DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Patrick Jordan
Petrak & Associates, Inc.
18114 Viceroy Drive
San Diego, CA 92128

RE: ***Expedited Judicial Review Determination***

14-0268GC	Citrus Valley 2007 DSH Medicaid Fraction Part C Days CIRP Group
14-0271GC	Citrus Valley 2007 DSH SSI Fraction Part C Days CIRP Group
14-1166GC	CVHP 2008 DSH Medicaid Fraction Part C Days CIRP Group
14-0969GC	CVHP 2008 DSH SSI Fraction Part C CIRP Group
14-3654GC	CVHP 2009 DSH Medicaid Fraction Dual Eligible Part C Days CIRP Group
14-3666GC	CVHP 2009 DSH SSI Fraction Part C Days CIRP Group
15-3211GC	CVHP 2010 DSH Medicaid Fraction Dual Eligible Part C Days CIRP Group
15-3210GC	CVHP 2010 DSH SSI Fraction Part C Days CIRP Group
15-3303GC	CVHP 2011 DSH Medicaid Fraction Dual Eligible Part C Days CIRP Group
15-3313GC	CVHP 2011 DSH SSI Fraction Part C Days CIRP Group
16-0204GC	CVHP 2012 DSH Medicaid Fraction Part C Days CIRP Group
16-0200GC	CVHP 2012 DSH SSI Fraction Part C Days CIRP Group
17-1114GC	CVHP 2013 DSH Medicaid Fraction Part C Days Pre 10/1 Discharges CIRP
17-1116GC	CVHP 2013 DSH SSI Fraction Part C Days Pre 10/1/2013 Discharges CIRP

Dear Mr. Jordan:

On December 12, 2019, the Provider Reimbursement Review Board ("Board") notified the Providers in the above-captioned fourteen (14) common issue related party ("CIRP") group cases that, pursuant to 42 C.F.R. § 405.1842(c), it was considering, on its own motion, whether Expedited Judicial Review ("EJR") was appropriate for these 14 CIRP group cases. The Providers and Federal Specialized Services ("FSS"), on behalf of the Medicare Contractor, have submitted comments as to whether the Board is without the authority to decide the following legal questions:[1]

> Whether the Medicare Contractor wrongfully included the Provider's Medicare Part C days in the Medicare Proxy used to calculate the Provider's allowable Medicare disproportionate share payment.[2]
>
> Whether the Medicare Contractor failed to include all of the Provider's Medicare Part C days in the numerator of the Medicaid

[1] The Providers' comments were received on January 10, 2020. Federal Specialized Services, on behalf of the Medicare Contractor, submitted its comments on January 13, 2020.
[2] *See, e.g.*, Case number 14-0271GC, Citrus Valley Medical Center-Inter-Community, provider no. 05-0382, FYE 12/31/07, Request for PRRB Hearing, Issue Statement at Tab 1B.

> Proxy used to calculate the Provider's allowable Medicare disproportionate share hospital ("DSH") payment.[3]

The Board's decision determining that Own Motion EJR is appropriate for the issue and federal fiscal years ("FFYs") under appeal is set forth below.

Statutory and Regulatory Background: Medicare DSH Payment

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the prospective payment system ("PPS").[4] Under PPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[5]

The PPS statute contains a number of provisions that adjust reimbursement based on hospital-specific factors.[6] These cases involve the hospital-specific DSH adjustment, which requires the Secretary to provide increased PPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[7]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[8] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.[9] The DPP is defined as the sum of two fractions expressed as percentages.[10] Those two fractions are referred to as the "Medicare/SSI" fraction and the "Medicaid" fraction. Both of these fractions consider whether a patient was "entitled to benefits under part A."

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

> the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter . . . .[11]

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[3] *See, e.g.*, Case number 14-0268GC, Citrus Valley Medical Center-Inter-Community, provider no. 05-0382, FYE 12/31/07, Request for PRRB Hearing, Issue Statement at Tab 1B.
[4] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[5] *Id.*
[6] *See* 42 U.S.C. § 1395ww(d)(5).
[7] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[8] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[9] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[10] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[11] Emphasis added.

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare Contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[12]

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

> [T]he fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX [the Medicaid program], but who were *not entitled to benefits under part A of this subchapter*, and the denominator of which is the total number of the hospital's patient days for such period.[13]

The Medicare Contractor determines the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period.[14]

Medicare Advantage Program

The Medicare program permits its beneficiaries to receive services from managed care entities. The managed care statute implementing payments to health maintenance organizations ("HMOs") and competitive medical plans ("CMPs") is found at 42 U.S.C. § 1395mm. The statute at 42 U.S.C. § 1395mm(a)(5) provides for "payment to the eligible organization under this section for individuals enrolled under this section with the organization and entitled to benefits under part A and enrolled under part B . . . ." Inpatient hospital days for Medicare beneficiaries enrolled in HMOs and CMPs prior to 1999 are referred to as Medicare HMO patient care days.

In the September 4, 1990 Federal Register, the Secretary[15] stated that:

> Based on the language of section 1886(d)(5)(F)(vi) of the Act [42 U.S.C. § 1395ww(d)(5)(F)(vi)], which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A," we believe it is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs, and therefore, were unable to fold this number into the calculation [of the DSH adjustment]. However, as

[12] 42 C.F.R. § 412.106(b)(2)-(3).
[13] Emphasis added.
[14] 42 C.F.R. § 412.106(b)(4).
[15] of Health and Human Services.

> of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[16]

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[17]

With the creation of Medicare Part C in 1997,[18] Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C days in the SSI ratios used by the Medicare contractors to calculate DSH payments for the fiscal year 2001-2004.[19]

No further guidance regarding the treatment of Part C days in the DSH calculation was provided until the 2004 Inpatient Prospective Payment System ("IPPS") proposed rules were published in the Federal Register. In that notice the Secretary stated that:

> [O]nce a beneficiary has elected to join an M+C plan, that beneficiary's benefits are no longer administered under Part A. . . . *once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage. These patient days should be included in the count of total patient days in the Medicaid fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction.*[20]

The Secretary purportedly changed her position in the Federal fiscal year ("FFY") 2005 IPPS final rule, by noting she was "revising our regulations at [42 C.F.R.] § 412.106(b)(2)(i) to include the days associated with [Part C] beneficiaries in the Medicare fraction of the DSH calculation."[21] In response to a comment regarding this change, the Secretary explained that:

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[16] 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).
[17] *Id.*
[18] The Medicare Part C program did not begin operating until January 1, 1999. *See* P.L. 105-33, 1997 HR 2015, *codified as* 42 U.S.C. § 1394w-21 Note (c) "Enrollment Transition Rule.- An individual who is enrolled [in Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered to be enrolled with that organization on January 1, 1999, under part C of Title XVIII . . . if that organization has a contract under that part for providing services on January 1, 1999 . . . ." This was also known as Medicare+Choice. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub.L. 108-173), enacted on December 8, 2003, replaced the Medicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.
[19] 69 Fed. Reg. 48916, 49099 (Aug. 11, 2004).
[20] 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).
[21] 69 Fed. Reg. at 49099.

> *[W]e do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A. We agree with the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction. . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.*[22]

This statement would require inclusion of Medicare Part C inpatient days in the Medicare fraction of the DSH calculation.

Although the change in DSH policy regarding 42 C.F.R. § 412.106(b)(2)(i) was included in the August 11, 2004, Federal Register, no change to the regulatory language was published until August 22, 2007, when the FFY 2008 IPPS final rule was issued.[23] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change adopted in the FFY 2005 IPPS final rule. These "technical corrections" are reflected at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).[24] As a result of these rulemakings, Part C days were required to be included in the Medicare fraction as of October 1, 2004 (the "Part C DSH policy"). Subsequently, as part of the FFY 2011 IPPS final rule published on August 15, 2010, CMS made a minor revision to §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) "to clarify" the Part C DSH policy by replacing the word "or" with "including."[25]

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[26] vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.[27] However, the Secretary has not acquiesced to that decision.

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[22] *Id.* (emphasis added).
[23] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[24] *Id*. at 47411.
[25] 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: "We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word 'or' with the word 'including' in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B)."); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff'd in part and rev'd in part*, 746 F. 3d 1102 (D.C. Cir. 2014).
[26] 746 F. 3d 1102 (D.C. Cir. 2014).
[27] *Id*. at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also*

More recently, in *Allina Health Services v. Price* ("*Allina II*"),[28] the D.C. Circuit confirmed that the Secretary's 2004 attempt to change the standard to include Part C days in the Medicare fraction had been vacated in *Allina I*.[29] The D.C. Circuit further found in *Allina II* that the Secretary failed to provide proper notice and comment before including Part C days in the Medicare fractions published for FY 2012.[30] Once again, the Secretary has not acquiesced to this decision.

Board's Consideration for Own Motion EJR

In the FFY 2005 Final Rule, the Secretary announced a policy change. This policy was to include Part C days in the Medicare Part A/SSI fraction and exclude them from the Medicaid fraction effective for discharges on or after October 1, 2004.[31] In *Allina I*, the Court affirmed the district court's decision "that the Secretary's final rule [for FFY 2005] was not a logical outgrowth of the proposed rule [for FFY 2005]."[32] The Providers maintain that CMS' policies and regulations requiring the inclusion of Part C days in the Medicare fraction and exclusion of dual eligible Part C days from the Medicaid fraction violate the notice and comment provisions of the Medicare Act and therefore are invalid.[33]

The Providers assert that CMS policy specified at page 49099 of the Federal Register dated August 11, 2004 and the regulations set forth at 42 C.F.R. § 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) result in the Medicare Contractor having no authority or discretion to exclude Part C days from the Medicare fraction used to calculate DSH payments.[34] The Providers argue that all Part C days should be excluded from the Part A/SSI fraction and the Medicaid-eligible Part C days should be included in the numerator of the Medicaid fraction.[35]

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 EJR 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

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Allina Health Servs. v. Sebelius, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").

[28] 863 F.3d 937 (D.C. Cir. 2017).

[29] *Id.* at 943.

[30] *Id.* at 943-945.

[31] 69 Fed. Reg. at 49,099.

[32] *Allina* at 1109.

[33] Case number 14-0271GC, Citrus Valley Medical Center-Inter-Community, provider no. 050382, FYE 12/31/07, Request for PRRB Hearing, Issue Statement at Tab 1B; Foothill Presbyterian Hospital, provider no. 05-0597, FYE 12/31/07, Disputed Audit Adjustments and/or Determination Challenged at Tab 2D.

[34] *Id.*

[35] Case number 14-0268GC, Citrus Valley Medical Center-Inter-Community, provider no. 05-0382, FYE 12/31/07, Request for PRRB Hearing, Issue Statement at Tab 1B; Foothill Presbyterian Hospital, provider no. 05-0597, FYE 12/31/07, Request for PRRB Hearing, Issue Statement at Tab 2B.

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.

Jurisdiction

The participants addressed in this Own Motion EJR determination have filed appeals involving fiscal years 2007 through 9/30/2013.

For purposes of Board jurisdiction over a participant's appeal for cost report periods ending prior to December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hosp. Ass'n v. Bowen* ("*Bethesda*").[36] 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.[37]

On August 21, 2008, new regulations governing the Board were effective.[38] Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hosp. v. Burwell* ("*Banner*").[39] 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.[40]

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

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[36] 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.).
[37] *Bethesda*, 108 S. Ct. at 1258-59.
[38] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[39] 201 F. Supp. 3d 131 (D.D.C. 2016)
[40] *Id.* at 142.

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.

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.[41] The Board notes that all participant revised NPR appeals included within this EJR request were issued after August 21, 2008.

The Board has determined that the participants' appeals involved with the instant own-motion EJR are governed by the decision in *Bethesda* and CMS-1727R as they are challenging a regulation. With two exceptions, each Provider appealed from an original NPR. Citrus Valley Medical Center-Inter-Community (Provider No. 05-0382 for the FYE 12/31/07) in Case Nos. 14-0268GC and 14-0271GC, who appealed from a revised NPR in which adjustments were made by the Medicare Contractor to revise the Medicare SSI fraction in the DSH calculation to ensure the accurate inclusion of Medicare Advantage data submitted by providers. Thus, Part C days were specifically adjusted.

In addition, the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for group appeals[42] and that the appeals were timely filed. The estimated amount in controversy is subject to recalculation by the Medicare Contractor for the actual final amount in each case. Accordingly, the Board finds that it has jurisdiction for the referenced appeals and the participants.

Board's Analysis Regarding the Appealed Issue

The appeals in these EJR requests involve the fiscal years 2007 through 9/30/2013 cost reporting periods. Thus, the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's Part C DSH policy being challenged which was adopted in the FFY 2005 IPPS final rule and later codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) as part of the FFY 2008 IPPS final rule (with a minor revision published in the FFY 2011 IPPS final rule). The Board recognizes that, for the time period at issue in these requests, the D.C. Circuit in *Allina I* vacated this regulation. However, the Secretary has not formally acquiesced to that *vacatur* and, in this regard, has not published any guidance on how the *vacatur* is being implemented (*e.g.*, only circuit-wide versus nationwide).[43] Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located.[44] Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR.

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[41] See 42 C.F.R. § 405.1889(b)(1) (2008).
[42] *See* 42 C.F.R. § 405.1837.
[43] *See generally Grant Med. Ctr. v. Burwell*, 204 F. Supp. 3d 68, 77-82 (D.D.C. 2016), *aff'd*, 875 F.3d 701 (D.C. Cir. 2017).
[44] *See* 42 U.S.C. § 1395oo(f)(1).

Board's Decision Regarding the Own Motion EJR

The Board finds that:

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

2) Based upon the participants' assertions regarding 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B), 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. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) codifying the Medicare Part C DSH policy adopted in the FFY 2005 IPPS final rule are valid.

Accordingly, the Board finds that the question of the validity of 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants its Own Motion EJR for the issue and the subject years. The participants have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in these cases, the Board hereby closes the cases.

Board Members Participating:

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

For the Board:

5/6/2020

X Clayton J. Nix

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

Enclosure: List of Providers

cc: Wilson Leong, Federal Specialized Services
Lorraine Frewert, Noridian Healthcare Solutions

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Christopher Crosswhite
Duane Morris
505 9th Street, N.W., Ste. 1000
Washington, DC 20004

Geoffrey Pike
First Coast Service Options, Inc.
532 Riverside Ave.
Jacksonville, FL 32202

RE: ***Jurisdictional Determination***
Memorial Regional Hospital (Prov. No. 10-0038)
FYE 4/30/2015
Case No. 18-1850

Dear Messrs. Crosswhite and Pike:

This case involves the Provider's appeal of its Medicare reimbursement for the fiscal year ending ("FYE") in 2015. The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Provider's documentation in response to the Medicare Contractor's jurisdictional challenge. Following review of the documentation, the Board finds that it does not have jurisdiction to hear the Provider's Inpatient Rehab Facilities – Low Income Payment ("IRF-LIP") reimbursement issues and dismisses the instant appeal.

Pertinent Facts

The Board received the Provider's request for a hearing ("RFH") regarding a Notice of Program Reimbursement ("NPR") for FYE ending in 2015 on September 17, 2018.[1] In its RFH, the Provider lists three issues for appeal, all relating to the calculation of the Low-Income Patient ("LIP") fraction of the Medicare DSH payment for inpatient rehabilitation distinct-part units ("IRFs"). Specifically, the RFH in the above appeal included the following three issues:

> ISSUE NO. 1 - LIP ADJUSTMENT SSI% DATA & MATCH PROCESS
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> Whether the Centers for Medicare & Medicaid Services ("CMS") has correctly determined the "SSI percentage" used in calculating the disproportionate patient percentage of the Provider's rehabilitation unit for purposes of the low-income patient adjustment under IRF PPS.

[1] Provider's Request for Hearing, PRRB Case No. 18-1850 (Sep. 17, 2018).

> ISSUE NO. 2 - LIP ADJUSTMENT NON-COVERED / DUAL ELIGIBLE DAYS
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> Whether in determining the rehabilitation unit's disproportionate patient percentage for the low-income patient adjustment, the rehabilitation unit's days of care that were rendered to Medicare beneficiaries but that were not covered under Medicare Part A should be included in its SSI percentage or in its Medicaid percentage (to the extent the noncovered days were for patients also eligible for Medicaid).
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> ISSUE NO. 3 - LIP A.DJUSTMENT PART C DAYS
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> Whether in determining the rehabilitation unit's disproportionate patient percentage for the low-income patient adjustment, the rehabilitation unit's Medicare Part C days should be included in its SSI percentage or in its Medicaid percentage (to the extent the Medicare Part C days were for patients also eligible for Medicaid).[2]

Medicare Contractor's Jurisdictional Challenge

The Medicare Contractor filed a Jurisdictional challenge on July 24, 2019, arguing the IRF/LIP adjustment "is a component of the IRF prospective payment rate established under Section 1886(j)(3)(A)(v)" of the Social Security Act (*i.e.*, 42 U.S.C. § 1395ww(j)(3)(A)(v)) and that, therefore, the Board "does not have subject matter jurisdiction over the IRF LIP payment or any of its components."[3] It argues that:

> [I]n accordance with Section 1886(j)(8)(B), there is no administrative or judicial review of the IRF prospective payment rates under paragraph (3). Because the IRF LIP payment has been established under paragraph (3), the contractor contends that the Board does not have subject matter jurisdiction over the IRF LIP payment or any of its components.[4]

Provider's Response

The Provider, in response, contends that Board jurisdiction is proper over the IRF/LIP adjustment issues in this appeal for three principal reasons. First, that the Provider satisfies the requirements for a Board hearing under 42 U.S.C. § 1395oo(a).[5] Second, the statutory provision

[2] *See* Provider's Preliminary Position Paper, at 1-2 (May 15, 2019).
[3] *Id*.
[4] *Id*. at 3.
[5] Provider's Jurisdictional Response, at 10 (Nov. 22, 2019).

regarding IRF PPS does not preclude review of the IRF/LIP adjustment at issue.[6] Third, any post-hoc statements by CMS to preclude review are contrary to the statute and fail to comply with notice and comment rulemaking requirements.[7]

Board's Analysis and Decision

Applicable Regulatory Provisions and Board Rules

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

Rehab Days in LIP Adjustment Calculations

Under 42 U.S.C. § 1395ww(j)(8)(B), Congress specifically precludes certain administrative or judicial review of the prospective payment rates ("PPS") for inpatient rehabilitation facilities ("IRFs"). Although providers have attempted to dispute exactly what rate-setting "steps" Congress intended to shield from review under the statute, the decision of the U.S. Court of Appeals for the District of Columbia Circuit ("D.C. Circuit") in *Mercy Hospital, Inc. v. Azar* ("*Mercy*"),[8] answers this question and clarifies what is shielded from review in its analysis of this issue.[9]

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."[10] 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. In *Mercy*, the

[6] *Id*.
[7] *Id*.
[8] *Mercy Hosp., Inc. v. Azar*, 891 F.3d 1062 (D.C. Cir. 2018).
[9] *Id*.
[10] *Id*. at 1064.

