**
>
> **A. Authority Requires Disallowance**

> If the Provider claims that the item being appealed was not claimed on the cost report because a regulation, manual, ruling, or some other legal authority predetermined that the item would not be allowed, the following information must be submitted:
>
> • a concise issue statement describing the self-disallowed item
> • the reimbursement or payment sought for the item, and
> • the authority that predetermined that the claim would be disallowed.
>
> ****
>
> **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.
>
> **8.2 – Disproportionate Share Cases** (e.g., dual eligible, general assistance, charity care, HMO days, etc.)

Here, the appeal request did not properly identify the alternative legal argument because it failed to explain why payment was incorrect (*i.e.*, failure to include additional SSI days in the numerator of the SSI fraction because the definition of "entitled to SSI benefits" was based on payment of SSI benefits rather than on SSI eligibility).[24] Instead, Borgess only sought exclusion of no-pay Part A days from the Medicare fraction and the inclusion of the subset of those no-pay days associated with dual eligible days in the SSI fraction. The class of days at issue identified in Issue 7 as being at issue were no-pay part A days and ***not*** SSI eligible days.[25]

Indeed, the EJR request is fatally flawed in that it fails to properly address jurisdiction and establish that the Board has jurisdiction over the issue(s) raised in the EJR request and that the Provider met the claim filing requirements. The Board Rules state the following in pertinent part regarding EJR requests:

> **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,

[24] In this regard, consistent with § 405.1835(b), a separate amount in controversy would need to be calculated for this alternative legal argument since the alternative legal argument is not the same issue and impacts the DSH calculation in different manner.
[25] While these two types of days may have some overlap they are distinctly different and refer to, and mean, different things. *See supra* note 24.

> 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.
>
> ****
>
> **42.3 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.[26]

Here, QRS filed an EJR request that included a jurisdiction section at page 4 of the EJR request. However, the section is fatally flawed and does not demonstrate jurisdiction and that it met the basic claims filing requirements.[27] Borgess is part of an individual appeal but the section improperly cites the rules governing group appeals stating, "the Board enjoys procedural jurisdiction over the Provider's appeal if (1) it is filed within 180 days of the final determination, (2) *the amount in controversy **for a group appeal** is at least $50,000* and the Provider is dissatisfied with the final determination."[28] QRS then goes on to state that "As evidenced by the Model Form A (Exhibit 2), the Provider Appeal *satisfies the $50,000 jurisdictional amount **for a group appeal***."[29] Indeed, it is the Board's finding that Issue 7 should have been part of the CIRP group under Case No. 13-3067GC rather than the individual appeal and QRS has not disputed this finding.

* * * * *

[26] (Underline emphasis added.)

[27] 42 C.F.R. § 405.1840 is entitled "Board Jurisdiction" but it also addresses the claim filing requirement that the appeal be timely. 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*. 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." (emphasis added.)).

[28] EJR Request at 4 (emphasis added.)

[29] *Id.* (emphasis added.)

In summary, the Board dismisses Issue 4 as it was required to be part of the Ascension Health CIRP group under Case No. 13-3062GC for which the Board closed on May 20, 2019 when it granted EJR. The further Board denies the EJR request because the Board has dismissed Issue 4 as not properly pending in Case No. 14-0848.

Similarly, the Board dismisses Issue 7 as it was required to be part of the Ascension Health CIRP group under Case No. 13-3062GC. As a separate and independent basis, pursuant to its authority under 42 C.F.R. § 405.1868(a)-(b), the Board dismisses Issue 7 for the failure of QRS to respond to the Board's directive that QRS either withdraw or show cause as to why the Board should dismiss Issue 7. The Board further denies EJR for these reasons as well as the fact that the EJR request itself was fatally flawed and relates, in part, to an issue that was never part of Issue 7.

Upon review of the facts surrounding the dismissals of Issues 4 and 7 as well as the Board's November 2, 2022 letter and the fact that similar CIRP group compliance issues have arisen in another Borgess appeal,[30] ***the Board admonishes QRS for its blatant disregard of the CIRP group regulations and Board Rules. This case has been pending for over 9 years without QRS making the requisite CIRP group transfers, notwithstanding the fact that both preliminary and final position papers were filed by QRS in this case on August 28, 2014 and May 1, 2020 respectively***.[31] *The Board reminds QRS that, in representing Borgess, it has a responsibility to work with Borgess and Ascension Health to identify and comply with Borgess' CIRP group obligations which necessarily impact Ascension Health as a whole. For example, under the operation of 42 C.F.R. § 405.1837(b)(1) and (e), an Ascension Health provider cannot pursue an issue common to other Ascension Health providers for the same year outside of the Ascension Health CIRP group established for that issue and year. Similarly, Ascension Health may not seek to establish a CIRP group for an issue that an Ascension Health provider has already adjudicated before the Board for the same year (e.g., as part of an individual appeal where the Board granted EJR for that provider). Accordingly, QRS is not only the agent of Borgess but also of Ascension Health's CIRP interests through that Provider. The fact that QRS was not the group representative on the numerous 2010 Ascension Health CIRP group cases that Borgess should have joined for Issue 2, 4, 5, 7 and 8 in no way diminishes QRS' responsibilities* ***as the agent*** *of the Provider (and of Ascension Health, through that Provider):*

(a) To actively screen this case to identify potential common issues that should be part of Ascension Health CIRP groups;[32]

---

[30] *See supra* note 1.
[31] *See infra* note 32 and accompanying text.
[32] The Board reminds QRS that, at the position paper stage, 42 C.F.R. § 405.1853(b)(2) requires that "[e]ach 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) . . . ." One aspect of jurisdiction is compliance with the mandatory CIRP group regulation (*i.e.*, there are instances where a provider does not have a right to pursue an issue in individual provider appeal but "must bring" that issue as part of a CIRP group per 42 C.F.R. § 405.1837(b)(1)). Accordingly, consistent with § 405.1853(b)(2), when preparing position papers, QRS should be screening its cases for potential jurisdiction issues, including screening of individual appeals for potential CIRP group issues. To this end, Board Rule 4.7.3 and 12.11 (2018) set forth the Board's expectation that transfers from individual appeals to group appeals will be effectuated prior to submission of the PPPs. As previously noted, QRS filed Borgess' PPP and FPP in this case on August 28, 2014 and May 1, 2020 respectively.

(b) To consult, as needed, with both the individual Provider and Ascension Health regarding potential common issues and existence of relevant Ascension Health CIRP Groups and obtain, as relevant, assurances from the Provider and Ascension Health about their compliance with CIRP group obligations; and

(c) To take actions to ensure compliance, such as coordinating with Ascension Health and Borgess for the transfer of identified common issues to the appropriate Ascension Health CIRP group.

*Similarly, **the Board also admonishes Ascension Health and reminds it** that it retained QRS as its agent in this Medicare reimbursement appeal and Ascension Health has responsibilities to oversee its agents, track and monitor its Board cases, **and** to ensure it (through its agents) complies with the CIRP group requirements and does not pursue **improper** claims/appeals.*[33]

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

Board Members Participating:

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

For the Board:

12/20/2022

X Clayton J. Nix

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

Enclosure: Exhibit A – Board Letter Dated November 2, 2022

cc: Scott Berends, Esq., Federal Specialized Services
Byron Lamprecht, WPS Government Health Administrators

[33] The appeal request filed on November 18, 2013 identifies Richard L. Felbinger as the Senior Vice President and Chief Financial Officer for ***both*** Ascension Health and Borgess where Ascension Health is listed as the corporate owner of Borgess. The appointment of designated representative was signed by Mr. Felbinger. Based on recently-filed CIRP group appeals for Ascension Health CIRP groups, the Board identified Ms. Davidson as the current Ascension Health contact for Board appeals.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Exhibit A

Provider Reimbursement Review Board
7500 Security Boulevard
Mail Stop: B1-01-31
Baltimore, MD 21244-1850
410-786-2671

Via Electronic Delivery

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

RE: ***Request for Information***
Borgess Medical Center (Prov. No. 23-0117)
FYE June 30, 2010
Case No. 14-0848

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the record for the reference appeal.

Background:

On November 18, 2013, Quality Reimbursement Services ("QRS") established Case No. 14-0848 by filing an appeal request for Borgess Medical Center which contained the following issues:

- Issue 1 – DSH Supplemental Security Income ("SSI") Percentage (Provider Specific) - **Dismissed**
- Issue 2 – DSH SSI Percentage (Systemic Errors)
- Issue 3 – DSH Medicaid Eligible Days
- Issue 4 – DSH SSI Fraction/Medicare Part C Days
- Issue 5 – DSH Medicaid Fraction/Medicare Part C Days
- Issue 6 – DSH Medicaid Eligible Labor Room Days – **Withdrawn by Provider**
- Issue 7 - DSH SSI Fraction/Dual Eligible Days
- Issue 8 – DSH Medicaid Fraction/Dual Eligible Days
- Issue 9 – Outlier Payments – Fixed Loss Threshold – **Withdrawn by Provider**

The Medicaid Eligible Labor Room Days issue was withdrawn by the Provider on August 28, 2014, and the Outlier Payments – Fixed Loss Threshold issue was withdrawn by the Provider on July 23, 2020. On April 17, 2020, the Board dismissed the DSH SSI Percentage (Provider Specific) issue from the appeal.

Remaining six (6) Issues in Appeal

There are six issues remaining in this appeal:

- Issue 2 – DSH SSI Percentage (Systemic Errors)
- Issue 3 – DSH Medicaid Eligible Days
- Issue 4 – DSH SSI Fraction/Medicare Part C Days
- Issue 5 – DSH Medicaid Fraction/Medicare Part C Days
- Issue 7 - DSH SSI Fraction/Dual Eligible Days
- Issue 8 – DSH Medicaid Fraction/Dual Eligible Days

Rules on Mandatory Common Issue Related Party (CIRP) Groups

By way of background, chain provider organizations are subject to the following requirement in 42 U.S.C. § 1395oo(f)(1):

> Any appeal to the Board or action for judicial review by providers which are under common ownership or control or which have obtained a hearing under subsection (b) ***must*** *be brought* by such providers *as a group* with respect to any matter involving an issue common to such providers.[1]

This statutory provision was implemented at 42 C.F.R. § 405.1837(b)(1)(i) and this regulation mandates the use of a CIRP group appeal where:

> *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*.

Further, 42 C.F.R. § 405.1835(b) address the "Contents of request for a Board hearing" and requires the following in paragraph (4) *when a provider is under common ownership or control*:

> (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.
>
> * * * *
>
> (4) **With respect to a provider under common ownership or control**, the name and address of its parent corporation, and a statement that –
>
> (i) To the best of the provider's knowledge, no other provider to which it is related by common ownership or control, has pending a request for a Board hearing pursuant to this section or pursuant to § 405.1837(b)(1) on any of the same issues contained in the provider's hearing request for a cost reporting period that ends within the same calendar year as the calendar year covered by the provider's hearing request; or

[1] (Emphasis added).

> (ii) Such a pending appeal(s) exists(s), and the provider name(s), provider number(s), and the case number(s) (if assigned), for such appeal(s).

42 C.F.R. § 405.1837(e)(1) and Board Rules further address the mandatory use of CIRP groups. First, 42 C.F.R. § 405.1837(e)(1) addresses full formation of groups:

> 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*.[2]

Further, the current Board Rules issued on September 30, 2021 (and effective November 1, 2021) states:

> **12.3 Types of Groups**
>
> **12.3.1 Mandatory Common Issue Related Party ("CIRP") Group**
>
> Providers under common ownership or control that wish to appeal a specific matter that is common to the providers for fiscal years that end in the same calendar year must bring the appeals a group appeal. *See* 42 C.F.R. § 405.1837(b).
>
> ****
>
> **Rule 19 – Full Formation of Groups**
>
> Refer to 42 C.F.R. § 405.1837(e) for group appeal procedures pending full formation of the group and issuance of a Board decision.
>
> **19.2 – Mandatory (CIRP) Groups**
>
> Mandatory CIRP group appeals must include all providers eligible to join the group that intend to appeal the disputed common issue for the year(s) covered by the CIRP group. Within the Board's Acknowledgement of a CIRP group appeal, the providers are notified that, at the one-year mark (if they had not previously done so), they must notify the Board if the group is complete, and if not, which providers have not yet received a final determination for the specified fiscal year and intend to join the group. Note: If a representative is uncertain whether the CIRP group requirements apply to a provider(s), then the representative may file a request for a ruling from the Board and that

[2] (Emphasis added.)

> request must include relevant information such as the provider acquisition date.
>
> The Board deems a CIRP group appeal fully formed (i.e., complete) upon the earlier of:
>
> - The filing of a notice from the group representative that the group is fully formed; or
>
> - An Order by the Board finding that the group is fully formed where the Order is issued after the group representative has had the opportunity to present evidence regarding whether any CIRP providers who have not received final determinations could potentially join the group;[3]

Six DSH issues remain in the appeal, Issues 2,3,4,5,7 and 8. Four of the issues under appeal, 4, 5 7 and 8, challenge the agency's interpretation of the regulation, and would be required to be pursued in a group appeal, if other providers in the chain, have appealed common issues for the same FYE. Chain providers are required to pursue common issues in CIRPs to the extent the other elements of 42 C.F.R. 405.1837(b)(1) are met. Therefore, the Board requests the following information.

Applicability of the Mandatory CIRP Rule:

It has come to the Board's attention that this Provider recognized in its appeal request that it is commonly owned by Ascension Health and that it had an obligation to transfer common issues to Ascension Health CIRP groups. On November 18, 2013, Borgess established Case No. 14-0848 by filing an appeal request using the Model Form A – Individual Appeal Request. On this form, Borgess provided the following information:

- Confirmed it was commonly owned or controlled by Ascension Health; and

- "[C]ertified, to the best of my knowledge that: . . . there may be other providers to which this provider is related by common ownership or control that have a pending request for a Board hearing on the same issues now being appealed for the cost reporting period that ends in the same calendar year covered in this appeal request. Accordingly, the Provider intends to transfer this Provider to an appropriate CIRP group appeal once this appeal of the NPR is established. See 42 C.F.R. § 405.1835(b)(4)(i).

The Board notes that, when Borgess established its individual appeal in November 2018, Ascension Health already had pending the following 2010 CIRP Groups for the common issues that Borgess appealed:

> Case No. 13-3062GC – Ascension Health 2010 DSH Medicare Fraction Part C Days
> Case No. 13-3066GC – Ascension Health 2010 DSH Medicaid Fraction Part C Days

[3] (Underline Emphasis added.)

Case No. 13-3067GC – Ascension Health 2010 DSH Medicare Fraction Dual Eligible Days
Case No. 13-3068GC – Ascension Health 2010 DSH SSI Post 1498R Data Match

Thus, based on the certification made in the appeal request, it is clear that Borgess filed the appeal knowing it needed to transfer common issues to the 2010 Ascension Health CIRP groups. Indeed, this is what Borgess did for its FY 2011 appeal under Case No. 15-2745. Specifically, for FY 2011, QRS represented Borgess in Case No. 15-2745 and transferred these same issues to Ascension CIRP groups under Case Nos. 14-2028GC (DSH – SSI Fraction/Dual Eligible Days), 14-2016GC (DSH/SSI (Systemic Errors)), 14-2029GC (DSH – SSI Fraction/Medicare Managed Care Part C Days), and 14-2033GC (DSH – Medicaid Fraction/Medicare Managed Care Part C Days). Significantly, ***for all of these 2010 and 2011 CIRP groups***, Hall, Render, Killian, Health & Lyman, P.C.("Hall Render") is the designated group representative appearing before the Board.

Finally, the Board notes that: (1) three of the above-noted Ascension 2010 CIRP groups were closed, on June 18, 2019 (13-3062GC), July 19, 2018 (13-3066GC), and June 1, 2018 (13-3067GC), respectively; and (2) Ascension Health continues to commonly own or control Borgess as Borgess continues to be listed as a participant in other Ascension Health CIRP groups where the group representative continues to be Hall Render (*e.g.*, Case No. 22-0653GC entitled "Ascension Health 2022 FFY Understated Standardized Amount Predicate Fact CIRP Group").

Based on the above findings, it is clear that (1) Borgess is subject to the mandatory CIRP group regulation at 42 C.F.R 405.1837(b)(1) and should have pursued these 4 issues (2, 4, 5, and 7) in the 2010 CIRP groups for Ascension Health; and (2) the closure of the Ascension Health 2010 CIRP groups for three of these issues, as noted above, precludes any other provider under the same ownership from pursuing that same issue in an appeal for the same fiscal year end. Accordingly, the Board requires that, ***within twenty-one (21) days of this letter's signature date***, Hall Render take the following actions:

1. Confer with Borgess and Ascension Health regarding whether Borges was owned or controlled by Ascension Health for the fiscal year at issue (*i.e.*, was a related party for the year at issue) ***and*** then either: (a) withdraw Issues 4, 5, and 7, which were pursued within the closed Ascension CIRP groups noted above, or (b) show cause as to why the Board should not dismiss Borgess for its failure to comply with the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1). Any show-cause response must include original source documentation (*e.g.*, affidavit from Ascension, purchase agreement) establishing why Borgess was ***not*** a related party, ***neither*** *by control* ***nor*** *ownership*, to Ascension for the year under appeal and provide good cause as to why the certifications made in the appeal request were incorrect;

2. Transfer Issue 2 to the appropriate CIRP group (Case No. 13-3068GC);

3. With respect to Issue 8 (which was not included in the closed group appeals), confer with Borgess and Ascension and either: (a) certify that no other Ascension Health providers are, or will be, pursuing an appeal for the same issue and same fiscal year end, or (b) transfer Issue 8 to an Ascension CIRP group appeal for the same issue.

*Be advised that this filing deadline is **firm** and, in this regard, the Board has determined to specifically **exempt** it from the Alert 19 suspension of Board filing deadlines. Accordingly, failure to respond by the filing deadline may result in dismissal of the 6 remaining issues and the case entirely.*

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

For the Board:

11/2/2022

X Kevin D. Smith, CPA

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Motion to Dismiss Medicaid Eligible Days***
Carolinas Medical Center (Prov. No. 34-0113)
FYE 12/31/2010
Case No. 15-2294

Dear Mr. Ravindran and Ms. Johnson,

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the documentation in Case No. 15-2294 in response to a Motion to Dismiss filed by the Medicare Contractor ("MAC"). The Board's decision is set forth below.

Background:

Quality Reimbursement Services, Inc. ("QRS") is the Provider's designated representative for this appeal. On April 20, 2015, QRS established Case No. 15-2294 on behalf of the Provider by filing the Provider's Individual Appeal Request appealing their October 22, 2014, Notice of Program Reimbursement ("NPR") for fiscal year ending December 31, 2010 ("FY 2010"). The initial appeal contained the eight (8) following issues:

Issue1: Disproportionate Share Hospital (DSH)/Supplemental Security Income (SSI) Percentage (Provider Specific)[1]
Issue 2: DSH/SSI (Systemic Errors)[2]
Issue 3: DSH Medicare Part C Days – SSI Fraction[3]
Issue 4: DSH Dual Eligible Days – SSI Fraction[4]
Issue 5: DSH Medicaid Eligible Days
Issue 6: DSH Medicare Part C Days – Medicaid Fraction[5]
Issue 7: DSH Dual Eligible Days – Medicaid Fraction[6]
Issue 8: Outlier Payments – Fixed Loss Threshold[7]

[1] The Board dismissed this issue in a Jurisdictional Decision on June 28, 2022
[2] Issue 2 transferred to Case No. 14-2601GC on December 30, 2015.
[3] Issue 3 transferred to Case No. 14-4411GC on November 18, 2015
[4] Issue 4 transferred to Case No. 14-2603GC on December 30, 2015.
[5] Issue 6 transferred to Case No. 14-4399GC November 18, 2015.
[6] Issue 7 transferred to Case No. 14-4412GC November 18, 2015.
[7] Issue 8 transferred to Case No. 14-4403GC November 18, 2015.

As a result of ensuing transfers and the Board's decision to dismiss Issue 1 (the SSI Provider Specific issue), only one issue remains in this case – Issue 5, Medicaid eligible days. The Medicare Contractor filed a Motion to Dismiss on May 23, 2022 regarding Issue 5-DSH Medicaid Eligible Days. The Provider did not file a response to the MAC's Motion to Dismiss. On June 3, 2022, the Provider filed a Postponement Request.

Medicare Contractor's Contentions[8]

On May 23, 2022, the Medicare Contractor filed a Motion to Dismiss the Medicaid Eligible Days issue arguing that the Provider has effectively abandoned the issue by failing to furnish documentation in support of its claim for additional Medicaid Eligible Days or describe why such documentation was and continues to be unavailable. The Motion outlines the Board's Rules which require a Provider to submit supporting documentation with its appeal or otherwise explain why it is unavailable, and what steps are being taken to obtain it. The Medicare Contractor also points to 42 C.F.R. § 412.106(b)(4)(iii) and § 413.24(c), which places the burden on the Provider with regard to furnishing this documentation. Finally, the Motion notes that both the Provider's Preliminary and Final Position Papers stated that an eligibility listing was being sent under separate cover. The Medicare Contractor claims that no listing has ever been provided in the 79[9] months since the appeal was filed. The MAC requests the Board to dismiss the additional Medicaid Eligible Days issue because the Provider has failed to furnish documentation in support of its claim.

Provider's Request for Postponement

On June 3, 2022, QRS requested a postponement of the hearing for this case and therein addressed the Medicare Contractor Motion to Dismiss by stating: "Although the Provider has indeed not submitted a listing of additional Medicaid Eligible days, this is not due to the Provider abandoning this case. Rather, there has been *a significant issue* with the State of North Carolina matching process and, more specifically, *the voiding of certain Medicaid patient records from the State system*. This issue has led to the Provider being unable to obtain an eligibility match listing which is needed to produce a listing of finalized days to the MAC. The Provider has been actively trying to work with the state to process eligibility which was mentioned in the previous postponement requests and communications with the MAC."[10]

In support of its contention, QRS describes the following efforts to obtain Medicaid eligible days data relating to the Provider's FY 2010:

[8] The Board notes that the Medicare Contractor filed a previous Jurisdictional Challenge on June 1, 2018, which included a challenge to the Medicaid eligible days issue which argued that the Board does not have jurisdiction over the issue because the MAC did not make an adjustment to the additional eligible days the Provider requested. This challenge was filed shortly after the issuance of CMS Ruling 1727-R, and the Medicare Contractor did not raise these arguments in its more recent Motion to Dismiss.
[9] The correct time frame is 99 months since the appeal was filed.
[10] Provider's Request for Postponement (June 3, 2022) (emphasis added).

> On July 28, 2020, QRS requested for the eligibility listing to be sent directly to the MAC from the respective state contact in the Business System Analyst department at the Information NC Department of Health and Human Services to see if the database used to process eligibility had been fixed. That same day, the contact in the Business System Analyst department informed QRS that, at that time, they did not foresee any updates to those older voided segments in the immediate future.
>
> On May 11, 2021, QRS reached out to the State contact for an update to see if the database had been fixed and if the providers could obtain direct access to the match system. The analyst stated there is now a workable database but doubts the Providers have direct access to it. These match issues are system-wide and do not relate to any specific provider. Please see the attached email correspondence related to the State match issues.
>
> QRS continues to work with the State to develop an alternative method to fix the deficiencies. The last discussions took place in May and June of 2022. Once the system issues at the State are addressed, the match will be processed, and a listing prepared. QRS believes that the State system issues will ultimately be solved, and this appeal will be finalized through an administrative resolution.

QRS ends by suggesting that the Medicare Contractor's opposition to QRS' postponement request "appears to be somewhat disingenuous as the MAC clearly does not have the authority to finalize an AR at this time" given that "on December 23, 2020 FSS was instructed not to implement Administrative Resolutions that impact DPP/DSH for cost reports prior to fiscal year end 2013."

Board Decision

According to its Appeal Request, the Provider asserts that all Medicaid eligible days were not included in the calculations of the DSH calculations for FY 2010. The Provider states Issue 5 as:

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

> of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.
>
> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.[11]

The Provider's appeal request did not include a list of the specific additional Medicaid eligible days for FY 2010 that are in dispute in this appeal and desire to be included in their Medicaid percentage and DSH computations for FY 2010, with their appeal request.

On December 23, 2015, the Provider filed their preliminary position paper in which it indicated that it would be sending the Medicaid eligibility listing for FY 2010 under separate cover.[12] Indeed, the position paper did not even identify how many Medicaid eligible days remained in dispute in this case for FY 2010. Specifically, the Provider's complete briefing of this issue in its position paper is as follows:

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

[11] Provider's Appeal Request (April 20, 2015).
[12] Provider's Preliminary Position Paper (December 23, 2015).

> system will be calculated to include all inpatient hospital days of service for patients who were eligible on that day for medical assistance under a state Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for these inpatient hospital services.
>
> Base on the Listing of Medicaid Eligible Days being sent under separate cover, the Provider contends that the total number of days reflected in its' [*sic*] 2010 cost report does not reflect an accurate number of Medicaid eligible days, as required by HCFA Ruling 97-2 and the pertinent Federal Court decisions.