D.C. Circuit affirmed the District Court, wherein the District Court concluded that 42 U.S.C. § 1395ww(j)(8) prohibits administrative or judicial review of the Medicare Contractor's determination of the LIP adjustment, because such review amounts to review of the establishment of the hospital's prospective payment rates.[11] The D.C. Circuit concluded that the Statute's plain language prohibits administrative and judicial review of not only the statutory adjustments, but also the "step two rates" utilized by the Medicare Contractor when adjusting the standardized reimbursement rate and then calculating a hospital's final payment.[12]

In the instant appeal, the Provider seeks Board review of three of the components utilized by the Medicare Contractor to determine the Provider's LIP adjustment, namely its SSI—or Medicare—Ratio; dual eligible days; and Part C Days. As 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 issues and dismisses the issues in the instant appeal that challenge this adjustment. In making this finding, the Board notes that the Court of Appeals decision in *Mercy* is controlling precedent because the Providers could bring suit in the D.C. Circuit.[13] As all the remaining issues in the appeal directly implicate the IRF LIP payment (and its components) and have been dismissed, the Board hereby closes Case No. 18-1850 and removes it from the Board's docket.

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

Board Members Participating:

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

For the Board:

5/13/2020

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services

[11] *Mercy Hosp., Inc. v. Burwell*, 206 F. Supp. 3d 93, 102 (D.D.C. 2016).
[12] *Mercy*, 891 F.3d at 1068.
[13] 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).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Anthony Hall
Hall Consulting Services
4765 SW 148 Ave., Ste. 501
Davie, FL 33330

RE: ***Denial of Request to Reconsider Dismissal Due to Untimely Filing***
Jackson Memorial Hospital (10-0022)
FYE 9/30/1999
Case No. 19-1073

Dear Mr. Hall:

The Provider Reimbursement Review Board ("Board") has reviewed the above-referenced appeal in response to your March 11, 2020, Request for Reconsideration ("Reconsideration Request") of Jackson Health System's ("Jackson" or "Provider") case. As explained more fully below, the Board denies your request for reconsideration of this case.

Pertinent Facts:

Jackson electronically filed a Group Appeal Request on February 11, 2019, for fiscal year ending September 30, 1999 in the Office of Hearings Case and Document Management System ("OH CDMS"). In its appeal, the Provider includes a number of issues related to its Notice of Program Reimbursement ("NPR") issued on August 10, 2018.

On March 20, 2019, ***after Jackson had filed its appeal request***, the Board issued the Case Acknowledgment and Critical Due Dates Notice ("Critical Due Dates Notice") and, therein, instructed Jackson to file its preliminary position paper by the October 9, 2019 filing deadline. This Notice advised the parties: "The parties ***must meet*** the following due dates regardless of any outstanding jurisdictional challenges, motions, or subpoena requests. *If the Provider misses any of its due dates, the Board* ***will dismiss*** *the appeal*."[1]

On November 12, 2019, the Board dismissed the appeal due to untimely filing of Jackson's Preliminary Position Paper. On October 30, 2019, Jackson filed a "Revised Provider Reimbursement Review Board Filing," utilizing the Preliminary Position Paper case action.[2] This filing was marked as "late" based on the fact that the due date provided by the Critical Due

[1] (Emphasis added).
[2] Provider's Preliminary Position Paper (Oct. 30, 2019).

Dates letter had already passed, and the fact that case was marked for dismissal, which as stated earlier, ultimately occurred on November 12, 2019.

On November 19, 2019, Jackson filed a Request for Reinstatement arguing that all documents were properly filed in accordance with all applicable deadlines.[3] Jackson argued that the listing of the documentation and the dates sufficiently provides support for the contention that its Preliminary Position Paper was filed timely. On February 20, 2020, the Board denied Jackson's Request for Reinstatement, reaffirming its finding that Jackson failed to timely file its preliminary position paper in compliance with the Board Rules and regulations.

On March 11, 2020, Jackson submitted a second Reinstatement Request. In this request, Jackson resubmitted that the listing of the documentation and the dates sufficiently provides support for the contention that the Preliminary Position Paper was timely filed, based on previous arguments. Jackson also alleged that there were a "considerable number of issues which were omitted and/or partially excluded."

Board's Determination

The Board has reviewed the initial appeal request and all additional submissions and documents filed in the case and declines to reverse its original dismissal.

42 C.F.R. 405.1853(b) addresses submission of position papers by the parties to narrow the issues and specifically states that they "must" be submitted in each case:

> (b) Position papers.
>
> (1) *After any preliminary narrowing of the issues, **the parties must file position papers*** in order to narrow the issues further. In each case, and as appropriate, *the Board establishes the deadlines as to when the provider(s)* and the contractor ***must** submit position papers to the Board*.
>
> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper must set forth the relevant facts and arguments 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

[3] Provider's Request for Reinstatement, at 1 (Nov. 19, 2019).

> timeframe to be decided by the Board through a schedule applicable to a specific case or through general instructions.

Pursuant to 42 C.F.R. § 405.1868(b) and Board Rule 27, if a provider fails to meet a filing deadline or other requirement established by the Board in a rule or order, the Board may dismiss the appeal with prejudice. Pursuant to 42 C.F.R. § 405.1801(a) and Board Rule 3, the date of filing is the date of receipt by the Board, or the date of delivery by a nationally-recognized next-day courier.

Board Rules 23 and 25 address preliminary position papers. The updated Board Rules, effective August 29, 2018, and superseding all previous rules and instructions, included an updated version of Board Rule 23. Board Rule 23 states that with the implementation of OH CDMS:

> [P]arties are ***now required*** *to file the* ***complete*** *preliminary position paper* with the narrative, listing of exhibits, and all exhibits. As the Board will now obtain a full copy of the preliminary position paper, which is required to have the fully developed position and identification of the controlling authority needed to support each issue in the appeal, final position papers will be optional for new appeals filed on or after the effective date of the rules. Final position papers are still mandatory for all appeals that were filed prior to that date.[4]

In concert with Rule 23, Board Rule 23.4 states that if the provider's preliminary position paper is not filed by the due date, "the case will be dismissed."[5]

To this end, as noted above, ***after*** ***Jackson filed its appeal request***, the Board issued the Board's March 20, 2019 Critical Due Dates Notice. This Notice acknowledged this appeal and set October 19, 2019 as the filing deadline for the Provider's preliminary positon paper and gave the following instructions regarding the content of the preliminary position paper that was to be filed:

> 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.[6]

[4] Provider Reimbursement Review Board Rules, Rule 23 (Aug. 29, 2018).
[5] *Id.* at Rule 23.4.
[6] (Bold emphasis added.)

Further, this Notice advised the Provider that "the Board will dismiss the appeal" if it failed to meet this filing deadline. As such, Jackson should have been well aware that it needed to file its preliminary position paper.

Further, the Board issued an alert to all external users and stakeholders regarding the change in the Board rules, both by email blast as well as an alert posted on the "Current Alerts" section of the Board website. This alerted highlighted specific important changes including the requirement that a full preliminary position paper be filed: "*[r]equire the filing of the full preliminary position paper to both the opposing party and the Board (currently the preliminary position paper is only filed on the opposing party with only a cover letter to the Board).*"[7]

Board Rule 25.1 specifies the content required to be expounded upon in the preliminary positon paper includes the following:

> A. Identify any issues that were raised in the appeal but are already resolved (whether by administrative resolution, agreement to reopen, transfer, withdrawal, dismissal, etc.) and require no further documentation to be submitted.
>
> B. For each issue that has not been fully resolved, state the material facts that support the provider's claim.
>
> C. Identify the controlling authority (e.g., statutes, regulations, policy, or case law) supporting the provider's position.
>
> D. Provide a conclusion applying the material facts to the controlling authorities.[8]

Further, Board Rule 25.3 lists the following filing requirements, in relevant part, for the preliminary position paper:

> Parties should file with the Board a **complete** preliminary position paper with a fully developed narrative (Rule 23.1 [*sic* 25.1]), all exhibits (Rule 23.2 [*sic* 25.2]), a listing of exhibits, and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. Any issue appealed, but not briefed by the Provider in its position paper will be considered withdrawn.

Further, the Commentary to Board Rule 25.3 cross-references Board Rule 23.4 and again warns providers that "Failure to file a **complete** preliminary position paper with the Board will result in

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[7] *ALERT 15: Revised PRRB Rules (August 29, 2018)*, Current Alerts, PRRB Review (last visited Jan. 17, 2019), https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/PRRB-Alerts.html.
[8] Board Rule 25.1

dismissal of your appeal or other actions in accordance with 42 C.F.R. § 405.1868. (*See* Rule 23.4.)"

Pursuant to 42 C.F.R. § 405.1868(b) and Board Rule 27, if a provider fails to meet a filing deadline or other requirement established by the Board in a rule or order, the Board may dismiss the appeal with prejudice. Pursuant to 42 C.F.R. § 405.1801(a) and Board Rule 3, the date of filing is the date of receipt by the Board, or the date of delivery by a nationally-recognized next-day courier.

Pursuant to 42 C.F.R. § 405.1868(b) and Board Rule 27, if a provider fails to meet a filing deadline or other requirement established by the Board in a rule or order, the Board may dismiss the appeal with prejudice. Pursuant to 42 C.F.R. § 405.1801(a) and Board Rule 3, the date of filing is the date of receipt by the Board, or the date of delivery by a nationally-recognized next-day courier.

Further, the Board issued an alert to all external users and stakeholders regarding the change in the PRRB rules, both by email blast as well as an alert posted on the "Current Alerts" section of the PRRB website. This alerted highlighted specific important changes including the requirement that a full preliminary position paper be filed: *"[r]equire the filing of the full preliminary position paper to both the opposing party and the Board (currently the preliminary position paper is only filed on the opposing party with only a cover letter to the Board)."*[9]

The Board previously found that Jackson did not comply with the Board rules regarding filing its preliminary position paper and, accordingly, dismissed the appeal on November 12, 2019. In this regard, the Board notes that Jackson should have been well aware that the Board would dismiss the appeal if Jackson failed to timely file its preliminary position paper in compliance with Board Rules as discussed above and the instructions in the Critical Due Dates Notice dated March 20, 2019 issued ***after*** *Jackson had filed its appeal*.

The Board continues to reject the contention that Jackson's issue statements in its appeal request can be considered its already-submitted preliminary position paper. The regulations, the Board Rules, and the March 20, 2019 Critical Due Dates Notice are clear that, after the appeal is filed ***and*** after the parties have conferred about that appeal (including potential resolution),[10] the provider's preliminary positon paper must be filed in order to develop the record (*e.g.*, exchange documents) and further narrow the issue(s). Regardless of what Jackson's Representative named the issue statements in its appeal request, Jackson was required to file preliminary position papers and it failed to do so. As explained more fully in the Board February 20, 2020 Denial of

[9] *ALERT 15: Revised PRRB Rules (August 29, 2018)*, Current Alerts, PRRB Review (last visited Jan. 17, 2019), https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/PRRB-Alerts.html.

[10] Indeed, initial step after a case is filed is for the parties to confer to determine if they can narrow and/or resolve issue(s) or the whole appeal. *See* 42 C.F.R. § 405.1853; Board Rule 23.1 (explaining the "Duty to Confer" and the case progression leading up to the preliminary position paper filing); Board Rule 25.3 (Parties should file a **complete** preliminary position paper with a fully developed narrative . . ., all exhibits . . ., and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853.). To this end, the Critical Due Dates Notice specifies that the preliminary position paper is to include "a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853."

Jackson's Request for Reinstatement, a review of Jackson's late-filed preliminary position paper submitted on October 30, 2019 highlights demonstrates why Jackson needed to file the preliminary position paper and, to that end, why the Board regulations and Board Rules require parties to submit preliminary position papers after an appeal is established. Indeed, Jackson's Second Reinstatement Request dated March 10, 2020 reflects how, subsequent to the appeal being filed, the parties conferred about the case and additional exhibits relevant to this case were identified.[11] Accordingly, based on the above analysis, the Board reaffirms its finding that the Provider failed to timely file its preliminary position paper in compliance with the Board Rules and regulations.

The Board further notes the Provider has offered no explanation, in either of its reconsideration requests, of why it filed its preliminary positon paper late other than the assertion that its original appeal request should be considered its preliminary positon paper. As explained above, the original appeal request cannot be considered the Provider's preliminary position paper and it is clear the Provider was required (and should have known it was required) to file one subsequent to filing its appeal request. Accordingly, the Board hereby declines to reverse its original dismissal and the case remains closed.

Board Members Participating:

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

For the Board:

5/15/2020

X Clayton J. Nix

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

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

[11] *See supra* note 10.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Sven Collins, Attorney
Squire Patton Boggs (US) LLP
1801 California St., Ste. 4900
Denver, CO 80202

Laurie Polson, Appeals Lead
Palmetto GBA c/o Nat'l Gov. Servs. (J-M)
MP: INA 101-AF42
P.O. Box 6474
Indianapolis, IN 46206-6474

RE: ***Squire Patton Boggs 2014 Medicare Outliers - NPR Optional Group III***
Case No. 18-1407G

Dear Mr. Collins and Ms. Polson:

The Provider Reimbursement Review Board ("the Board") has reviewed the subject group appeal in response to the Medicare Contractor's November 26, 2019 challenge to jurisdiction and the Representative's December 20, 2019 response. The pertinent facts of the case and the Board's determination are set forth below.

Pertinent Facts:

On June 26, 2018, Squire Patton Boggs, LLP ("Squire Patton"/ "Representative") filed an optional group for the 2014 Medicare Outlier Issue. The group contains two participants:

Provider	**FYE**
Weirton Medical Center (51-0023)	6/30/2014
Denver Health Medical Center (06-0011)	12/31/2014

On November 26, 2019, the Medicare Contractor ("the MAC") filed a challenge over the Board's jurisdiction.

- The MAC contends that Weirton Medical Center ("Weirton") is appealing the same issue in its individual appeal (Case No. 18-1473) and the subject group. The MAC notes that, per Board Rules, a single issue from the same determination cannot be appealed in multiple cases.

- With regard to Denver Health Medical Center ("Denver Health"), the MAC advises that this Provider already appealed the issue as part of the Squire Patton Boggs 2014 Medicare Outliers Group, Case No. 16-1459G.[1] Accordingly, the MAC notes, again, that the Provider is precluded from going through the appeals process in multiple cases for the same issue for the same FYE.

[1] The MAC's jurisdictional challenge erroneously referenced the group appeal in which Denver Health was a participant as Case No. 16-1649GC.

The Representative responded to the MAC's jurisdictional review in a letter dated December 20, 2019.

- The Representative agrees that Denver Health has a perfected court appeal with respect to the Outlier issue for FYE 2014 and stated that it would later withdraw the Provider, without prejudice, from Case No. 18-1407G.[2]

- With regard to Weirton, the Representative argues that the issue in the group appeal and the individual appeal are different. Specifically, the Provider notes that the group appeal is challenging ". . . its IPPS outlier payments . . . due to the prospectively set outlier fixed loss thresholds for inpatient services . . .", while, in contrast, the individual appeal (Case No. 18-1473) involves the ". . . retrospective decision to reconcile and recoup OPPS outlier payments for outpatient services . . . ."[3]

Board Determination:

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

In the subject group case, the Board agrees with both Parties' positions that Denver Health has a perfected court appeal with respect to the Outlier issue for FYE 2014 as a participant in Case No. 16-1459GC. Pursuant to Board Rule 4.6.2., a Provider is not permitted to appeal the same issue from a distinct determination in more than one appeal.[4] Therefore, the Board hereby dismisses Denver Health from the subject group.

As a result of this dismissal, Case No. 18-1407G has only a single participant, Weirton. The regulation at 42 C.F.R. § 405.1837(b)(2) and Board Rule 12.6.2 require that an ***optional*** group appeal have two or more providers, both at inception and at full formation. As there is only one remaining participant in Case No. 18-1407G, the Board is transferring the group's issue back to Weirton's pending individual appeal, Case No. 18-1473. Further, in this regard, the Board finds that the issues in Weirton's individual and the issue being transferred from Case No. 18-1407G back to the individual appeal are separate and distinct issues as the group issue involves prospective IPPS outlier payments, while the individual appeal issue involves retrospective OPPS outlier payments.

Finally, the Board notes that position papers have already been submitted in both Weirton's individual appeal, Case No. 18-1473, and the group appeal, Case No. 18-1470G. Accordingly,

[2] A withdrawal request for Denver Health has not yet been submitted.
[3] Representative's December 20, 2019 Response to Jurisdictional Review at 2.
[4] Board Rules (Aug. 29, 2018).

to the extent the parties have not briefed the issue being transferred back from the group appeal *in the position papers* ***filed in the individual case i.e., Case No. 18-1473***, then Board requires:

1. The Provider to file a supplemental position paper within 45 days of this letter's signature date.
2. The Medicare Contactor to file a responsive supplemental position paper within 45 days of the Provider's filing deadline.

The Board notes that, in light of the developing circumstance surrounding COVID-19, the Board issued Alert 19 to give flexibility to providers in managing their case load in recognition of the fact that the immediate focus and priorities of providers should be on caring for their patients. In this regard, the Board recognizes that, until further notice, the Alert suspends the above Board-set deadlines. Notwithstanding, the Board is still accepting all filings and, in particular, encourages electronic fillings through OH CDMS. Therefore, if you are able to submit filings, we encourage you to do so, as appropriate, to avoid the ripple effects delayed filings could have in the future. Similarly, if a party anticipates relying on Alert 19 (while it is in effect) to not meet one or more deadlines in the above schedule," then the Board encourages that party to communicate with the other party to the extent possible.

Finally, as there are no remaining participants in the group, Case No. 18-1407G is hereby closed and removed from the Board's docket.

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

For the Board:

5/15/2020

X Clayton J. Nix

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Maureen O'Brien Griffin, Esq.
Hall, Render, Killian, Health & Lyman, P.C.
500 North Meridian St., Ste. 400
Indianapolis, IN 46204

Byron Lamprecht
WPS Government Health Adm'rs
2525 N. 117th Ave., Ste. 200
Omaha, NE 68164

RE: ***Jurisdictional Decision***
Memorial Healthcare (Prov. No. 23-0121)
FYE 12/31/2004
Case No. 17-1920

Dear Ms. Griffin and Mr. Lamprecht,

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the record in the above-captioned appeal and, as set forth below, is dismissing the Disproportionate Share Hospital ("DSH") payment Social Security Income ("SSI") fraction data match ("DSH SSI Data Match") issue from this appeal.

Pertinent Facts:

On July 26, 2017, Memorial Healthcare ("Provider") filed a request for hearing based on a Revised Notice of Program Reimbursement ("RNPR") dated January 27, 2017. The appeal request included two issues entitled "DSH SSI Ratio Dual Eligible Days" and "DSH SSI Data Match."

On July 23, 2019, the Board issue a Notice of Hearing and Critical Due Dates ("Critical Due Dates Notice") that notified the Provider that it must file its Final Position Paper ("FPP") by November 30, 2019.

On November 27, 2019, the Provider timely filed its FPP. On December 27, 2020, the Medicare Contractor timely filed its FPP. On January 27, 2020, the Provider filed its Optional Responsive Brief.

On December 19, 2019, the Board issued an EJR decision regarding the DSH SSI Ratio Dual Eligible Days issue. This issue is stated as "whether the Provider's Medicare DSH reimbursement calculations were understated due to the…failure to include all patient days for patients who were enrolled in and eligible for the SSI program but did not receive an SSI cash payment for the month in which they received services from the Providers ('SSI Eligible Days'), in the numerator of the Medicare Fraction of

the DSH percentage…"[1] The Board found EJR was appropriate for this issue as the Board is bound by the Uncodified SSI Data Match Regulation contained in the preamble to the FY 2011 IPPS Final Rule.[2] The Board explained it cannot invalidate the alleged erroneous data matching process used by CMS to calculate providers' DSH SSI Ratios. As a result of the EJR, the sole remaining issue in this case is the DSH SSI Data Match issue.

Provider's Position

A. Appeal Request

With regards to the DSH SSI Data Match issue, the Provider alleged in its appeal request that the DSH SSI or Medicare fraction is "improperly ***understated*** due to a number of factors, including CMS's inaccurate and improper matching or use of data along with policy changes to determine both the number of Medicare Part A SSI patient days in the numerator of the fraction and the total Medicare Part A patient days in the denominator…"[3] The Provider referenced the *Baystate*[4] case in which the Board previously identified certain data matching process errors in the process to compile Medicare SSI days in the DSH computation. The Provider argued that the D.C. District Court[5] decision in *Baystate* which supported the Board's underlying decision in that same case found that CMS did not use "the most reliable best available" data to determine which patient days should be counted in the SSI percentage and asserted that "[t]he Court additionally held that if an agency has sole possession of the information needed by an opposing party to prove its claim, then it cannot simply reject the party's allegations based upon the party's lack of proof."[6]

The Provider claimed that, despite the revised and corrected data match process CMS used in response to the *Baystate* case (as set forth in CMS Ruling 1498-R), "errors and problems still exist in the data match process, as well as improper policy changes by CMS, which are resulting in understated DSH adjustments for Provider, including the failure to include all Dual Eligible (Medicare/Medicaid) patient days in the Medicare fraction numerator intended by Congress or alternatively in the Medicaid fraction numerator."[7] In addition, the Provider asserts that "Dually Eligible crossover days, including such days that are Medicare Non-Covered Days, . . . are not [all] properly being captured in the Medicare proxy of the DSH calculation."[8]

---

[1] Provider's EJR Request ( ) at 2.
[2] 75 Fed. Reg. 23852, 24002-07.
[3] Provider's Model Form A – Individual Appeal Request (July 25, 2017), Tab 3 at 3.
[4] *Baystate Med. Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006), *declined to review*, CMS Adm'r Dec. (May 11, 2006).
[5] *Baystate Med. Ctr. v. Leavitt*, 545 F. Supp.2d F. Supp.2d 20 (D.D.C. 2008), *amended in part*, 587 F. Supp. 2d 37 (D.D. C 2008).
[6] Provider's Model Form A – Individual Appeal Request, Tab 3 at 3.
[7] *Id.*
[8] *Id.*

B. Provider's Final Position Paper

The Provider's FPP states the DSH SSI Data Match issue as follows:

> [W]hether the Provider's Medicare Disproportionate Share Hospital ("DSH") reimbursement calculations were understated due to [CMS'] and the MAC's failure to include all patients who were entitled to Medicare and SSI benefits ("SSI Patient days") in the numerator of the Medicare fraction of the DSH percentage, as required by 42 U.S.C. § 1395ww(d)(5)(F)(vi), because CMS ***failed to identify*** all appropriate SSI Patient days in matching Medicare program records with SSI program records maintained by the Social Security Administration.[9]

In addition, the FPP describes, in relevant part, the facts related to the DSH SSI Data Match issue and purports to divide its discussion of this issue into subsection "A" and subsection "B."[10]

Subsection A asserts that, despite the fact that CMS has revised its DSH SSI data matching process to correct any errors pursuant to the *Baystate* case, the revised DSH SSI ratio continues to be understated. The Provider alleges that the inaccuracies related to the DSI SSI Ratio Data Match Issue pertain to missing Medicare Advantage days, and it has uncovered 2011 and 2012 SSI Ratios that are missing Medicare Advantage days:

> While it was anticipated that hospitals' SSI ratios would increase once the problems identified in the *Baystate* case were addressed, around twenty percent (20%) of hospitals saw basically no change, and approximately fifty-five percent (55%) of hospitals nationwide actually saw a decrease in their SSI ratios for 2007, leaving only twenty-five percent (25%) who saw an increase in their SSI ration. Partially explaining the decline in SSI Ratios for some providers was the inclusion of Medicare Advantage Days in the SSI ratio at the same time the recalculation was done. Because in many states the Medicare Advantage days were only added to the denominator of the Medicare Fraction, this had a dilutive effect on a provider's SSI Ratio.[11]

[9] (Emphasis added.)
[10] Provider's Final Position Paper (Nov. 27, 2019) at 49-54.
[11] *Id.* at 50.

The Provider also indicates it has uncovered 2011 and 2012 revised SSI Ratios that still contain inaccuracies pertaining to Medicare Advantage days:

> CMS Representatives have acknowledged at the AHLA Medicare/Medicaid conference that there continue to be *inaccuracies* with the 2013 SSI Ratio, particularly with the capturing of Medicare Advantage days. However, Providers' Representatives have uncovered 2011 and 2012 SSI Ratios that are post-Baystate and still have inaccuracies related to the SSI Ratio, also pertaining to Medicare Advantage days. The Medicare Advantage days are missing from the SSI Ratio from the provider in each year, despite those days being reported on the PS&R 118 Report on the provider's cost report. We have no way of confirming whether similar inaccuracies are latent in the remainder of the numerator of the Medicare fraction, but it is a reasonable concern given this very obvious deficiency with the information that the provider can access.[12]

Subsection B of the Provider's FPP for the DSH SSI Data Match issue challenges CMS' interpretation of which patient days are included in the numerator of the SSI fraction. Specifically, the Provider alleges that the SSI Fraction is missing SSI eligible beneficiaries who receive a cash benefit under the Medicare Part D Extra Help program. The Provider insists that the DSH statute requires the term "entitled" to be read to include all benefits that a person receives as a result of their enrollment in the SSI Program, including the Medicare Part D Extra Help subsidy. The Provider asserts that CMS' statutory interpretation that a beneficiary who qualifies for a Medicare Part D Extra Help subsidy is a "recipient" of SSI benefits, but is not "entitled" to SSI benefits for the purposes of the DSH payment calculation, is erroneous.[13] However, Subsection B is not relevant to this determination as it is distinguishable from the SSI Data Match issue (*i.e.*, not a *Baystate* data matching process issue where CMS failed to apply its data matching process) since it is arguing that the ***criteria*** used in determining an SSI eligible day is wrong. More specifically, this Subsection is arguing for an expansion of "entitled to [SSI] benefits" beyond the 3 SSI codes that are currently used (*i.e.*, codes C01, M01, and M02).[14] As a result, this Subsection is part of the Issue 1 for which the Board granted EJR as confirmed by the fact that it is included as part of the analysis in the request for EJR and is discussed in the FPP's argument section for Issue 1.[15]

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[12] *Id.* at 50.
[13] Provider's Final Position Paper (Nov. 27, 2019) at 51-54.
[14] *See infra* note 34 and accompanying text.
[15] *See, e.g.*, EJR Request at 7. *See also* Provider's Final Position Paper at 17-19, 28-29.

C. Provider's Optional Responsive Brief

On January 29, 2020, the Representative filed the Provider Optional Responsive Brief and states that it "has been diligently working on this case and is desirous of bringing them to resolution."[16] In this regard, the Provider informed the Board that "there may be something under consideration at CMS that could potentially impact this appeal, and lead to the possibility of eliminating the need for a [Board] hearing in these combined cases" and that the Provider desired to have an opportunity to file a supplemental briefing "once they become fully aware of what CMS decides to do with respect to instances where the hospital has appealed or otherwise raised issues involving it's [*sic* its] SSI ratio."[17]

Board Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2016), a provider has a right to a hearing before the Board with respect to specific items claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination. The appeal of an RNPR is limited in scope to only those matters specifically revised in the RNPR.[18]

For each cost issue appealed, providers are required to give a brief summary of the determination being appealed and the basis for dissatisfaction.[19] For cost issues relating to the DSH payment adjustment, which has multiple components, providers are required to appeal each separate DSH component as a separate issue which is described as narrowly as possible.[20]

When it set the Provider's FPP filing deadline, the Notice of Critical Due Dates also gave the following instruction regarding the FPP filing:

> For each remaining issue, the position paper must *state the **material** facts* that support the appealed claim, ***identify the controlling authority*** (e.g., statutes, regulations, policy, or case law), and provide arguments *applying the **material** facts to the controlling authorities*. This filing *must also include **any** exhibits* the Provider will use to support its position. See Board Rule 27 for more specific content requirements. If the Provider misses its due date, the Board will dismiss the cases.[21]

[16] Provider's Responsive Brief at 2.
[17] *Id*. at 3
[18] 42 C.F.R. § 405.1889(b).
[19] Board Rule 7 (version dated July 1, 2015).
[20] Board Rule 8.1 (version dated July 1, 2015).
[21] (Footnote omitted and emphasis added.)

In this regard, with respect to position papers, the regulations at 42 C.F.R. § 405.1853(b)(2) state the following:

> Each position paper *must set forth the relevant facts* and arguments regarding the Board's jurisdiction over each remaining matter at issue in the appeal, *and the merits* of the provider's Medicare payment claims for each remaining issue.[22]

The Board issued Board Rules 25 and 27 (version dated Aug. 29, 2018) to implement this regulation. Board Rule 27 addresses final position papers and incorporates the requirements for preliminary position papers as delineated in Board Rule 25. In this regard, these Rules state the following, in pertinent part:

> **Rule 27 Final Position Papers**
>
> ****
>
> 27.2 Content
>
> The final position paper should address <u>*each*</u> remaining issue. *The minimum requirements* for the position paper narrative and exhibits *are the same as those outlined for preliminary position papers at Rule 25*.[23]
>
> **Rule 25 Preliminary Position Papers**
>
> 25.1 Content of Position Paper Narrative
>
> The text of the position papers *must* contain the elements addressed in the following subsections.
>
> 25.1.1 Provider's Position Paper
>
> A. Identify any issues that were raised in the appeal but are already resolved (whether by administrative resolution, agreement to reopen, transfer, withdrawal, dismissal, etc.) and require no further documentation to be submitted.
>
> B. For <u>*each*</u> issue that has not been fully resolved, *state the <u>material</u> facts that support the provider's claim.*
>
> C. *Identify the <u>controlling authority</u>*, (e.g. statutes, regulations, policy or, case law) *supporting the provider's position*.
>
> D. *Provide a conclusion applying the <u>material</u> facts to the <u>controlling</u> authorities*. . . .
>
> 25.2 Position Paper Exhibits

[22] (Italics emphasis added)
[23] (Italics emphasis added.)

> 25.2.1 General
>
> With the position papers, *the parties must exchange all available documentation as exhibits to fully support your position*. . . .
>
> 25.2.2 Unavailable and Omitted Documents
>
> *If documents necessary to support your position are still unavailable, identify the missing documents, explain why the documents remain unavailable, state the efforts made to obtain the documents, and explain when the documents will be available*.
>
> Once the documents become available, promptly forward them to the Board and the opposing party. . . .
>
> 25.3 Filing Requirements to Board
>
> Parties should file with the Board a **complete** preliminary position paper with *a fully developed narrative* (Rule 23.1 [*sic* 25.1]), *all* exhibits (Rule 23.2 [*sic* 25.2), a listing of exhibits, and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. Any issue appealed, but not briefed by the Provider in its position paper will be considered withdrawn.[24]

Finally, 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-
>
> (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.

[24] (Italics and underline emphasis added.)

This Provider's *Model Form A – Individual Appeal Request* (dated July 25, 2017) describes the DSH SSI Data Match Issue as the Provider's DSH SSI ratio is "improperly understated" due to improper data match, improper data use, and "policy changes."[25]

As discussed more fully below, the Board finds that the Provider's FPP failed to meet the Board's position paper filing requirements delineated in 42 C.F.R. § 405.1853(b)(2) and Board Rules 25 and 27 because it was perfunctory and failed to sufficiently develop and set forth the relevant facts and arguments regarding the *merits* of its claim. In making this finding, the Board notes that, as previously noted, Subsection B on FPP section on the DSH SSI Data Match issue does not pertain to the DSH SSI Data Match issue but rather to the issue for which the Board granted EJR. Further, the Board notes that the Responsive Brief only addresses potential administrative resolution with CMS and does not address the substance of the DSH SSI Data Match issue.[26] As a result, the Provider' briefing of its argument and analysis on the DSH SSI Data Match issue is only located in only Subsection A of the FPP section on the DSH SSI Data Match issue and, while the FPP is 66 pages, this subsection is just essentially 2 pages long. Accordingly, the Board focused on Subsection A of the DSH SSI Data Mach Issue in the FPP at pages 49 to 51.

With regards to the DSH SSI Data Match Issue, the Provider acknowledges that "CMS revised its SSI data match process to correct many errors and flaws and to address other problems identified by the [Board] and the D.C. District Court"[27] in the *Baystate* case. However, the Provider claims in its FPP that, notwithstanding the revised data matching process adopted by CMS in the FY 2011 IPPS final rule, "CMS continues to make matching errors with the SSI patients in the numerator of the Medicare Fraction"[28] and "there continue to be inaccuracies."[29] This revised data matching process was used in calculating the Provider's Medicare/SSI ratio for the cost report under appeal. As a result of the corrections that CMS had made to the data matching process following *Baystate*, the Provider had expected SSI ratios to increase. However, the Provider notes that SSI ratios generally stayed the same or declined following *Baystate*. As a result, the Provider questions the data used to calculate its SSI

[25] Provider's *Model Form A – Individual Appeal Request* (July 25, 2017), Tab 3 at 3.
[26] If the Provider had needed more time *to meet the position paper filing requirements*, the Provider could have requested a "good cause" extension. In this regard, the Board notes that Board Rule 23.5 permits parties to request extension on position paper filing deadlines: "Requests for extensions for filing a PJSO or preliminary position paper must be filed at least three weeks before the due date and will be granted *only for* ***good cause***." (Emphasis added.) However, the Provider did not request such a "good cause" extension of the FPP and instead made an insufficient FPP filing as explained below. The Board recognizes that the Provider alerted the Board about potential administrative resolution in its Responsive Brief and did later file a request for abeyance. However, the Provider made these filings well after the FPP had been filed and Board Rule 23.6 makes it clear that even "***pending*** requests (such as . . . requests for abeyance, . . . mediation, . . . or other motions), until complete or ruled on favorably by the Board where applicable, *will* ***not*** *suspend these [position paper] filing requirements*" and "[i]f a motion or request is not complete or has not been ruled on, you must proceed as if it will not occur or will not be granted." (Emphasis added.)
[27] Provider's Final Position Paper (Nov. 27, 2019) at 49.
[28] Provider's Final Position Paper (Nov. 27, 2019) at 6.
[29] Provider's Final Position Paper (Nov. 27, 2019) at 50.

ratio and states that "[p]artially explaining the decline in the SSI Ratios for some providers was the inclusion of Medicare Advantage Days in the SSI Ratio at the same time the recalculation was done."[30] The Provider makes the broad allegation without any support or detail that "CMS Representatives have acknowledged at the AHLA Medicare/Medicaid conference that there continue to be inaccuracies with the 2013 SSI Ratio, particular with the capturing of Medicare Advantage days."[31] The Provider then asserts that "[w]e have no way of confirming whether similar inaccuracies are latent in the remainder of the Medicare fraction, but it is a reasonable concern given this very obvious deficiency with the information that the provider can access."

This case had been pending at the Board since July 2017. Yet, *for the DSH SSI Data Match issue*, the Provider's FPP is perfunctory and fails to sufficiently set forth the merits of its claim, explain why the agency's SSI calculation is wrong, and provide documents and analysis to support its position. In this regard, there are sweeping statements without explanation or proof in Subsection A of the FPP for the DSH SSI Data Match issue.[32] Indeed, the Board notes that the FPP's discussion on the DSH SSI Data Match issue did not include ***any*** evidence to establish the material facts in this case relating to the SSI fraction at issue or ***any*** evidence pertaining to the alleged systemic SSI ratio data match errors or issues,[33] notwithstanding the fact that, unlike the issue for which the Board granted EJR, the DSH SSI Data Match issue is not a legal driven issue but rather is fact driven.[34] While the Provider makes allegations that there are certain errors in DSH SSI Ratios and related data for other providers and fiscal year ends, these allegations are unsupported generic broad brush strokes and contain no references, examples or supporting evidence. In particular, the Provider has failed to submit any available data (including its own internal data) regarding the alleged errors for this Provider and fiscal year end in its appeal request or FPP. In this regard, the Board notes that the Providers can obtain certain data used to calculate their DSH SSI Ratios from the Centers for Medicare and Medicaid Services ("CMS").[35]

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[30] Provider's Final Position Paper (Nov. 27, 2019) at 50.