In its Motion to Dismiss, the MAC asserts that the Provider has failed to submit a list of additional Medicaid eligible days in dispute for FY 2010. While the Calculation Support filed with their appeal notes a net impact of $19,584, with an increase in days, it is unclear whether this amount continues to be in dispute as of the Provider's filing of the position paper.

Board Rule 7.3.1.2 (Nov. 2021) 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 MAC asserts that the Provider neglected to include all supporting documentation, or alternatively, state the efforts made to obtain the 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 for FY 2010 with its preliminary position paper or submitted such list under separate cover. The MAC thus asserts that the Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it cannot produce those documents, as required by the regulations and the Board Rules.[13]

42 C.F.R. § 405.1853 requires that position papers set forth the relevant facts and arguments regarding the merits of each remaining issue and affirms that the Board has the authority to require that any supporting exhibits be submitted with the position paper:

---

[13] *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.

> (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*.[14]

With regard to the filing of an individual appeal, Board Rule 7 (Support for Appealed Final Determination, Issue-Related Information and Claim of Dissatisfaction) (Jul. 2015) states:

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

Similarly, with regard to position papers,[15] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[16] 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.[17]

[14] (Emphasis added.)
[15] The minimum requirements for Final Position Paper narratives and exhibits is the same as those for Preliminary Position Papers. *See* Board Rule 27.2.
[16] (Emphasis added.)
[17] (Emphasis added.)

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 from FY 2010 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" [18] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable.

Based on the record before it, the Board finds that the Provider has failed to provide a listing of the FY 2010 Medicaid eligible days in dispute (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. The year in question is FY 2010 which ended *over 11 years ago* and this appeal was filed *more than 7 ½ years ago* on April 20, 2015. Notwithstanding all of this time, QRS has yet to identify ***any*** Medicaid eligible days in dispute.

[18] (Emphasis added.)

The Provider filed its preliminary position paper on December 23, 2015 and then its final position paper on March 4, 2021. However, QRS failed to comply with Board Rules 25.2.2 regarding "unavailable and omitted documents" by failing to include ***any*** information about the alleged North Carolina database deficiency or any issues with pulling information. Rather, these papers suggest otherwise by simply stating that an eligibility listing is "being sent under separate cover." Thus, following the filing of the final position papers, the Board must conclude that the amount in controversy sole remaining issue is $0 since the Provider has not identified ***any*** Medicaid eligible days being in dispute notwithstanding the years that have passed since FY 2010 ended.[19]

Accordingly, the Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of Board Rules 25.2.1 and 25.2.2 related to identifying the days in dispute and the submission of documentary evidence required to support its claims or describe why said evidence is unavailable, which the Provider has failed to do as part of its position papers.[20] The Board requirement that position papers fully develop the merits of each issue and include all supporting exhibits is consistent with the requirements in 42 C.F.R. § 405.1853(b)(2)-(3) as quoted above. Based on the above findings, the Board is exercising its authority under 42 C.F.R. § 405.1868(a)-(b) to dismiss the Medicaid eligible days issue for failure to develop the merits of the issue in compliance with Board Rules. The Board takes administrative notice that it has made similar dismissal in other cases in which QRS was the designated representative and, notwithstanding, QRS failed to provide the Medicaid eligible days listing with its preliminary position paper.[21]

Even if QRS had included the explanation it now *belatedly* offers as part of its position papers, the Board would still dismiss for failure of the Provider to sufficiently develop the merits of its case because the explanation fails to document the Provider's ***diligence*** and fails to sufficiently explain why ***no*** days have been identified as being in dispute and why the documents remain unavailable. QRS has *belatedly* alleged that there is "a significant issue" with the State of North Carolina data base preventing it from identifying Medicaid eligible days in dispute. Specifically, QRS has the alleged that the Provider has been prevented from identifying Medicaid eligible days in dispute due to "*a significant issue* with the State of North Carolina matching process and, more specifically, *the voiding of certain Medicaid patient records from the State system*."[22] In support, it cursorily describes efforts it made beginning on July 28, 2020 and on May 11, 2021, and then generically in May and June 2022. These descriptions refer to "a significant issue," "voiding … records" and "fix[ing] deficiencies" but does not explain what those deficiencies/voiding were, the timing of those deficiencies/voiding, or what needed fixing. Similarly, QRS' description of its July 28, 2020

[19] Whether the Medicare Contractor may or may not enter into an administrative resolution has nothing to do with the Provider's obligation to develop its case and present that case to the Board in compliance with Board rules and procedures as set forth in the Board Rules and 42 C.F.R. Part 405, Subpart R.
[20] Board Rule 25, of which 25.2.1 and 25.2.2 are a part, is applicable to final position papers via Board Rule 27.2.
[21] Examples of cases in which QRS was the designated representative and which the Board dismissed for failure of the Provider to provide a listing of Medicaid eligible days at issue include, but are not limited to: Case No. 14-2674 (by letter dated 5/5/2022); Case No. 16-2521 (by letter dated 5/5/2022); Case No. 16-0054 (by letter dated 5/5/2022); Case Nos. 13-3022, 13-3211, 14-2506, 14-4313, 16-1712 (by letter dated 9/30/2022). These dismissals were triggered by the Medicare Contractor filing a Motion to Dismiss.
[22] (Emphasis added.)

exchange with the State suggests the deficiency was that there would be no "updates to those older voided segments in the immediate near future." As a result, the issue appears to be with "updates" to "older voided segments" rather than access to those "older voided segments."[23] The use of the term "older voided segments" also suggests that the portion of the database relevant to the Provider's FY 2010 was accessible earlier and that the State sunsets or alters access to older data (*e.g.*, after 7 years).[24] There is just insufficient information here to know what is going on.

Indeed, even with this *belated* explanation, it is unclear why, *prior to July 2020*, the Provider/QRS had not identified ***any*** Medicaid eligible days in dispute. What did QRS or the Provider do prior to July 28, 2020? Did the Provider and QRS wait until July 2020 to begin its efforts? At that point in time, the case had been pending before the Board for more than 5 years and the fiscal year itself had been closed ***for 9 ½ years***. Was the State database as it relates to 2010 data (referred to as "those older voided segments") previously accessible or inaccessible prior to 2020? It is unclear, particularly since the data for which QRS is seeking is in some cases *more than 12 years old given* that the appeal relates to FY 2010. Accordingly, the Board finds that QRS has failed to sufficiently explain the Provider's diligence and what efforts QRS and the Provider have made to obtain the Medicaid eligible days information during the past 7 ½ years since the appeal was filed on the April 20, 2015 and the nature of the problem with the North Carolina database.

****

In summary, pursuant to its authority under 42 C.F.R. § 405.1868(a)-(b), the Board hereby dismisses the Medicaid eligible days issue as the Provider has failed to meet the Board requirements for position papers for this issue relative to developing the merits of its case and filing supporting exhibits. Indeed, the record before the Board reflects ***no*** specific Medicaid eligible days in dispute ($0 in actual controversy) at this very late post-position paper stage of the appeal. As no issues remain pending, the Board hereby closes Case No. 15-2294 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.
Gregory H. Ziegler, CPA
Robert A. Evarts, Esq.
Kevin D. Smith, CPA
Ratina Kelly, CPA

For the Board:

12/20/2022

X Clayton J. Nix

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

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

[23] In this regard, the Board notes that Attachment to the Provider's Request for Postponement includes a copy of email exchanges with the State. In a July 28, 2020 email, the State states "I don't forsee any ***updates*** to those *older voided segments* anytime soon based on the response *from the eligibility group*." (Emphasis added.)

[24] The use of the phrase "older voided segments" (*see supra* note 22) suggests that this may be part of a normal planned progression of data from an active database to an archive database (*e.g.*, sunsetting data from the active database to an archive database after 7 years). It does not appear to refer to lost data or inaccessible data.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Gary A. Rosenberg
Verrill Dana, LLP
One Boston Place, Suite 1600
Boston, MA 02108-4407

RE: ***Motion for Reinstatement***
Massachusetts General Hospital (22-0071, FYE 9/30/2013) *as a participant in*
Case No. 17-0588GC – Partners 2013 Medical Physics Residency Program CIRP Grp.

Dear Mr. Rosenberg,

The Provider Reimbursement Review Board ("Board") has reviewed the Motion for Reinstatement of Appeal Due to Failure of the Medicare Contractor ("MAC") to Reopen Cost Report ("Motion for Reinstatement") submitted by Massachusetts General Hospital ("Provider") on June 3, 2022. The decision of the Board is set forth below.

Pertinent Facts:

On December 6, 2016, the Group Representative, Verrill Dana, LLP, filed an appeal request, assigned Case No. 17-0588GC, with one Provider: Massachusetts General Hospital (Prov. No. 22-0071, FYE 9/30/2013). The Provider argued that the Medicare Contractor improperly disallowed the Provider's reasonable/pass-through costs of claimed allied health training program costs associated with the medical physics residency program.[1]

Massachusetts General Hospital was issued a Notice of Reopening of Cost Report on January 28, 2019, which indicated that the MAC was reopening the cost report in order, in part:

- To review the Allied Health Medical Physics Residency Program

On June 4, 2019, pursuant to the MAC's Notice of Reopening, the Provider withdrew the medical physics residency program issue.[2] The Provider and MAC agreed to utilize 42 C.F.R. § 405.1885 to resolve the appealed issue via a reopening.[3] The group appeal was closed on June 4, 2019 Massachusetts General Hospital was the only provider in the group.

The Provider's three-year reinstatement window closed on June 4, 2022. Therefore, in accordance with the August 29, 2018 PRRB rules 46, 47.1, and 47.2 in effect at the time the

[1] Provider's Request to Reinstate Appeal (hereinafter "Request to Reinstate").
[2] *Id*.
[3] Request to Reinstate, Exhibit P-2

issue was withdrawn, the Provider filed a Motion for Reinstatement of the withdrawn issue on June 3, 2022 because the MAC failed to issue a revised NPR ("RNPR").

Statutory and Regulatory Background

A Medicare Contractor may reopen a cost report within three years of the date of the NPR.[4] A provider may withdraw an issue in an appeal for which the MAC has agreed to reopen the final determination (*i.e.*, the cost report).[5] Following such a withdrawal, the provider may file a motion for reinstatement (1) within three years of the Board's decision to dismiss an issue/case or, if no dismissal was issued, (2) within three years of the Board's receipt of the provider's withdrawal of the issue.[6] The motion must be in writing and include copies of the provider's reopening request and the MAC's agreement to reopen the final determination.[7]

Board's Decision:

The Board finds that the MAC agreed to reopen the cost report at issue in this case but has failed to issue a revised NPR. The Provider has filed for reinstatement within the three year time frame and attached their request for reopening the cost report and the MAC's agreement to do so.

Based on the foregoing, the Board hereby grants Provider's Motion for Reinstatement. Pursuant to 42 C.F.R. § 405.1837(b)(1), a CIRP group is appropriate when there are, "***Two or more providers*** under common ownership or control that wish to appeal to the Board a specific matter at issue." With the Board's reinstatement of Massachusetts General Hospital, there would only be one Provider in the CIRP group, therefore the Board is establishing an individual appeal for Massachusetts General Hospital (22-0071, FYE 9/30/2013) for the reinstatement of the allied health training program costs associated with the medical physics residency program. The Board grants reinstatement of Case No. 17-0588GC in order to transfer Massachusetts General to its individual appeal.

The Board has established Case No. 23-0403 for Massachusetts General Hospital's (22-0071, FYE 9/30/2013) individual appeal, and hereby transfers the Provider from Case No. 17-0588GC to Case No. 23-0403. As no providers remain pending, Case No. 17-0588GC is once again closed. Case No. 23-0403 will be scheduled for hearing at the Board's earliest convenience.

Board Members Participating:

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

For the Board:

12/20/2022

X Clayton J. Nix

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

[4] 42 C.F.R. § 405.1885.
[5] Board Rule 46 (Aug. 29, 2018).
[6] Board Rule 47.1.
[7] Board Rule 47.2.2.

cc: Wilson C. Leong, Esq., Federal Specialized Services
Danelle Decker, National Government Services, Inc. (J-K)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Gary A. Rosenberg, Esq.
Verrill Dana, LLP
One Boston Pl., Ste. 1600
Boston, MA 02108-4407

RE: ***Motion for Reinstatement***
Massachusetts General Hospital (22-0071, FYE 9/30/2014), *as a participant in*
Case No. 18-0450GC – Partners 2014 Medical Physics Residency Program CIRP Grp.

Dear Mr. Rosenberg,

The Provider Reimbursement Review Board ("Board") has reviewed the Motion for Reinstatement of Appeal Due to Failure of the Medicare Contractor ("MAC") to Reopen Cost Report ("Motion for Reinstatement") submitted by Massachusetts General Hospital ("Provider") on June 3, 2022. The decision of the Board is set forth below.

Pertinent Facts:

On January 9, 2018, the Group Representative, Verrill Dana, LLP, filed an appeal request, assigned Case No. 18-0450GC, with one Provider: Massachusetts General Hospital (Prov. No. 22-0071, FYE 9/30/2014). The Provider argued that the MAC improperly disallowed the Provider's reasonable/pass-through costs of claimed allied health training program costs associated with the medical physics residency program.[1]

Massachusetts General Hospital was issued a Notice of Reopening of Cost Report on January 28, 2019, which indicated that the MAC was reopening the cost report in order, in part:

- To review the Allied Health Medical Physics Residency Program

On June 4, 2019, pursuant to the MAC's Notice of Reopening, the Provider withdrew the medical physics residency program issue.[2] The Provider and MAC agreed to utilize 42 C.F.R. § 405.1885 to resolve the appealed issue via a reopening.[3] The case was closed on June 4, 2019, as Massachusetts General Hospital was the only provider in the group.

The Provider's three-year reinstatement window closed on June 4, 2022. Therefore, in accordance with the August 29, 2018 PRRB rules 46, 47.1, and 47.2 in effect at the time the case

[1] Provider's Request to Reinstate Appeal (hereinafter "Request to Reinstate").
[2] *Id*.
[3] Request to Reinstate, Exhibit P-2

was withdrawn, the Provider filed on June 3, 2022 a Motion for Reinstatement of the withdrawn issue because the MAC failed to issue a revised NPR ("RNPR").

Statutory and Regulatory Background

A Medicare Contractor may reopen a cost report within three years of the date of the NPR.[4] A provider may withdraw an issue in an appeal for which the MAC has agreed to reopen the final determination (*i.e.*, the cost report).[5] Following such a withdrawal, the provider may file a motion for reinstatement (1) within three years of the Board's decision to dismiss an issue/case or, if no dismissal was issued, (2) within three years of the Board's receipt of the provider's withdrawal of the issue.[6] The motion must be in writing and include copies of the provider's reopening request and the MAC's agreement to reopen the final determination.[7]

Board's Decision:

The Board finds that the MAC agreed to reopen the cost report at issue in this case but has failed to issue a revised NPR. The Provider has filed for reinstatement within the three year time frame and attached their request for reopening the cost report and the MAC's agreement to do so. Based on the foregoing, the Board hereby grants Provider's Motion for Reinstatement. Pursuant to 42 C.F.R. § 405.1837(b)(1), a CIRP group is appropriate when there are, "***Two or more providers*** under common ownership or control that wish to appeal to the Board a specific matter at issue." With the Board's reinstatement of Massachusetts General Hospital, there would only be one Provider in the CIRP group, therefore the Board is establishing an individual appeal for Massachusetts General Hospital (22-0071, FYE 9/30/2013) for the reinstatement of the allied health training program costs associated with the medical physics residency program. The Board grants reinstatement of Case No. 18-0450GC in order to transfer Massachusetts General to its individual appeal.

The Board has established Case No. 23-0404 for Massachusetts General Hospital's (22-0071, FYE 9/30/2014) individual appeal, and hereby transfers the Provider from Case No. 18-0450GC to Case No. 23-0404. As no providers remain pending, Case No. 18-0450GC is one again closed. Case No. 23-0404 will be scheduled for hearing at the Board's earliest convenience.

Board Members Participating:

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

For the Board:

12/21/2022

X Clayton J. Nix

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

[4] 42 C.F.R. § 405.1885.
[5] Board Rule 46 (Aug. 29, 2018).
[6] Board Rule 47.1.
[7] Board Rule 47.2.2.

cc: Wilson C. Leong, Esq., Federal Specialized Services
Danelle Decker, National Government Services, Inc. (J-K)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Stephen Price, Sr.
Wyatt, Tarrant & Combs, LLP
500 West Jefferson St., Ste. 2800
Louisville, KY 40202-2898

RE: ***EJR Determination***
TJ Sampson Community Hospital (Prov. No 18-0017)
FYE 9/30/2010
Case No. 14-3285

Dear Mr. Price:

The Provider Reimbursement Review Board ("Board") has reviewed TJ Sampson Community Hospital's ("Provider's") November 30, 2022 request for expedited judicial review ("EJR") in the above-referenced individual appeal. The decision of the Board is set forth below.

Issues in Dispute

This appeal was filed on April 22, 2014. In its appeal request, the Provider states its SSI Matching Issue as follows:

> **ISSUE 1:** Whether the Fiscal Intermediary's calculation of the Provider's disproportionate patient percent, used for purposes of calculating the Medicare Disproportionate Share ("DSH") Adjustment, was incorrect due to CMS' inaccurate and improper matching technique used to determine both the number of Medicare Part A SSI days in the numerator and the total number of Medicare Part A patient days in the denominator of the Medicare fraction.[1]

The Provider estimated the amount in controversy to be $80,000 based on the addition of 83 days to the numerator of the SSI fraction.

In its appeal request, the Provider states its two dual eligible days issues as follows:

> **ISSUE 4:** Whether the Fiscal Intermediary's calculation of the Provider's disproportionate patient percent, used for purposes of calculating the Medicare Disproportionate Share ("DSH") Adjustment, was incorrect due to CMS' improper treatment of the

[1] Individual Appeal Request (Apr. 22, 2014).

Medicare Non-Covered Days, which includes but is not limited to Dual Eligible, Medicare Exhausted and Medicare Secondary Payor days. The improper treatment of these days affects the numerator of the Medicaid fraction.

****

According to the interpretation of 42 C.F.R. § 412.106(b), the regulation currently interprets the statutory language "entitled to benefits under [Medicare] Part A" as requiring the inclusion of patient days for all Medicare beneficiaries, even if a beneficiary has exhausted his or her Medicare coverage. This interpretation requires the exclusion from the Medicaid fraction of patient days for those individuals who are "eligible" for both Medicare and Medicaid, but who have exhausted their Medicare benefits. Per the ruling from *Metro. Hosp., Inc. v. US. Dep 't of Health & Human Servs*.,702 F. Supp. 2d 808, 825-26 (W.D. Mich. 2010), the district court determined that the interpretation at section 412.106(b) was invalid as contrary to the plain meaning of the DPP statute, reasoning that "entitled" requires payment for hospital services, rather than mere eligibility. Thus, dual-eligible patients with exhausted Medicare benefits would be included in the numerator of the Medicaid fraction.

****

ISSUE 5: Whether the Fiscal Intermediary's calculation of the Provider's disproportionate patient percent, used for purposes of calculating the Medicare Disproportionate Share ("DSH") Adjustment, was incorrect due to CMS' improper treatment of the Medicare Non-Covered Days, which includes but is not limited to Dual Eligible, Medicare Exhausted and Medicare Secondary Payor days. The improper treatment of these days affects both the numerator and the denominator of the Medicare fraction.

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If Medicare interprets "entitled" to Medicare as "eligible" for Medicare, and thus their basis for including these days in the Medicare fraction, then they also must interpret "entitled" to SSI as "eligible" for SSI and allow Dual Eligible days that are "eligible" for SSI, which includes days where the patient may only be receiving their SSI medical benefit/Medicaid, to be included in the Medicare numerator.[2]

[2] *Id.*

For Issues 4 and 5, the Provider performed two different estimated amount-in-controversy calculations. One pertains to its assertion that no-pay dual eligible days should be removed from the SSI fraction and moved to the numerator of the Medicaid fraction, and the amount in controversy was estimated to be $1,514,181 ($1,460,745 for SSI fraction[3] and $53,436 for Medicaid fraction[4]) and it appears to involve Issues 4 and 5 (where Issue 4 is focused on the Medicaid fraction and Issue 5 is focused on the SSI fraction).

The second one pertains to the alternative argument that the definition of "entitled to SSI benefits" as used in the numerator of the SSI fraction should be expanded to include days where a patient is eligible for SSI benefits, the amount in controversy was estimated to be $1,420,193 (based on the addition of 1484 days to the numerator of the SSI fraction). This second calculation only involves the SSI fraction and, as such, only relates to Issue 5.

In its request for Expedited Judicial Review, the Provider noted it will be withdrawing Issue 4 which relates to the exclusion of no-pay Part A days in the SSI fraction and the inclusion of the subset of those days relating to dual eligible beneficiaries in the Medicaid fraction because, based on the Supreme Court's decision in *Becerra v. Empire Health Foundation For Valley Hospital Medical Center*, 142 S. Ct. 2354, 2368 (June 24, 2022) ("*Empire*"), "the Provider acknowledges the dual eligible days should be excluded from the Medicaid numerator."[5] As such, the only remaining aspect of the dual eligible days issue (Issue 5) is the treatment of dual eligible days in the numerator of the Medicaid fraction where the Provider is stating that "entitled to SSI benefits" must be interpreted to include not just SSI paid days (as represented by SSI codes C01, M01, and M02) but also to include SSI eligible days.

Statutory and Regulatory Background:

A. The Secretary's policy on what the phrase "entitled to supplemental security income benefits" in 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I) means for purposes of the numerator of the SSI fraction used in the DSH adjustment calculation

The Medicare program pays inpatient hospital services based on predetermined, standardized amounts subject to certain payment adjustments under Medicare's inpatient prospective payment system ("IPPS").[6] One of these adjustments, the Medicare DSH adjustment, provides additional payments to certain qualifying hospitals that treat a disproportionate share of low income patients.[7] The Medicare DSH adjustment is calculated using two fractions known as the Medicare fraction (also referred to as the SSI fraction or SSI ratio) and the Medicaid fraction. Pursuant to 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I), the Medicare fraction is calculated by using: (a) in the numerator, the "number of such hospital's patient days…which were made up of patients who (for such days) were

[3] This amount is based on the removal of 293 days from the denominator of the SSI fraction.
[4] This amount is based on the addition of 98 days to the numerator of the Medicaid fraction.
[5] Provider Request for Expedited Review, n.5 (Nov. 30, 2022) ("EJR Request").
[6] 42 C.F.R. Part 412.
[7] 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I).

entitled to benefits under part A of the subchapter and were ***entitled*** to supplementary security income benefits…under subchapter XVI of this chapter…";[8] and (b) in the denominator, the number of days of care that are furnished to patients who were entitled to Medicare Part A. The Secretary incorporated this statutory provision into the regulations at 42 C.F.R. § 412.106(b)(2)(i)(B) which states:

> (2) *First computation: Federal fiscal year.* For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS –
>
> (i) Determines the number of patient days that –
>
> (A) Are associated with discharges occurring during each month; and
>
> (B) Are furnished to patients who during that month were **entitled to** both Medicare Part A (including Medicare Advantage (Part C)) and **SSI**, excluding those patients who received only State supplementation;
>
> (ii) Adds the results for the whole period; and
>
> (iii) Divides the number determined under paragraph (b)(2)(ii) of this section by the total number of days that –
>
> (A) Are associated with discharges that occur during that period; and
>
> (B) Are furnished to patients entitled to Medicare Part A (including Medicare Advantage (Part C)).[9]

The dispute in these appeals involves CMS' determination of which patients are "entitled to" both Medicare Part A and SSI benefits for purposes of the Medicare fraction of the DSH calculation.

The SSI program is a federal cash assistance program for low-income individuals who are aged, blind, or disabled,[10] administered by the Social Security Administration ("SSA"). The statutory provisions governing SSI, generally, do not use the term "entitled" to SSI benefits. Rather, the SSI statutory provisions typically refer to whether an individual is "eligible for benefits."[11] In order to be "eligible" for SSI benefits, a person must be: (1) 65 years of age or older, blind or disabled; (2) a lawful resident of the United States; (3) have limited income and resources; (4) not be fleeing to avoid prosecution for a crime or violating a condition of parole; and (5) file an application for benefits.[12]

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[8] (Emphasis added.)
[9] (Bold emphasis added and italics emphasis in original.) *See also* 42 U.S.C. § 1395w2(d)(5)(F)(vi)(I).
[10] 42 U.S.C. § 1382.
[11] 42 U.S.C. §§ 1381a, 1382(a) (emphasis added).
[12] 20 C.F.R. § 416.202.

In contrast, the Medicare program is an insurance program where an individual is automatically "entitled" to Medicare Part A when the person reaches age 65 and is entitled to Social Security benefits or becomes disabled and had been entitled to disability benefits for 24 calendar months.[13] In addition, the Medicare program provides that certain qualifying individuals with end stage renal disease are entitled to Medicare Part A.[14]

Unlike entitlement for Medicare Part A benefits, an individual who is currently eligible for SSI benefits may later become *in*eligible for SSI benefits. In this regard, SSA conducts periodic redeterminations to ensure continued eligibility[15] and may terminate,[16] suspend[17] or stop payments to individuals who are either temporarily or permanently ineligible for payment of SSI benefits.[18] In particular, SSI eligibility may be lost if a person no longer meets the basic requirements. For example, an individual may lose SSI eligibility if the individual is no longer disabled or the individual meets one of the following reasons set forth in §§ 416.207-416.216:

1. The individual fails to give the SSA permission to contact financial institutions;[19]
2. The individual fails to apply for other benefits to which the individual may be entitled;[20]
3. The individual fails to participate in drug or alcohol addiction treatment;[21]
4. The individuals is absent from the United States for more than 30 days;[22] or
5. The individual becomes a resident of a public institutions or prison.[23]

In addition, under certain circumstances, SSA may not pay benefits for administrative reasons, such as removal of a representative payee, an unknown address for the beneficiary, or because of income from a previous month.[24]

After the Medicare DSH statutory provisions were enacted in 1984, CMS (then known as the Health Care Financing Administration ("HCFA")) announced that the Secretary of Health and Human Services, rather than hospitals, would be solely responsible for computation of the Medicare fraction because the data necessary to calculate the Medicare fraction is voluminous and much of this data needed to be obtained from another agency, SSA.[25] CMS noted that, as of

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[13] 42 U.S.C. § 426.
[14] 42 U.S.C. § 426-1.
[15] 20 C.F.R. § 416.204.
[16] 20 C.F.R. §§ 416.1331-1335.
[17] 20 C.F.R. §§ 416.1320-1330.
[18] 20 C.F.R. § 1320.
[19] 20 C.F.R. § 416.207.
[20] 20 C.F.R. § 416.210.
[21] 20 C.F.R. § 416.214.
[22] 20 C.F.R. § 416.215.
[23] 20 C.F.R. § 416.211.
[24] *See* SSA Program Operations Manual ("POMS") § SI 02301.201 (describing certain SSI post-eligibility events on the internet at https://secure.ssa.gov/apps10/poms.nsf/lnx/0502301201).
[25] 51 Fed. Reg. 31454, 31459 (Sept. 3, 1986).

1986, the data sources for the computation of the Medicare fraction included approximately 11 million billing records from the Medicare inpatient discharge file and over 5 million records from the SSI file compiled by SSA.[26] To compute the Medicare fraction, CMS had to match individual Medicare billing records to individual SSI records.[27] Considering the administrative burdens and complexity of the data matching process, CMS concluded that the Secretary would be responsible for the data matching process, which she would conduct retrospectively for every eligible Medicare hospital on a "federal fiscal year" basis—that is, based on discharges occurring in the federal fiscal year.[28] CMS notifies Medicare contractors of the SSI ratios after they are calculated. CMS currently makes this notification by posting the resulting SSI percentages on its website. Medicare contractors then use the posted SSI ratios to calculate the Medicare DSH percentage to determine each qualifying hospital's Medicare DSH payment adjustment.[29]

The Medicare DSH payment adjustment has been the subject of much litigation and, from that litigation, the following case is of particular relevance to this appeal: *Baystate v. Leavitt*, 545 F. Supp. 2d 20 *as amended* 587 F. Supp. 2d 37, 44 (D.D.C. 2008) ("*Baystate*"). In *Baystate*, the plaintiff alleged that the Secretary's process to identify and gather the data necessary to calculate each hospital's SSI ratio was deficient and the Court remanded the case to the Administrator for further action. The Board notes that this case discusses the Secretary's historical practice of basing "entitled to . . . SSI" under 42 C.F.R. § 412.106(b)(2) on actual payment of SSI cash benefits.[30]

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

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

Social Security numbers (SSNs) as well as HICANs and Title II numbers."[31] The Ruling also stated that "in the FY 2011 proposed rule, CMS is proposing to adopt the same revised data matching process" for use with all hospitals and that "[i]n the forthcoming FY 2011 IPPS final rule, CMS expects to respond to public comments filed on the proposed new data matching process, make any changes to such matching process that seem appropriate, and adopt finally a new data matching process."[32] Finally, CMS stated that it would "use that new data matching process in calculating SSI fractions and DSH payments for specific claims that are found to qualify for relief under this Ruling."[33]

Consistent with Ruling 1498-R, the Secretary published the new data matching process in the FY 2011 IPPS proposed rule published on May 4, 2010.[34] The proposed rule includes references to the Secretary's historical practice of basing "entitled to . . . SSI" under 42 C.F.R. § 412.106(b)(2) on actual payment of SSI cash benefits.[35]

The Secretary finalized that data matching process in the FY 2011 IPPS final rule published on August 16, 2010 ("FY 2011 IPPS Final Rule").[36] Significantly, in the preamble to the FY 2011 IPPS Final Rule, CMS acknowledged a public comment that: (1) requested that "CMS include both paid and unpaid days for both SSI entitlement and Medicare entitlement such that there would be consistency between the numerator and denominator of the SSI fraction"; and (2) provided examples of "several SSI codes that represent individuals who were eligible for SSI but not eligible for SSI payments, that should be included as SSI-entitled for purposes of the data match process."[37] CMS responded in detail to this comment and explained that CMS interprets SSI entitlement to correspond with any month for which an individual *receives* payment of SSI benefits. In this regard, CMS stated that the three SSI codes denoted as C01, M01, and M02 "accurately captures all SSI-entitled individuals during the month(s) they are entitled to receive SSI benefits."[38] CMS explicitly rejected the inclusion of other SSA codes because "SSI entitlement can change from time to time" and none of these codes "would be used to describe an individual who was entitled to receive SSI benefits during the month that one of these codes was used."[39] Finally, in the preamble,

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[31] CMS-1498-R at 5.
[32] *Id.*
[33] *Id.* at 5-6.
[34] 85 Fed. Reg. 23852, 24002-24007 (May 4, 2010).
[35] *See, e.g.,* 75 Fed. Reg. at 24003 (discussing SSI cash payment issues discussed in the *Baystate* decision), 24003-24004 (discussing the proposed matching process where "[t]he SSI eligibility file serves as the system of record for whether or not SSA made a payment of SSI benefits to an individual who applied for SSI"), 24004-06 (discussing the time of the matching process including how "it is important to find an appropriate balance between administrative finality (that is, the final settlement of a hospital's cost report) and the inclusion of retroactive SSI eligibility determinations and the lifting of SSI payment suspensions by using the best and latest available SSI eligibility data at the time of cost report settlement benefits").
[36] 75 Fed. Reg. 50041, 50280-50281. (Aug. 16, 2010).
[37] *Id.* at 50280.
[38] *Id.* at 50280-50281.
[39] *Id.* This include all codes with the "S" prefix indicating a suspension of payment; codes beginning with "N" for nonpayment; code "E01" indicating that the individual had countable income which eliminated the SSI payment; and code "E02" indicating that the patient was not entitled to SSI benefits during that month but became entitled during a subsequent month.

CMS confirms that "[t]he same data matching process [used for FY 2011 and beyond] will be used to calculate SSI fractions for cost reporting periods covered under the Ruling [1498-R]."[40]

While the new data matching process established in the preamble to the FY 2011 IPPS Final Rule was effective October 1, 2010 (*i.e.*, for FY 2011 and forward), Ruling 1498-R directed that the Medicare contractors apply "the same, unitary relief" consisting of SSI fractions that the Secretary had calculated using the new "suitably revised" data matching process to: (1) any Medicare cost report that had not been settled; and (2) all properly pending Medicare DSH appeals of the SSI fraction data matching process issue.[41] The Ruling noted that hospitals dissatisfied with the initial or revised NPR issued using the new SSI ratios in the Medicare DSH adjustment calculation could seek administrative and judicial review provided they met the jurisdictional and procedural requirements of 42 U.S.C. § 1395oo, the Medicare regulations, and other agency rules and guidelines.[42] In the FY 2011 IPPS Final Rule, the Secretary explicitly recognized that "[t]he data matching process provisions of the Ruling would apply to . . . open cost reports for cost reporting periods beginning prior to October 1, 2010 (that is those preceding the effective date of the FY 2011 IPPS final rule)."[43]

Finally, on April 22, 2015, CMS published Ruling 1498-R2 modifying and amending Ruling 1498-R by allowing hospitals to elect whether to use new Medicare SSI fractions calculated on the basis of "total days" or "covered days" for cost reports involving patient discharges *prior* to October 1, 2004.[44]

However, neither Ruling 1498-R nor Ruling 1498-R2 are applicable to this appeal since the NPR at issue was issued after Ruling 1498-R and since the fiscal year at issue is not covered by Ruling 1498-R2. As a result of the new regulation and new data match process, CMS calculated SSI percentages for the Provider for the fiscal year at issue.[45] The Provider is challenging the adoption of the policy stated therein that only SSI paid days as represented by SSI codes S01, M01 and M02 are included in the numerator of the SSI fraction for purposes of representing days "entitled to [SSI] benefits."

B. FY 2005 IPPS Final Rule

The FY 2005 IPPS Final Rule announced policy changes relative to the treatment of dual eligible days and Medicare Part C days in the SSI fraction.[46] However, it did not address or announce any policy statements or changes relative to what the phrase "entitled to [SSI] benefits" as used in 42 U.S.C. § 1395ww(d)(F)(vi)(I) means.

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[40] *Id.* at 50285.
[41] CMS-1498-R at 6-7, 31.
[42] *Id.* at 28, 31.
[43] 75 Fed. Reg. at 24006.
[44] CMS-1498-R2 at 2, 6.
[45] CMS published the SSI ratios for FY 2010 on or about October 17, 2012. SSI ratios are published and can be accessed at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.
[46] 69 Fed. Reg. 48916, 49090-99 (Aug. 11, 2004).

Providers' Position

A. SSI Matching Issue

In its Final Position Paper, the Provider states that it received a data file from CMS and compared the SSI days in that file to data from Kentucky's State Medicaid program. This comparison showed 129 days that were not included in CMS' data file and, thus, were improperly excluded from the numerator of the Medicare fraction. It notes that Kentucky Medicaid assigns a specific code type for all Medicaid eligible patients, but that none of these days were included in the Medicare Fraction. The Provider claims "CMS simply did not use the best available data" and that the Medicare Contractor should adjust its data accordingly.[47]

In its EJR Request, the Provider has also claimed that the SSI Matching issue is inextricably intertwined with the dual eligible days issue the data match patient days are a subset of the total dual eligible patient days improperly excluded from the Medicare fraction.[48] Indeed, the Provider claims for these days it can demonstrate that certain beneficiaries were "entitled to SSI benefits" in that they *actually received* cash payments during the month of their hospital stay but were nevertheless excluded from the Medicare fraction numerator.

The Provider acknowledges that, pursuant to 42 C.F.R. § 405.1867, the Board is bound to comply with CMS Rulings 1498-R and 1498-R2, but claims that "the Rulings do not provide for a mechanism to address the challenge being made by the Provider regarding the proper interpretation of the phrase "entitled to [SSI] benefits" and, thus, EJR is appropriate.[49]

The Medicare Contractor argues that the NPR at issue in this case was issued four years after CMS Ruling 1498-R was issued and that the cost report was settled with a Medicare Fraction that incorporated the revised data matching process.[50] The Provider has not disputed this at any point, but appears to argue that certain Kentucky-specific SSI codes prove SSI entitlement, but that these are not one of the three SSI codes used by CMS in its revised data matching process (*i.e.,* SSI codes C01, M01, and M02).[51]

B. Dual Eligible Days Issue

In its EJR Request, the Provider acknowledges that, following the Supreme Court's decision in *Empire*, dual eligible days should be excluded from the Medicaid numerator.[52] It argues, however, that there is now an inconsistency between the interpretation of "entitled to benefits under Part A" (which encompasses any patient who satisfies the statutory eligibility criteria whether or not Medicare actually pays), and "entitled to SSI" (which encompasses only patient days where SSI

[47] Provider's Final Position Paper at 18-19.
[48] EJR Request at n.3.
[49] *Id.* at 5-6.
[50] Medicare Administrative Contractor's Final Position Paper at 19-20 (July 6, 2021).
[51] Provider's Final Position Paper at 18-19.
[52] EJR Request at 2.

cash payments were actually received).[53] This discrepancy excludes a large number of days from the Medicare fraction numerator.[54] In this regard, the Provider is located in Kentucky where a dual eligible patient is entitled to SSI benefits by definition, and argues that not only should all Kentucky dual eligible patient days be included in the Medicare numerator (Issue 1) but also all situations where a patient was "eligible" for SSI benefits (remaining aspect of Issue 5).[55] The Provider acknowledges that, if they are successfully in expanding the interpretation of the phrase "entitled to [SSI] benefits" to include SSI eligibility, then Issue 1 becomes moot (*i.e.*, the contention not all SSI paid days were counted/identified as established through the Kentucky Medicaid eligibility data).[56] In seeking to expand this interpretation, the Provider is challenging the Secretary's policy stated in the FY 2011 IPPS Final Rule that "entitled to [SSI] benefits" must be interpreted to include only SSI paid days as represented by SSI codes C01, M01, and M02.[57]

As previously noted, in its EJR Request, the Provider noted it is withdrawing the Medicaid Fraction dual eligible issue (Issue 4 and the related aspect of Issue 5) in light of the Supreme Court's decision in *Empire*.[58] As such, the only aspect of Issue 5 remaining in this appeal is the determination of SSI entitled days as used in the numerator of the Medicare fraction.

Decision of the Board

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

A. Preliminary Rulings on the Scope of the EJR Request

The Provider has suggested that it is challenging the FY 2005 IPPS Final Rule based on the following finding it included at the end of its EJR request:

> [The Board] is without the authority to decide the legal question of whether 42 C.F.R. § 412.106 codifying the CMS policies adopted in the FY 2005 IPPS Final Rule and the FY 2011 Final Rule are valid.

However, the EJR request only mentions the FY 2005 IPPS Final Rule in one other place as follows:

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[53] *Id.*
[54] *Id.*
[55] *Id.* at 2-4.
[56] *Id.* at 4.
[57] *Id.* at 15, 19.
[58] *Id.* at n.5.

> In the 2005 Rule construing the Medicare fraction, CMS interpreted the phrase "entitled to benefits under Part A" to encompass any patient who satisfied Part A statutory *eligibility* criteria whether or not Medicare actually pays for the care.

The Provider has recognized that the Supreme Court upheld this policy:

> In *Becerra v. Empire Health Foundation For Valley Hospital Medical Center*, 142 S.Ct. 2354, 2368 (June 24, 2022), the Supreme Court upheld the Secretary's interpretation of the phrase "entitled to benefits" in the numerator of the Medicare fraction to include those individuals qualifying for Medicare regardless of whether that program actually paid for their day of care. The Supreme Court found that the Secretary's reading of "entitled to benefits" comported with the statute's two-population structure because "[a]ll low-income people fit naturally into one or the other box, with the sum of the two leaving no one out." *Id.* at 2367. Accordingly, the Provider acknowledges the dual eligible days should be excluded from the Medicaid numerator.[59]

The Provider then confirmed in a footnote at the end of this excerpt confirming that "[t]he Provider will be dismissing [*sic* withdrawing] the Medicaid dual eligible issue in this case."

Moreover, the Board notes that the FY 2005 IPPS Final Rule does not include any statement regarding the Secretary's interpretation of the phrase "entitled to [SSI] benefits" as used in 42 U.S.C. § 1395ww(d)(F)(vi)(I). Nor does the Provider claim it does.

Accordingly, the Board finds that the EJR request has ***not*** laid a sufficient foundation for a challenge to the FY 2005 IPPS Final Rule. In so ruling, it does not mean that it does not have relevance to what is being challenged, namely the FY 2011 IPPS Final Rule as set forth below. However, it is not what is actually being challenged. In this regard, the Provider is maintaining that the term "entitled" should be consistently interpreted across 42 U.S.C. § 1395 and that "entitled to [SSI] benefits" should be broadly interpreted consistent with how the Secretary interpreted "entitled to benefits under [Medicare] Part A" as used in 42 U.S.C. 1395ww(d)(F)(vi)(I) and explained in the FY 2005 IPPS Final Rule and upheld by the Supreme Court in *Empire*, as noted above.

With regard to Issue 1 relating to the SSI data matching process, the Provider has suggested that EJR is appropriate for that issue based on its assertion that it is inextricably intertwined with the challenge in Issues 4 and 5 to the Secretary's interpretation of "entitled to [SSI] benefits." Specifically, it has stated in footnote 3 of the EJR request that "the data match issue is inextricably intertwined with the Medicare dual eligible issue because it is also impacted by the interpretation of the phrase 'entitled to [SSI] benefits.'" The Provider further explains that:

[59] EJR request at 2 (footnotes omitted).

> In this case, the data match issue is intertwined with the Medicare dual eligible issue because the data match patient days are a subset of the total dual eligible patient days improperly excluded from the Medicare fraction. Although the Provider contends that CMS improperly excluded all dual eligible patients days by misinterpreting the phrase "entitled to [SSI] benefits," the data match issue relates to patients days for which the Provider can demonstrate that the beneficiary was "entitled to SSI benefits" even using CMS' restrictive interpretation. CMS uses three SSI codes to determine which patient days it will include in the Medicare numerator. These codes reflect beneficiaries who actually *received SSI cash payments* during the month of their hospital stay. The data match amount in controversy was calculated by comparing Medicaid data with CMS' Med Par data in order to identify those patients with associated Medicaid codes indicating that the patients received SSI payments while hospitalized. These patient days were not included by CMS in the Medicare numerator. Thus, even using CMS' constricted definition, there are additional days to include in the Medicare fraction numerator. However, this amount is encompassed by the overall Medicare dual eligible SSI issue. So, if a court determines that "entitled to benefits" has the same meaning with respect to SSI benefits as Part A benefits, then the data match issue will be moot.[60]

In footnote 7 of the EJR request appended to the end of the above excerpt, the Provider makes the following statement regarding the intertwinement:

> If the Board determines that the data match issue is not inextricably intertwined with the Medicare dual eligible entitled to SSI benefits or is otherwise not inclined to grant EJR on that issue, then the Provider requests that the data match issue be held in abeyance pending a court's resolution of the Medicare DE "entitled to [SSI]" dispute.

The Board disagrees with the Provider's characterization of the SSI Data Match issue. The Board finds that the fact that the SSI Data Match issue may be impacted by the outcome of the Provider's challenge to the Secretary's interpretation of the phrase "entitled to [SSI] benefits" (and rendered moot if the "entitled" interpretation issue is decided favorably for the Provider) does ***not*** mean that EJR of the Data Match Issue is appropriate. In this regard, the Board notes that it has already had a case with the same issue, namely *Pomona Valley Hospital Medical Center v. Noridian Healthcare Solutions*, PRRB Dec. No. 2018-D50 (Aug. 17, 2017). In that case, the Provider maintained that certain California Medicaid records documenting the assignment of certain "aid codes" by the Social Security Administration could be relied upon to

[60] (Footnote omitted.)

confirm whether a patient was "entitled to [SSI] benefits" and that these records confirmed that the SSI percentage published by CMS for the provider for the fiscal year at issue was understated. The Board ultimately found that the provider "did not submit sufficient quantifiable data in the record to prove that the SSI percentages calculated by CMS, and used in [the provider]'s FYE 12/31/2006, 12/31/2007, and 12/31/2008 cost reports, were flawed" and, accordingly, affirmed the SSI percentages used by the Medicare Contractor.

The Provider has not stated any specific challenge to the FY 2011 IPPS Final Rule as it relates to Issue 1 (*e.g.*, that the Secretary's adoption of C01, M01, and M02 to capture SSI paid days for ***all*** hospital across the U.S. is improper because that adoption was procedurally invalid and/or substantively invalid). As such, the EJR request as it relates to Issue 1 is fatally flawed.

Rather, similar to the *Pomona Valley* case,[61] there appears to be a factual issue in dispute here that the Board needs to resolve regarding the Provider's assertions about Kentucky Medicaid documentation, namely that "in Kentucky the fact that a [dual eligible] patient was eligible for Medicaid when receiving hospital services is evidence that, for such days, the patient was entitled to SSI benefits" and that "[a]ccordingly, patient days excluded from the Medicaid numerator due to a [dual eligible] patient's Part A Medicare status should then be automatically included in the Medicare numerator."[62] As such, it appears to be a variation on *Baystate* where the Provider is asserting that the process used by CMS is flawed because it can establish that the process used to capture SSI paid days is flawed and results in understated SSI fractions. To highlight the factual dispute the Board points to the Medicare Contractor's position paper which recognizes that "[t]he Provider focuses on patient days that were excluded because these days have been matched with SSA codes by using the Kentucky Medicaid" but asserts that "the Provider has not demonstrated that the patients **were eligible for SSI benefits on the days for which care was provided**."[63] Accordingly, the Board denies the EJR request as it relates to Issue 1 because there is a factual dispute to resolve and the Provider has not set forth, with sufficient detail, any challenge to a regulation or CMS Ruling for Issue 1.

B. Appeals of Cost Report Periods Beginning Prior to January 1, 2016

1. Statutory and Regulatory Background

The Provider appealed a cost reporting period beginning prior to January 1, 2016. For purposes of Board jurisdiction over a provider's appeal for cost report periods ending on or after December 31, 2008, the provider may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming it as a "self-disallowed cost," pursuant to the

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[61] In pointing similarities to *Pomona Valley*, the Board is not suggesting the outcome of this case, particularly since this case involves a *different* state Medicaid program with presumably different record systems for Medicaid eligibility) but merely that there is a factual dispute here. Similarly, given the decision issued on appeal, there is also a dispute about who has the burden of proof. *See Pomona Valley Hosp. Med. Ctr. v. Azar*, Civ. No. 18-2763, 2020 WL 5816486 (D.D.C. 2020), *appeal filed*, Case No. 20-5350 (D.C. Cir. Nov. 30, 2020).
[62] EJR Request at 14.
[63] Medicare Contractor Final Position Paper at 10.

Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen* ("*Bethesda*").[64] In that case, the Supreme Court concluded that a cost report submitted in full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.[65]

On August 21, 2008, new regulations governing the Board were effective.[66] Among the new regulations implemented in the Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hospital v. Burwell* ("*Banner*").[67] In *Banner*, the provider filed its cost report in accordance with the applicable outlier regulations and did not protest the additional outlier payment it was seeking. The provider's request for EJR was denied because the Board found that it lacked jurisdiction over the issue. The District Court concluded that, under *Bethesda,* the 2008 self-disallowance regulation could not be applied to appeals raising a legal challenge to a regulation or other policy that the Medicare Contractor could not address.[68]

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

2. Jurisdiction

The Board has determined that the Issue 5 as it relates to the meaning of "entitled to [SSI] benefits" is governed by CMS Ruling CMS-1727-R since the Provider is challenging the Secretary's interpretation of this phrase as set forth in the FY 2011 IPPS Final Rule and that Board review of this issue is not otherwise precluded by statute or regulation. In addition, the Provider's

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[64] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).
[65] *Bethesda*, 108 S. Ct. at 1258-59.
[66] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[67] 201 F. Supp. 3d 131 (D.D.C. 2016).
[68] *Id.* at 142.

documentation shows that the estimated amount in controversy exceeds $10,000, as required for an individual appeal.[69] The appeal was timely filed and no jurisdictional impediments have been identified for the Provider as it relates to the remaining aspect of Issue 5. Based on the above, the Board finds that it has jurisdiction for the above-captioned individual appeal as it relates to the remaining aspect of Issue 5.

C. Board's Analysis of the Appealed Issue

As noted above, the Secretary revised the SSI data match process in light of the *Baystate* decision through notice and comment in the form of an uncodified regulation. First, the Secretary issued CMS Ruling 1498-R on April 28, 2010, authorizing remands of pending appeals of the SSI data match issue to recalculate the SSI fraction based on a revised data match.[70] The Secretary also stated in the ruling that, where cost reports had not been settled, those providers' SSI fractions would be calculated using the revised data match.[71] Contemporaneous with CMS' issuance of Ruling 1498-R[72] the Secretary published the FY 2011 IPPS Proposed Rule[73] which, in pertinent part, proposed to adopt the same data match for 2011 and forward. This proposed rule was adopted as the FY 2011 Final IPPS Rule in which the Secretary explained that:

> [W]e used a revised data matching process . . . that comports with the court's decision [in *Baystate* to recalculate the hospitals' SSI fractions]. As the revised data matching process was completed using SSI eligibility data compiled between 13 and 16 years beyond the fiscal years at issue in the *Baystate* case, we believe any issues associated with retroactive determinations of SSI eligibility and the lifting of payment suspensions had been long since resolved. Furthermore, because we believe that the revised match process used to implement the *Baystate* decision addressed all of the concerns found by the court, in the FY 2011 IPPS/LTCH PPS proposed rule we proposed to use the same revised data matching process for calculating hospitals' SSI fractions for FY 2011 and subsequent fiscal years.[74]

Then she announced that:

> We have adopted the proposed data matching process for FY 2011 and beyond as final. The only modification we are making to the proposed matching process is adopting a policy to exclude a record from the data matching process if we find a HICAN in the

[69] *See* 42 C.F.R. § 405.1835(a)(2).
[70] CMS Ruling 1498-R at 27.
[71] *Id.* at 31.
[72] *Id.* at 5.
[73] 75 Fed. Reg. 23,852, 24,002-07.
[74] 75 Fed. Reg. at 50,277.