[31] The Provider alleges that "[t]he Medicare Advantage days are missing from the SSI Ratio from the provider in each year despite those days being reported on the PS&R 118 Report and on the provider's cost report." However, if true, the inclusion of these alleged missing days in the SSI fraction would only decreased (not increase) the Provider's SSI ratio as they acknowledge in its FPP.

[32] For example, the FPP does not go through each of the specific data match issues raised in the *Baystate* case and explain and analyze (or even express concern) on how each continues or may continue to exist in the new data match process at issue that was implemented subsequent to Ruling 1498-R.

[33] The FPP includes 30 exhibits but none of these appear relevant. In this regard, Subsection A of the FPP on the DSH SSI Data Match issue does not contain any citations to exhibits and only contains reference to the *Baystate* decision and to the IPPS final rule published on August 16, 2010 (75 Fed. Reg. 50144, 50281).

[34] Issue 1 for which the Board granted EJR challenged the Agency's interpretation of "entitled to [SSI] benefits" and claims that the Agency is improperly limiting that interpretation to beneficiaries who receive cash SSI benefits. In contrast, the DSH SSI Data Match issue is focused on challenging whether the Agency's used the best available data and is properly following its data match process along the lines laid out in the *Baystate* case. *See* Ruling 1498-R at 4-6 (discussing history of *Baystate* case).

[35] *See e.g.*, https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh (last accessed Apr. 10, 2020); https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH (last accessed Apr. 10, 2020) (CMS webpage describing access to DSH data ***from 1998 to 2017***:

Providers can also view Medicare enrollment information for their hospital inpatients.[36] However, there is no indication that the Provider's has obtained or even attempted to obtain this data in order to analyze it for potential errors or inaccuracies in support of their overall allegations.[37] The lack of any evidence or data analysis on the DSH SSI Data Match issue in this case stands in stark contrast to the significant argument, analysis and evidence that was presented in the *Baystate* case.[38]

Similarly, the FPP's discussion on the DSH SSI Data Match issue obliquely suggests that certain State Medicaid eligibility data may be helpful to determine whether inaccuracies exist in the DSH SSI data matching process because many states have adopted Medicaid eligibility standards that are exactly the same as SSI. However, the Provider fails to connect the dots and, in particular, fails to confirm whether Michigan (where the Provider is located) is actually one of those states and, if so, provide any data and analysis from Michigan Medicaid to support its position. Indeed, the Board has addressed this very issue in the context of a different state (California) where a provider furnished certain California Medicaid data on SSI eligibility.[39] However, the Provider's FPP discussion on the DSH SSI Data Matching issue fails to even mention or discuss this California case as a controlling authority even though: (1) the Board's decision in that case raised significant concerns about the sufficiency of the California Medicaid data as a substitute for SSI eligibility data; and (2) the California case is currently on appeal and pending before the D.C. District Court.[40]

The Board recognizes that the Provider asserts in the DSH SSI Data Match issue section of the FPP that it has "no way of confirming whether similar inaccuracies are latent."[41] However, the Provider fails to provide any support or citations for this bald assertion such as explaining why it cannot confirm or

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"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.").

[36] *Id.*

[37] In this regard, the Board notes that the FOIA request included at Exhibit P-30 was discussed at length in the Section of the FPP pertaining to Issue 1 and is only relevant to Issue 1 as it requested "data demonstrating the total number of beneficiaries who were enrolled in [SSI] program, but did ***not*** *receive federal SSI payments* in a given month (preferably December) for fiscal years 2006, 2007, 2008, and 2009 and broken down by age categories." Exhibit P-30. To this end, this Exhibit is not referenced or discussed in the subsection A pertaining to the DSH SSI Data Match issue.

[38] For example, as noted in the Board's decision in the *Baystate* case: "the Provider eventually obtained SSA eligibility records for a small sample of patients that consented to the release of their information. CMS also produced various records including a memorandum asking SSA to include records for those beneficiaries that had died subsequent to the run of SSI data. The Provider also obtained some SSI eligibility information from the state of Massachusetts through a separate request." PRRB Dec. No. 2006-D20 at 4.

[39] *See Pomona Valley Hosp. Med. Ctr. v. Noridian Healthcare Solutions*, PRRB Dec. No. 2018-D50 (Sep. 21, 2018).

[40] *See Pomona Valley Hosp. Med. Ctr. v. Azar*, No. 18-02763 (D.D.C. filed Nov. 27, 2018).

[41] In recognizing this statement, the Board is being generous as the "similar inaccuracies" to which it is referring are in the preceding sentence relate to the alleged ***undercounting*** of Medicare Advantage days in other years of which it allegedly has evidence but fails to produce. Specifically, the Provider does not include any exhibits/evidence for this bald assertion that there are "inaccuracies," including if and how many "Medicare Advantage days are missing from the SSI Ratio from the provider in each year [*i.e.*, 2011 and 2012], despite those days being reported on the PS&R 118 Report and on the provider's cost report." Provider's FPP at 50.

cannot provide any other basis to support why the alleged inaccuracies persist notwithstanding the acknowledged changes that CMS made to the data matching process ***following*** the *Baystate* case. More specifically, to the extent documents or information are not available to support its position and claims regarding the DSH SSI Data Match issue, the Provider has failed to comply with Board Rule 25.2.2 (as discussed above) and identify them, explain why they are unavailable, describe its efforts to obtain such items, and explain when they will be available. Board Rule 25.2 makes it clear that the FPP must include all documentation supporting the allegations and assertions of material facts unless it is unavailable. In such situations, Board Rule 25.2.2 provides the following instructions:

> If documents necessary to support your position are still unavailable, ***identify*** the missing documents, ***explain why*** the documents remain unavailable, ***state the efforts made to obtain*** the documents, and ***explain when*** the documents will be available.[42]

The FPP does not identify any document or data that are missing or unavailable relative to the DSH SSI Data Match issue. If there were any such documents, the FPP was required to include an explanation of why they were unavailable, a description of the efforts made to obtain them, and an explanation of when they will become available.[43, 44]

In summary, the Board is dismissing the DSH SSI Data Match issue from the appeal as the Provider has failed to fully develop its case for the DSH SSI Data Match issue as required by the regulations and the Board Rules. The Board has determined that the Provider has violated Board Rule 25 via 27 (including 25.1.1 and 25.2.2) and 42 C.F.R. § 405.1853(b)(2) because it is abundantly clear that the Provider's final position paper did not set forth a "fully developed narrative" with the relevant arguments, controlling authorities and facts regarding the merits of this Provider's claims on the DSH SSI Data Match issue and did not include "all exhibits" related to this issue.[45] Essentially, the Provider abandoned the DSH SSI Data Match issue by filing a position paper that failed to properly develop this issue but rather only provided a 2-page skeletal perfunctory discussion and analysis of this issue devoid of any supporting exhibits or evidence.

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[42] (Emphasis added.)

[43] The Board recognizes that, ***in its appeal request***, the Provider asserts that, in *Baystate*, "[t]he Court additionally held that if an agency has sole possession of the information needed by an opposing party to prove its claim, then it cannot simply reject the party's allegations based upon the party's lack of proof." Provider's Model Form A – Individual Appeal Request, Tab 3 at 3. Regardless, the Provider abandoned this argument as it relates to the DSH SSI Data Match issue because, the FPP argument on the DSH SSI Data Match issue does not discuss this alleged *Baystate* holding, including how it continues to be relevant in a post-1498-R world as a controlling authority.

[44] Compare the essentially perfunctory skeletal two-page discussion in the FPP on the DSH SSI Data Match issue from the top of page 49 to top of page 51 (that contains no footnotes or cross references) to the detailed argument and discussion in the FPP on Issue 1 (concerning the SSI eligibility issue) from the top of page 9 through the bottom of page 48.

[45] Board Rule 25.3.

As there are no remaining issues in Case No. 17-1920, the Board dismisses it and removes it from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members

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

FOR THE BOARD

5/20/2020

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Jurisdictional Decision***

20-0911GC	Beacon Health FFY 2020 Uncompensated Care Payments CIRP Group
20-0913GC	Cook County Health FFY 2020 Uncompensated Care Payments CIRP Group
20-0914GC	Community Health Network FFY 2020 Uncompensated Care Paymts. CIRP Grp.
20-0915GC	Rush FFY 2020 Uncompensated Care Payments CIRP Group
20-0951GC	McLaren Health FFY 2020 Uncompensated Care Payments Involving FY 2015 S-10 Audits CIRP Group
20-0952GC	Premier Health Partners FFY 2020 Uncompensated Care Payments Involving FY 2015 S-10 Audits CIRP Group
20-0953GC	Univ of Rochester FFY 2020 Uncompensated Care Payments Involving FY 2015 S-10 Audits CIRP Group

Dear Ms. O'Brien Griffin,

The Provider Reimbursement Review Board ("Board") has reviewed the documents in the above-referenced seven (7) common issue related party ("CIRP") group appeals and finds that it does not have jurisdiction over the Uncompensated Care Payment issue. The jurisdictional decision of the Board is set forth below.

Pertinent Facts:

The Providers are appealing from the FY 2020 IPPS final rule published in the Federal Register on August 16, 2019. The issue being appealed is a challenge to the Disproportionate Share Hospital ("DSH") payment for Uncompensated Care Costs ("UCC"). Specifically, Providers are appealing the Medicare Contractors' ("MACs'") alleged failure to include appropriate costs on their S-10 worksheets for CY 2015, which impacts their FY 2020 UCC DSH payments. They claim that their S-10's were arbitrarily audited without issuing adequate UCC reporting guidelines or going thorough adequate notice and comment requirements. They state that audits of the Providers' S-10's were inconsistent and unfair. The Providers raise several arguments about the accuracy of the S-10 data used, and the methodology in auditing those worksheets. While they acknowledge that the estimates used by the Secretary for the UCC DSH payment are not subject to review, they claim that data collection policies which are enacted in violation of notice and comment requirements are procedurally unlawful and, therefore, subject to review.

The Providers continue by claiming that the disparate treatment that the MACs showed in auditing different hospitals' S-10 worksheets is unlawful, arbitrary and capricious, and *ultra vires*, and that a statutory bar on administrative and judicial review does not extend to these types of actions. Finally, the

Providers state that *Allina*[1] holds that "when CMS does anything affecting benefits, payment, or eligibility, it must first through [*sic*] the notice-and-comment requirement under the Medicare statute."[2] For additional support, they cite to the recent decision issued by the U.S. District Court for Connecticut in *Yale New Haven Hospital v. Azar* ("*Yale New Haven*").[3] They claim that, in *Yale New Haven*, the District Court reviewed an Uncompensated Care payment issue and applied the Supreme Court's recent ruling in *Allina*. The Providers further claim that, despite the judicial bar in the UC DSH statute, the District Court pulled from the *Allina* decision in agreeing that the Hospital's claims challenging "the procedure by which the Secretary established" a FFY 2014 policy is "separate from the substance of any such rules or policies or the determination of its estimates based on the substance of those rules or policies" and is thus not barred by judicial review.[4]

Board's Decision:

The Board finds that it does not have jurisdiction over the Uncompensated Care DSH payment issue because jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2). In this regard, 42 C.F.R. § 412.106(g)(2) implements essentially *verbatim* the bar on certain administrative/judicial review that is delineated in 42 U.S.C. § 1395ww(r)(3):

> *Preclusion of administrative and judicial review*. There is no administrative or judicial review under sections 1869 or 1878 of the Act [*i.e.*, 42 U.S.C. §§ 1395ff or 1395oo], or otherwise, of the following:
>
> (A) **Any estimate** of the Secretary for purposes of determining the factors described in paragraph (g)(1) of this section;[5] and
>
> (B) Any period selected by the Secretary for such purposes.[6]

Further, in *Fla. Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Serv.* ("*Tampa General*"),[7] the D.C. Circuit Court upheld a D.C. District Court decision[8] that there is no judicial or administrative review of UCC DSH payments. In *Tampa General*, the provider challenged the calculation of the amount it would receive for uncompensated care for fiscal year 2014. The provider claimed that the Secretary used inappropriate data when she selected the hospital cost data

[1] *Allina Health Servs. v. Sebelius*, 746 F.3d 1102, 1111 (D.C. Cir. 2014).
[2] Group Issue Statement.
[3] 409 F. Supp. 3d 3 (D. Cn. 2019).
[4] Group Issue Statement.
[5] Paragraph (g)(1) is a reference to the three factors that make up the uncompensated care payment. Factor 1 represents 75 percent of estimated DSH payments that would be paid in absence of § 1395ww(r). 78 Fed. Reg. 50495, 50627-28 (Aug. 19, 2013). Factor 2, for FYs 2014-2017, is one (1) minus the percentage of individuals under age 65 who are uninsured in 2013. *Id.* at 50631. Factor 3 is a hospital-specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital with the potential to receive DSH payments relative to the estimated uncompensated care amount for all hospitals estimated to receive DSH payments in the fiscal year for which the uncompensated care payment is to be made. *Id.* at 50634.
[6] (Bold emphasis added and italics emphasis in original.)
[7] 830 F.3d 515 (D.C. Cir. 2016).
[8] 89 F. Supp. 3d 121 (D.D.C. 2015).

updated in March 2013, instead of data updated in August 2013, when calculating its uncompensated care payments. The provider argued that it was not challenging the estimate of its uncompensated care, but rather the underlying data on which the Secretary relied, judicial review of which is not barred.

The D.C. Circuit affirmed the District Court's finding that there was specific language in the statute that precluded administrative or judicial review of Tampa General's claims because in challenging the use of the March 2013 update data, the hospital was seeking review of an "estimate" used by the Secretary to determine the factors used to calculate additional payments. The D.C. Circuit Court went on to hold that, "the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well."[9] The D.C. Circuit also rejected Tampa General's argument that it could challenge the underlying data, finding that there cannot be judicial review of the underlying data because they are "indispensable" and "integral" to, and "inextricably intertwined" with, the Secretary's estimate of uncompensated care.[10]

The D.C. Circuit went on to address Tampa General's attempt to reframe its challenge to something other than an estimate of the Secretary. Specifically, it rejected the characterization as a challenge to the "general rules leading to the estimate rather than as a challenge to the estimate itself []" because it was merely an attempt to undo a shielded determination.[11] Finally, it addressed the argument that the estimate made by the Secretary was *ultra vires*, or beyond the scope of statutory authority, but plainly found that "the Secretary's choice of data is not obviously beyond the terms of the statute."[12]

In 2019, the D.C. Circuit Court revisited the judicial and administrative bar on review of uncompensated care DSH payments again in *DCH Regional Med. Ctr. V. Azar* ("*DCH v. Azar*").[13] In *DCH v. Azar*, the provider alleged that it was challenging the methodology adopted and employed by the Secretary to calculate Factor 3 of the DSH payment, and that the bar on review applied only to the estimates themselves, and not the methodology used to make the estimates. The D.C. Circuit disagreed, stating that "a challenge to the methodology for estimating uncompensated care is unavoidably a challenge to the estimates themselves" and that there is "no way to review the Secretary's method of estimation without reviewing the estimate itself."[14] It further stated that, allowing an attack on the methodology "would eviscerate the statutory bar, for almost any challenge to an estimate could be recast as a challenge to its underlying methodology." The D.C. Circuit recognized that it had previously held in *Tampa General* that the choice of data used to estimate an uncompensated care DSH payment was not reviewable because the data is "inextricably intertwined" with the estimates themselves. The D. C. Circuit then applied this holding *DCH v. Azar* and found that the same relationship existed with regard to the methodology used to generate the estimates.[15]

As noted above, the District Court for Connecticut recently considered the bar on review of UCC DSH payments in *Yale New Haven*.[16] There, the District Court dismissed all of the providers' counts in their

[9] 830 F.3d 515, 517.
[10] *Id.* at 519.
[11] *Id.* at 521-22.
[12] *Id.* at 522.
[13] 925 F.3d 503 (D.C. Cir. 2019).
[14] *Id.* at 506.
[15] *Id.* at 507.
[16] 2019 WL 3387041 (July 25, 2019).

federal complaint except one. Those that clearly sought to "undo the Secretary's estimate of its uncompensated care by recasting its challenge to that estimate as an attack on the underlying methodology" were dismissed.[17] The remaining count, the District Court held, did "not challenge the Secretary's estimate of [the provider's] DSH payment, any of the underlying data, or the Secretary's choice of such data. Instead, it [was] a challenge to the procedure by which the Secretary established the" issue under appeal. The court noted that it was a close call, but there was no bar on review of "the *promulgation* of the Secretary's rules and policies, separate from the *substance* of any such rules or policies or the determination of its estimates based on the substance of those rules or policies."[18]

The Board finds that the same findings are applicable to the Providers' challenge to their UCC payments in this appeal. The Providers are all appealing from the Federal Register notice published on August 6, 2019. As evidenced by their Group Issue Statement and the calculation support for the amount in controversy, the issue actually being appealed is the amount of DSH UCC payments they will receive for FY 2020, due to allegedly inaccurate data used in finalizing the FFY 2020 Final Rule for UCC Payments. The Providers claim to be challenging arbitrary and capricious or *ultra vires* actions of CMS in their failure to provide notice and receive comments on how the data for FY 2020 would be collected. It is ultimately a direct attack against the underlying methodology used to generate the Secretary's estimates for DSH UCC purposes, which is not reviewable.[19] The statute and regulation found at 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2) specifically bar administrative and judicial review of the estimates used by the Secretary in calculating the UCC payments. Furthermore, a challenge to any underlying data[20] (or lack of support for the data used) is barred, as well. *Tampa General* specifically held that the underlying data used for UCC payments cannot be reviewed or challenged. Likewise, any challenge to the methodology used to determine the payment amounts was rejected in *DSCH v. Azar*, finding that the methodology was just as "inextricably intertwined" with the actual estimates as the underlying data, and barred from review. In making these findings, the Board notes that, for purposes of the Board's review, the D.C. Circuit's decisions in both *Tampa General* and *DCH v. Azar* are controlling precedent for the interpretation of the statutory and regulatory provisions at issue because the Providers could bring suit in the D.C. Circuit.[21]

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[17] *Id.* at *8 (quoting *DCH v. Azar* at 508).
[18] *Id.* at *9.
[19] *DCH v. Azar* at 507.
[20] Specifically, the Group Issue Statement claims that the policy being challenged "produced inappropriate data that was used in [CMS'] calculation of Factor 3 in the DSH Uncompensated Care Payment formula . . . ."
[21] The CMS Administrator generally has applied as controlling precedent the law of the Circuit in which the provider is located. *See, e.g., QRS CHW DSH Labor room Days Groups v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (Apr. 13, 2009), affirming, PRRB Dec. No. 2009-D11 (Feb. 27, 2009); *St. Vincent Mercy Med. Ctr. v. BlueCross BlueShield Ass'n*, Adm'r Dec. (Nov. 17, 2008), *affirming in part and reversing in part*, PRRB Dec. No. 2008-D35 (Sept. 15, 2008). However, in recognizing that providers may file suit with the appropriate District Court either in the Circuit in which they are located or the D.C. Circuit, the Administrator also applies as controlling precedent the law of the D.C. Circuit. *See, e.g., Jordan Hosp. v. Blue Cross Blue Shield Ass'n.*, Adm'r Dec. (Apr. 30, 2007), *vacating*, PRRB Dec. No. 2007-D23 (Feb. 28, 2007). It is true that the district court case cited by the Providers (*Yale New Haven Hospital v. Azar*, 2019 WL 3387041 (D. Conn. 2019)) permitted a direct attack against a policy that failed to follow notice and comment procedures. This is because it was not a challenge to the Secretary's estimate of that hospital's payment or any specific underlying data. Here, the Providers have listed an amount in controversy related to their specific hospitals, which they believe should be higher based on different S-10 worksheet data. They are "simply trying to undo the Secretary's estimate of [their] uncompensated care by recasting [their] challenge to that estimate as an attack on the underlying methodology." *DCH v. Azar* at 508.