> MedPAR file that we are not able to locate in the EDB[75]which is an extremely unlikely situation as noted in the prior discussion in this final rule. We are adopting this additional step in our validation process to respond to public comment and provide even more assurances that our data matching process will yield accurate SSI fractions and capture all Medicare beneficiaries who were entitled to SSI at the time of their inpatient hospital stay. The same data matching process will be used to calculate SSI fractions for cost reporting periods covered under the ruling.[76]

As part of the adopted data match process, CMS explicitly finalized a policy that SSI codes C01, M01, and M02 would capture all SSI entitled days:

> *Comment*: **One commenter stated that CMS** uses total (that is, "paid and unpaid") Medicare days in the denominator of the SSI fraction, but **uses paid SSI days in the numerator of the SSI fraction**. The commenter requested that CMS interpret the word "entitled" to mean "paid" for both SSI-entitled days used for the numerator and Medicare-entitled days used in the denominator, or alternatively, that CMS include both paid and unpaid days for both SSI entitlement and Medicare entitlement such that there is consistency between the numerator and the denominator of the SSI fraction. **The commenter stated that there were several SSI codes that represent individuals who were eligible for SSI, but not eligible for SSI payments, that should be included as SSI-entitled for purposes of the data matching process**. Specifically, the commenter stated that at least the following codes should be considered to be SSI-entitlement:
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> • E01 and E02
> • N06, N10, N11, N18, N35, N39, N42, N43, N46, N50, and N54
> • P01
> • S04, S05, S06, S07, S08, S09, S10, S20, S21, S90, and S91
> • T01, T20, T22, and T31
>
> *Response*: In response to the comment that we are incorrectly applying a different standard in interpreting the word "entitled" with respect to SSI entitlement versus Medicare entitlement, we disagree. The authorizing DSH statute at section 1886(d)(5)(F)(vi)(I) of the Act limits the numerator to individuals entitled to Medicare benefits who are also "*entitled* to supplemental security income benefits (excluding

[75] (Medicare) Enrollment Database.
[76] 75 Fed. Reg. at 50,285.

any State supplementation)" (emphasis added).[77] **Consistent with this requirement, we have requested, and are using in the data matching process, those SSA codes that reflect "entitlement to" receive SSI benefits**. Section 1602 of the Act provides that "[e]very aged, blind, or disabled individual who is determined under Part A to be eligible on the basis of his income and resources shall, in accordance with and subject to the provisions of this title, be *paid* benefits by the Commissioner of the Social Security" (emphasis added). However, eligibility for SSI benefits does not automatically mean that an individual will receive SSI benefits for a particular month. For example, section 1611(c)(7) of the Act provides that an application for SSI benefits becomes effective on the later of either the month following the filing of an application for SSI benefits or the month following eligibility for SSI benefits.

On the other hand, section 226 of the Act provides that an individual is automatically "entitled" to Medicare Part A when the person reaches age 65 and is entitled to Social Security benefits under section 202 of the Act (42 U.S.C. 402) or becomes disabled and has been entitled to disability benefits under section 223 of the Act (42 U.S.C. 423) for 24 calendar months. Section 226A of the Act provides that qualifying individuals with end-stage renal disease shall be entitled to Medicare Part A. In addition, section 1818(a)(4) of the Act provides that, "unless otherwise provided, any reference to an individual entitled to benefits under [Part A] includes an individual entitled to benefits under [Part A] pursuant to enrollment under [section 1818] or section 1818A." We believe that Congress used the phrase "entitled to benefits under part A" in section 1886(d)(5)(F)(vi) of the Act to refer individuals who meet the criteria for entitlement under these sections.

Moreover, unlike the SSI program (in which entitlement to receive SSI benefits is based on income and resources and, therefore, can vary from time to time), once a person becomes entitled to Medicare Part A, the individual does not lose such entitlement simply because there was no Medicare Part A coverage of a specific inpatient stay. Entitlement to Medicare Part A reflects an individual's entitlement to Medicare Part A benefits, not the hospital's entitlement or right to receive payment for services provided to such individual. Such

[77] As a side note, we have used the phrase ''SSI-eligible'' interchangeably with the term ''SSI-entitled'' in the FY 2011 proposed rule as well as prior proposed and final rules, but the statute requires that we include individuals who were entitled to SSI benefits in the SSI fractions. Although we have used these terms interchangeably, we intended no different meaning, and our policy has always been to include only Medicare beneficiaries who are entitled to receive SSI benefits in the numerator of the SSI fraction.

Medicare entitlement does not cease to exist simply because Medicare payment for an individual inpatient hospital claim is not made. Again, we are bound by section 1886(d)(5)(F)(vi)(I) of the Act, which defines the SSI fraction numerator as the number of SSI-entitled inpatient days for persons who were "entitled to benefits under [P]art A," and the denominator as the total number of inpatient days for individuals who were "entitled" to Medicare Part A benefits.

In response to the comment about specific SSI status codes, SSA has provided information regarding all of the SSI status codes mentioned by the commenter to assist in the determination of whether <u>any</u> of these codes represent individuals who were entitled to SSI benefits for the purposes of calculating the SSI fraction for Medicare DSH. With respect to the codes that begin with the letter "T," SSA informed us that all of the codes represent individuals whose SSI entitlement was terminated. Code "T01" represents records that were terminated because of the death of the individual, but we confirmed that this code would not be used until the first full month after the death of the individual. That is, for example, if a Medicare individual was entitled to SSI during the month of October, was admitted to the hospital on October 1 and died in the hospital on October 15, the individual would show up as entitled to SSI for the entire month of October on the SSI file (code T01 would not be used on the SSI file until November) and 15 Medicare/SSI inpatient hospital days for that individual would be counted in the numerator and the denominator of the SSI fraction for that hospital.

Codes beginning with the letter "S" reflect records that are in a "suspended" status and, according to SSA, do not represent individuals who are entitled to SSI benefits.

SSA maintains that code "P01" is obsolete and has not been used since the mid-1980s. Therefore, it would not be used on any SSI files reflecting SSI entitlement for FY 2011 and beyond.

Codes that begin with the letter "N" represent records on "nonpayment" and are not used for individuals who are entitled to SSI benefits.

Code "E01" represents an individual who is a resident of a medical treatment facility and is subject to a $30 payment limit, but has countable income of $30 or more. Such an individual is not entitled to receive SSI payment. Alternatively, an individual who is a resident of a medical treatment facility and is subject to a $30 payment limit, but does not have countable income of at least $30, would be reflected on the SSI file as a "C01" (which denotes SSI entitlement)

> for any month in which the requirements described in this sentence are met. Code "E02" is used to identify a person who is not entitled to SSI payments in the month in which that code is used pursuant to section 1611(c)(7) of the Act, which provides that an application for SSI benefits shall be effective on the later of (1) the first day of the month following the date the application is filed, or (2) the first day of the month following the date the individual becomes eligible for SSI based on that application. Such an individual is not entitled to SSI benefits during the month that his or her application is filed or is determined to be eligible for SSI, but, for the following month, would be coded as a "C01" because he or she would then be entitled to SSI benefits.
>
> Therefore, both codes E01 and E02 represent individuals who are not entitled to SSI benefits and are reflected accordingly on the SSI file. If the individual's entitlement to SSI benefits is initiated the ensuing month, that individual would then be coded as a "C01" on the SSI file and would be included as SSI-entitled for purposes of the data matching process.
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> As we have described above, **none of the SSI status codes that the commenter mentioned would be used to describe an individual who was entitled to receive SSI benefits during the month that one of those status codes was used**. SSI entitlement can change from time to time, and **we believe that including SSI codes of C01, M01, and M02 accurately captures all SSI-entitled individuals during the month(s) that they are entitled to receive SSI benefits**.
>
> After consideration of the public comments we received, we are adopting the proposed data matching process for FY 2011 and beyond as final. The only modification we are making to the proposed data matching process is adopting a policy to exclude a record from the data matching process if we find a HICAN in the MedPAR file that we are not able to locate in the EDB, which is an extremely unlikely situation as noted in the prior discussion in this final rule. We are adopting this additional step in our validation process in response to public comments to provide even more assurances that **our data matching process will** yield accurate SSI fractions and **capture all Medicare beneficiaries who were <u>entitled</u> to SSI at the time of their inpatient hospital stay**.[78]

The Secretary did not incorporate, into the Code of Federal Regulations, the above new policy involving the revised data match process (including but not limited to portion of that policy

[78] 75 Fed. Reg. at 50280-81 (footnote in original; bold and underline emphasis added).

relating to the use of SSI code C01, M01, and M02 to capture SSI entitled days). However, it is clear from the language in the final IPPS rule, as set forth above, that the Secretary intended to bind the regulated parties and establish a *binding* data match process to be used by the Medicare Contractors in calculating (or recalculating) providers' SSI fractions.

Accordingly, the Board finds that the Secretary intended this policy change for the data match process to be a binding but uncodified regulation and will refer to portion of that policy as it relates to the adoption of the SSI codes C01, M01, and M02 to capture SSI entitled days as the "Uncodified SSI Entitled Days Regulation." Indeed, this finding is consistent with the Secretary's obligations under 42 U.S.C. § 1395hh(a)(2) to promulgate any "substantive legal standard governing . . . the payment of services" as a regulation."[79]

Pursuant to 42 C.F.R. § 405.1867, the Board is bound to apply the statutory and regulatory provisions governing the Medicare program. Consequently, the Board finds that it is bound by the Uncodified SSI Entitled Days Regulation published in the FY 2011 Final Rule and the Board does not have the authority to grant the relief sought by the Provider, namely invalidating the Uncodified SSI Entitled Days Regulation which they allege fails to include all of the SSI codes used by SSA to determine SSI eligibility. As a result, the Board finds that EJR is appropriate for the issue for the calendar year under appeal in this case.

D. Board's Decision Regarding the EJR Request

The Board finds that:

1) It denies the portion of the EJR request relating to Issue 1 because there are findings of fact for resolution by the Board and the EJR request fails to lay out a specific challenge to a regulation or CMS Rule for Issue 1;

2) It dismisses both Issue 4 and that aspect of Issue 5 which relate to the exclusion of no-pay Part A days in the SSI fraction and the inclusion of the subset of those days relating to dual eligible beneficiaries in the Medicaid fraction because the Provider has notified the Board it is withdrawing that issue based on the Supreme Court's decision in *Empire*;

3) It has jurisdiction over the remaining aspect of Issue 5 for the subject year and that the Provider is entitled to a hearing before the Board;

4) Based upon the Provider's assertions regarding 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule), there are no findings of fact for resolution by the Board for the remaining aspect of Issue 5;

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[79] 42 U.S.C. § 1395hh(a)(2) states "[n]o rule, requirement, or other statement of policy . . . that establishes or changes a substantive legal standard governing . . . the payment of services . . . shall take effect unless it is promulgated by the Secretary by regulation . . . ."

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

6) It is without authority to decide the legal question of whether the Uncodified SSI Entitled Days Regulation as adopted in the preamble to the FY 2011 Final IPPS Rule is valid.

Accordingly, the Board denies the EJR request as it relates to Issue 1, dismisses both Issue 4 and that aspect of Issue 5 which relate to the *Empire* decision, and finds that the question of the validity of the Uncodified SSI Entitled Days Regulation (the remaining aspect of Issue 5) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Provider's request for EJR for that remaining aspect of Issue 5. The Provider has 60 days from the receipt of this decision to institute the appropriate action for judicial review. The case remains open as there is an issue remaining in this case.

Board Members Participating:

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

FOR THE BOARD:

12/29/2022

X Clayton J. Nix

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

cc: Judith Cummings, CGS Administrators (J-15)
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Stephen Price, Sr.
Wyatt, Tarrant & Combs, LLP
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RE: ***EJR Determination***
King's Daughters' Medical Center (Prov. No 18-0009)
FYE 9/30/2010
Case No. 15-2109

Dear Mr. Price:

The Provider Reimbursement Review Board ("Board") has reviewed King's Daughters' Medical Center's ("Provider's") November 30, 2022 request for expedited judicial review ("EJR") in the above-referenced individual appeal. The decision of the Board is set forth below.

Issues in Dispute

This appeal was filed on April 3, 2015. In its appeal request, the Provider states its SSI Matching Issue as follows:

> **ISSUE 1:** Whether the Fiscal Intermediary's calculation of the Provider's disproportionate patient percent, used for purposes of calculating the Medicare Disproportionate Share ("DSH") Adjustment, was incorrect due to CMS' inaccurate and improper matching technique used to determine both the number of Medicare Part A SSI days in the numerator and the total number of Medicare Part A patient days in the denominator of the Medicare fraction. [1]

The Provider estimated the amount in controversy to be $292,000 based on the addition of 232 days to the numerator of the SSI fraction.

In its appeal request, the Provider states its two dual eligible days issues as follows:

> **ISSUE 4:** Whether the Fiscal Intermediary's calculation of the Provider's disproportionate patient percent, used for purposes of calculating the Medicare Disproportionate Share ("DSH") Adjustment, was incorrect due to CMS' improper treatment of the

[1] Individual Appeal Request, 1-2 (Apr. 3, 2015).

> Medicare Non-Covered Days, which includes but is not limited to Dual Eligible, Medicare Exhausted and Medicare Secondary Payor days. The improper treatment of these days affects the numerator of the Medicaid fraction.
>
> ****
>
> According to the interpretation of 42 C.F.R. § 412.106(b), the regulation currently interprets the statutory language "entitled to benefits under [Medicare] Part A" as requiring the inclusion of patient days for all Medicare beneficiaries, even if a beneficiary has exhausted his or her Medicare coverage. This interpretation requires the exclusion from the Medicaid fraction of patient days for those individuals who are "eligible" for both Medicare and Medicaid, but who have exhausted their Medicare benefits. Per the ruling from *Metro. Hosp., Inc. v. US. Dep 't of Health & Human Servs*.,702 F. Supp. 2d 808, 825-26 (W.D. Mich. 2010), the district court determined that the interpretation at section 412.106(b) was invalid as contrary to the plain meaning of the DPP statute, reasoning that "entitled" requires payment for hospital services, rather than mere eligibility. Thus, dual-eligible patients with exhausted Medicare benefits would be included in the numerator of the Medicaid fraction.
>
> ****
>
> **ISSUE 5:** Whether the Fiscal Intermediary's calculation of the Provider's disproportionate patient percent, used for purposes of calculating the Medicare Disproportionate Share ("DSH") Adjustment, was incorrect due to CMS' improper treatment of the Medicare Non-Covered Days, which includes but is not limited to Dual Eligible, Medicare Exhausted and Medicare Secondary Payor days. The improper treatment of these days affects both the numerator and the denominator of the Medicare fraction.
>
> If Medicare interprets "entitled" to Medicare as "eligible" for Medicare, and thus their basis for including these days in the Medicare fraction, then they also must interpret "entitled" to SSI as "eligible" for SSI and allow Dual Eligible days that are "eligible" for SSI, which includes days where the patient may only be receiving their SSI medical benefit/Medicaid, to be included in the Medicare numerator.[2]

For Issues 4 and 5, the Provider performed two different estimated amount-in-controversy calculations. One pertains to its assertion that no-pay dual eligible days should be removed from the SSI fraction and moved to the numerator of the Medicaid fraction, and the amount in

[2] *Id.* at 4-6.

controversy was estimated to be $12,547,843 ($12,490,672 for SSI fraction[3] and $57,171 for Medicaid fraction[4]) and it appears to involve Issues 4 and 5 (where Issue 4 is focused on the Medicaid fraction and Issue 5 is focused on the SSI fraction).

The second one pertains to the alternative argument that the definition of "entitled to SSI benefits" as used in the numerator of the SSI fraction should be expanded to include days where a patient is eligible for SSI benefits, the amount in controversy was estimated to be 12,302,393 (based on the addition of 9769 days to the numerator of the SSI fraction). This second calculation only involves the SSI fraction and, as such, only relates to Issue 5.

In its request for Expedited Judicial Review, the Provider noted it will be withdrawing Issue 4 which relates to the exclusion of no-pay Part A days in the SSI fraction and the inclusion of the subset of those days relating to dual eligible beneficiaries in the Medicaid fraction because, based on the Supreme Court's decision in *Becerra v. Empire Health Foundation For Valley Hospital Medical Center*, 142 S. Ct. 2354, 2368 (June 24, 2022) ("*Empire*"), "the Provider acknowledges the dual eligible days should be excluded from the Medicaid numerator."[5] As such, the only remaining aspect of the dual eligible days issue (Issue 5) is the treatment of dual eligible days in the numerator of the Medicaid fraction where the Provider is stating that "entitled to SSI benefits" must be interpreted to include not just SSI paid days (as represented by SSI codes C01, M01, and M02) but also to include SSI eligible days.

Statutory and Regulatory Background:

A. The Secretary's policy on what the phrase "entitled to supplemental security income benefits" in 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I) means for purposes of the numerator of the SSI fraction used in the DSH adjustment calculation

The Medicare program pays inpatient hospital services based on predetermined, standardized amounts subject to certain payment adjustments under Medicare's inpatient prospective payment system ("IPPS").[6] One of these adjustments, the Medicare DSH adjustment, provides additional payments to certain qualifying hospitals that treat a disproportionate share of low income patients.[7] The Medicare DSH adjustment is calculated using two fractions known as the Medicare fraction (also referred to as the SSI fraction or SSI ratio) and the Medicaid fraction. Pursuant to 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I), the Medicare fraction is calculated by using: (a) in the numerator, the "number of such hospital's patient days…which were made up of patients who (for such days) were ***entitled*** to benefits under part A of the subchapter and were ***entitled*** to supplementary security income benefits…under subchapter XVI of this chapter…";[8] and (b) in the denominator, the number of days of care that are furnished to patients who were entitled to Medicare Part A.

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[3] This amount is based on the removal of 1273 days from the denominator of the SSI fraction.
[4] This amount is based on the addition of 91 days to the numerator of the Medicaid fraction.
[5] Provider Request for Expedited Review, n.5 (Nov. 30, 2022) ("EJR Request").
[6] 42 C.F.R. Part 412.
[7] 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I).
[8] (Emphasis added.)

The Secretary incorporated this statutory provision into the regulations at 42 C.F.R. § 412.106(b)(2)(i)(B) which states:

> (2) *First computation: Federal fiscal year.* For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS –
>
> (i) Determines the number of patient days that –
>
> (A) Are associated with discharges occurring during each month; and
>
> (B) Are furnished to patients who during that month were **entitled to** both Medicare Part A (including Medicare Advantage (Part C)) and **SSI**, excluding those patients who received only State supplementation;
>
> (ii) Adds the results for the whole period; and
>
> (iii) Divides the number determined under paragraph (b)(2)(ii) of this section by the total number of days that –
>
> (A) Are associated with discharges that occur during that period; and
>
> (B) Are furnished to patients entitled to Medicare Part A (including Medicare Advantage (Part C)).[9]

The dispute in these appeals involves CMS' determination of which patients are "entitled to" both Medicare Part A and SSI benefits for purposes of the Medicare fraction of the DSH calculation.

The SSI program is a federal cash assistance program for low-income individuals who are aged, blind, or disabled,[10] administered by the Social Security Administration ("SSA"). The statutory provisions governing SSI, generally, do not use the term "entitled" to SSI benefits. Rather, the SSI statutory provisions typically refer to whether an individual is "eligible for benefits."[11] In order to be "eligible" for SSI benefits, a person must be: (1) 65 years of age or older, blind or disabled; (2) a lawful resident of the United States; (3) have limited income and resources; (4) not be fleeing to avoid prosecution for a crime or violating a condition of parole; and (5) file an application for benefits.[12]

In contrast, the Medicare program is an insurance program where an individual is automatically "entitled" to Medicare Part A when the person reaches age 65 and is entitled to Social Security benefits or becomes disabled and had been entitled to disability benefits for 24 calendar months.[13]

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[9] (Bold emphasis added and italics emphasis in original.) *See also* 42 U.S.C. § 1395w2(d)(5)(F)(vi)(I).
[10] 42 U.S.C. § 1382.
[11] 42 U.S.C. §§ 1381a, 1382(a) (emphasis added).
[12] 20 C.F.R. § 416.202.
[13] 42 U.S.C. § 426.

In addition, the Medicare program provides that certain qualifying individuals with end stage renal disease are entitled to Medicare Part A.[14]

Unlike entitlement for Medicare Part A benefits, an individual who is currently eligible for SSI benefits may later become *in*eligible for SSI benefits. In this regard, SSA conducts periodic redeterminations to ensure continued eligibility[15] and may terminate,[16] suspend[17] or stop payments to individuals who are either temporarily or permanently ineligible for payment of SSI benefits.[18] In particular, SSI eligibility may be lost if a person no longer meets the basic requirements. For example, an individual may lose SSI eligibility if the individual is no longer disabled or the individual meets one of the following reasons set forth in §§ 416.207-416.216:

1. The individual fails to give the SSA permission to contact financial institutions;[19]
2. The individual fails to apply for other benefits to which the individual may be entitled;[20]
3. The individual fails to participate in drug or alcohol addiction treatment;[21]
4. The individuals is absent from the United States for more than 30 days;[22] or
5. The individual becomes a resident of a public institutions or prison.[23]

In addition, under certain circumstances, SSA may not pay benefits for administrative reasons, such as removal of a representative payee, an unknown address for the beneficiary, or because of income from a previous month.[24]

After the Medicare DSH statutory provisions were enacted in 1984, CMS (then known as the Health Care Financing Administration ("HCFA")) announced that the Secretary of Health and Human Services, rather than hospitals, would be solely responsible for computation of the Medicare fraction because the data necessary to calculate the Medicare fraction is voluminous and much of this data needed to be obtained from another agency, SSA.[25] CMS noted that, as of 1986, the data sources for the computation of the Medicare fraction included approximately 11 million billing records from the Medicare inpatient discharge file and over 5 million records from the SSI file compiled by SSA.[26] To compute the Medicare fraction, CMS had to match individual

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[14] 42 U.S.C. § 426-1.
[15] 20 C.F.R. § 416.204.
[16] 20 C.F.R. §§ 416.1331-1335.
[17] 20 C.F.R. §§ 416.1320-1330.
[18] 20 C.F.R. § 1320.
[19] 20 C.F.R. § 416.207.
[20] 20 C.F.R. § 416.210.
[21] 20 C.F.R. § 416.214.
[22] 20 C.F.R. § 416.215.
[23] 20 C.F.R. § 416.211.
[24] *See* SSA Program Operations Manual ("POMS") § SI 02301.201 (describing certain SSI post-eligibility events on the internet at https://secure.ssa.gov/apps10/poms.nsf/lnx/0502301201).
[25] 51 Fed. Reg. 31454, 31459 (Sept. 3, 1986).
[26] *Id.*

Medicare billing records to individual SSI records.[27] Considering the administrative burdens and complexity of the data matching process, CMS concluded that the Secretary would be responsible for the data matching process, which she would conduct retrospectively for every eligible Medicare hospital on a "federal fiscal year" basis—that is, based on discharges occurring in the federal fiscal year.[28] CMS notifies Medicare contractors of the SSI ratios after they are calculated. CMS currently makes this notification by posting the resulting SSI percentages on its website. Medicare contractors then use the posted SSI ratios to calculate the Medicare DSH percentage to determine each qualifying hospital's Medicare DSH payment adjustment.[29]

The Medicare DSH payment adjustment has been the subject of much litigation and, from that litigation, the following case is of particular relevance to this appeal: *Baystate v. Leavitt*, 545 F. Supp. 2d 20 *as amended* 587 F. Supp. 2d 37, 44 (D.D.C. 2008) ("*Baystate*"). In *Baystate*, the plaintiff alleged that the Secretary's process to identify and gather the data necessary to calculate each hospital's SSI ratio was deficient and the Court remanded the case to the Administrator for further action. The Board notes that this case discusses the Secretary's historical practice of basing "entitled to . . . SSI" under 42 C.F.R. § 412.106(b)(2) on actual payment of SSI cash benefits.[30]

On April 28, 2010, the Secretary (through CMS) acted on the *Baystate* remand order and published CMS Ruling CMS-1498-R ("Ruling 1498-R"). Specifically, the Ruling stated that CMS had implemented the *Baystate* remand order by recalculating the plaintiff's SSI fractions and Medicare DSH payment adjustments using a revised data matching process that used "updated and refined SSI eligibility data and Medicare records, and by matching individuals' records with reference to Social Security numbers (SSNs) as well as HICANs and Title II numbers."[31] The Ruling also stated that "in the FY 2011 proposed rule, CMS is proposing to adopt the same revised data matching process" for use with all hospitals and that "[i]n the