The Board concludes that it does not have jurisdiction over the Uncompensated Care DSH issue in these 7 CIRP group appeals because judicial and administrative review of the calculation is barred by statute and regulation. As the Uncompensated Care DSH issue is the only issue in the appeals, the Board hereby closes the referenced 7 CIRP group appeals and removes them from its docket.

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

Board Members Participating:

Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Gregory H. Ziegler, CPA, CPC-A
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

For the Board:

5/20/2020

X Clayton J. Nix

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

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services
Byron Lamprecht, WPS Government Health Administrators
Judith Cummings, CGS Administrators
Danene Hartley, National Government Services, Inc.
Pam VanArsdale, National Government Services, Inc.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

Geoffrey Pike
Senior Auditor (Provider Appeals)
First Coast Service Options, Inc.
532 Riverside Ave.
Jacksonville, FL 32202

RE: ***Jurisdictional Determination***
Larkin Community Hospital (Prov. No. 10-0181)
FYE December 31, 2006
Case No. 13-3055

Dear Mr. Ravindran and Mr. Pike:

This case involves the appeal of Larkin Community Hospital ("Larkin" or "Provider") of its Revised Notice of Program Reimbursement ("RNPR") for the fiscal year ending on December 31, 2006 ("FY 2006"). The Provider Reimbursement Review Board ("Board") has reviewed Larkin's documentation in response to the Medicare Contractor's Jurisdictional Challenge (received September 24, 2014). As set forth below, the Board has reviewed this documentation and finds that it does not have jurisdiction to hear Larkin's appeal because none of the remaining "matters" appealed by Larkin were specifically revised in the RNPR at issue.[1]

Pertinent Facts

On August 29, 2013, the Board received Larkin's request for a hearing ("RFH") regarding its March 1, 2013 RNPR for FY 2006. In its RFH, Larkin initially challenges six issues, but following its request to transfer some of the issues to group appeals and a withdrawal of another issue,[2] the instant appeal is left with only two Disproportionate Share Hospital ("DSH") payment issues—a Supplemental Security Income ("SSI") Percentage[3] "Provider-Specific" issue and a Medicaid Eligible Days issue.

On September 24, 2014, the Board received the Medicare Contractor's Jurisdictional Challenge in which the Medicare Contractor questions the Board's jurisdiction to hear Larkin's SSI Percentage Provider-Specific issue and its Medicaid Eligible Days issue.[4] The Medicare Contractor states:

[1] *See* 42 C.F.R. § 405.1889(b)(1)-(2) (2012).
[2] Within its April 7, 2014 correspondence to the Board, Larkin transferred its SSI "Systemic" issue, its Medicare Part C Days issue, and its Dual Eligible Exhausted Medicare Part A Days issue to group appeals. Within its October 10, 2014 Jurisdictional Response, Larkin withdrew its Rural Floor Budget Neutrality Adjustment ("RFBNA") issue. This determination does not address the Board's jurisdiction over the transferred issues.
[3] Also known as the "Medicare Percentage" or "Medicare Fraction."
[4] The Medicare Contractor's Jurisdictional Challenge also questions the Board's jurisdiction to hear Larkin's

> [N]one of the issues under appeal for this case are specifically related to the adjustments in the last NPR for which this appeal is based. While the DSH percentage was revised to reflect the revised total days, it was not a result of a change in the Medicaid days or the SSI percentage . . .[5]

On October 14, 2014, the Board received Larkin's Jurisdictional Response in which Larkin argues that the RNPR "corrections" to its "DSH calculation and Medicaid Days" are "enough to warrant Board jurisdiction over the DSH/SSI and DSH/Medicaid Eligible Days issues."[6] Larkin goes on to state that the appealed RNPR included "corrections to the Medicaid proxy of the DSH calculation and an adjustment that affected a net change in the number of Medicaid Eligible Days[,]" and that, overall, it "is dissatisfied with the amount of DSH reimbursement that it received on the [R]NPR."[7]

Board's Analysis and Decision

Under 42 C.F.R. § 405.1835 (2012), 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, and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

The Code of Federal Regulations provides for an opportunity for an RNPR. 42 C.F.R. § 405.1885 (2012) provides in relevant part:

> A determination of [a Medicare contractor] . . . may be reopened with respect to findings on matters at issue in such determination or decision, by such [Medicare contractor] . . . , either on motion of such [Medicare contractor] . . . or on the motion of the provider affected by such determination or decision to revise any matter in issue at any such proceedings.

In accordance with 42 C.F.R. § 405.1889 (2012), an RNPR is considered a separate and distinct determination from which the provider may appeal. The regulation provides:

> (a) If a revision is made in a Secretary or [Medicare contractor's] 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, §

RFBNA issue, but, as mentioned above, Larkin withdrew this issue within its Jurisdictional Response.
[5] Jurisdictional Challenge at unnumbered page 3.
[6] Jurisdictional Response at 1.
[7] *Id*. at 2.

> 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.

Here, Larkin timely filed an August 29, 2013 RFH in which it claims that the amount in controversy exceeds the regulatory minimum.[8] As Larkin's RFH is based on its March 1, 2013 RNPR, in order for Larkin to establish that the Board has jurisdiction over its two remaining issues, Larkin must demonstrate that the matters under appeal were "specifically revised" in the RNPR.[9]

The Medicare Contractor's November 27, 2012 Notice of Reopening states that the purpose in reopening Larkin's cost report was in order "[t]o revise [the] Medicaid Utilization Percentage."[10] Larkin's reopening work papers associated with the appealed RNPR show that the Medicare Contractor did, indeed, adjust Larkin's Medicaid percentage[11] but *not* its SSI/Medicare percentage.[12]

To this end, the pertinent Audit Adjustment Report demonstrates that, *with respect to the* ***Medicaid*** *percentage*, the Contractor adjusted Larkin's Worksheet S-3, Part I, Line 1.00.[13] Worksheet S-3, Part I, Line 1.00 represents **total patient days**, *i.e.*, the denominator of the Medicaid percentage, and not the Medicaid eligible days, *i.e.*, the numerator of the Medicaid percentage.[14] Thus, while the Medicare Contractor adjusted Larkin's Medicaid percentage in the RNPR, the Contractor did not specifically adjust—or revise—Larkin's Medicaid Eligible days. Instead, the change in the Medicaid percentage was due to an increase in total patient days in the denominator of the fraction's calculation.

As such, the Board finds that, within the appealed RNPR, the Medicare Contractor did not specifically revise Larkin's SSI/Medicare percentage nor did it specifically revise Larkin's Medicaid Eligible Days within its Medicaid percentage. Therefore, under the regulatory mandates of 42 C.F.R. § 405.1889(b), Larkin's RNPR appeals of its SSI Percentage Provider Specific issue and Medicaid Eligible Days issue are not within the scope of the Board's jurisdiction.

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[8] RFH at unnumbered page 4.
[9] *See* 42 C.F.R. § 405.1889(b).
[10] RFH Notice of Reopening TAB at unnumbered page 1.
[11] The term "Medicaid percentage" is synonymous with the term "Medicaid fraction."
[12] RFH Reopening Workpapers TAB at 3.
[13] RFH Notice of Reopening TAB at unnumbered page 19.
[14] Medicare Provider Reimbursement Manual, Part 2, Chapter 40, Section 4005.1, at 56.

Conclusion

As the Board has concluded that, pursuant to 42 C.F.R. § 405.1889(b), it does not have the requisite jurisdiction to hear Larkin's RNPR appeals of its SSI Percentage Provider Specific issue and its Medicaid Eligible Days issue. Accordingly, the Board hereby dismisses these issues from the instant appeal. As no other issues remain open within the case, the Board closes the instant appeal and removes it from the Board's docket.

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

Board Members Participating:
Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Gregory Ziegler, CPA
Rob Evarts, Esq.
Susan A. Turner, Esq.

For the Board:

5/21/2020

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Leslie Goldsmith, Esq.
Baker, Donelson, Bearman, Caldwell & Berkowitz
100 Light Street
Baltimore, MD 21042

Judith Cummings, Acct. Mngr.
CGS Administrators (J-15)
CGS Audit & Reimbursement
P.O. Box 20020
Nashville, TN 37202

RE: ***Untimely Request for Hearing***
Ohio State Health System CY 2017 DGME Penalty to FTE Count CIRP Group
Case No. 20-1465GC

Dear Ms. Goldsmith and Ms. Cummings:

The Provider Reimbursement Review Board ("Board") is in receipt of the above-referenced Common Issue Related Party ("CIRP") group appeal request and notes a jurisdictional impediment pursuant to 42 C.F.R. § 405.1840. The pertinent facts and Board determination are set forth below.

Pertinent Facts:

On Friday, February 28, 2020, the Representative sent a Model Form B – Group Appeal Request in hard copy (*i.e.*, it was sent outside of the Board's electronic filing and case management system, known as OH CDMS) and the Board received this filing on Monday, March 2, 2020. The group appeal challenged the determination made by the Medicare Administrative Contractor ("MAC") regarding the DGME Penalty to FTE Count issue for providers owned/operated by the Ohio State University with cost reporting periods in calendar year 2017.

The request for group appeal was filed with a Model Form E – Request To Directly Add Provider To Group for the provider, the Arthur G. James Cancer Hospital (Prov. No. 36-0242) ("the James Cancer Hospital"). In addition, this Model Form E indicates that the James Cancer Hospital's direct add request is based on a Notice of Program Reimbursement ("NPR") for fiscal year ending June 30, 2017 ("FY 2017"). The MAC issued this FY 2017 NPR on August 14, 2019.

On March 24, 2020, the Board acknowledged receipt of the group appeal request and assigned it to case number 20-1465GC.

Board Determination:

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

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

Specifically, 42 C.F.R. § 405.1835(a)(3) indicates that, unless the Provider qualifies for a good cause extension, the Board must receive a Provider's hearing request no later than 180 days after the date of receipt of the final determination, with a five-day presumption for mailing. Additionally, pursuant to Board Rule 4.5, the date of receipt is presumed to be the date stamped "received" by the Board for documents submitted by regular mail, hand delivery or couriers not recognized as a national next-day courier.

The sole provider being used to establish this CIRP group appeal, the James Cancer Hospital, is appealing its FY 2017 NPR dated August 14, 2019. The filing date for the group appeal and the associated direct add for the James Cancer Hospital was Monday, March 2, 2020 which is 201 days after the issuance of the August 14, 2019 NPR. The 185th day fell on Saturday, February 15, 2020 and, therefore, the due date for filing a timely appeal would have been Monday, February 17, 2020. As such, it is clear that the direct add request was not timely filed. In this regard, the Board notes that even the date that the group appeal request and direct add request were sent to the Board for filing (*i.e.*, Friday, February 28, 2020) was well after the February 17, 2020 filing deadline.

Based on the above, the Board finds that the direct add request for the James Cancer Hospital was not timely filed and, therefore, does not meet the regulatory requirements for a proper appeal. As there are no remaining providers in Case No. 20-1465GC, the Board hereby dismisses Case No. 20-1465GC 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 405.1877.

Board Members Participating:
Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Gregory H. Ziegler, CPA, CPC-A
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

For the Board:

5/21/2020

X Clayton J. Nix

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

David J. Vernon, Esq.
Hooper, Lundy and Bookman
401 9th Street, NW, Ste. 550
Washington, D.C. 20004

RE: ***Expedited Judicial Review Determination***
20-0852G HLB FFY 2020 Area Wage Index Lowest Quartile IPPS Payment

Dear Mr. Vernon:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' April 29, 2020 request for expedited judicial review ("EJR") in the above referenced appeal.[1] The decision of the Board to grant EJR is set forth below.

The issue for which EJR has been requested is:

> [W]hether the Hospitals' FFY 2020 standardized amount and hospital-specific operating IPPS [inpatient prospective payment system] payment rate[s] were improperly reduced by approximately 0.2016% for FFY 2020.[2]

Statutory and Regulatory Background

The statute, 42 U.S.C. § 1395ww(d), sets forth a system of payment for the operating costs of acute care hospital inpatient stays under Medicare Part A based on prospectively set rates[3] known as the Inpatient Prospective Payment System ("IPPS"). Under IPPS, Medicare payments for hospital inpatient operating costs are made at predetermined, specific rates for each hospital discharge. Discharges are classified according to a list of diagnosis-related groups ("DRGs").

[1] The Board recognizes that this EJR request was submitted subsequent to the Board's temporary change in operations due to the COVID-19 developments as discussed more fully in Board Alert 19. Notwithstanding, the Board was still able to process this EJR request for these group appeals within 30 calendar days of the EJR filing as it only involves appeals of a Federal Register Notice and there are no challenges under 42 C.F.R. § 405.1873.
[2] Providers' EJR request at 1.
[3] 84 Fed. Reg. 42044, 42052 (Aug. 16, 2019).

The base payment rate is comprised of a standardized amount[4] for all subsection (d) hospitals located in an "urban" or "rural" area.[5]

As part of the methodology for determining prospective payments to hospitals, 42 U.S.C. § 1395ww(d)(3)(E) requires that the Secretary[6] 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.[7] The wage index also reflects certain geographic reclassifications of hospitals to another labor market area in accordance with 42 U.S.C. §§ 1395ww(d)(8)(B) and 1395ww(d)(10).[8]

The statute further requires that the Secretary update the wage index annually, based on a survey of wages and wage-related costs of short-term, acute care hospitals.[9] Data included in the wage index is derived from the Medicare Cost Report, the Hospital Wage Index Occupational Mix Survey, hospitals' payroll records, contracts, and other wage-related documentation. In computing the wage index, the Secretary determines an average hourly wage for each labor market area (total wage costs divided by total hours for all hospitals in the geographic area) and a national average hourly wage (total wage costs divided by total hours for all hospitals in the nation).[10] A labor market area's wage index value is the ratio of the area's average hourly wage to the national average hourly wage. The wage index adjustment factor is applied only to the labor portion of the standardized amounts.[11]

Changes to the Wage Index Calculation

In the FFY 2019 IPPS proposed rule, the Secretary invited the public to submit comments, suggestions, and recommendations for regulatory and policy changes to the Medicare wage index.[12] Subsequently, the Secretary discussed the responses it received from this request for

[4] The standardized amount is based on per discharge averages from a base period and are updated in accordance with 42 U.S.C. §1395ww(d). Sections 1395ww(d)(2)(C) and (d)(2)(B)(ii) require that updated base-year per discharge costs be standardized in order to remove the cost data that effects certain sources of variation in costs among hospitals. These include case mix, differences in area wage levels, cost of living adjustments for Alaska and Hawaii, indirect medical education costs, and payments to disproportionate share hospitals. 59 Fed. Reg. 27433, 27765-27766 (May 27, 1994). Section 1395ww (d)(3)(E) requires the Secretary from time-to-time to estimate the proportion of the hospitals' costs that are attributable to wages and wage-related costs. The standardized amount is divided into labor-related and nonlabor-related amounts; only the portion considered the labor related amount is adjusted by the wage index. 71 Fed. Reg. 47870, 48146 (August 18, 2006).
[5] 42 U.S.C. § 1395ww(d)(2)(A)-(D).
[6] of the Department of Health and Human Services.
[7] 84 Fed. Reg. 42044, 42300 (Aug. 16, 2019).
[8] *See* https://cms.gov/Medicare/Medicare-Fee-For-Service-Payment/AcuteInpatientPPS/wage.
[9] 84 Fed. Reg. at 42300.
[10] *Id.* at 42305.
[11] *Id.*
[12] 83 Fed. Reg. 20164, 20372-77 (May 7, 2018).

information ("RFI") as part of the FFY 2020 IPPS proposed rule.[13] Therein, the Secretary noted that many respondents expressed: (1) "a common concern that the current wage index system perpetuates and exacerbates the disparities between high and low wage index hospitals"; and (2) "concern that the calculation of the rural floor has allowed a limited number of States to manipulate the wage index system to achieve higher wages for many urban hospitals in those states at the expense of hospitals in other states, which also contributes to wage index disparities."[14] Based on these concerns, the Secretary proposed "[t]o help mitigate the wage index disparities" by "reduc[ing] the disparity between high and low wage index hospitals by increasing wage index values for certain low wage index hospitals with low wage index values and decreasing the wage index values for certain hospitals with high wage index values to maintain budget neutrality, and changing the calculation of the rural floor . . . ."[15]

In the FY 2020 IPPS final rule, the Secretary summarizes its proposal as follows:

> [N]otwithstanding the challenges associated with comprehensive wage index reform, we agree with respondents to the request for information who indicated that some current wage index policies create barriers to hospitals with low wage index values from being able to increase employee compensation due to the lag between when hospitals increase the compensation and when those increases are reflected in the calculation of the wage index. (We noted that this lag results from the fact that the wage index calculations rely on historical data.) We also agreed that addressing this systemic issue did not need to wait for comprehensive wage index reform given the growing disparities between low and high wage index hospitals, including rural hospitals that may be in financial distress and facing potential closure." Therefore, in response to these concerns, in the FFY 2020 LTCH PPS proposed rule . . . we proposed a policy that would provide certain low wage index hospitals with an opportunity to increase employee compensation without the usual lag in those increases being reflected in the calculation of the wage index.[16]