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[27] *Id.*
[28] *Id.* at 31459–31460; 42 C.F.R. § 412.106(b).
[29] 42 C.F.R. § 412.106(b)(5); 42 C.F.R. § 405.1803.
[30] *Baystate* began with a hearing before the Board. *See Baystate Med. Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006), *modified by*, CMS Adm'r Dec. (May 11, 2006). The Board heard extensive testimony on the Secretary's then-existing data match process. This included testimony from several SSA employees on the data tapes historically sent from SSA to CMS that included "42 monthly indicators (ones and zeros) denoting the payment or non-payment of Federal SSI cash benefits during the period covered by the SSA tape." *Id.* at 11 (citations omitted). Further, this testimony established that SSA's program would "assign a '1' to a month if the CMPH field shows one of two payment codes, C01 (current pay status) or M01 (manual or forced pay), and the FAM field reflects an amount due for the month" and that "[o]therwise, the program assigns a '0' to that month." *Id.* The provider in *Baystate* contested among other things: (1) "the omission of SSI records relating to individuals who received a forced payment from an SSA filed office; (2) "the omission of SSI days associated with individuals whose SSI benefits were temporarily on hold or in suspense when SSA ran each year's SSI tape;" (3) "the omission of SSI days associated with individuals whose benefits were restored or retroactively after SSA ran each year's tape;" and (4) "the omission of individuals who were entitled to non-cash Federal SSI benefits." *Id.* at 23. The Board's discussion of these contentions confirms SSI days were counted when there was actual SSI cash benefits. *See id*. at 26-30. The CMS Administrator's decision and the ensuing decision of the D.C. District Court also contain references to the Secretary's policy. *See, e.g.,* Adm'r Dec. at 5, 16, 39, 41, 48-49; 545 F. Supp. 2d at 28-29 n.13 & n.17, 36-39.
[31] CMS-1498-R at 5.

forthcoming FY 2011 IPPS final rule, CMS expects to respond to public comments filed on the proposed new data matching process, make any changes to such matching process that seem appropriate, and adopt finally a new data matching process."[32] Finally, CMS stated that it would "use that new data matching process in calculating SSI fractions and DSH payments for specific claims that are found to qualify for relief under this Ruling."[33]

Consistent with Ruling 1498-R, the Secretary published the new data matching process in the FY 2011 IPPS proposed rule published on May 4, 2010.[34] The proposed rule includes references to the Secretary's historical practice of basing "entitled to . . . SSI" under 42 C.F.R. § 412.106(b)(2) on actual payment of SSI cash benefits.[35]

The Secretary finalized that data matching process in the FY 2011 IPPS final rule published on August 16, 2010 ("FY 2011 IPPS Final Rule").[36] Significantly, in the preamble to the FY 2011 IPPS Final Rule, CMS acknowledged a public comment that: (1) requested that "CMS include both paid and unpaid days for both SSI entitlement and Medicare entitlement such that there would be consistency between the numerator and denominator of the SSI fraction"; and (2) provided examples of "several SSI codes that represent individuals who were eligible for SSI but not eligible for SSI payments, that should be included as SSI-entitled for purposes of the data match process."[37] CMS responded in detail to this comment and explained that CMS interprets SSI entitlement to correspond with any month for which an individual *receives* payment of SSI benefits. In this regard, CMS stated that the three SSI codes denoted as C01, M01, and M02 "accurately captures all SSI-entitled individuals during the month(s) they are entitled to receive SSI benefits."[38] CMS explicitly rejected the inclusion of other SSA codes because "SSI entitlement can change from time to time" and none of these codes "would be used to describe an individual who was entitled to receive SSI benefits during the month that one of these codes was used."[39] Finally, in the preamble, CMS confirms that "[t]he same data matching process [used for FY 2011 and beyond] will be used to calculate SSI fractions for cost reporting periods covered under the Ruling [1498-R]."[40]

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[32] *Id.*
[33] *Id.* at 5-6.
[34] 85 Fed. Reg. 23852, 24002-24007 (May 4, 2010).
[35] *See, e.g.,* 75 Fed. Reg. at 24003 (discussing SSI cash payment issues discussed in the *Baystate* decision), 24003-24004 (discussing the proposed matching process where "[t]he SSI eligibility file serves as the system of record for whether or not SSA made a payment of SSI benefits to an individual who applied for SSI"), 24004-06 (discussing the time of the matching process including how "it is important to find an appropriate balance between administrative finality (that is, the final settlement of a hospital's cost report) and the inclusion of retroactive SSI eligibility determinations and the lifting of SSI payment suspensions by using the best and latest available SSI eligibility data at the time of cost report settlement benefits").
[36] 75 Fed. Reg. 50041, 50280-50281. (Aug. 16, 2010).
[37] *Id.* at 50280.
[38] *Id.* at 50280-50281.
[39] *Id.* This include all codes with the "S" prefix indicating a suspension of payment; codes beginning with "N" for nonpayment; code "E01" indicating that the individual had countable income which eliminated the SSI payment; and code "E02" indicating that the patient was not entitled to SSI benefits during that month but became entitled during a subsequent month.
[40] *Id.* at 50285.

While the new data matching process established in the preamble to the FY 2011 IPPS Final Rule was effective October 1, 2010 (*i.e.*, for FY 2011 and forward), Ruling 1498-R directed that the Medicare contractors apply "the same, unitary relief" consisting of SSI fractions that the Secretary had calculated using the new "suitably revised" data matching process to: (1) any Medicare cost report that had not been settled; and (2) all properly pending Medicare DSH appeals of the SSI fraction data matching process issue.[41] The Ruling noted that hospitals dissatisfied with the initial or revised NPR issued using the new SSI ratios in the Medicare DSH adjustment calculation could seek administrative and judicial review provided they met the jurisdictional and procedural requirements of 42 U.S.C. § 1395oo, the Medicare regulations, and other agency rules and guidelines.[42] In the FY 2011 IPPS Final Rule, the Secretary explicitly recognized that "[t]he data matching process provisions of the Ruling would apply to . . . open cost reports for cost reporting periods beginning prior to October 1, 2010 (that is those preceding the effective date of the FY 2011 IPPS final rule)."[43]

Finally, on April 22, 2015, CMS published Ruling 1498-R2 modifying and amending Ruling 1498-R by allowing hospitals to elect whether to use new Medicare SSI fractions calculated on the basis of "total days" or "covered days" for cost reports involving patient discharges *prior* to October 1, 2004.[44]

However, neither Ruling 1498-R nor Ruling 1498-R2 are applicable to this appeal since the NPR at issue was issued after Ruling 1498-R and since the fiscal year at issue is not covered by Ruling 1498-R2. As a result of the new regulation and new data match process, CMS calculated SSI percentages for the Provider for the fiscal year at issue.[45] The Provider is challenging the adoption of the policy stated therein that only SSI paid days as represented by SSI codes S01, M01 and M02 are included in the numerator of the SSI fraction for purposes of representing days "entitled to [SSI] benefits."

B. FY 2005 IPPS Final Rule

The FY 2005 IPPS Final Rule announced policy changes relative to the treatment of dual eligible days and Medicare Part C days in the SSI fraction.[46] However, it did not address or announce any policy statements or changes relative to what the phrase "entitled to [SSI] benefits" as used in 42 U.S.C. § 1395ww(d)(F)(vi)(I) means.

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[41] CMS-1498-R at 6-7, 31.
[42] *Id.* at 28, 31.
[43] 75 Fed. Reg. at 24006.
[44] CMS-1498-R2 at 2, 6.
[45] CMS published the SSI ratios for FY 2010 on or about October 17, 2012. SSI ratios are published and can be accessed at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.
[46] 69 Fed. Reg. 48916, 49090-99 (Aug. 11, 2004).

Providers' Position

A. SSI Matching Issue

In its Final Position Paper, the Provider states that it received a data file from CMS and compared the SSI days in that file to data from Kentucky's State Medicaid program. This comparison showed 129 days that were not included in CMS' data file and, thus, were improperly excluded from the numerator of the Medicare fraction. It notes that Kentucky Medicaid assigns a specific code type for all Medicaid eligible patients, but that none of these days were included in the Medicare Fraction. The Provider claims "CMS simply did not use the best available data" and that the Medicare Contractor should adjust its data accordingly.[47]

In its EJR Request, the Provider has also claimed that the SSI Matching issue is inextricably intertwined with the dual eligible days issue the data match patient days are a subset of the total dual eligible patient days improperly excluded from the Medicare fraction.[48] Indeed, the Provider claims for these days it can demonstrate that certain beneficiaries were "entitled to SSI benefits" in that they *actually received* cash payments during the month of their hospital stay but were nevertheless excluded from the Medicare fraction numerator.

The Provider acknowledges that, pursuant to 42 C.F.R. § 405.1867, the Board is bound to comply with CMS Rulings 1498-R and 1498-R2, but claims that "the Rulings do not provide for a mechanism to address the challenge being made by the Provider regarding the proper interpretation of the phrase "entitled to [SSI] benefits" and, thus, EJR is appropriate.[49]

The Medicare Contractor argues that the NPR at issue in this case was issued four years after CMS Ruling 1498-R was issued and that the cost report was settled with a Medicare Fraction that incorporated the revised data matching process.[50] The Provider has not disputed this at any point, but appears to argue that certain Kentucky-specific SSI codes prove SSI entitlement, but that these are not one of the three SSI codes used by CMS in its revised data matching process (*i.e.,* SSI codes C01, M01, and M02).[51]

B. Dual Eligible Days Issue

In its EJR Request, the Provider acknowledges that, following the Supreme Court's decision in *Empire*, dual eligible days should be excluded from the Medicaid numerator.[52] It argues, however, that there is now an inconsistency between the interpretation of "entitled to benefits under Part A" (which encompasses any patient who satisfies the statutory eligibility criteria whether or not

[47] Provider's Final Position Paper at 16.
[48] EJR Request at n.3.
[49] *Id.* at 4-5.
[50] Medicare Administrative Contractor's Final Position Paper at 22 (Jan. 7, 2022).
[51] Provider's Final Position Paper at 16.
[52] EJR Request at 2.

Medicare actually pays), and "entitled to SSI" (which encompasses only patient days where SSI cash payments were actually received).[53] This discrepancy excludes a large number of days from the Medicare fraction numerator.[54] In this regard, the Provider is located in Kentucky where a dual eligible patient is entitled to SSI benefits by definition and argues that not only should all Kentucky dual eligible patient days be included in the Medicare numerator (Issue 1) but also all situations where a patient was "eligible" for SSI benefits (remaining aspect of Issue 5).[55] The Provider acknowledges that, if they are successfully in expanding the interpretation of the phrase "entitled to [SSI] benefits" to include SSI eligibility, then Issue 1 becomes moot (*i.e.*, the contention not all SSI paid days were counted/identified as established through the Kentucky Medicaid eligibility data).[56] In seeking to expand this interpretation, the Provider is challenging the Secretary's policy stated in the FY 2011 IPPS Final Rule that "entitled to [SSI] benefits" must be interpreted to include only SSI paid days as represented by SSI codes C01, M01, and M02.[57]

As previously noted, in its EJR Request, the Provider noted it is withdrawing the Medicaid Fraction dual eligible issue (Issue 4 and the related aspect of Issue 5) in light of the Supreme Court's decision in *Empire*.[58] As such, the only aspect of Issue 5 remaining in this appeal is the determination of SSI entitled days as used in the numerator of the Medicare fraction.

Decision of the Board

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

A. Preliminary Rulings on the Scope of the EJR Request

The Provider has suggested that it is challenging the FY 2005 IPPS Final Rule based on the following finding it included at the end of its EJR request:

> [The Board] is without the authority to decide the legal question of whether 42 C.F.R. § 412.106 codifying the CMS policies adopted in the FY 2005 IPPS Final Rule and the FY 2011 Final Rule are valid.

However, the EJR request only mentions the FY 2005 IPPS Final Rule in one other place as follows:

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[53] *Id.*
[54] *Id.*
[55] *Id.* at 2-4.
[56] *Id*. at 4.
[57] *Id.* at 15, 19.
[58] *Id.* at n.5.

> In the 2005 Rule construing the Medicare fraction, CMS interpreted the phrase "entitled to benefits under Part A" to encompass any patient who satisfied Part A statutory *eligibility* criteria whether or not Medicare actually pays for the care.

The Provider has recognized that the Supreme Court upheld this policy:

> In *Becerra v. Empire Health Foundation For Valley Hospital Medical Center*, 142 S.Ct. 2354, 2368 (June 24, 2022), the Supreme Court upheld the Secretary's interpretation of the phrase "entitled to benefits" in the numerator of the Medicare fraction to include those individuals qualifying for Medicare regardless of whether that program actually paid for their day of care. The Supreme Court found that the Secretary's reading of "entitled to benefits" comported with the statute's two-population structure because "[a]ll low-income people fit naturally into one or the other box, with the sum of the two leaving no one out." *Id.* at 2367. Accordingly, the Provider acknowledges the dual eligible days should be excluded from the Medicaid numerator.[59]

The Provider then confirmed in a footnote at the end of this excerpt confirming that "[t]he Provider will be dismissing [*sic* withdrawing] the Medicaid dual eligible issue in this case."

Moreover, the Board notes that the FY 2005 IPPS Final Rule does not include any statement regarding the Secretary's interpretation of the phrase "entitled to [SSI] benefits" as used in 42 U.S.C. § 1395ww(d)(F)(vi)(I). Nor does the Provider claim it does.

Accordingly, the Board finds that the EJR request has ***not*** laid a sufficient foundation for a challenge to the FY 2005 IPPS Final Rule. In so ruling, it does not mean that it does not have relevance to what is being challenged, namely the FY 2011 IPPS Final Rule as set forth below. However, it is not what is actually being challenged. In this regard, the Provider is maintaining that the term "entitled" should be consistently interpreted across 42 U.S.C. § 1395 and that "entitled to [SSI] benefits" should be broadly interpreted consistent with how the Secretary interpreted "entitled to benefits under [Medicare] Part A" as used in 42 U.S.C. 1395ww(d)(F)(vi)(I) and explained in the FY 2005 IPPS Final Rule and upheld by the Supreme Court in *Empire*, as noted above.

With regard to Issue 1 relating to the SSI data matching process, the Provider has suggested that EJR is appropriate for that issue based on its assertion that it is inextricably intertwined with the challenge in Issues 4 and 5 to the Secretary's interpretation of "entitled to [SSI] benefits." Specifically, it has stated in footnote 3 of the EJR request that "the data match issue is inextricably intertwined with the Medicare dual eligible issue because it is also impacted by the interpretation of the phrase 'entitled to [SSI] benefits.'" The Provider further explains that:

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[59] EJR request at 2 (footnotes omitted).

> In this case, the data match issue is intertwined with the Medicare dual eligible issue because the data match patient days are a subset of the total dual eligible patient days improperly excluded from the Medicare fraction. Although the Provider contends that CMS improperly excluded all dual eligible patients days by misinterpreting the phrase "entitled to [SSI] benefits," the data match issue relates to patients days for which the Provider can demonstrate that the beneficiary was "entitled to SSI benefits" even using CMS' restrictive interpretation. CMS uses three SSI codes to determine which patient days it will include in the Medicare numerator. These codes reflect beneficiaries who actually *received SSI cash payments* during the month of their hospital stay. The data match amount in controversy was calculated by comparing Medicaid data with CMS' Med Par data in order to identify those patients with associated Medicaid codes indicating that the patients received SSI payments while hospitalized. These patient days were not included by CMS in the Medicare numerator. Thus, even using CMS' constricted definition, there are additional days to include in the Medicare fraction numerator. However, this amount is encompassed by the overall Medicare dual eligible SSI issue. So, if a court determines that "entitled to benefits" has the same meaning with respect to SSI benefits as Part A benefits, then the data match issue will be moot.[60]

In footnote 7 of the EJR request appended to the end of the above excerpt, the Provider makes the following statement regarding the intertwinement:

> If the Board determines that the data match issue is not inextricably intertwined with the Medicare dual eligible entitled to SSI benefits or is otherwise not inclined to grant EJR on that issue, then the Provider requests that the data match issue be held in abeyance pending a court's resolution of the Medicare DE "entitled to [SSI]" dispute.

The Board disagrees with the Provider's characterization of the SSI Data Match issue. The Board finds that the fact that the SSI Data Match issue may be impacted by the outcome of the Provider's challenge to the Secretary's interpretation of the phrase "entitled to [SSI] benefits" (and rendered moot if the "entitled" interpretation issue is decided favorably for the Provider) does ***not*** mean that EJR of the Data Match Issue is appropriate. In this regard, the Board notes that it has already had a case with the same issue, namely *Pomona Valley Hospital Medical Center v. Noridian Healthcare Solutions*, PRRB Dec. No. 2018-D50 (Aug. 17, 2017). In that case, the Provider maintained that certain California Medicaid records documenting the assignment of certain "aid codes" by the Social Security Administration could be relied upon to confirm whether a patient

[60] (Footnote omitted.)

was "entitled to [SSI] benefits" and that these records confirmed that the SSI percentage published by CMS for the provider for the fiscal year at issue was understated. The Board ultimately found that the provider "did not submit sufficient quantifiable data in the record to prove that the SSI percentages calculated by CMS, and used in [the provider]'s FYE 12/31/2006, 12/31/2007, and 12/31/2008 cost reports, were flawed" and, accordingly, affirmed the SSI percentages used by the Medicare Contractor.

The Provider has not stated any specific challenge to the FY 2011 IPPS Final Rule as it relates to Issue 1 (*e.g.*, that the Secretary's adoption of C01, M01, and M02 to capture SSI paid days for ***all*** hospital across the U.S. is improper because that adoption was procedurally invalid and/or substantively invalid). As such, the EJR request as it relates to Issue 1 is fatally flawed.

Rather, similar to the *Pomona Valley* case,[61] there appears to be a factual issue in dispute here that the Board needs to resolve regarding the Provider's assertions about Kentucky Medicaid documentation, namely that "in Kentucky the fact that a [dual eligible] patient was eligible for Medicaid when receiving hospital services is evidence that, for such days, the patient was entitled to SSI benefits" and that "[a]ccordingly, patient days excluded from the Medicaid numerator due to a [dual eligible] patient's Part A Medicare status should then be automatically included in the Medicare numerator."[62] As such, it appears to be a variation on *Baystate* where the Provider is asserting that the process used by CMS is flawed because it can establish that the process used to capture SSI paid days is flawed and results in understated SSI fractions. To highlight the factual dispute the Board points to the Medicare Contractor's position paper which recognizes that "[t]he Provider focuses on patient days that were excluded because these days have been matched with SSA codes by using the Kentucky Medicaid" but asserts that "the Provider has not demonstrated that the patients **were eligible for SSI benefits on the days for which care was provided**."[63] Accordingly, the Board denies the EJR request as it relates to Issue 1 because there is a factual dispute to resolve and the Provider has not set forth, with sufficient detail, any challenge to a regulation or CMS Ruling for Issue 1.

B. Appeals of Cost Report Periods Beginning Prior to January 1, 2016

1. Statutory and Regulatory Background

The Provider appealed a cost reporting period beginning prior to January 1, 2016. For purposes of Board jurisdiction over a provider's appeal for cost report periods ending on or after December 31, 2008, the provider may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming it as a "self-disallowed cost," pursuant to the

[61] In pointing similarities to *Pomona Valley*, the Board is not suggesting the outcome of this case, particularly since this case involves a *different* state Medicaid program with presumably different record systems for Medicaid eligibility) but merely that there is a factual dispute here. Similarly, given the decision issued on appeal, there is also a dispute about who has the burden of proof. *See Pomona Valley Hosp. Med. Ctr. v. Azar*, Civ. No. 18-2763, 2020 WL 5816486 (D.D.C. 2020), *appeal filed*, Case No. 20-5350 (D.C. Cir. Nov. 30, 2020).
[62] EJR Request at 14.
[63] Medicare Contractor Final Position Paper at 11 (Jan. 7, 2022).

Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen* ("*Bethesda*").[64] In that case, the Supreme Court concluded that a cost report submitted in full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.[65]

On August 21, 2008, new regulations governing the Board were effective.[66] Among the new regulations implemented in the Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hospital v. Burwell* ("*Banner*").[67] In *Banner*, the provider filed its cost report in accordance with the applicable outlier regulations and did not protest the additional outlier payment it was seeking. The provider's request for EJR was denied because the Board found that it lacked jurisdiction over the issue. The District Court concluded that, under *Bethesda,* the 2008 self-disallowance regulation could not be applied to appeals raising a legal challenge to a regulation or other policy that the Medicare Contractor could not address.[68]

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

2. Jurisdiction

The Board has determined that the Issue 5 as it relates to the meaning of "entitled to [SSI] benefits" is governed by CMS Ruling CMS-1727-R since the Provider is challenging the Secretary's interpretation of this phrase as set forth in the FY 2011 IPPS Final Rule and that Board review of this issue is not otherwise precluded by statute or regulation. In addition, the Provider's documentation shows that the estimated amount in controversy exceeds $10,000, as required for an

[64] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self- disallowed the item.).
[65] *Bethesda*, 108 S. Ct. at 1258-59.
[66] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[67] 201 F. Supp. 3d 131 (D.D.C. 2016).
[68] *Id.* at 142.

individual appeal.[69] The appeal was timely filed and no jurisdictional impediments have been identified for the Provider as it relates to the remaining aspect of Issue 5. Based on the above, the Board finds that it has jurisdiction for the above-captioned individual appeal as it relates to the remaining aspect of Issue 5.

C. Board's Analysis of the Appealed Issue

As noted above, the Secretary revised the SSI data match process in light of the *Baystate* decision through notice and comment in the form of an uncodified regulation. First, the Secretary issued CMS Ruling 1498-R on April 28, 2010, authorizing remands of pending appeals of the SSI data match issue to recalculate the SSI fraction based on a revised data match.[70] The Secretary also stated in the ruling that, where cost reports had not been settled, those providers' SSI fractions would be calculated using the revised data match.[71] Contemporaneous with CMS' issuance of Ruling 1498-R,[72] the Secretary published the FY 2011 IPPS Proposed Rule[73] which, in pertinent part, proposed to adopt the same data match for 2011 and forward. This proposed rule was adopted as the FY 2011 Final IPPS Rule in which the Secretary explained that:

> [W]e used a revised data matching process . . . that comports with the court's decision [in *Baystate* to recalculate the hospitals' SSI fractions]. As the revised data matching process was completed using SSI eligibility data compiled between 13 and 16 years beyond the fiscal years at issue in the *Baystate* case, we believe any issues associated with retroactive determinations of SSI eligibility and the lifting of payment suspensions had been long since resolved. Furthermore, because we believe that the revised match process used to implement the *Baystate* decision addressed all of the concerns found by the court, in the FY 2011 IPPS/LTCH PPS proposed rule we proposed to use the same revised data matching process for calculating hospitals' SSI fractions for FY 2011 and subsequent fiscal years.[74]

Then she announced that:

> We have adopted the proposed data matching process for FY 2011 and beyond as final. The only modification we are making to the proposed matching process is adopting a policy to exclude a record from the data matching process if we find a HICAN in the MedPAR file that we are not able to locate in the EDB[75]which is an extremely unlikely situation as noted in the prior discussion in

[69] *See* 42 C.F.R. § 405.1835(a)(2).
[70] CMS Ruling 1498-R at 27.
[71] *Id.* at 31.
[72] *Id.* at 5.
[73] 75 Fed. Reg. 23,852, 24,002-07.
[74] 75 Fed. Reg. at 50,277.
[75] (Medicare) Enrollment Database.

> this final rule. We are adopting this additional step in our validation process to respond to public comment and provide even more assurances that our data matching process will yield accurate SSI fractions and capture all Medicare beneficiaries who were entitled to SSI at the time of their inpatient hospital stay. The same data matching process will be used to calculate SSI fractions for cost reporting periods covered under the ruling.[76]

As part of the adopted data match process, CMS explicitly finalized a policy that SSI codes C01, M01, and M02 would capture all SSI entitled days:

> *Comment*: **One commenter stated that CMS** uses total (that is, "paid and unpaid") Medicare days in the denominator of the SSI fraction, but **uses paid SSI days in the numerator of the SSI fraction**. The commenter requested that CMS interpret the word "entitled" to mean "paid" for both SSI-entitled days used for the numerator and Medicare-entitled days used in the denominator, or alternatively, that CMS include both paid and unpaid days for both SSI entitlement and Medicare entitlement such that there is consistency between the numerator and the denominator of the SSI fraction. **The commenter stated that there were several SSI codes that represent individuals who were eligible for SSI, but not eligible for SSI payments, that should be included as SSI-entitled for purposes of the data matching process**. Specifically, the commenter stated that at least the following codes should be considered to be SSI-entitlement:
>
> • E01 and E02
> • N06, N10, N11, N18, N35, N39, N42, N43, N46, N50, and N54
> • P01
> • S04, S05, S06, S07, S08, S09, S10, S20, S21, S90, and S91
> • T01, T20, T22, and T31
>
> *Response*: In response to the comment that we are incorrectly applying a different standard in interpreting the word "entitled" with respect to SSI entitlement versus Medicare entitlement, we disagree. The authorizing DSH statute at section 1886(d)(5)(F)(vi)(I) of the Act limits the numerator to individuals entitled to Medicare benefits who are also "*entitled* to supplemental security income benefits (excluding any State supplementation)" (emphasis added).[77] **Consistent with**

[76] 75 Fed. Reg. at 50,285.
[77] As a side note, we have used the phrase ''SSI-eligible'' interchangeably with the term ''SSI-entitled'' in the FY 2011 proposed rule as well as prior proposed and final rules, but the statute requires that we include individuals who

this requirement, we have requested, and are using in the data matching process, those SSA codes that reflect "entitlement to" receive SSI benefits. Section 1602 of the Act provides that "[e]very aged, blind, or disabled individual who is determined under Part A to be eligible on the basis of his income and resources shall, in accordance with and subject to the provisions of this title, be *paid* benefits by the Commissioner of the Social Security" (emphasis added). However, eligibility for SSI benefits does not automatically mean that an individual will receive SSI benefits for a particular month. For example, section 1611(c)(7) of the Act provides that an application for SSI benefits becomes effective on the later of either the month following the filing of an application for SSI benefits or the month following eligibility for SSI benefits.

On the other hand, section 226 of the Act provides that an individual is automatically "entitled" to Medicare Part A when the person reaches age 65 and is entitled to Social Security benefits under section 202 of the Act (42 U.S.C. 402) or becomes disabled and has been entitled to disability benefits under section 223 of the Act (42 U.S.C. 423) for 24 calendar months. Section 226A of the Act provides that qualifying individuals with end-stage renal disease shall be entitled to Medicare Part A. In addition, section 1818(a)(4) of the Act provides that, "unless otherwise provided, any reference to an individual entitled to benefits under [Part A] includes an individual entitled to benefits under [Part A] pursuant to enrollment under [section 1818] or section 1818A." We believe that Congress used the phrase "entitled to benefits under part A" in section 1886(d)(5)(F)(vi) of the Act to refer individuals who meet the criteria for entitlement under these sections.

Moreover, unlike the SSI program (in which entitlement to receive SSI benefits is based on income and resources and, therefore, can vary from time to time), once a person becomes entitled to Medicare Part A, the individual does not lose such entitlement simply because there was no Medicare Part A coverage of a specific inpatient stay. Entitlement to Medicare Part A reflects an individual's entitlement to Medicare Part A benefits, not the hospital's entitlement or right to receive payment for services provided to such individual. Such Medicare entitlement does not cease to exist simply because Medicare payment for an individual inpatient hospital claim is not made. Again, we are bound by section 1886(d)(5)(F)(vi)(I) of the

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were entitled to SSI benefits in the SSI fractions. Although we have used these terms interchangeably, we intended no different meaning, and our policy has always been to include only Medicare beneficiaries who are entitled to receive SSI benefits in the numerator of the SSI fraction.

Act, which defines the SSI fraction numerator as the number of SSI-entitled inpatient days for persons who were "entitled to benefits under [P]art A," and the denominator as the total number of inpatient days for individuals who were "entitled" to Medicare Part A benefits.

In response to the comment about specific SSI status codes, SSA has provided information regarding all of the SSI status codes mentioned by the commenter to assist in the determination of whether <u>any</u> of these codes represent individuals who were entitled to SSI benefits for the purposes of calculating the SSI fraction for Medicare DSH. With respect to the codes that begin with the letter "T," SSA informed us that all of the codes represent individuals whose SSI entitlement was terminated. Code "T01" represents records that were terminated because of the death of the individual, but we confirmed that this code would not be used until the first full month after the death of the individual. That is, for example, if a Medicare individual was entitled to SSI during the month of October, was admitted to the hospital on October 1 and died in the hospital on October 15, the individual would show up as entitled to SSI for the entire month of October on the SSI file (code T01 would not be used on the SSI file until November) and 15 Medicare/SSI inpatient hospital days for that individual would be counted in the numerator and the denominator of the SSI fraction for that hospital.

Codes beginning with the letter "S" reflect records that are in a "suspended" status and, according to SSA, do not represent individuals who are entitled to SSI benefits.

SSA maintains that code "P01" is obsolete and has not been used since the mid-1980s. Therefore, it would not be used on any SSI files reflecting SSI entitlement for FY 2011 and beyond.

Codes that begin with the letter "N" represent records on "nonpayment" and are not used for individuals who are entitled to SSI benefits.

Code "E01" represents an individual who is a resident of a medical treatment facility and is subject to a $30 payment limit, but has countable income of $30 or more. Such an individual is not entitled to receive SSI payment. Alternatively, an individual who is a resident of a medical treatment facility and is subject to a $30 payment limit, but does not have countable income of at least $30, would be reflected on the SSI file as a "C01" (which denotes SSI entitlement) for any month in which the requirements described in this sentence are met. Code "E02" is used to identify a person who is not entitled to SSI payments

> in the month in which that code is used pursuant to section 1611(c)(7) of the Act, which provides that an application for SSI benefits shall be effective on the later of (1) the first day of the month following the date the application is filed, or (2) the first day of the month following the date the individual becomes eligible for SSI based on that application. Such an individual is not entitled to SSI benefits during the month that his or her application is filed or is determined to be eligible for SSI, but, for the following month, would be coded as a "C01" because he or she would then be entitled to SSI benefits.
>
> Therefore, both codes E01 and E02 represent individuals who are not entitled to SSI benefits and are reflected accordingly on the SSI file. If the individual's entitlement to SSI benefits is initiated the ensuing month, that individual would then be coded as a "C01" on the SSI file and would be included as SSI-entitled for purposes of the data matching process.
>
> As we have described above, **none of the SSI status codes that the commenter mentioned would be used to describe an individual who was entitled to receive SSI benefits during the month that one of those status codes was used**. SSI entitlement can change from time to time, and **we believe that including SSI codes of C01, M01, and M02 accurately captures all SSI-entitled individuals during the month(s) that they are entitled to receive SSI benefits**.
>
> After consideration of the public comments we received, we are adopting the proposed data matching process for FY 2011 and beyond as final. The only modification we are making to the proposed data matching process is adopting a policy to exclude a record from the data matching process if we find a HICAN in the MedPAR file that we are not able to locate in the EDB, which is an extremely unlikely situation as noted in the prior discussion in this final rule. We are adopting this additional step in our validation process in response to public comments to provide even more assurances that **our data matching process will** yield accurate SSI fractions and **capture all Medicare beneficiaries who were <u>entitled</u> to SSI at the time of their inpatient hospital stay**.[78]

The Secretary did not incorporate, into the Code of Federal Regulations, the above new policy involving the revised data match process (including but not limited to portion of that policy relating to the use of SSI code C01, M01, and M02 to capture SSI entitled days). However, it is clear from the language in the final IPPS rule, as set forth above, that the Secretary intended to

[78] 75 Fed. Reg. at 50280-81 (footnote in original; bold and underline emphasis added).

bind the regulated parties and establish a *binding* data match process to be used by the Medicare Contractors in calculating (or recalculating) providers' SSI fractions.

Accordingly, the Board finds that the Secretary intended this policy change for the data match process to be a binding but uncodified regulation and will refer to the portion of that policy as it relates to the adoption of the SSI codes C01, M01, and M02 to capture SSI entitled days as the "Uncodified SSI Entitled Days Regulation." Indeed, this finding is consistent with the Secretary's obligations under 42 U.S.C. § 1395hh(a)(2) to promulgate any "substantive legal standard governing . . . the payment of services" as a regulation."[79]

Pursuant to 42 C.F.R. § 405.1867, the Board is bound to apply the statutory and regulatory provisions governing the Medicare program. Consequently, the Board finds that it is bound by the Uncodified SSI Entitled Days Regulation published in the FY 2011 Final Rule and the Board does not have the authority to grant the relief sought by the Provider, namely invalidating the Uncodified SSI Entitled Days Regulation which they allege fails to include all of the SSI codes used by SSA to determine SSI eligibility. As a result, the Board finds that EJR is appropriate for the issue for the calendar year under appeal in this case.

D. Board's Decision Regarding the EJR Request

The Board finds that:

1) It denies the portion of the EJR request relating to Issue 1 because there are findings of fact for resolution by the Board and the EJR request fails to lay out a specific challenge to a regulation or CMS Rule for Issue 1;

2) It dismisses both Issue 4 and that aspect of Issue 5 which relate to the exclusion of no-pay Part A days in the SSI fraction and the inclusion of the subset of those days relating to dual eligible beneficiaries in the Medicaid fraction because the Provider has notified the Board it is withdrawing that issue based on the Supreme Court's decision in *Empire*;

3) It has jurisdiction over the remaining aspect of Issue 5 for the subject year and that the Provider is entitled to a hearing before the Board;

4) Based upon the Provider's assertions regarding 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule), there are no findings of fact for resolution by the Board for the remaining aspect of Issue 5;

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

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[79] 42 U.S.C. § 1395hh(a)(2) states "[n]o rule, requirement, or other statement of policy . . . that establishes or changes a substantive legal standard governing . . . the payment of services . . . shall take effect unless it is promulgated by the Secretary by regulation . . . ."

6) It is without authority to decide the legal question of whether the Uncodified SSI Entitled Days Regulation as adopted in the preamble to the FY 2011 Final IPPS Rule is valid.

Accordingly, the Board denies the EJR request as it relates to Issue 1, dismisses both Issue 4 and that aspect of Issue 5 which relate to the *Empire* decision, and finds that the question of the validity of the Uncodified SSI Entitled Days Regulation (the remaining aspect of Issue 5) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Provider's request for EJR for that remaining aspect of Issue 5. The Provider has 60 days from the receipt of this decision to institute the appropriate action for judicial review. The case remains open as there is an issue remaining in this case.

Board Members Participating:

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

FOR THE BOARD:

12/29/2022

X Clayton J. Nix

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

cc: Judith Cummings, CGS Administrators (J-15)
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Stephen Price, Sr.
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RE: ***EJR Determination***
King's Daughters' Medical Center (Prov. No 18-0009)
FYE 9/30/2012
Case No. 15-2594

Dear Mr. Price:

The Provider Reimbursement Review Board ("Board") has reviewed King's Daughters' Medical Center's ("Provider's") November 30, 2022 request for expedited judicial review ("EJR") in the above-referenced individual appeal. The decision of the Board is set forth below.

Issues in Dispute

This appeal was filed on May 8, 2015. In its appeal request, the Provider states its SSI Matching Issue as follows:

> **ISSUE 1:** Whether the Fiscal Intermediary's calculation of the Provider's disproportionate patient percent, used for purposes of calculating the Medicare Disproportionate Share ("DSH") Adjustment, was incorrect due to CMS' inaccurate and improper matching technique used to determine both the number of Medicare Part A SSI days in the numerator and the total number of Medicare Part A patient days in the denominator of the Medicare fraction.

The Provider estimated the amount in controversy to be $159,000 based on the addition of 129 days to the numerator of the SSI fraction.

In its appeal request, the Provider states its dual eligible days issue as follows:

> **ISSUE 3:** Whether the Fiscal Intermediary's calculation of the Provider's disproportionate patient percent, used for purposes of calculating the Medicare Disproportionate Share ("DSH") Adjustment, was incorrect due to CMS' improper treatment of the Medicare Non-Covered Days, which includes but is not limited to Dual Eligible, Medicare Exhausted and Medicare Secondary Payor

> days. The improper treatment of these days affects both the numerator and the denominator of the Medicare fraction and the Numerator of the Medicaid fraction.[1]
>
> ****
>
> According to the interpretation of 42 C.F.R. § 412.106(b), the regulation currently interprets the statutory language "entitled to benefits under [Medicare] Part A" as requiring the inclusion of patient days for all Medicare beneficiaries, even if a beneficiary has exhausted his or her Medicare coverage. This interpretation requires the exclusion from the Medicaid fraction of patient days for those individuals who are "eligible" for both Medicare and Medicaid, but who have exhausted their Medicare benefits. The district court in *Metropolitan Hospital* determined that the interpretation at section 412.106(b) was invalid as contrary to the plain meaning of the DPP statute, reasoning that "entitled" requires payment for hospital services, rather than mere eligibility. (*Metro. Hosp., Inc. v. US. Dep 't of Health & Human Servs*.,702 F. Supp. 2d 808, 825-26 (W.D. Mich. 2010). Thus, dual-eligible patients with exhausted Medicare benefits would be included in the numerator of the Medicaid fraction.
>
> ****
>
> If Medicare interprets "entitled" to Medicare as "eligible" for Medicare, and thus their basis for including these days in the Medicare fraction, then they also must interpret "entitled" to SSI as "eligible" for SSI and allow Dual Eligible days that are "eligible" for SSI, which includes days where the patient may only be receiving their SSI medical benefit/Medicaid, to be included in the Medicare numerator.

For Issue 3, the Provider performed two different estimated amount-in-controversy calculations. One pertains to its assertion that no-pay dual eligible days should be removed from the SSI fraction and moved to the numerator of the Medicaid fraction, and the amount in controversy was estimated to be $11,991,703 ($11,965,468 for SSI fraction[2] and $26,235 for Medicaid fraction[3]). The second one pertains to the alternative argument that the definition of "entitled to SSI benefits" as used in the numerator of the SSI fraction should be expanded to include days where a patient is eligible for SSI benefits, the amount in controversy was estimated to be 11,808,648 (based on the addition of 9644 days to the numerator of the SSI fraction).

[1] Individual Appeal Request, 2 (May 7, 2015).
[2] This amount is based on the removal of 1068 days from the denominator of the SSI fraction.
[3] This amount is based on the addition of 32 days to the numerator of the Medicaid fraction.

In its request for Expedited Judicial Review, the Provider noted it will be withdrawing the portion of Issue 3 that relates to the exclusion of no-pay Part A days in the SSI fraction and the inclusion of the subset of those days relating to dual eligible beneficiaries in the Medicaid fraction because, based on the Supreme Court's decision in *Becerra v. Empire Health Foundation For Valley Hospital Medical Center*, 142 S. Ct. 2354, 2368 (June 24, 2022) ("*Empire*"), "the Provider acknowledges the dual eligible days should be excluded from the Medicaid numerator."[4] As such, the only remaining aspect of the dual eligible days issue (Issue 3) is the treatment of dual eligible days in the numerator of the Medicaid fraction where the Provider is stating that "entitled to SSI benefits" must be interpreted to include not just SSI paid days (as represented by SSI codes C01, M01, and M02) but also to include SSI eligible days.

Statutory and Regulatory Background:

A. The Secretary's policy on what the phrase "entitled to supplemental security income benefits" in 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I) means for purposes of the numerator of the SSI fraction used in the DSH adjustment calculation

The Medicare program pays inpatient hospital services based on predetermined, standardized amounts subject to certain payment adjustments under Medicare's inpatient prospective payment system ("IPPS").[5] One of these adjustments, the Medicare DSH adjustment, provides additional payments to certain qualifying hospitals that treat a disproportionate share of low income patients.[6] The Medicare DSH adjustment is calculated using two fractions known as the Medicare fraction (also referred to as the SSI fraction or SSI ratio) and the Medicaid fraction. Pursuant to 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I), the Medicare fraction is calculated by using: (a) in the numerator, the "number of such hospital's patient days…which were made up of patients who (for such days) were ***entitled*** to benefits under part A of the subchapter and were ***entitled*** to supplementary security income benefits…under subchapter XVI of this chapter…";[7] and (b) in the denominator, the number of days of care that are furnished to patients who were entitled to Medicare Part A. The Secretary incorporated this statutory provision into the regulations at 42 C.F.R. § 412.106(b)(2)(i)(B) which states:

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

[4] Provider Request for Expedited Review, n.5 (Nov. 30, 2022) ("EJR Request").
[5] 42 C.F.R. Part 412.
[6] 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I).
[7] (Emphasis added.)

> (B) Are furnished to patients who during that month were **entitled to** both Medicare Part A (including Medicare Advantage (Part C)) and **SSI**, excluding those patients who received only State supplementation;
>
> (ii) Adds the results for the whole period; and
>
> (iii) Divides the number determined under paragraph (b)(2)(ii) of this section by the total number of days that –
>
> (A) Are associated with discharges that occur during that period; and
>
> (B) Are furnished to patients entitled to Medicare Part A (including Medicare Advantage (Part C)).[8]

The dispute in these appeals involves CMS' determination of which patients are "entitled to" both Medicare Part A and SSI benefits for purposes of the Medicare fraction of the DSH calculation.

The SSI program is a federal cash assistance program for low-income individuals who are aged, blind, or disabled,[9] administered by the Social Security Administration ("SSA"). The statutory provisions governing SSI, generally, do not use the term "entitled" to SSI benefits. Rather, the SSI statutory provisions typically refer to whether an individual is "eligible for benefits."[10] In order to be "eligible" for SSI benefits, a person must be: (1) 65 years of age or older, blind or disabled; (2) a lawful resident of the United States; (3) have limited income and resources; (4) not be fleeing to avoid prosecution for a crime or violating a condition of parole; and (5) file an application for benefits.[11]

In contrast, the Medicare program is an insurance program where an individual is automatically "entitled" to Medicare Part A when the person reaches age 65 and is entitled to Social Security benefits or becomes disabled and had been entitled to disability benefits for 24 calendar months.[12] In addition, the Medicare program provides that certain qualifying individuals with end stage renal disease are entitled to Medicare Part A.[13]

Unlike entitlement for Medicare Part A benefits, an individual who is currently eligible for SSI benefits may later become *in*eligible for SSI benefits. In this regard, SSA conducts periodic redeterminations to ensure continued eligibility[14] and may terminate,[15] suspend[16] or stop

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[8] (Bold emphasis added and italics emphasis in original.) *See also* 42 U.S.C. § 1395w2(d)(5)(F)(vi)(I).
[9] 42 U.S.C. § 1382.
[10] 42 U.S.C. §§ 1381a, 1382(a) (emphasis added).
[11] 20 C.F.R. § 416.202.
[12] 42 U.S.C. § 426.
[13] 42 U.S.C. § 426-1.
[14] 20 C.F.R. § 416.204.
[15] 20 C.F.R. §§ 416.1331-1335.
[16] 20 C.F.R. §§ 416.1320-1330.

payments to individuals who are either temporarily or permanently ineligible for payment of SSI benefits.[17] In particular, SSI eligibility may be lost if a person no longer meets the basic requirements. For example, an individual may lose SSI eligibility if the individual is no longer disabled or the individual meets one of the following reasons set forth in §§ 416.207-416.216:

1. The individual fails to give the SSA permission to contact financial institutions;[18]
2. The individual fails to apply for other benefits to which the individual may be entitled;[19]
3. The individual fails to participate in drug or alcohol addiction treatment;[20]
4. The individuals is absent from the United States for more than 30 days;[21] or
5. The individual becomes a resident of a public institutions or prison.[22]

In addition, under certain circumstances, SSA may not pay benefits for administrative reasons, such as removal of a representative payee, an unknown address for the beneficiary, or because of income from a previous month.[23]

After the Medicare DSH statutory provisions were enacted in 1984, CMS (then known as the Health Care Financing Administration ("HCFA")) announced that the Secretary of Health and Human Services, rather than hospitals, would be solely responsible for computation of the Medicare fraction because the data necessary to calculate the Medicare fraction is voluminous and much of this data needed to be obtained from another agency, SSA.[24] CMS noted that, as of 1986, the data sources for the computation of the Medicare fraction included approximately 11 million billing records from the Medicare inpatient discharge file and over 5 million records from the SSI file compiled by SSA.[25] To compute the Medicare fraction, CMS had to match individual Medicare billing records to individual SSI records.[26] Considering the administrative burdens and complexity of the data matching process, CMS concluded that the Secretary would be responsible for the data matching process, which she would conduct retrospectively for every eligible Medicare hospital on a "federal fiscal year" basis—that is, based on discharges occurring in the federal fiscal year.[27] CMS notifies Medicare contractors of the SSI ratios after they are calculated. CMS currently makes this notification by posting the resulting SSI percentages on its

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[17] 20 C.F.R. § 1320.
[18] 20 C.F.R. § 416.207.
[19] 20 C.F.R. § 416.210.
[20] 20 C.F.R. § 416.214.
[21] 20 C.F.R. § 416.215.
[22] 20 C.F.R. § 416.211.
[23] *See* SSA Program Operations Manual ("POMS") § SI 02301.201 (describing certain SSI post-eligibility events on the internet at https://secure.ssa.gov/apps10/poms.nsf/lnx/0502301201).
[24] 51 Fed. Reg. 31454, 31459 (Sept. 3, 1986).
[25] *Id.*
[26] *Id.*
[27] *Id.* at 31459–31460; 42 C.F.R. § 412.106(b).

website. Medicare contractors then use the posted SSI ratios to calculate the Medicare DSH percentage to determine each qualifying hospital's Medicare DSH payment adjustment.[28]

The Medicare DSH payment adjustment has been the subject of much litigation and, from that litigation, the following case is of particular relevance to this appeal: *Baystate v. Leavitt*, 545 F. Supp. 2d 20 *as amended* 587 F. Supp. 2d 37, 44 (D.D.C. 2008) ("*Baystate*"). In *Baystate*, the plaintiff alleged that the Secretary's process to identify and gather the data necessary to calculate each hospital's SSI ratio was deficient and the Court remanded the case to the Administrator for further action. The Board notes that this case discusses the Secretary's historical practice of basing "entitled to . . . SSI" under 42 C.F.R. § 412.106(b)(2) on actual payment of SSI cash benefits.[29]

On April 28, 2010, the Secretary (through CMS) acted on the *Baystate* remand order and published CMS Ruling CMS-1498-R ("Ruling 1498-R"). Specifically, the Ruling stated that CMS had implemented the *Baystate* remand order by recalculating the plaintiff's SSI fractions and Medicare DSH payment adjustments using a revised data matching process that used "updated and refined SSI eligibility data and Medicare records, and by matching individuals' records with reference to Social Security numbers (SSNs) as well as HICANs and Title II numbers."[30] The Ruling also stated that "in the FY 2011 proposed rule, CMS is proposing to adopt the same revised data matching process" for use with all hospitals and that "[i]n the forthcoming FY 2011 IPPS final rule, CMS expects to respond to public comments filed on the proposed new data matching process, make any changes to such matching process that seem appropriate, and adopt finally a new data matching process."[31] Finally, CMS stated that it would "use that new data matching process in calculating SSI fractions and DSH payments for specific claims that are found to qualify for relief under this Ruling."[32]

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[28] 42 C.F.R. § 412.106(b)(5); 42 C.F.R. § 405.1803.

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

[30] CMS-1498-R at 5.

[31] *Id.*

[32] *Id.* at 5-6.

Consistent with Ruling 1498-R, the Secretary published the new data matching process in the FY 2011 IPPS proposed rule published on May 4, 2010.[33] The proposed rule includes references to the Secretary's historical practice of basing "entitled to . . . SSI" under 42 C.F.R. § 412.106(b)(2) on actual payment of SSI cash benefits.[34]

The Secretary finalized that data matching process in the FY 2011 IPPS final rule published on August 16, 2010 ("FY 2011 IPPS Final Rule").[35] Significantly, in the preamble to the FY 2011 IPPS Final Rule, CMS acknowledged a public comment that: (1) requested that "CMS include both paid and unpaid days for both SSI entitlement and Medicare entitlement such that there would be consistency between the numerator and denominator of the SSI fraction"; and (2) provided examples of "several SSI codes that represent individuals who were eligible for SSI but not eligible for SSI payments, that should be included as SSI-entitled for purposes of the data match process."[36] CMS responded in detail to this comment and explained that CMS interprets SSI entitlement to correspond with any month for which an individual *receives* payment of SSI benefits. In this regard, CMS stated that the three SSI codes denoted as C01, M01, and M02 "accurately captures all SSI-entitled individuals during the month(s) they are entitled to receive SSI benefits."[37] CMS explicitly rejected the inclusion of other SSA codes because "SSI entitlement can change from time to time" and none of these codes "would be used to describe an individual who was entitled to receive SSI benefits during the month that one of these codes was used."[38] Finally, in the preamble, CMS confirms that "[t]he same data matching process [used for FY 2011 and beyond] will be used to calculate SSI fractions for cost reporting periods covered under the Ruling [1498-R]."[39]

While the new data matching process established in the preamble to the FY 2011 IPPS Final Rule was effective October 1, 2010 (*i.e.*, for FY 2011 and forward), Ruling 1498-R directed that the Medicare contractors apply "the same, unitary relief" consisting of SSI fractions that the Secretary had calculated using the new "suitably revised" data matching process to: (1) any Medicare cost report that had not been settled; and (2) all properly pending Medicare DSH

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[33] 85 Fed. Reg. 23852, 24002-24007 (May 4, 2010).
[34] *See, e.g.,* 75 Fed. Reg. at 24003 (discussing SSI cash payment issues discussed in the *Baystate* decision), 24003-24004 (discussing the proposed matching process where "[t]he SSI eligibility file serves as the system of record for whether or not SSA made a payment of SSI benefits to an individual who applied for SSI"), 24004-06 (discussing the time of the matching process including how "it is important to find an appropriate balance between administrative finality (that is, the final settlement of a hospital's cost report) and the inclusion of retroactive SSI eligibility determinations and the lifting of SSI payment suspensions by using the best and latest available SSI eligibility data at the time of cost report settlement benefits").
[35] 75 Fed. Reg. 50041, 50280-50281. (Aug. 16, 2010).
[36] *Id.* at 50280.
[37] *Id.* at 50280-50281.
[38] *Id.* This include all codes with the "S" prefix indicating a suspension of payment; codes beginning with "N" for nonpayment; code "E01" indicating that the individual had countable income which eliminated the SSI payment; and code "E02" indicating that the patient was not entitled to SSI benefits during that month but became entitled during a subsequent month.
[39] *Id.* at 50285.

appeals of the SSI fraction data matching process issue.[40] The Ruling noted that hospitals dissatisfied with the initial or revised NPR issued using the new SSI ratios in the Medicare DSH adjustment calculation could seek administrative and judicial review provided they met the jurisdictional and procedural requirements of 42 U.S.C. § 1395oo, the Medicare regulations, and other agency rules and guidelines.[41] In the FY 2011 IPPS Final Rule, the Secretary explicitly recognized that "[t]he data matching process provisions of the Ruling would apply to . . . open cost reports for cost reporting periods beginning prior to October 1, 2010 (that is those preceding the effective date of the FY 2011 IPPS final rule)."[42]

Finally, on April 22, 2015, CMS published Ruling 1498-R2 modifying and amending Ruling 1498-R by allowing hospitals to elect whether to use new Medicare SSI fractions calculated on the basis of "total days" or "covered days" for cost reports involving patient discharges *prior* to October 1, 2004.[43]

However, neither Ruling 1498-R nor Ruling 1498-R2 are applicable to this appeal since the NPR at issue was issued after Ruling 1498-R and since the fiscal year at issue is not covered by Ruling 1498-R2. As a result of the new regulation and new data match process, CMS calculated SSI percentages for the Provider for the fiscal year at issue.[44] The Provider is challenging the adoption of the policy stated therein that only SSI paid days as represented by SSI codes S01, M01 and M02 are included in the numerator of the SSI fraction for purposes of representing days "entitled to [SSI] benefits."