In the FFY 2020 IPPS final rule, the Secretary finalized the "proposal to increase the wage index for hospitals with a wage index value below the 25th percentile wage index by half the difference between the otherwise applicable final wage index value for a year for that hospital and the 25th percentile wage index value across all hospitals [which] is 0.8457."[17] In doing so, the Secretary determined that "quartiles are a reasonable method of dividing the distribution of hospitals' wage

[13] 84 Fed Reg 19158, 19393-94 (May 3, 2019)).
[14] *Id.*
[15] *Id.*
[16] 84 Fed. Reg. at 42326 (citations omitted).
[17] *Id.* at 42328.

index values" and that "identifying hospitals in the lowest quartile as low wage index hospitals, hospitals in the second and third 'middle' quartiles as hospitals with wages index values that are neither low nor high, and hospitals in the highest quartile as hospitals with high wage index values, is a reasonable method of determining low wage index and high wage index hospitals for purposes of our proposals . . . addressing wage index disparities."[18]

The Secretary acknowledged that "there is no set standard for identifying hospitals as having low or high wage index values"; however, he believes his "proposed quartile approach is reasonable for this purpose, given that . . . quartiles are a common way to divide distributions, and that our approach is consistent with approaches used in other areas of the Medicare program." The Secretary stated in the proposed rule that, based on the data for the proposed rule, for FY 2020, the 25th percentile wage index value across all hospitals was 0.8482 and that this number would be updated in the final rule based on the final wage index values.[19] When the FFY 2020 IPPS final rule was published the 25th percentile wage index value across all hospitals for FFY 2020 was 0.8457.[20]

Under the Secretary's methodology, he decided to increase the wage index for hospitals with a wage index value below the 25th percentile wage index. The increase in the wage indices for these hospitals would be equal to half of the difference between the otherwise applicable final wage index value for a year for that hospital and the 25th percentile wage index value for that year for all hospitals.[21] The Secretary announced that this policy would be in effect for at least 4 years beginning in FFY 2020, in order to allow employee compensation increases implemented by low wage index value hospitals sufficient time to be reflected in the wage index calculation. The Secretary explained that, for the FFY 2020 wage index, data from 2016 cost reports was used to calculate the wage indices and 4 years is the minimum time before increases in employee compensation included in Medicare cost reports could be reflected in the wage index. The Secretary acknowledged that additional time may be necessary to determine the duration of the policy.[22]

Budget Neutrality and the Wage Index

In the 2020 Proposed IPPS Rule, the Secretary explained that he believed that, while it would not be appropriate to create a wage index floor or a wage index ceiling, it would be appropriate to provide a mechanism to increase the wage index of low wage index hospitals while maintaining budget neutrality for that increase through an adjustment to the wage index of high wage index hospitals. The Secretary maintains that this action has two key merits: (1) "by compressing the wage index for hospitals on the high and low ends, that is, those hospitals with a low wage index and those hospitals with a high wage index, such a methodology increases the impact on existing wage index disparities more than by simply addressing one end;" and (2) "such a methodology

[18] *Id.* at 42326.
[19] *Id.*
[20] *Id*
[21] *Id.*
[22] *Id.* at 42326-7.

ensures those hospitals in the middle, that is, those hospitals whose wage indices are not considered high or low, do not have their wage index values affected by this proposed policy."[23] Thus, the Secretary concludes that, "given the growing disparities between low wage index hospitals and high wage index hospitals, . . . it would be appropriate to maintain budget neutrality for the low wage index policy proposed . . .by adjusting the wage index for high wage index hospitals."[24]

Following significant criticism from commenters to the proposed rule, the Secretary acknowledged that "some commenters have presented reasonable policy arguments that we should consider further regarding the relationship between the proposed budget neutrality adjustment targeting high wage hospitals and the design of the wage index to be a relative measure of the wages and wage-related costs of subsection (d) hospitals in the United States."[25] Based on this feedback, the Secretary decided to "finalize a budget neutrality adjustment for our low wage hospital policy but . . . not [to] finaliz[e] our proposal to target that budget neutrality adjustment on high wage hospitals" given that: (1) budget neutrality is required under [§ 1395ww(d)(3)(E)]; (2) even if it were not required, he believes that it would be inappropriate to use the wage index to increase or decrease overall IPPS spending; and (3) he wished to consider further the policy arguments raised by commenters regarding the budget neutrality proposal.[26] Specifically, "consistent with the Secretary's current methodology for implementing wage index budget neutrality under [§ 1395ww(d)(3)(E)] and the alternative approach we considered in the proposed rule (84 FR 19672), we are finalizing a budget neutrality adjustment to the national standardized amount for all hospitals so that the increase in the wage index for low wage index hospitals, as finalized in the rule, is implemented in a budget neutral manner."[27]

Providers' Position

The Providers are challenging their IPPS payments for 2020 on the grounds that those payments were and continue to be improperly *understated* as a result of the reduction to the standardized amount, which the Secretary allegedly unlawfully imposed as part of the new policy increasing the wage index values of hospitals with an average wage index ("AWI") in the lowest quartile. The Providers explain that, in the FFY 2020 IPPS final rule, the Secretary sought to address what he called "wage index disparities" by adopting a number of new policies that impacted the AWI values and IPPS reimbursement hospitals receive. One of the policies increases the AWI values of hospitals with an AWI in the lowest quartile nationally ("AWI subsidy"). The Providers contend that the AWI subsidy increased the AWI values of hospitals with AWI values in the lowest quartile by half of the difference between their accurately calculated AWI and the 25th percentile of AWI values. Further, the Providers note that, while the Secretary asserted that he had the authority to implement this new policy under 42 U.S.C. § 1395ww(d)(3)(E), this section of the statute only authorizes the Secretary to adjust the labor-related portion of hospital

[23] *Id*. at 42329.
[24] *Id.* at 42328-9.
[25] *Id.* at 42331.
[26] *Id*.
[27] *Id*.

payments to account "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."

Further, the Providers allege issues with the Secretary's election to implement the new AWI Subsidy in a budget neutral manner. Specifically, the Providers allege, the Secretary decreased the standardized payment amounts of all IPPS hospitals by 0.2016 percent to offset the AWI increases to those hospitals in the lowest AWI quartile. The Providers point out that the Secretary asserts that he had the authority to implement this budget neutrality adjustment under 42 U.S.C. § 1395ww(d)(3)(E) and that, even if he did not have such authority under § 1395ww(d)(3)(E), he would invoke his statutory "exceptions and adjustments" authority in support of such a budget neutrality adjustment. This "exceptions and adjustments" authority provision, codified at 42 U.S.C. § 1395ww(d)(5)(I), addresses IPPS payments and states: "The Secretary shall provide by regulation for such other exceptions and adjustments to such payment amounts under this subsection as the Secretary deems appropriate."

The Providers argue that the Secretary lacks the authority, under his "exceptions and adjustment" authority under 42 U.S.C. § 1395ww(d)(3)(E), or otherwise in order to establish the AWI subsidy in the manner set forth in the FFY 2020 Final IPPS Rule. Similarly, the Provider argue that, even if he had lawfully established such a subsidy, he cannot lawfully reduce the standardized amount in the manner that he did as part of his implementation of the AWI Subsidy. Consequently, the Providers are challenging the reduction of the standardized amount on several grounds, including, but not limited to, that: (1) it exceeds statutory authority; (2) it contradicts the AWI congressional mandated; (3) it was developed in an arbitrary and capricious manner; (4) it lacks support from substantial evidence; and (5) it is otherwise defective both procedurally and substantively. The Providers further contend that there is no statute that precludes administrative or judicial review of the Secretary's adjustments for different area wage levels under 42 U.S.C. § 1395ww(d)(3)(E) or adjustments under 42 U.S.C. § 1395ww(d)(5)(I).

Accordingly, the Providers maintain that EJR is appropriate because the Board has jurisdiction over the appeals, the Providers are dissatisfied with the final determination of the Secretary, and the Board lacks the authority to decide the question at issue and cannot grant the relief sought. Pursuant to 42 C.F.R. § 405.1867, the Board must comply with all the provisions of Title XVIII of the Social Security Act and is therefore, bound to apply the 0.2016 percent reduction issued by the Secretary in the FFY 2020 IPPS final rule.

Decision of the Board

The participants that comprise the group appeal within this EJR request have filed an appeal involving FFY 2020 based on their appeal from the FFY 2020 IPPS Final Rule.

A. Jurisdiction and Request for EJR

As previously noted, all of the participants appealed from the FFY 2020 IPPS Final Rule.[28] The Board has determined that: (1) the participants' documentation shows that the estimated amount in controversy exceeds $50,000,[29] as required for a group appeal;[30] and (2) the appeals were timely filed. Based on the above, the Board finds that it has jurisdiction for the above-captioned appeal and the underlying Providers. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

B. Application of 42 C.F.R. § 405.1873

The Board notes that the relevant *cost reporting period(s)* of the participants in these group appeals that are impacted by the FFY 2020 IPPS final rule begin well after January 1, 2016 and, as such, are subject to the newly-added 42 C.F.R. § 405.1873 and the related revisions to 42 C.F.R. § 413.24(j) regarding submission of cost reports.[31] However, the Board notes that § 405.1873(b) has not been triggered because neither party has questioned whether the relevant participants' cost reports included an appropriate claim for the specific item under appeal, presumably because any such potential issue is not yet ripe. In this regard, the Board notes that the participants appealed the FFY 2020 Federal Register Notice and the cost reports impacted by such notice have not yet been filed to trigger § 413.24(j)'s general substantive payment requirement for cost reports.[32]

C. Analysis Regarding Appealed Issue

As set forth below, the Board finds that the Secretary's determination to finalized a budget neutrality adjustment to the national standardized amount for all hospitals so that the increase in the wage index for low wage index hospitals was implemented in a budget neutral manner was made through notice and comment in the form of an uncodified regulation.[33] Specifically, in the preamble to FFY 2020 IPPS Final Rule, the Secretary announced the following wage index issues:

1. "To help mitigate . . . wage index disparities [between high and low wage index hospitals], including those resulting from the inclusion of hospitals

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[28] The CMS Administrator has determined that a Federal Register notice is a final determination from which a provider may appeal to the Board. *See District of Columbia Hosp. Ass'n Wage Index Grp. Appeal*, HCFA Adm'r Dec. (Jan. 15, 1993), CCH Medicare & Medicaid Guide ¶ 41,025, *rev'g*, PRRB Juris. Dec. (Case No. 92-1200G, Nov. 18, 1992). *See also* 80 Fed. Reg. 70298, 70569-70 (Nov. 13, 2015) [30] *See* 42 C.F.R. § 405.1837.
[29] The amount in controversy is approximately $3,796,402.
[30] *See* 42 C.F.R. § 405.1837.
[31] *See* 80 Fed. Reg. 70298, 70555-70604 (Nov. 13, 2015).
[32] *See* 80 Fed. Reg. at 70556, 70569-70.
[33] *See* 84 Fed. Reg. 42044, 42325-36 "II. Changes to the Hospital Wage Index for Acute Care Hospitals, N. Policies to Address Wage Index Disparities Between High and Low Wage Index Hospitals.

> with rural reclassifications under 42 CFR 412.103 in the calculation of the rural floor, . . . we . . . reduce the disparity between high and low wage index hospitals by increasing wage index values for certain low wage index hospitals with low wage index values and decreasing the wage index values for certain hospitals with high wage index values to maintain budget neutrality, and changing the calculation of the rural floor . . . .";[34] and

2. "[A]ddressing this systemic issue does not need to wait for comprehensive wage index reform given the growing disparities between low and high wage index hospitals, including rural hospitals that may be in financial distress and facing potential closure."[35]

The Secretary did not incorporate into the Code of Federal Regulations the new policy setting forth a modification to the wage index calculation determination by finalizing a budget neutrality adjustment to the national standardized amount for all hospitals so that there was an increase in the wage index for low wage index hospitals. However, it is clear from the use of the following language in the preamble to the FFY 2020 IPPS Final Rule that the Secretary intended to bind the regulated parties and establish a binding uniform payment policy through formal notice and comment:

> We acknowledge, however, that some commenters have presented reasonable policy arguments that we should consider further regarding the relationship between our proposed budget neutrality adjustment targeting high wage hospitals and the design of the wage index to be a relative measure of the wages and wage-related costs of subsection (d) hospitals in the United States. Therefore, given that budget neutrality is required under section 1886(d)(3)(E) of the Act, given that even if it were not required, we believe it would be inappropriate to use the wage index to increase or decrease overall IPPS spending, and given that we wish to consider further the policy arguments raised by commenters regarding our budget neutrality proposal, we are finalizing a budget neutrality adjustment for our low wage hospital policy, but we are not finalizing our proposal to target that budget neutrality adjustment on high wage hospitals. Instead, consistent with CMS's current methodology for implementing wage index budget neutrality under section 1886(d)(3)(E) of the Act and the alternative approach we considered in the proposed rule . . ., we are finalizing a budget neutrality adjustment to the national standardized amount for all hospitals so that the increase in the wage index for low wage index

[34] *Id.* at 42326.
[35] *Id.*

> hospitals, as finalized in this rule, is implemented in a budget neutral manner.[36]

Accordingly, the Board finds that the Secretary intended this policy change to be a binding but uncodified regulation and will refer to the above policy as the "Uncodified Regulation on Wage Index." 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."[37]

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 to by the Uncodified Regulation on Wage Index published in the FFY 2020 IPPS Final Rule and the Board does not have the authority to grant the relief sought by the Providers, namely invalidating the Uncodified Regulation on Wage Index which they allege improperly reduces the standardized amount. As a result, the Board finds that EJR is appropriate for the issue for the fiscal year under appeal in this case.

D. Board's Decision Regarding the EJR Request

The Board finds that:

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

2) Based upon the participants' assertions regarding the FFY 2020 IPPS final rule, there are no findings of fact for resolution by the Board;

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

4) It is without the authority to decide the legal question of whether the Uncodified Regulation on Wage Index published in the IPPS 2020 final rule is valid.

Accordingly, the Board finds that the question of the validity of the Uncodified Regulation on Wage Index as published in the FFY 2020 IPPS final rule properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for EJR for the issue and the subject year. The Providers have 60 days from the receipt of this decision to institute the

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[36] *Id.* at 42331.
[37] 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 . . . ."

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.
Charlotte F. Benson, CPA
Gregory H. Ziegler, CPA
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

FOR THE BOARD:

5/27/2020

X Clayton J. Nix

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

Enclosure: Schedule of Providers

cc: Lorraine Frewert, Noridian Healthcare Solution c/o Cahababa Safeguard Administrators
Wilson Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Nicholas Putnam
Strategic Reimbursement Group
360 W. Butterfield Rd., Ste. 310
Elmhurst, IL 60126

RE: ***EJR Determination for SRI Medicare & Medicaid Fraction Part C Days Groups***
16-2304G SRI 2011 Disproportionate Share Patient Percentage Medicare Part C Group
16-2590G SRI 2009 Disproportionate Share Patient Percentage Medicare Part C Group
17-0285G SRI 2013 Disproportionate Share Patient Percentage Medicare Part C Group
17-1072G SRI 2010 Disproportionate Share Patient Percentage Medicare Part C Group
17-1379G SRI 2012 Disproportionate Share Patient Percentage Medicare Part C Group

Dear Mr. Putnam:

The Provider Reimbursement Review Board ("Board") has reviewed the records in the above-referenced five (5) optional group appeals and, on December 12, 2019, as required by 42 C.F.R. § 405.1842(c), notified the Providers that it was considering, on its own motion, whether Expedited Judicial Review ("EJR") was appropriate for the above referenced cases.[1] The Providers, as well as, Federal Specialized Services (FFS), on behalf of the Medicare Contractors,[2] have submitted comments as to whether EJR is appropriate.

Issues in Dispute

The Board is considering whether it is without the authority to decide the following legal questions:

> The provider requests that days included in the numerator or the denominator of the SSI ratio that pertain to recipients of Medicare Part C (MC+/HMO) be removed from the calculation of the SSI ratio in order to correct the ratio to be consistent with statute 42 USC 1395ww(d)(5)(F)(vi)(I).
>
> The provider challenges the exclusion of days pertaining to patients with both the Medicaid and Medicare Part C (MC+/HMO) from the calculation of the Medicaid ratio used in

[1] The Board's own motion EJR letter covered 13 SRI optional group appeals. Only five of those are addressed in this determination, the others will be addressed in separate correspondence.
[2] The Providers' comments were received on January 13, 2020. The MAC's comments were received on January 10, 2020.

> the determination of the provider's Operating Disproportionate Share Hospital adjustment calculations.[3]

Statutory and Regulatory Background: Medicare DSH Payment

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the prospective payment system ("PPS").[4] Under PPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[5]

The PPS statute contains a number of provisions that adjust reimbursement based on hospital-specific factors.[6] These cases involve the hospital-specific DSH adjustment, which requires the Secretary to provide increased PPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[7]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[8] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.[9] The DPP is defined as the sum of two fractions expressed as percentages.[10] Those two fractions are referred to as the "Medicare/SSI" fraction and the "Medicaid" fraction. Both of these fractions consider whether a patient was "entitled to benefits under part A."

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

> the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter . . . .[11]

[3] Request for Hearing, Issue Statement, at Tab. 2 (Aug. 25, 2016), 16-2304G.
[4] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[5] *Id.*
[6] *See* 42 U.S.C. § 1395ww(d)(5).
[7] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[8] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[9] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[10] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[11] Emphasis added.

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[12]

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

> [T]he fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX [the Medicaid program], but who were *not entitled to benefits under part A of this subchapter,* and the denominator of which is the total number of the hospital's patient days for such period.[13]

The Medicare contractor determines the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period.[14]

Medicare Advantage Program

The Medicare program permits its beneficiaries to receive services from managed care entities. The managed care statute implementing payments to health maintenance organizations ("HMOs") and competitive medical plans ("CMPs") is found at 42 U.S.C. § 1395mm. The statute at 42 U.S.C. § 1395mm(a)(5) provides for "payment to the eligible organization under this section for individuals enrolled under this section with the organization and entitled to benefits under part A of this subchapter and enrolled under part B of this subchapter . . ." Inpatient hospital days for Medicare beneficiaries enrolled in HMOs and CMPs prior to 1999 are referred to as Medicare HMO patient care days.

In the September 4, 1990 Federal Register, the Secretary[15] stated that:

> Based on the language of section 1886(d)(5)(F)(vi) of the Act [42 U.S.C. § 1395ww(d)(5)(F)(vi)], which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A," we believe it is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs, and therefore, were unable to fold this number into the calculation [of the DSH adjustment].

[12] 42 C.F.R. § 412.106(b)(2)-(3).
[13] Emphasis added.
[14] 42 C.F.R. § 412.106(b)(4).
[15] of Health and Human Services.

> However, as of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[16]

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[17]

With the creation of Medicare Part C in 1997,[18] Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C days in the SSI ratios used by the Medicare contractors to calculate DSH payments for the fiscal years 2001-2004.[19]

No further guidance regarding the treatment of Part C days in the DSH calculation was provided until the 2004 Inpatient Prospective Payment System ("IPPS") proposed rules were published in the Federal Register. In that notice the Secretary stated that:

> . . . once a beneficiary has elected to join an M+C plan, that beneficiary's benefits are no longer administered under Part A . . . . *once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage. These patient days should be included in the count of total patient days in the Medicaid fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction . . . .*[20]

The Secretary purportedly changed her position in the Federal fiscal year ("FFY") 2005 IPPS final rule, by noting she was "revising our regulations at [42 C.F.R.] § 412.106(b)(2)(i) to

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[16] 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).
[17] *Id.*
[18] The Medicare Part C program did not begin operating until January 1, 1999. *See* P.L. 105-33, 1997 HR 2015, *codified as* 42 U.S.C. § 1394w-21 Note (c) "Enrollment Transition Rule.- An individual who is enrolled [in Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered to be enrolled with that organization on January 1, 1999, under part C of Title XVIII . . . if that organization as a contract under that part for providing services on January 1, 1999 . . . ." This was also known as Medicare+Choice. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub.L. 108-173), enacted on December 8, 2003, replaced the Medicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.
[19] 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).
[20] 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).

include the days associated with [Part C] beneficiaries in the Medicare fraction of the DSH calculation."[21] In response to a comment regarding this change, the Secretary explained that:

> *. . . We do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A. We agree with the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.*[22]

This statement would require inclusion of Medicare Part C inpatient days in the Medicare fraction of the DSH calculation.

Although the change in DSH policy regarding 42 C.F.R. § 412.106(b)(2)(i) was included in the August 11, 2004, Federal Register, no change to the regulatory language was published until August 22, 2007, when the FFY 2008 IPPS final rule was issued.[23] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change adopted in the FFY 2005 IPPS final rule. These "technical corrections" are reflected at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).[24] As a result of these rulemakings, Part C days were required to be included in the Medicare fraction as of October 1, 2004 (the "Part C DSH policy"). Subsequently, as part of the FFY 2011 IPPS final rule published on August 15, 2010, CMS made a minor revision to §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) "to clarify" the Part C DSH policy by replacing the word "or" with "including."[25]

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius*

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[21] 69 Fed. Reg. at 49099.
[22] *Id.* (emphasis added).
[23] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[24] *Id*. at 47411.
[25] 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: "We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word 'or' with the word 'including' in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B)."); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff'd in part and rev'd in part*, 746 F. 3d 1102 (D.C. Cir. 2014).

("*Allina I*"),[26] vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.[27] However, the Secretary has not acquiesced to that decision.

More recently, in *Allina Health Services v. Price* ("*Allina II*"),[28] the D.C. Circuit confirmed that the Secretary's 2004 attempt to change the standard to include Part C days in the Medicare fraction had been vacated in *Allina I*.[29] The D.C. Circuit further found in *Allina II* that the Secretary failed to provide proper notice and comment before including Part C days in the Medicare fractions published for FY 2012.[30] Once again, the Secretary has not acquiesced to this decision.

Board's Consideration for Own Motion EJR

In the FFY 2005 Final Rule, the Secretary announced a policy change. This policy was to include Part C days in the Medicare Part A/SSI fraction and exclude them from the Medicaid fraction effective for discharges on or after October 1, 2004.[31] In *Allina I*, the Court affirmed the district court's decision "that the Secretary's final rule [for FFY 2005] was not a logical outgrowth of the proposed rule [for FFY 2005]."[32] In these cases, the Providers contend that all Part C days should be excluded from the Part A/SSI fraction and the Medicaid-eligible Part C days should be excluded from SSI ratio to be consistent with 42 U.S.C. § 1395ww(d)(5)(F)(i).[33]

Decision of the Board

Pursuant to 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R. § 405.1842(f)(1) (2017), the Board may grant EJR 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

The participants encompassed by this own-motion EJR determination have filed appeals involving fiscal years 2009-2013.[34]

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[26] 746 F. 3d 1102 (D.C. Cir. 2014).
[27] *Id*. at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").
[28] 863 F.3d 937 (D.C. Cir. 2017).
[29] *Id.* at 943.
[30] *Id.* at 943-945.
[31] 69 Fed. Reg. at 49,099.
[32] *Allina* at 1109.
[33] *See e.g.* Case No. 14-1401G, Providers' October 28, 2013 Hearing Request, Tab 2,
[34] The FY 2013 periods at issue in these appeals precedes October 1, 2013, when CMS issued the final rule

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hosp. Ass'n v. Bowen* ("*Bethesda*").[35] 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.[36]

On August 21, 2008, new regulations governing the Board were effective.[37] Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hosp. v. Burwell* ("*Banner*").[38] 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.[39]

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.

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published on August 19, 2013, in which CMS readopted its then existing regulations at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) without "any change to the regulation text because the current text reflects the policy."

[35] 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.).

[36] *Bethesda*, 108 S. Ct. at 1258-59.

[37] 73 Fed. Reg. 30190, 30240 (May 23, 2008).

[38] 201 F. Supp. 3d 131 (D.D.C. 2016)

[39] *Id.* at 142.

The Board has determined that the participants' appeals involved with the instant own-motion EJR are governed by the decision in *Bethesda* and CMS Ruling CMS-1727-R. The Providers appealed from original NPRs. In addition, the participants' documentation, in each case, shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal[40] and that the appeals were timely filed. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case. Accordingly, the Board finds that it has jurisdiction for the referenced appeals and the participants.

B. Board's Analysis Regarding the Appealed Issue

The appeals in this EJR request involve fiscal years 2009-2013. Thus, the appealed cost reporting periods falls squarely within the time frame applicable to the Secretary's Part C DSH policy being challenged which was adopted in the FFY 2005 IPPS final rule and later codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) as part of the FFY 2008 IPPS final rule (with a minor revision published in the FFY 2011 IPPS final rule). The Board recognizes that, for the time period at issue in these requests, the D.C. Circuit in *Allina I* vacated this regulation. However, the Secretary has not formally acquiesced to that *vacatur* and, in this regard, has not published any guidance on how the *vacatur* is being implemented (*e.g.*, only circuit-wide versus nationwide).[41] Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located.[42] Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

C. Board's Decision Regarding the Own Motion EJR

The Board finds that:

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

2) Based upon the participants' assertions regarding 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B), 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. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (2011) codifying the Medicare Part C DSH policy adopted in the FFY 2005 IPPS final rule are valid.

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[40] *See* 42 C.F.R. § 405.1837.
[41] *See generally Grant Med. Ctr. v. Burwell*, 204 F. Supp. 3d 68, 77-82 (D.D.C. 2016), *aff'd*, 875 F.3d 701 (D.C. Cir. 2017).
[42] *See* 42 U.S.C. § 1395oo(f)(1).

Accordingly, the Board finds that the question of the validity of 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (2011) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants EJR for the issue and the subject years. The participants have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in these cases, the Board hereby closes the cases.

Board Members Participating:

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

FOR THE BOARD:

5/28/2020

X Clayton J. Nix

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

Enclosures: Schedules of Providers

cc: Danene Hartley, NGS
Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators
Wilson Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Healthcare Reimbursement Services, Inc.
Corrina Goron
c/o Appeals Department
17101 Preston Rd., Ste. 220
Dallas, TX 75248-1372

Novitas Solutions, Inc.
Bruce Snyder
Director, JL Provider Audit & Reimbursement
707 Grant St., Ste. 400
Pittsburgh, PA 15219

RE: ***Jurisdictional Determination***
Provider Name: St. Dominic – Jackson Memorial Hospital
FYEs: 12/31/07, 12/31/08, 12/31/09, 12/31/10
Case Nos.: 13-2937, 14-0220, 14-0263, 14-4048

Dear Ms. Goron and Mr. Snyder,

The Provider Reimbursement Review Board (the "Board") has reviewed jurisdiction in the four (4) above-captioned individual appeals for St. Dominic – Jackson Memorial Hospital ("Provider") for its fiscal years ("FYs") 2007 through 2010. The Board's jurisdictional decision on the above-captioned 4 cases (hereinafter "the 4 cases") is set forth below.

Background

The Provider submitted requests for hearings for the 4 cases on August 22, 2013, October 18, 2013, October 23, 2013 and August 28, 2014 based on Notices of Program Reimbursement ("NPRs") dated February 25, 2013, April 24, 2013, July 10, 2013 and March 28, 2014 respectively relating to FYs 2007 through 2010. Each of the 4 cases had the following two issues:

> Issue 1 – Inclusion of Medicare Part C Patient Days in the DSH Patient Percentage
>
> Issue 2 – Data Matching Process Used in Calculating the Supplemental Security Income ("SSI") Fraction[1]

On December 31, 2019, the Board sent a revised notice of consolidated hearing ("NoH") for the 4 cases that required the Provider to file a consolidated final position paper by March 11, 2020.

On January 3, 2020, having received and reviewed comments on its own motion to consider expedited judicial review ("EJR") on Issue 1 in the 4 cases, the Board found that EJR was appropriate for Issue 1 (DSH Medicare Part C Days issue) and issued a determination to grant

[1] Provider's Appeal Requests.

that EJR for Issue 1 in the 4 cases. As a result, the sole remaining issue in the 4 cases is Issue 2 (the SSI Data Matching issue).

On February 21, 2020, the Provider sent the Board notice that it had changed the representative on the 4 cases to Healthcare Reimbursement Services, Inc. ("HRS"). On March 11, 2020, consistent with the deadline set in the revised NoH, HRS timely filed the Provider's Consolidated Final Position Paper briefing the last issue in the 4 cases.

On April 9, 2020, the Medicare Contractor submitted a jurisdictional challenge on Issue 2 (the SSI Data Matching issue) in each of the 4 cases.

On April 17, 2020 (after the jurisdictional challenge was submitted, but before the Provider responded to the challenge), the Provider submitted an EJR request over the following issue and, in so doing, suggests the Board has jurisdiction over it as:

> In these individual appeals, the Provider contends that CMS has acted unlawfully by applying inconsistent interpretations to the term "entitled" in the context of the Medicare fraction of the Medicare DSH formula. Provider asks the Board to grant Expedited Judicial Review because they challenge regulation 42 C.F.R. 412.106(b), as amended by the FY 2005 IPPS Final Rule and as in effect for the cost years at issue. Provider believes the regulation is procedurally invalid, including violating the rulemaking requirements of the Medicare Statute and the Administrative Procedure Act. Provider also believes that the FY 2005 IPPS Final Rule is substantively invalid as contrary to the Medicare Statute and arbitrary and capricious in including total Medicare days in the Medicare Fraction, or, alternatively, is impermissibly inconsistent in its treatment of how it counts Medicare and SSI days (total Medicare days for the former and only paid days for the latter). Alternatively, to the extent that the MAC did not apply the FY 2005 IPPS Final Rule, it applied a different rule that has substantive effect, but which was not promulgated pursuant to notice and comment rulemaking procedures and which is also substantively invalid.

Medicare Contractor's Jurisdictional Challenge

The Medicare Contractor is asserting that the Board does not have jurisdiction over the sole remaining issue – Issue 2 on the Data Matching Process Used in Calculating the SSI Fraction. The Medicare Contractor asserts that, by way of its Consolidated Final Position Paper, the Provider has added a subsidiary issue asserting the Secretary failed to adhere to required notice and comment rulemaking procedures. Additionally, the Medicare Contractor alleges that the Provider has abandoned its assertion that data from the Mississippi Division of Medicaid is the

more reliable data from which its SSI fraction should be calculated and that, by abandoning this assertion, the Provider has essentially abandoned the sole issue remaining in the appeal.[2]

A. Addition of New Issue

The Medicare Contractor argues that, in its Consolidated Final Position Paper, the Provider seeks to add a new issue regarding notice and comment rulemaking procedures in adopting policy on exhausted benefit days, Medicare secondary payor days and Medicare Advantage days. The Medicare Contractor asserts that there is no reference to exhausted benefit days, Medicare secondary payor days or Medicare Advantage days in either the Provider's appeal request or its preliminary position paper discussion of the SSI fraction. Rather, the first reference to these days is in the Provider's Consolidated Final Position Paper. The only earlier reference to Medicare Advantage days was in relation to Issue 1 – Inclusion of Medicare Part C Patient Days in the DSH Patient Percentage, for which the Board granted EJR on January 3, 2020.[3]

In support of its position, the Medicare Contractor cites to the regulations for adding issues to a hearing request at 42 C.F.R. § 405.1835(c) and Board Rule 6.2.1 addressing adding issues. The Medicare Contractor goes on to point out that Board Rule 27.4 prohibits expanding Scope of Arguments in Final Position Papers. The Medicare Contractor asserts that the Provider has violated these Rules and regulations by attempting to improperly expand its argument from its appeal request and Preliminary Position Paper via its Consolidated Final Position Paper.[4]

B. Best Data Available Issue

The Medicare Contractor notes that the Provider's appeal request defined Issue 2 as:

> St. Dominic challenges the calculation of the Medicare/SSI fraction. The number of SSI eligible days use to calculate the Medicare/SSI fraction was not based upon the best data available.

The Medicare Contractor points out that, in its preliminary position paper, the Provider advanced the argument that CMS did not use the "best available data" in the calculation of the Provider's Medicare fraction of the DSH calculation. The Medicare Contractor notes the Provider's argument relied extensively on the notion that because data acquired by the Provider from the Mississippi Division of Medicaid showed a greater number of patients eligible for SSI, and such data was readily available to CMS, such data was the "best available data."[5] In this regard, the Provider stated:

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[2] Medicare Contractor's Jurisdictional Challenge at 3.
[3] *Id.*
[4] *Id.* at 4.
[5] *Id.* at 5.

> Using SSI eligibility data obtained from Mississippi Division of Medicaid, Horne determined that a significant number of SSI eligible days, 1,330 days, were excluded from CMS's calculation.

The Medicare Contractor maintains that, in its appeal request and preliminary position paper, the Provider is attempting to claim that because the data obtained from the Mississippi Division of Medicaid contains more eligible days than what CMS has determined, it must be used as the source for the "best available data" as required by the Court in *Baystate*.[6]

The Medicare Contractor states that the Consolidated Final Position Paper does not discuss and abandons the Provider's "best available data" arguments regarding the Mississippi Division of Medicaid information as the "best available data"; an argument which dates back to its appeal request.[7] The Provider instead makes a new argument:

> The Provider needs to perform a review of the data to determine if there are any missing records, then the Provider will still need to verify with the SSA to confirm SSI entitlement for these patients CMS may have failed to include in their determination of the SSI percentage.[8]

The Medicare Contractor argues that the Provider's assertion that it "needs to perform a review of the data to determine if there are any missing records" is tantamount to stating that it has not reviewed the MedPAR data. In this regard, the Medicare Contractor notes that the Provider requested and received the MedPAR data for the periods at issue even before filing its appeals in these cases and that CMS has confirmed in response to the Provider requests that it provided the MedPAR data for the periods in question.[9]

Further, the Medicare Contractor contends that the Provider's Consolidated Final Position Paper advances the following new issues:

> The Provider contends that the SSI percentage calculated by the Centers for Medicare and Medicaid Services ("CMS") and used by the MAC to settle their Cost Report is incorrectly computed because of the following reasons.
>
> - Availability of MEDPAR and SSA Records
> - Paid Days vs. Eligible Days
> - Not in Agreement with Provider's Records
> - Fundamental Problems in the SSI Percentage Calculation

[6] *Id.* at 5.
[7] *Id.*
[8] *Id.* at 6.
[9] *Id.*

- Covered Days vs. Total days
- Matching Methodology Pursuant to CMS Ruling 1498-R
- Failure to Adhere to Required Notice and Comment Rulemaking Procedures in Adopting Policy on EB, MSP and MA Days[10]

The Medicare Contractor notes that the Provider's new argument asserts that the CMS calculation of the SSI percentage is incorrect. The Medicare Contractor goes on to state that the Provider presents no analysis of the MedPAR data in its possession to substantiate its claim that the data is faulty.[11]

Lastly, the Medicare Contractor contends that the Provider's argument advanced in its Consolidated Final Position Paper is tantamount to abandoning its appeal. The Board recently reached a similar conclusion in its jurisdictional decision in a case involving the provider, Lakeland Regional Health.[12] The Medicare Contractor asserts that the Board's jurisdictional decision in that case is applicable to the Provider's appeal. Specifically, similar to Lakeland Regional Health, the Provider has failed to develop its case as required by the regulations and the Board Rules notwithstanding the fact that the Provider's appeals have been pending since 2013 and 2014. The Provider has essentially abandoned its appeal by filing a perfunctory Consolidated Final Position Paper.

Provider's Position

The Provider contends that the Board has jurisdiction over the 4 cases pursuant to 42 U.S.C. § 1395oo(a) and the regulation 42 C.F.R. § 405.1840. More specifically, the Provider asserts that, per these authorities, the Board has jurisdiction over an appeal if the provider or providers have expressed dissatisfaction with the contractor or Secretary determination at issue, if it or they meet the amount in controversy requirement, and if the appeal was timely filed.

In support of its position *regarding **individual** appeals,* the Provider notes that, where the Board determines that there is more than one legal question *in a **group** appeal*, it does not have the authority to dismiss the appeal on this basis.[13] In this regard, the Provider states that the regulations governing group appeals provide that:

> (2) If the Board finds jurisdiction over a group appeal hearing request under § 405.1840 of this subpart –
>
> (i) The Board must determine whether the appeal involves specific matters at issue that raise more than one factual or legal question common to each provider; and

[10] *Id.* at 5-6.
[11] *Id.* at 6.
[12] Copy included as Exhibit C-4.
[13] Provider's Jurisdictional Response at 2.