B. FY 2005 IPPS Final Rule

The FY 2005 IPPS Final Rule announced policy changes relative to the treatment of dual eligible days and Medicare Part C days in the SSI fraction.[45] However, it did not address or announce any policy statements or changes relative to what the phrase "entitled to [SSI] benefits" as used in 42 U.S.C. § 1395ww(d)(F)(vi)(I) means.

Providers' Position

A. SSI Matching Issue

In its Final Position Paper, the Provider states that it received a data file from CMS and compared the SSI days in that file to data from Kentucky's State Medicaid program. This comparison showed 129 days that were not included in CMS' data file and, thus, were improperly excluded from the numerator of the Medicare fraction. It notes that Kentucky

[40] CMS-1498-R at 6-7, 31.
[41] *Id.* at 28, 31.
[42] 75 Fed. Reg. at 24006.
[43] CMS-1498-R2 at 2, 6.
[44] CMS published the SSI ratios for FY 2012 on or about June 12, 2014. SSI ratios are published and can be accessed at https://www.cms.gov/Medicare/ Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.
[45] 69 Fed. Reg. 48916, 49090-99 (Aug. 11, 2004).

Medicaid assigns a specific code type for all Medicaid eligible patients, but that none of these days were included in the Medicare Fraction. The Provider claims "CMS simply did not use the best available data" and that the Medicare Contractor should adjust its data accordingly.[46]

In its EJR Request, the Provider has also claimed that the SSI Matching issue is inextricably intertwined with the dual eligible days issue the data match patient days are a subset of the total dual eligible patient days improperly excluded from the Medicare fraction.[47] Indeed, the Provider claims for these days it can demonstrate that certain beneficiaries were "entitled to SSI benefits" in that they *actually received* cash payments during the month of their hospital stay but were nevertheless excluded from the Medicare fraction numerator.

The Provider acknowledges that, pursuant to 42 C.F.R. § 405.1867, the Board is bound to comply with CMS Rulings 1498-R and 1498-R2, but claims that "the Rulings do not provide for a mechanism to address the challenge being made by the Provider regarding the proper interpretation of the phrase "entitled to [SSI] benefits" and, thus, EJR is appropriate.[48]

The Medicare Contractor argues that the NPR at issue in this case was issued four years after CMS Ruling 1498-R was issued and that the cost report was settled with a Medicare Fraction that incorporated the revised data matching process.[49] The Provider has not disputed this at any point, but appears to argue that certain Kentucky-specific SSI codes prove SSI entitlement, but that these are not one of the three SSI codes used by CMS in its revised data matching process (*i.e.,* SSI codes C01, M01, and M02).[50]

B. Dual Eligible Days Issue

In its EJR Request, the Provider acknowledges that, following the Supreme Court's decision in *Empire*, dual eligible days should be excluded from the Medicaid numerator.[51] It argues, however, that there is now an inconsistency between the interpretation of "entitled to benefits under Part A" (which encompasses any patient who satisfies the statutory eligibility criteria whether or not Medicare actually pays), and "entitled to SSI" (which encompasses only patient days where SSI cash payments were actually received).[52] This discrepancy excludes a large number of days from the Medicare fraction numerator.[53] In this regard, the Provider is located in Kentucky where a dual eligible patient is entitled to SSI benefits by definition, and argues that not only should all Kentucky dual eligible patient days be included in the Medicare numerator (Issue 1) but also all situations where a patient was "eligible" for SSI benefits (the remaining aspect of Issue 3).[54] The

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[46] Provider's Final Position Paper at 15.
[47] EJR Request at n.3.
[48] *Id.* at 4-5.
[49] Medicare Administrative Contractor's Final Position Paper at 21 (Jan. 7, 2022).
[50] Provider's Final Position Paper at 15.
[51] EJR Request at 2.
[52] *Id.*
[53] *Id.*
[54] *Id.* at 2-4.

Provider acknowledges that, if they are successfully in expanding the interpretation of the phrase "entitled to [SSI] benefits" to include SSI eligibility, then Issue 1 becomes moot (*i.e*., the contention not all SSI paid days were counted/identified as established through the Kentucky Medicaid eligibility data).[55] In seeking to expand this interpretation, the Provider is challenging the Secretary's policy stated in the FY 2011 IPPS Final Rule that "entitled to [SSI] benefits" must be interpreted to include only SSI paid days as represented by SSI codes C01, M01, and M02.[56]

As previously noted, in its EJR Request, the Provider noted it is withdrawing the aspect of Issue 3 relating to the Medicaid Fraction dual eligible issue in light of the Supreme Court's decision in *Empire*.[57] As such, the only aspect of Issue 3 remaining in this appeal is the determination of SSI entitled days as used in the numerator of the Medicare fraction.

Decision of the Board

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

A. Preliminary Rulings on the Scope of the EJR Request

The Provider has suggested that it is challenging the FY 2005 IPPS Final Rule based on the following finding it included at the end of its EJR request:

> [The Board] is without the authority to decide the legal question of whether 42 C.F.R. § 412.106 codifying the CMS policies adopted in the FY 2005 IPPS Final Rule and the FY 2011 Final Rule are valid.

However, the EJR request only mentions the FY 2005 IPPS Final Rule in one other place as follows:

> In the 2005 Rule construing the Medicare fraction, CMS interpreted the phrase "entitled to benefits under Part A" to encompass any patient who satisfied Part A statutory *eligibility* criteria whether or not Medicare actually pays for the care.

The Provider has recognized that the Supreme Court upheld this policy:

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[55] *Id*. at 4.
[56] *Id.* at 15, 19.
[57] *Id.* at n.5.

> In *Becerra v. Empire Health Foundation For Valley Hospital Medical Center*, 142 S.Ct. 2354, 2368 (June 24, 2022), the Supreme Court upheld the Secretary's interpretation of the phrase "entitled to benefits" in the numerator of the Medicare fraction to include those individuals qualifying for Medicare regardless of whether that program actually paid for their day of care. The Supreme Court found that the Secretary's reading of "entitled to benefits" comported with the statute's two-population structure because "[a]ll low-income people fit naturally into one or the other box, with the sum of the two leaving no one out." *Id.* at 2367. Accordingly, the Provider acknowledges the dual eligible days should be excluded from the Medicaid numerator.[58]

The Provider then confirmed in a footnote at the end of this excerpt confirming that "[t]he Provider will be dismissing [*sic* withdrawing] the Medicaid dual eligible issue in this case."

Moreover, the Board notes that the FY 2005 IPPS Final Rule does not include any statement regarding the Secretary's interpretation of the phrase "entitled to [SSI] benefits" as used in 42 U.S.C. § 1395ww(d)(F)(vi)(I). Nor does the Provider claim it does.

Accordingly, the Board finds that the EJR request has ***not*** laid a sufficient foundation for a challenge to the FY 2005 IPPS Final Rule. In so ruling, it does not mean that it does not have relevance to what is being challenged, namely the FY 2011 IPPS Final Rule as set forth below. However, it is not what is actually being challenged. In this regard, the Provider is maintaining that the term "entitled" should be consistently interpreted across 42 U.S.C. § 1395 and that "entitled to [SSI] benefits" should be broadly interpreted consistent with how the Secretary interpreted "entitled to benefits under [Medicare] Part A" as used in 42 U.S.C. 1395ww(d)(F)(vi)(I) and explained in the FY 2005 IPPS Final Rule and upheld by the Supreme Court in *Empire*, as noted above.

With regard to Issue 1 relating to the SSI data matching process, the Provider has suggested that EJR is appropriate for that issue based on its assertion that it is inextricably intertwined with the Issue 3 challenge to the Secretary's interpretation of "entitled to [SSI] benefits." Specifically, it has stated in footnote 3 of the EJR request that "the data match issue is inextricably intertwined with the Medicare dual eligible issue because it is also impacted by the interpretation of the phrase 'entitled to [SSI] benefits.'" The Provider further explains that:

> In this case, the data match issue is intertwined with the Medicare dual eligible issue because the data match patient days are a subset of the total dual eligible patient days improperly excluded from the Medicare fraction. Although the Provider contends that CMS improperly excluded all dual eligible patients days by misinterpreting the phrase "entitled to [SSI] benefits," the data match issue relates to patients days for which the Provider can demonstrate that the

[58] EJR request at 2 (footnotes omitted).

> beneficiary was "entitled to SSI benefits" even using CMS' restrictive interpretation. CMS uses three SSI codes to determine which patient days it will include in the Medicare numerator. These codes reflect beneficiaries who actually *received SSI cash payments* during the month of their hospital stay. The data match amount in controversy was calculated by comparing Medicaid data with CMS' Med Par data in order to identify those patients with associated Medicaid codes indicating that the patients received SSI payments while hospitalized. These patient days were not included by CMS in the Medicare numerator. Thus, even using CMS' constricted definition, there are additional days to include in the Medicare fraction numerator. However, this amount is encompassed by the overall Medicare dual eligible SSI issue. So, if a court determines that "entitled to benefits" has the same meaning with respect to SSI benefits as Part A benefits, then the data match issue will be moot.[59]

In footnote 7 of the EJR request appended to the end of the above excerpt, the Provider makes the following statement regarding the intertwinement:

> If the Board determines that the data match issue is not inextricably intertwined with the Medicare dual eligible entitled to SSI benefits or is otherwise not inclined to grant EJR on that issue, then the Provider requests that the data match issue be held in abeyance pending a court's resolution of the Medicare DE "entitled to [SSI]" dispute.

The Board disagrees with the Provider's characterization of the SSI Data Match issue. The Board finds that the fact that the SSI Data Match issue may be impacted by the outcome of the Provider's challenge to the Secretary's interpretation of the phrase "entitled to [SSI] benefits" (and rendered moot if the "entitled" interpretation issue is decided favorably for the Provider) does ***not*** mean that EJR of the Data Match Issue is appropriate. In this regard, the Board notes that it has already had a case with the same issue, namely *Pomona Valley Hospital Medical Center v. Noridian Healthcare Solutions*, PRRB Dec. No. 2018-D50 (Aug. 17, 2017). In that case, the Provider maintained that certain California Medicaid records documenting the assignment of certain "aid codes" by the Social Security Administration could be relied upon to confirm whether a patient was "entitled to [SSI] benefits" and that these records confirmed that the SSI percentage published by CMS for the provider for the fiscal year at issue was understated. The Board ultimately found that the provider "did not submit sufficient quantifiable data in the record to prove that the SSI percentages calculated by CMS, and used in [the provider]'s FYE 12/31/2006, 12/31/2007, and 12/31/2008 cost reports, were flawed" and, accordingly, affirmed the SSI percentages used by the Medicare Contractor.

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[59] (Footnote omitted.)

The Provider has not stated any specific challenge to the FY 2011 IPPS Final Rule as it relates to Issue 1 (*e.g.*, that the Secretary's adoption of C01, M01, and M02 to capture SSI paid days for ***all*** hospital across the U.S. is improper because that adoption was procedurally invalid and/or substantively invalid). As such, the EJR request as it relates to Issue 1 is fatally flawed.

Rather, similar to the *Pomona Valley* case,[60] there appears to be a factual issue in dispute here that the Board needs to resolve regarding the Provider's assertions about Kentucky Medicaid documentation, namely that "in Kentucky the fact that a [dual eligible] patient was eligible for Medicaid when receiving hospital services is evidence that, for such days, the patient was entitled to SSI benefits" and that "[a]ccordingly, patient days excluded from the Medicaid numerator due to a [dual eligible] patient's Part A Medicare status should then be automatically included in the Medicare numerator."[61] As such, it appears to be a variation on *Baystate* where the Provider is asserting that the process used by CMS is flawed because it can establish that the process used to capture SSI paid days is flawed and results in understated SSI fractions. To highlight the factual dispute the Board points to the Medicare Contractor's position paper which recognizes that "[t]he Provider focuses on patient days that were excluded because these days have been matched with SSA codes by using the Kentucky Medicaid" but asserts that "the Provider has not demonstrated that the patients **were eligible for SSI benefits on the days for which care was provided**."[62] Accordingly, the Board denies the EJR request as it relates to Issue 1 because there is a factual dispute to resolve and the Provider has not set forth, with sufficient detail, any challenge to a regulation or CMS Ruling for Issue 1.

B. Appeals of Cost Report Periods Beginning Prior to January 1, 2016

1. Statutory and Regulatory Background

The Provider appealed a cost reporting period beginning prior to January 1, 2016. For purposes of Board jurisdiction over a provider's appeal for cost report periods ending on or after December 31, 2008, the provider may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming it as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen* ("*Bethesda*").[63] In that case, the Supreme Court concluded that a cost report submitted in full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with

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[60] In pointing similarities to *Pomona Valley*, the Board is not suggesting the outcome of this case, particularly since this case involves a *different* state Medicaid program with presumably different record systems for Medicaid eligibility) but merely that there is a factual dispute here. Similarly, given the decision issued on appeal, there is also a dispute about who has the burden of proof. *See Pomona Valley Hosp. Med. Ctr. v. Azar*, Civ. No. 18-2763, 2020 WL 5816486 (D.D.C. 2020), *appeal filed*, Case No. 20-5350 (D.C. Cir. Nov. 30, 2020).

[61] EJR Request at 14.

[62] Medicare Contractor Final Position Paper at 10 (Jan. 7, 2022).

[63] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).

the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.[64]

On August 21, 2008, new regulations governing the Board were effective.[65] Among the new regulations implemented in the Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hospital v. Burwell* ("*Banner*").[66] In *Banner*, the provider filed its cost report in accordance with the applicable outlier regulations and did not protest the additional outlier payment it was seeking. The provider's request for EJR was denied because the Board found that it lacked jurisdiction over the issue. The District Court concluded that, under *Bethesda,* the 2008 self-disallowance regulation could not be applied to appeals raising a legal challenge to a regulation or other policy that the Medicare Contractor could not address.[67]

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

2. Jurisdiction

The Board has determined that the Issue 3 as it relates to the meaning of "entitled to [SSI] benefits" is governed by CMS Ruling CMS-1727-R since the Provider is challenging the Secretary's interpretation of this phrase as set forth in the FY 2011 IPPS Final Rule and that Board review of this issue is not otherwise precluded by statute or regulation. In addition, the Provider's documentation shows that the estimated amount in controversy exceeds $10,000, as required for an individual appeal.[68] The appeal was timely filed and no jurisdictional impediments have been identified for the Provider as it relates to the remaining aspect of Issue 3. Based on the above, the Board finds that it has jurisdiction for the above-captioned individual appeal as it relates to the remaining aspect of Issue 3.

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[64] *Bethesda*, 108 S. Ct. at 1258-59.
[65] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[66] 201 F. Supp. 3d 131 (D.D.C. 2016).
[67] *Id.* at 142.
[68] *See* 42 C.F.R. § 405.1835(a)(2).

C. Board's Analysis of the Appealed Issue

As noted above, the Secretary revised the SSI data match process in light of the *Baystate* decision through notice and comment in the form of an uncodified regulation. First, the Secretary issued CMS Ruling 1498-R on April 28, 2010, authorizing remands of pending appeals of the SSI data match issue to recalculate the SSI fraction based on a revised data match.[69] The Secretary also stated in the ruling that, where cost reports had not been settled, those providers' SSI fractions would be calculated using the revised data match.[70] Contemporaneous with CMS' issuance of Ruling 1498-R,[71] the Secretary published the FY 2011 IPPS Proposed Rule[72] which, in pertinent part, proposed to adopt the same data match for 2011 and forward. This proposed rule was adopted as the FY 2011 Final IPPS Rule in which the Secretary explained that:

> [W]e used a revised data matching process . . . that comports with the court's decision [in *Baystate* to recalculate the hospitals' SSI fractions]. As the revised data matching process was completed using SSI eligibility data compiled between 13 and 16 years beyond the fiscal years at issue in the *Baystate* case, we believe any issues associated with retroactive determinations of SSI eligibility and the lifting of payment suspensions had been long since resolved. Furthermore, because we believe that the revised match process used to implement the *Baystate* decision addressed all of the concerns found by the court, in the FY 2011 IPPS/LTCH PPS proposed rule we proposed to use the same revised data matching process for calculating hospitals' SSI fractions for FY 2011 and subsequent fiscal years.[73]

Then she announced that:

> We have adopted the proposed data matching process for FY 2011 and beyond as final. The only modification we are making to the proposed matching process is adopting a policy to exclude a record from the data matching process if we find a HICAN in the MedPAR file that we are not able to locate in the EDB[74]which is an extremely unlikely situation as noted in the prior discussion in this final rule. We are adopting this additional step in our validation process to respond to public comment and provide even more assurances that our data matching process will yield accurate SSI fractions and capture all Medicare beneficiaries who were

[69] CMS Ruling 1498-R at 27.
[70] *Id.* at 31.
[71] *Id.* at 5.
[72] 75 Fed. Reg. 23,852, 24,002-07.
[73] 75 Fed. Reg. at 50,277.
[74] (Medicare) Enrollment Database.

> entitled to SSI at the time of their inpatient hospital stay. The same data matching process will be used to calculate SSI fractions for cost reporting periods covered under the ruling.[75]

As part of the adopted data match process, CMS explicitly finalized a policy that SSI codes C01, M01, and M02 would capture all SSI entitled days:

> *Comment*: **One commenter stated that CMS** uses total (that is, "paid and unpaid") Medicare days in the denominator of the SSI fraction, but **uses paid SSI days in the numerator of the SSI fraction**. The commenter requested that CMS interpret the word "entitled" to mean "paid" for both SSI-entitled days used for the numerator and Medicare-entitled days used in the denominator, or alternatively, that CMS include both paid and unpaid days for both SSI entitlement and Medicare entitlement such that there is consistency between the numerator and the denominator of the SSI fraction. **The commenter stated that there were several SSI codes that represent individuals who were eligible for SSI, but not eligible for SSI payments, that should be included as SSI-entitled for purposes of the data matching process**. Specifically, the commenter stated that at least the following codes should be considered to be SSI-entitlement:
>
> • E01 and E02
> • N06, N10, N11, N18, N35, N39, N42, N43, N46, N50, and N54
> • P01
> • S04, S05, S06, S07, S08, S09, S10, S20, S21, S90, and S91
> • T01, T20, T22, and T31
>
> *Response*: In response to the comment that we are incorrectly applying a different standard in interpreting the word "entitled" with respect to SSI entitlement versus Medicare entitlement, we disagree. The authorizing DSH statute at section 1886(d)(5)(F)(vi)(I) of the Act limits the numerator to individuals entitled to Medicare benefits who are also "*entitled* to supplemental security income benefits (excluding any State supplementation)" (emphasis added).[76] **Consistent with this requirement, we have requested, and are using in the data matching process, those SSA codes that reflect "entitlement to"**

[75] 75 Fed. Reg. at 50,285.

[76] As a side note, we have used the phrase ''SSI-eligible'' interchangeably with the term ''SSI-entitled'' in the FY 2011 proposed rule as well as prior proposed and final rules, but the statute requires that we include individuals who were entitled to SSI benefits in the SSI fractions. Although we have used these terms interchangeably, we intended no different meaning, and our policy has always been to include only Medicare beneficiaries who are entitled to receive SSI benefits in the numerator of the SSI fraction.

receive SSI benefits. Section 1602 of the Act provides that "[e]very aged, blind, or disabled individual who is determined under Part A to be eligible on the basis of his income and resources shall, in accordance with and subject to the provisions of this title, be *paid* benefits by the Commissioner of the Social Security" (emphasis added). However, eligibility for SSI benefits does not automatically mean that an individual will receive SSI benefits for a particular month. For example, section 1611(c)(7) of the Act provides that an application for SSI benefits becomes effective on the later of either the month following the filing of an application for SSI benefits or the month following eligibility for SSI benefits.

On the other hand, section 226 of the Act provides that an individual is automatically "entitled" to Medicare Part A when the person reaches age 65 and is entitled to Social Security benefits under section 202 of the Act (42 U.S.C. 402) or becomes disabled and has been entitled to disability benefits under section 223 of the Act (42 U.S.C. 423) for 24 calendar months. Section 226A of the Act provides that qualifying individuals with end-stage renal disease shall be entitled to Medicare Part A. In addition, section 1818(a)(4) of the Act provides that, "unless otherwise provided, any reference to an individual entitled to benefits under [Part A] includes an individual entitled to benefits under [Part A] pursuant to enrollment under [section 1818] or section 1818A." We believe that Congress used the phrase "entitled to benefits under part A" in section 1886(d)(5)(F)(vi) of the Act to refer individuals who meet the criteria for entitlement under these sections.

Moreover, unlike the SSI program (in which entitlement to receive SSI benefits is based on income and resources and, therefore, can vary from time to time), once a person becomes entitled to Medicare Part A, the individual does not lose such entitlement simply because there was no Medicare Part A coverage of a specific inpatient stay. Entitlement to Medicare Part A reflects an individual's entitlement to Medicare Part A benefits, not the hospital's entitlement or right to receive payment for services provided to such individual. Such Medicare entitlement does not cease to exist simply because Medicare payment for an individual inpatient hospital claim is not made. Again, we are bound by section 1886(d)(5)(F)(vi)(I) of the Act, which defines the SSI fraction numerator as the number of SSI-entitled inpatient days for persons who were "entitled to benefits under [P]art A," and the denominator as the total number of inpatient days for individuals who were "entitled" to Medicare Part A benefits.

In response to the comment about specific SSI status codes, SSA has provided information regarding all of the SSI status codes mentioned by the commenter to assist in the determination of whether <u>any</u> of these codes represent individuals who were entitled to SSI benefits for the purposes of calculating the SSI fraction for Medicare DSH. With respect to the codes that begin with the letter "T," SSA informed us that all of the codes represent individuals whose SSI entitlement was terminated. Code "T01" represents records that were terminated because of the death of the individual, but we confirmed that this code would not be used until the first full month after the death of the individual. That is, for example, if a Medicare individual was entitled to SSI during the month of October, was admitted to the hospital on October 1 and died in the hospital on October 15, the individual would show up as entitled to SSI for the entire month of October on the SSI file (code T01 would not be used on the SSI file until November) and 15 Medicare/SSI inpatient hospital days for that individual would be counted in the numerator and the denominator of the SSI fraction for that hospital.

Codes beginning with the letter "S" reflect records that are in a "suspended" status and, according to SSA, do not represent individuals who are entitled to SSI benefits.

SSA maintains that code "P01" is obsolete and has not been used since the mid-1980s. Therefore, it would not be used on any SSI files reflecting SSI entitlement for FY 2011 and beyond.

Codes that begin with the letter "N" represent records on "nonpayment" and are not used for individuals who are entitled to SSI benefits.

Code "E01" represents an individual who is a resident of a medical treatment facility and is subject to a $30 payment limit, but has countable income of $30 or more. Such an individual is not entitled to receive SSI payment. Alternatively, an individual who is a resident of a medical treatment facility and is subject to a $30 payment limit, but does not have countable income of at least $30, would be reflected on the SSI file as a "C01" (which denotes SSI entitlement) for any month in which the requirements described in this sentence are met. Code "E02" is used to identify a person who is not entitled to SSI payments in the month in which that code is used pursuant to section 1611(c)(7) of the Act, which provides that an application for SSI benefits shall be effective on the later of (1) the first day of the month following the date the application is filed, or (2) the first day of the month following the date the individual becomes eligible for SSI based on that

> application. Such an individual is not entitled to SSI benefits during the month that his or her application is filed or is determined to be eligible for SSI, but, for the following month, would be coded as a "C01" because he or she would then be entitled to SSI benefits.
>
> Therefore, both codes E01 and E02 represent individuals who are not entitled to SSI benefits and are reflected accordingly on the SSI file. If the individual's entitlement to SSI benefits is initiated the ensuing month, that individual would then be coded as a "C01" on the SSI file and would be included as SSI-entitled for purposes of the data matching process.
>
> As we have described above, **none of the SSI status codes that the commenter mentioned would be used to describe an individual who was entitled to receive SSI benefits during the month that one of those status codes was used**. SSI entitlement can change from time to time, and **we believe that including SSI codes of C01, M01, and M02 accurately captures all SSI-entitled individuals during the month(s) that they are entitled to receive SSI benefits**.
>
> After consideration of the public comments we received, we are adopting the proposed data matching process for FY 2011 and beyond as final. The only modification we are making to the proposed data matching process is adopting a policy to exclude a record from the data matching process if we find a HICAN in the MedPAR file that we are not able to locate in the EDB, which is an extremely unlikely situation as noted in the prior discussion in this final rule We are adopting this additional step in our validation process in response to public comments to provide even more assurances that **our data matching process will** yield accurate SSI fractions and **capture all Medicare beneficiaries who were <u>entitled</u> to SSI at the time of their inpatient hospital stay**.[77]

The Secretary did not incorporate, into the Code of Federal Regulations, the above new policy involving the revised data match process (including but not limited to portion of that policy relating to the use of SSI code C01, M01, and M02 to capture SSI entitled days). However, it is clear from the language in the final IPPS rule, as set forth above, that the Secretary intended to bind the regulated parties and establish a *binding* data match process to be used by the Medicare Contractors in calculating (or recalculating) providers' SSI fractions.

Accordingly, the Board finds that the Secretary intended this policy change for the data match process to be a binding but uncodified regulation and will refer to the portion of that policy as it relates to the adoption of the SSI codes C01, M01, and M02 to capture SSI entitled days as the

[77] 75 Fed. Reg. at 50280-81 (footnote in original; bold and underline emphasis added).

"Uncodified SSI Entitled Days Regulation." Indeed, this finding is consistent with the Secretary's obligations under 42 U.S.C. § 1395hh(a)(2) to promulgate any "substantive legal standard governing . . . the payment of services" as a regulation."[78]

Pursuant to 42 C.F.R. § 405.1867, the Board is bound to apply the statutory and regulatory provisions governing the Medicare program. Consequently, the Board finds that it is bound by the Uncodified SSI Entitled Days Regulation published in the FY 2011 Final Rule and the Board does not have the authority to grant the relief sought by the Provider, namely invalidating the Uncodified SSI Entitled Days Regulation which they allege fails to include all of the SSI codes used by SSA to determine SSI eligibility. As a result, the Board finds that EJR is appropriate for the issue for the calendar year under appeal in this case.

D. Board's Decision Regarding the EJR Request

The Board finds that:

1) It denies the portion of the EJR request relating to Issue 1 because there are findings of fact for resolution by the Board and the EJR request fails to lay out a specific challenge to a regulation or CMS Rule for Issue 1;

2) It dismisses that portion of Issue 3 which relates to that relates to the exclusion of no-pay Part A days in the SSI fraction and the inclusion of the subset of those days relating to dual eligible beneficiaries in the Medicaid fraction because the Provider has notified the Board it is withdrawing that issue based on the Supreme Court's decision in *Empire*;

3) It has jurisdiction over the remaining aspect of Issue 3 for the subject year and that the Provider is entitled to a hearing before the Board;

4) Based upon the Provider's assertions regarding 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule), there are no findings of fact for resolution by the Board for the remaining aspect of Issue 3;

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

6) It is without authority to decide the legal question of whether the Uncodified SSI Entitled Days Regulation as adopted in the preamble to the FY 2011 Final IPPS Rule is valid.

Accordingly, the Board denies the EJR request as it relates to Issue 1, dismisses the *Empire* portion of Issue 3, and finds that the question of the validity of the Uncodified SSI Entitled Days Regulation (the remaining aspect of Issue 3) properly falls within the provisions of 42 U.S.C.

[78] 42 U.S.C. § 1395hh(a)(2) states "[n]o rule, requirement, or other statement of policy . . . that establishes or changes a substantive legal standard governing . . . the payment of services . . . shall take effect unless it is promulgated by the Secretary by regulation . . . ."

§ 1395oo(f)(1) and hereby grants the Provider's request for EJR for that question. The Provider has 60 days from the receipt of this decision to institute the appropriate action for judicial review. The case remains open as there is an issue remaining in this case.

Board Members Participating:

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

FOR THE BOARD:

12/29/2022

X Clayton J. Nix

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

cc: Judith Cummings, CGS Administrators (J-15)
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Board Decision to Dismiss Remaining Issues***
Stamford Hospital (Prov. No. 07-0006)
FYE 09/30/2016
Case No. 20-2155

Dear Mr. Ravindran and Ms. Decker:

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the documentation in Case No. 20-2155 pursuant to a jurisdictional challenge filed by the Medicare Contractor ("MAC") on October 17, 2022. The Provider's representative, Quality Reimbursement Services, Inc. ("QRS"), did not file a response to this challenge. Set forth below is the Board's decision agreeing with the challenge and dismissing the 2 remaining issues in this case.

Background

A. Procedural History for Case No. 20-2155

On March 18, 2020, Stamford Hospital (the "Provider") filed its appeal request, appealing the Notice of Program Reimbursement (NPR) dated September 24, 2019, for its fiscal year dating September 30, 2016 ("FY 2016"). The Provider appealed the following issues:[1]

- Issue 1: DSH SSI Percentage (Provider Specific)
- Issue 2: DSH SSI Percentage
- Issue 3: DSH SSI Percentage - Medicare Managed Care Part C Days
- Issue 4: DSH SSI Percentage - Dual Eligible Days (Exhausted Part A Benefit Days, MSP Days and No-Part A Days)
- Issue 5: DSH – Medicaid Eligible Days
- Issue 6: DSH - Medicaid Fraction/Medicare Managed Care Part C Days
- Issue 7: DSH - Medicaid Fraction/Dual Eligible Days
- Issue 8: DSH - DSH - Medicaid Eligible Days - CT State Administered GA
- Issue 9: Uncompensated Care ("UCC") Distribution Pool
- Issue 10: 2 Midnight Census IPPS Payment Reduction
- Issue 11: Standardized Payment Amount

[1] Provider's Request for Hearing, Tab 3, at Issue Statement (Mar. 18, 2020).

On September 28, 2020, the Board issued an Acknowledgement and Critical Due Dates Notice to acknowledge the appeal request and setting deadlines for preliminary position papers ("PPPs") where the Provider's PPP was due by January 26, 2021 and the Medicare Contractor's PPP was due by May 26, 2021. The Notice gave the Provider the following instructions regarding the content of its PPP:

> Provider's Preliminary Position Paper – For each issue, the position paper must state the material facts that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), and provide arguments applying the material facts to the controlling authorities. This filing must include any exhibits the Provider 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.

On December 1, 2020, the Provider transferred 5 issues (Issues 2, 3, 4, 6, 7, and 11) and, then shortly thereafter, on December 3, 2020, withdrew 3 issues (Issues 8, 9, and 10). As a result, only two issues remain in this appeal, namely Issue 1, DSH SSI Percentage (Provider Specific), and Issue 5, DSH – Medicaid Eligible Days.[2]

On January 22, 2021, the Provider filed its PPP.[3] On May 21, 2021, the MAC filed its PPP.

On October 17, 2022, the MAC filed a Jurisdictional Challenge regarding both Issue 1, addressing the DSH SSI Percentage (Provider Specific) issue, and Issue 5, DSH – Medicaid Eligible Days.

On Novmeber 9, 2022, QRS filed notice that the Provider had appointed it as the new designated representative for this case. However, on November 10, 2022, the Board sent QRS notice that the change of representation was fatally flawed. Accordingly, on November 11, 2022, QRS filed an updated change of representation.

Significantly, the Provider (whether directly or through its new representative, QRS[4]) did not file a response to the Jurisdictional Challenge within the 30 days allotted under Board Rule 44.4.3 which specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

B. Description of Issue 1 in the Appeal Request and the Transfer of Issue 2 to the Optional Group under Case No. 21-0235G

[2] MAC's Jurisdictional Challenge, at 1 (Oct. 17, 2022).
[3] The PPP was filed January 22, 2021 and the cover letter to the PPP was filed subsequently on January 27, 2021 as it was left out of the original filing.
[4] Board Rule 5.5.1 entitled "Deadlines Must Continue To Be Met" specifies, in pertinent part, that "the recent appointment of a new case representative, generally[,] will not be considered cause for delay of any deadlines or proceedings."

1. *Issue 1 – DSH SSI Percentage (Provider Specific)*

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

> **Statement of Issue**
>
> Whether the Administrative Contractor ("MAC") used the correct Supplemental Security Income ("SSI") percentage in the Disproportionate Share Hospital ("DSH") calculation.
>
> **Statement of the Legal Basis**
>
> The Provider contends that the MAC did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the MAC's calculation of how the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations.
>
> The provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> The Provider contends that the SSI percentage issued by CMS is flawed.
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *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 SSI but did not receive an SSI payment.
>
> Audit Adjustment Number(s): 1, 13, 16, S-3 *See* Tab 4.
> Estimated Reimbursement Amount: $92,000. *See* Tab 5.[5]

[5] Provider's Request for Hearing, Issue Statement (Mar. 18, 2020).

The estimated reimbursement amount calculation for Issue 1 at Tab 5 is as follows:

Estimated Impact of .25% (3) increase in SSI Percentage due to the Provider Specific

DRG	(1)	$44,664,189
Multiplier	(2)	82.50%
Net Impact	(1) x (2) x (3)	$ 92,120

The Provider included no explanation on how it determined the estimated impact of 0.25 percent or on what it based that estimate.

On January 22, 2021, the Provider filed its PPP. The following is the Provider's ***complete*** position on Issue 1 set forth therein for Case No. 20-2155:

Calculation of the SSI Percentage

The Provider contends that the Lead MAC's determination of Medicare Reimbursement for DSH Payments are not in accordance with the Medicare Statute 42 U.S.C. § 1395ww(d)(5)(F)(i). 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 was incorrectly computed because of the following reasons:

Provider Specific

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 the Provider's DSH calculation. This is based on certain data from the State of Connecticut and the Provider does not support SSI percentage issued by CMS.

The Provider has worked with the State of Connecticut and has learned that similar to *Loma Linda Community Hospital v. Dept of Health and Human Services*, No. CVT94- 0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records.

The Provider is seeking the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") 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 ot its' [*sic*] 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 only exhibit included with the preliminary position paper that relates to Issue 1 was Exhibit 1, which was listed as an Eligibility Listing, but noted that it would be sent under separate cover. Exhibit 2 shows the amount in controversy as $92,000. This is the same amount that is listed as the amount in controversy for this Provider for Issue 2 which was transferred to the optional group under Case No. 21-0235G and which continues to be listed therein for the Provider as $92,000.

2. *Issue 2 – DSH SSI as Transferred to the Optional Group Under Case No. 21-0235G*

The Provider's appeal request describes Issue 2 – the DSH/SSI issue as follows:

> **Statement of the Issue:**
>
> Whether the Medicare/SSl 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/SSl fraction calculation per the Medicare Statute at 42 U.S.C. § 1395ww(d)(5)(F)(vi)?
>
> **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 [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 further contends 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
>
> Audit Adjustment Number(s): 1, 13, 16, S-D *See* Tab 4.
> Estimated Reimbursement Amount: $92,000 *See* Tab 5.

The estimated reimbursement amount calculation for Issue 2 at Tab 5 is as follows:

> Estimated Impact of .25% (3) increase in SSI Percentage due to the Provider Systemic Errors
>
DRG	(1)	$44,664,189
Multiplier	(2)	82.50%
Net Impact4	(1) x (2) x (3)	$ 92,120

The Provider included no explanation on how it determined the estimated impact of 0.25 percent or on what it based that estimate.

On December 1, 2022, the Provider transferred Issue 2 to the optional group under Case No. 21-0235G entitled "QRS CY 2016 DSH SSI Percentage (2) Group." This optional group has the following issue statement:

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

Statement of the Legal Basis

The Provider(s) contend(s) that the MAC's determination for their DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww(d)(5)(F)(vi). The Provider(s) further contend(s) that the SSI percentages calculated by [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. 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.

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, 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.[6]

Again, the amount in controversy for the Provider as a participant in the optional group under Case No. 21-0235G is listed $92,000 which is the same amount listed in the original appeal request for Case No. 20-1255 for Issue 2 (prior to being transferred to Case No. 21-235G) and for Issue 1.

MAC's Contentions

Issue 1 – DSH SSI Percentage (Provider Specific)

The MAC contends that the portion of Issue 1 concerning SSI data accuracy should be dismissed because it is duplicative of Issue 2, which was transferred into Group Case No. 21-0235G, *QRS CY 2016 DSH SSI Percentage (2) Group*. The Portion of Issue 1 concerning realignment should be dismissed because there was no final determination over SSI realignment and the Provider's appeal is premature as the Provider has not exhausted all available remedies.[7]

With respect to SSI realignment, the MAC contends that this issue has been abandoned. The Provider did not brief the issue of SSI realignment within its preliminary position paper. As a result, it should be considered withdrawn in accordance with Board Rule 25.3. Alternatively, the MAC asserts that the Board does not have jurisdiction over realignment. There was no final determination over the SSI realignment and the appeal is premature as the Provider has not exhausted all available remedies. This issue should be dismissed. It should also be noted that the Provider's fiscal year end is the same as the federal fiscal year end (September 30). The result of the Medicare computation based on the Provider's fiscal year end would therefore be the same as the Medicare computation based on the federal fiscal year end.[8]

Issue 5 – DSH – Medicaid Eligible Days

The MAC contends that the Provider abandoned Issue 5 when it failed to properly develop the merits of this issue within its preliminary position paper in accordance with Board Rule 25. Additionally, the Provider has failed to submit (either as part of its appeal request or its preliminary position paper) a list of additional Medicaid eligible days or any other supporting documents or explanation for why it cannot produce those documents.[9] In this regard, the MAC notes in footnote 21 of its Challenge that it "requested the listing of additional eligible days in dispute from the Provider's Representative on 2/11/2021, 08/03/2021, and 02/04/2022" but that "[t]he MAC received no response to the requests."

[6] Group Issue Statement, Case No. 21-0235G.
[7] MAC's Jurisdictional Challenge, at 2.
[8] *Id*.
[9] *Id*.

Provider's Response

The Provider did not file a response to the jurisdictional challenge. As previously noted, Board Rule 44.4.3 which specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record." Further, Board Rule 5.5.1 entitled "Deadlines Must Continue To Be Met" specifies that "the recent appointment of a new case representative, generally[,] will not be considered cause for delay of any deadlines or proceedings."

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.

A. SSI 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 directly filed into Group Case No. 21-0235G, QRS CY 2016 DSH SSI Percentage (2) Group.

The Board finds that the first aspect of Issue 1 (the DSH/SSI (Provider Specific) issue) in this appeal is duplicative of Issue 2 (the DSH/SSI (Systemic Errors) issue) that was directly filed into Case No. 21-0235G. The first aspect of Issue 1 in the present appeal concerns "whether the Medicare Administrative Contractor used the correct [SSI] percentage in the [DSH] Calculation."[10] The Provider's legal basis for this aspect of Issue 1 is simply that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[11] Similarly, the Provider argues that "it[s] SSI percentage published by [CMS] was incorrectly computed . . ." and it ". . . [s]pecifically . . . disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42

[10] Individual Appeal Request, Issue 1.
[11] *Id.*

C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[12] The DSH systemic issues filed into Case No. 21-0235G, similarly alleges that the Medicare Contractor and CMS improperly calculated the DSH/SSI Percentage, the DSH/SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F)(i). Indeed, the Provider has the same amount in controversy for both Issue 1 and for its participation in the optional group, namely $92,000.

Thus, the Board finds that the first aspect of Issue 1 in this appeal is duplicative of the group issue in Case No. 21-0235G, for this same provider and fiscal year. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (Mar. 1, 2013), the Board dismisses this aspect of the DSH/SSI (Provider Specific) issue.

In making this finding, the Board further notes that CMS regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, is pursuing that issue as part of the group under Case 21-0235G. 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.[13] 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. 21-0235G. Indeed, the ***group*** issue statement references one aspect of the ***group*** issue as "[n]ot in agreement with provider's records."

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. 21-0235G, 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 describe its efforts to obtain the MEDPAR data, much less explain why the MEDPAR data is unavailable. More specifically, the Provider has only nebulously stated that it "is seeking" MEDPAR data without confirming whether it has, in fact, submitted a request for the MEDPAR data (much less explain both its efforts, with dates, to obtain the data and why it remains unavailable). In this regard, Board Rule 25.2.2 specifies:

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[12] *Id.*

[13] 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.

Similarly, the Provider has made the general ascertain that "***certain*** data from the State of Connecticut and the Provider"[14] support its position that the SSI percentage is understated. However, the Provider has not explained what that "data" is, has not entered that "data" into the record (even though the Notice of Critical Due Dates and Board Rule 25.2.1[15] require that all available exhibits supporting its position be submitted with the position paper), and has not explained why that documentation was not produced with its position paper in compliance with Board Rule 24.2.2.

The Board further notes that the MEDPAR data may be readily available to the Provider. 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:

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[14] (Emphasis added.)

[15] This Rule states in pertinent part, that "[w]ith the position papers, the parties must exchange ***all*** *available* documentation as exhibits to fully support your position." (Emphasis added.)

> 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]

Finally, the Board recognizes that one aspect of Issue 1 concerned the Provider's contention "that CMS inconsistently interprets the term 'entitled' as it is used in the statute." More specifically, the appeal request further acknowledges that "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" and that "CMS interprets the term 'entitled' broadly as it applies to the denominator by including patient days of individuals that are in some sense 'eligible' for SSI but did not receive an SSI payment." However, this aspect of the Issue 1 did not comply with the content requirements explained in 42 C.F.R. § 405.1835(b) in that it fails to sufficiently explain "[w]hy the provider believes Medicare payment is incorrect" as it relates to the alleged inconsistent interpretation of the term "entitled" and "how and why the provider believes Medicare payment must be determined differently" with respect to the alleged inconsistent interpretation of the term "entitled." In this regard, the Board notes that the amount in controversy calculation fails to provide this information. Indeed, the Board finds that the Provider *wholly* abandoned this aspect of Issue 1 in its preliminary position paper because there is not discussion or reference to this aspect of Issue 1 (much less a complete brief of the merits of this aspect of Issue 1 in compliance with Board Rule 25 and 42 C.F.R. § 405.1853(b)(2)-(3) (as quoted *infra*). In this regard, the Board notes that Board Rule 25.3 states, in pertinent part, that "[i]f the provider fails to brief an appealed issue in its position paper, the Board will consider the unbriefed issue abandoned and effectively withdrawn."

Accordingly, the Board must find that Issues 1 and the group issue in the optional group under Case No. 21-0235G, are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (2015), the Board dismisses this component of the DSH/SSI (Provider Specific) issue. As an alternative and independent bases, the Board dismisses Issue 1 for failure of the Provider to properly brief the issue in its position paper in compliance with Board Rules and 42 C.F.R. 405.1853(b)(2)-(3) and for failing to meet the appeal request "content" requirements in 42 C.F.R. 405.1835(b).

2. Second Aspect of Issue 1

The second aspect of the DSH SSI Percentage (Provider Specific) issue—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—has been abandoned and effectively withdrawn. As noted above, Board Rule 25.3 specifies that if the Provider fails to brief an appealed issue in its position paper, then the Board will consider the unbriefed issue as effectively withdrawn and abandoned. This is consistent with the position paper requirements in § 405.1853(b)(2)-(3).

[16] (Last accessed Nov. 21, 2022.)
[17] (Emphasis added.)

Even if the Board found that it had been abandoned, the Board would dismiss it for lack of jurisdiction and as premature. Under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request…" Without this written request, the Medicare Contractor cannot issue a final determination from which the Provider can be dissatisfied with for appealing purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding the Provider's DSH SSI Percentage realignment as such there is no "determination" to appeal and the appeal of this issue is otherwise premature.

B. Issue 5 -- 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 calculations. The Provider states Issue 5 as:

> **Statement of the Issue**
>
> Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.
>
> **Statement of the Legal Basis**
>
> The Provider contends the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.
>
> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.[18]

The amount in controversy calculation and protested item documentation for this issue suggests the number of Medicaid eligible days at issue is 150; however, this appears to be an estimate rather than based on a listing since that 150 days is described as a "0.25%" impact similar to Issues 1 through 4. In this regard, the Board notes that the Provider's appeal request did not explain what the 0.25% estimate was based on, ***or*** include a list of the specific additional Medicaid eligible days that are in dispute in this appeal and that the Provider desires to be included in their Medicaid percentage and DSH computations.

[18] *Id*.

While the Calculation Support filed with their appeal notes a net impact of $92,000, with an increase in days, it is unclear whether this estimated amount continues to be in dispute as of the Provider's filing of the position paper. Board Rule 7.3.1.2 (Nov. 2021) 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 MAC asserts that the Provider neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2.

Notably, the Provider has not included a list of additional Medicaid eligible days with its preliminary position paper filed on January 22, 2021 or submitted such list under separate cover. It has been almost 2 years since the Provider filed its preliminary position paper and it still has not filed the promised listing. Indeed, subsequent to the Provider filing its position paper, the MAC has represented in footnote 21 of its Challenge that it contacted the Provider's representative, QRS, on 3 separate occasions (2/11/2021, 08/03/2021, and 02/04/2022), requesting a copy of the promised listing of additional eligible days in dispute and that QRS failed to respond to any of these requests. Thus, the MAC asserts that the Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it cannot produce those documents, as required by the regulations and the Board Rules.[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*

[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.

> *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) (Jul. 2015) states:

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

Similarly, regarding position papers,[21] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[22] This requirement is consistent with 42 C.F.R. § 405.1853(b)(3).

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

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

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

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

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

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[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.)
[23] (Emphasis added.)

> 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 25.2.2.

The Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of Board Rules 25.2.1 and 25.2.2 related to identifying the days in dispute and the submission of documentary evidence required to support its claims or describe why said evidence is unavailable, which the Provider has failed to do.[25] The fact remains that, at this late stage of the appeal, the Provider has failed to identify for the record a single Medicaid eligible day in dispute (*even after being repeatedly as by the MAC to provide that listing*) and, as such, the Board must conclude that the ***actual*** amount in controversy is $0. The Board takes administrative notice that it has made similar dismissal in other cases in which QRS was the designated representative and, notwithstanding, QRS failed to provide the Medicaid eligible days listing with its preliminary position paper.[26]

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[24] (Emphasis added.)
[25] Board Rule 25, of which 25.2.1 and 25.2.2 are a part, is applicable to final position papers via Board Rule 27.2.
[26] Examples of cases in which QRS was the designated representative and which the Board dismissed for failure of the Provider to provide a listing of Medicaid eligible days at issue include, but are not limited to: Case No. 14-2674 (by letter dated 5/5/2022); Case No. 16-2521 (by letter dated 5/5/2022); Case No. 16-0054 (by letter dated 5/5/2022); Case Nos. 13-3022, 13-3211, 14-2506, 14-4313, 16-1712 (by letter dated 9/30/2022). Moreover, the Board's

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In summary, as explained above, the Board hereby dismisses the SSI Provider Specific issue from this appeal based on multiple and independent bases, including that it is duplicative of the issue in Case No. 21-0235G, 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 in 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rules (as well as failed to meet the appeal request "content" requirements under 42 C.F.R. § 405.1835(b) for at least one aspect of Issue 1). The Board also dismisses the Medicaid Eligible days issue as the Provider also failed to meet the Board requirements for position papers for this issue. Indeed, at this late stage of the appeal, the Provider has failed to identify for the record a single Medicaid eligible day in dispute for Issue 5 and, as such, the Board must conclude that the ***actual*** amount in controversy for Issue 5 is $0. As no issues remain pending in this appeal, the Board hereby closes Case No. 20-2155 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.
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Kevin D. Smith, CPA
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For the Board:

12/30/2022

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services

attention to the filing deficiency was brought to the Board's attention via a motion to dismiss filed by the Medicare Contractor (as a motion or in a position paper) well in advance of the position paper filed in this case.