> (ii) When the appeal is found to involve more than factual or legal question common to each provider, *the Board **must** assign a separate case number to the appeal of each common factual or legal question and conduct further proceedings in the various appeals separately for each case*.[14]

Thus, the Provider asserts that the question is not one of jurisdiction but whether each of the appeals raises more than one "factual or legal question," or, in other parlance, more than one "issue."[15]

The Providers essentially contend that there is only one issue in each of the four appeals, specifically that the issue per the Model A forms is "Whether the Secretary properly calculated the Provider's Disproportionate Share Hospital ("DSH")/Supplemental Security Income ("SSI") percentage." The Provider asserts that this is the same single issue that it presented in its Preliminary Position Papers for FYs 2008 to 2010 and that the Providers gave, in their statement of the legal basis, more than one reason as to why their DSH reimbursement was incorrect. Accordingly, the Provider asserts that the fact remains that the appeals all involve only the issue of whether their DSH reimbursement was correctly determined. Similarly, the legal authority that is being challenged in all of the appeals is 42 C.F.R. § 412.106. In this regard, the Providers claim that the regulation is procedurally and substantively invalid for various reasons and that each separate argument as to why that regulation is invalid does not constitute a separate issue.[16]

As stated by the Provider, "[t]o put it another way, there may be more than one *matter* at issue in the appeals, but this is not a disqualifying factor for either bringing an individual appeal." In this regard, the Provider states that other regulations and the Board's Rules support its contention that an "issue" or "legal question" is broad in nature and may include several "matters" or "components." The Provider then cites to 42 C.F.R. § 405.1835 as an example of a regulation that repeatedly refers to the specific "item" under appeal and asserts that the regulations use of the language *"how and why the provider believes Medicare payment must be determined differently for each disputed item"* supports the idea that there can be multiple reasons for why a provider believes a single adjustment is incorrect. Similarly, the Provider cites to Board Rule 7 as supporting its contention that an "issue" is coterminous with "an adjustment." It states that "[f]or each issue under appeal, [the provider is to] give a brief summary of the determination being appealed and the basis for dissatisfaction," including:

- the adjustment, including, the adjustment number,
- why the adjustment is incorrect, and
- how the payment should be determined differently.[17]

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[14] 42 C.F.R. § 405.1837(f)(2) (emphasis added).
[15] Provider's Jurisdictional Response at 1-2.
[16] *Id.* at 2.
[17] *Id.* at 2-3.

The Provider notes that Board Rule 8.1 says that an issue may have several "components" and that it follows that, to state that an "issue" may have "multiple components" is to acknowledge that "components" are contained *within an "issue" and are not "issues" themselves*. The Provider acknowledge that Board Rule 8.1 also says "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;" however, the Provider claims that there is no "regulatory requirement" that components of an issue must be identified as separate items in dispute and appealed as separate items.[18]

The Provider maintains that it appealed the SSI Systemic issue in these cases. In its issue language included in the Consolidated Final Position Paper, the Provider lists various reasons for the understatement of its SSI percentage, including Covered v. Total Days. The Provider's Consolidated Final Position Paper expands this component of the issue through its argument that CMS should be required to recalculate the SSI percentages using a denominator based solely upon covered and paid for Medicare Part A days, or alternatively, expand the numerator of the SSI percentage to include paid/covered/entitled as well as unpaid/non-covered/eligible SSI days. The Provider contends this is not a new argument, but rather, a further detailed explanation of a component of the issue in the original appeal request.[19]

Finally, the Provider argues that it has not abandoned the "Data Matching" component of the SSI Systemic issue which was included in its original appeal request and preliminary position paper. In this regard, the Provider contends that the SSI Systemic issue addresses the various factors which led to the inaccurate SSI percentages at issue as well as the deficiencies as described in *Baystate*. In its Consolidated Final Position Paper, the Provider continues to support the position that its SSI percentage was incorrectly computed due to inaccurate methods used to calculate the SSI percentage.[20]

Board's Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1841, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

A. Issue 2 – Data Matching Process Used in Calculating the SSI Fraction

Per ***each*** of the appeal requests filed for the 4 cases for FYs 2008 through 2010, the Provider entitled Issue 2 as "Data Matching Process Used in Calculating the SSI Fraction." Therein, ***for each appeal request***, the Provider states that it challenges the calculation of the Medicare SSI fraction because "[t]he number of SSI eligible days use [*sic* used] to calculate the Medicare/SSI

[18] *Id.* at 3.
[19] *Id.* at 3.
[20] *Id.* at 3-4.

fraction was not based upon the best data available." The Provider gives the context for this allegation by walking through the "best available data" litigation in the *Baystate Med. Ctr. v. Leavitt* that resulted in CMS issuing Ruling 1498-R and the revised data matching process set forth in the FY 2011 IPPS final rule. The Provider then asserts that there is a "discrepancy between data obtained from the Mississippi Division of Medicaid, which has been tested for reliability, and the data used by CMS" and that, as a result, "its SSI eligible days for [each of the fiscal years at issue] is not based upon the best available data, is arbitrary and capricious, and not in compliance with the applicable standards and regulations." Accordingly, for each appeal, the Provider attached "[t]he proper calculation of the Medicare/SSI fraction . . . as Exhibit A" to the appeal request. The Provider concludes that, "[b]y failing to use the best available data to determine [the Provider's] SSI eligible days, CMS understated [the Provider's] DSH payment by" the amount specified in Exhibit A which in each instance uses the Mississippi Medicaid's data on SSI days to calculate revised SSI fractions.[21]

Thus, in reviewing the Provider's original appeal requests in the 4 cases, it is clear that Issue 2 disputes a single aspect of the DSH adjustment calculation. Specifically, the Provider disputes that CMS used the "best available" data on SSI eligible days to calculate the SSI fractions at issue and argues that more reliable SSI eligibility data can be obtained from the Mississippi Division of Medicaid which shows more SSI eligible days than CMS utilized in its calculation.

The Provider filed preliminary position papers in the 4 appeals that: (1) briefed Issue 2 consistent with the original appeal requests' description of Issue 2; and (2) consistent with the Board Rule 25, further developed the merits of is claim in Issue 2. In particular, the sample preliminary positon paper that the Medicare Contractor included as Exhibit C-2 explained how its consultant, Horne, LLP, assessed the reliability of Mississippi Medicaid data on SSI eligibility and included an exhibit providing Horne's analysis on the reliability of this Mississippi Medicaid data.[22] In this regard, the preliminary positon paper states: "More specifically, the omitted patients come primarily [95 percent] from two Categories of Eligibility ("COE"): (I) COE 001[23] . . . (2) COE 013" [24] and asserts that "[t]hese findings lead to the logical conclusion that either CMS failed to use the best data available or systemic flaws in CMS's data source or matching process caused patients in these particular categories to be omitted." The Provider's Preliminary Position Papers makes clear that Horne's analysis is in part based on certain data obtained from CMS per a Data Use Agreement. The Preliminary Positon Papers conclude that,

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[21] For FY 2007, the Provider claims an increase to 8,484 in SSI days based on Mississippi Medicaid data with a resulting amount in controversy of $1,655,725. For FY 2008, the Provider claims an increase to 8,975 in SSI days based on Mississippi Medicaid data with a resulting amount in controversy of $2,048,447. For FY 2009, the Provider claims an increase to 8,633 in SSI days based on Mississippi Medicaid data with a resulting amount in controversy of $1,794,056. For FY 2010, the Provider claims an increase to 7,959 in SSI days based on Mississippi Medicaid data with a resulting amount in controversy of $1,578,018.

[22] Provider's Preliminary Position Paper for FY 2010 at 2 (copy included at Exhibit C-2).

[23] Per the Provider's Preliminary Position Papers, the eligibility code COE 001 is for individuals designated by SSA as an individual receiving SSI benefits. *Id.* at 20.

[24] *Id.* Per the Provider's Preliminary Positon Papers, the eligibility code COE 013 is for individuals whose residence is a nursing home and whose SSI benefits are paid directly to the nursing home. The Provider asserts that, as these patients are both eligible for and receive SSI benefits, they should be included in the hospital's SSI percentage computation. *Id.*

since "this [Mississippi Medicaid] data was readily available to CMS . . . . CMS did not use the best available data as required by CMS Ruling No. CMS-1498-R and the 2011 IPPS Final Rule to calculate the Medicare/SSI fraction."[25]

Under Board Rules and regulations, providers are obligated to fully develop the merits of their claims. In this regard, the regulations at 42 C.F.R. § 405.1853(b)(2) state:

> (b) Position papers. (1) After any preliminary narrowing of the issues, *the parties must file position papers in order to narrow the issues further*. In each case, and as appropriate, the Board establishes the deadlines as to when the provider(s) and the contractor must submit position papers to the Board.
>
> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper *must set forth the relevant facts and arguments 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.[26]

In regards to final position papers, Board Rule 27 (August 2018) incorporates the requirements for preliminary position papers as delineated in Board Rule 25. In this regard, it states the following, in pertinent part:

> **Rule 27 Final Position Papers**
>
> ****
>
> 27.2 Content
>
> The final position paper should address <u>*each*</u> remaining issue. *The minimum requirements* for the position paper narrative and exhibits *are the same as those outlined for preliminary position papers at Rule 25*.[27]

[25] *Id.* at 23.
[26] (Italics emphasis added.)
[27] (Italics emphasis added.)

Rule 25 Preliminary Position Papers

25.1 Content of Position Paper Narrative

The text of the position papers *must* contain the elements addressed in the following subsections.

25.1.1 Provider's Position Paper

A. Identify any issues that were raised in the appeal but are already resolved (whether by administrative resolution, agreement to reopen, transfer, withdrawal, dismissal, etc.) and require no further documentation to be submitted.

B. For *each* issue that has not been fully resolved, *state the material facts that support the provider's claim.*

C. *Identify the controlling authority*, (e.g. statutes, regulations, policy or, case law) *supporting the provider's position*.

D. *Provide a conclusion applying the material facts to the controlling authorities*.

25.2 Position Paper Exhibits

25.2.2 Unavailable and Omitted Documents

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

25.3 Filing Requirements to Board

Parties should file with the Board a **complete** preliminary position paper with *a fully developed narrative* (Rule 23.1 [*sic* 25.1]), *all exhibits* (Rule 23.2 [*sic* 25.2), a listing of exhibits, and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. Any issue appealed, but not briefed by the Provider in its position paper will be considered withdrawn.[28]

[28] (Italics and underline emphasis added.)

Finally, 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-
>
> (1) Dismiss the appeal with prejudice;
>
> (2) Issue an order requiring the provider to show cause why the Board should not dismiss the appeal; or
>
> (3) Take any other remedial action it considers appropriate.

The Board finds that the Provider abandoned Issue 2 as set forth in the appeal requests for the 4 cases and as further developed and expounded on in its Preliminary Position Papers for the 4 cases. In this regard, the Board notes that the Consolidated Position Paper only obliquely refers to the original dispute regarding the "best data available" and fails to include ***any*** of the arguments included in the original appeal request for the 4 cases or the arguments and exhibits included in the Preliminary Position Papers for the 4 cases. In particular, the Board notes that the Consolidated Final Position Paper fails to discuss (or even mention) the relevance of the Mississippi Medicaid data, the CMS Medicare data that was pulled under a data use agreement,[29] or the analysis done by the Horne Group on that Mississippi Medicaid or CMS Medicare data.[30] Moreover, no exhibits were included concerning either that data or the Horne Group analysis.

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[29] Indeed, the Consolidated Position Paper obliquely insinuates that it may not have access to certain needed MedPAR and SSA records but does not identify those records with any particularity and how the records that are in fact available are insufficient. In this regard, the Board notes that the Consolidated Position Paper does not discuss the records and CMS data to which the Horne Group had already accessed through a user agreement with CMS or the MedPAR data that is available to it as a provider. In particular, the Board notes that providers can obtain certain data used to calculate their DSH SSI Ratios from the Centers for Medicare and Medicaid Services ("CMS"). *See e.g.*, https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh (last accessed Apr. 10, 2020); https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH (last accessed Apr. 10, 2020) (CMS webpage describing access to DSH data ***from 1998 to 2017***: "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.").

[30] The Consolidated Position Paper includes a pithy three-sentence section entitled "Not in Agreement with Provider's Records" that makes the broad-brush stroke assertions that "the SSI entitlement of individuals can be ascertained from State records" and that "[t]he Provider has reason to believe that the joint eligible beneficiary percentages determined by CMS are incorrect." The Provider then asserts that it "needs to perform a review of the

The Board recognizes that the Consolidated Position Paper does contain two argument sections that discuss the data matching process for SSI percentages[31] but finds that these are not relevant to the original "best data available" issue.[32] First is the argument section entitled "Fundamental Problems in the SSI Percentage Calculation." However, this section only includes roughly 2 pages of perfunctory skeletal arguments and broad unsupported allegations relating to the original *Baystate* data match process and do not discuss the original allegation that CMS did not use the "best data available" which allegedly is the Mississippi Medicaid data (much less explain how the *Baystate* data match issues continue notwithstanding CMS' revisions to its data match process following *Baystate*).[33] Second is the argument section entitled "Matching Methodology Pursuant to Ruling 1498-R." While this section asserts that "the revised matching methodology contemplated by CMS in formulating . . . SSI percentages is deficient," it does not reference or relate to the original issue appealed, namely the "best data available" argument.[34]

Finally, Board Rule 25.2 makes it clear that a provider's final position paper must include all documentation supporting the allegations and assertions of material facts unless it is unavailable. In such situations, Board Rule 25.2.2 provides the following instructions:

[State] data to determine if there are any missing records." However, at no time does the Consolidated Position Paper identify the state at issue (*i.e*, Mississippi) or, more importantly discuss or reference the previous Mississippi Medicaid data, the CMS data, and the Horne Group analysis that was discussed in and included as exhibits to the Provider's preliminary position papers.

[31] The Board notes that, since the NPRs at issue were issued after April 28, 2010 (the issuance date for CMS Ruling 1498-R), CMS Ruling 1498-R is not applicable. Rather, the data match process laid out in the FY 2011 IPPS Final Rule published on August 16, 2010 is applicable and was the one that CMS used to generate the SSI percentages at issue

[32] The focus here is on how these sections do not discuss or relate to the original issue appealed. In fact, they are new issues that were not timely added to the appeal as discussed in the next section of the determination.

[33] The Board recognizes that. while the Consolidated Position Paper does use the term "best data available" *in its argument and analysis*, it does list (in very broad skeletal terms) the *Baystate* data match errors that ultimately supported the finding by both the Board and the Courts in the *Baystate* case that CMS failed to use the best data available. The Provider then "is *not* simply contending that the errors in the calculation of the SSI percentages are the same ones at issue in *Baystate*," but rather that "the methodology employed by CMS and the MAC to determine their SSI percentages is inconsistent with the statute." The Provider's Consolidated Position Paper fails to support or explain that contention much less include any exhibits or evidence supporting that allegation, notwithstanding CMS revised data matching process issued subsequent to *Baystate*. *See* CMS Ruling 1498-R.

[34]The deficiencies cited are all new issues such as: (1) alleged matching errors resulting from using the Medicare Enrollment Database ("EDB") rather than social security numbers; (2) contenting that CMS "appl[ied] inconsistent interpretations to the term 'entitled' in the context of the Medicare fraction of the Medicare DSH formula" and challenging determining days an individual is entitled to SSI being based on receipt of SSI payments for such days; and (3) challenging the limited number of SSA status codes that CMS uses in the data matching process to be expanded to include 29 additional SSA codes where the individual is eligible for benefits but did not receive a payment. At no point is there a mention of Mississippi Medicaid data (much less the Mississippi codes COE 001 or COE 013) where the Provider had previously argued that these codes fit within CMS current criteria that only those days where the beneficiary received SSI payments can be counted. Indeed, the Provider claimed in its Preliminary Position Paper for FY 2010 (*see* Exhibit C-2 at 20) that the "omitted patients" associated with COE 001 and COE 013 accounted for roughly 95 percent of its claim; yet this is not even referenced or discussed in the Consolidated Final Position Paper.

> If documents necessary to support your position are still unavailable, ***identify*** the missing documents, ***explain why*** the documents remain unavailable, ***state the efforts made to obtain*** the documents, and ***explain when*** the documents will be available.

The Consolidated Position Paper does not identify any document or data that are missing or unavailable relative to the DSH SSI Data Match issue.[35] If there were any such documents, the Consolidated Final Position Paper was required to include an explanation of why they were unavailable, a description of the efforts made to obtain them, and an explanation of when they will become available.

Based on the above, the Board finds that the Provider abandoned the merits of its claim in Issue 2 that CMS failed to use the best data available in calculating the SSI ratio. These cases have been pending at the Board since 2013 and 2014 and, without a good cause showing to the contrary, the Board concludes that the Provider has had adequate time to prepare its arguments regarding the merits of its claims for Issue 2. Instead, the Provider filed a Consolidated Final Position Paper that wholly abandons Issue 2.[36] As such, the Board determines that the Provider has violated Board Rule 25 (via 27) and 42 C.F.R. § 405.1853(b)(2) because the Provider's Consolidated Final Position Paper did not set forth the relevant facts and arguments regarding the merits of the Provider's claim. Accordingly, the Board dismisses Issue 2 pursuant to its authority under 42 C.F.R. §§ 405.1853(b) and 405.1868(b).

B. Addition of New Issues

The Board finds that it does not have jurisdiction over the myriad of new issues raised in the Provider's Consolidated Final Position Paper and that these new issues were not raised in the appeal request or timely added. These new issues include, but are not limited to:

1. Challenging CMS policy to count only SSI paid days (as reflected by SSA pay codes CO-1, MO-1, and MO-2) when determining the number of days a beneficiary was

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[35] The Board recognizes that the Provider Consolidated Final Position Paper obliquely insinuates that certain data or records may be unavailable and states that "[t]he Provider needs to review [State] data." However, as discussed at *supra* notes 27 and 28, the Provider's fails to identify with any particularity the missing or unavailable data, much less the basis for that unavailability consistent with the requirements laid out in Board Rule 25.2.2.

[36] If the Provider needed more time *to meet the position paper content requirements*, the Provider could have requested a "good cause" extension. In this regard, the Board notes that Board Rule 23.5 permits parties to request extension on position paper filing deadlines: "Requests for extensions for filing a PJSO or preliminary position paper must be filed at least three weeks before the due date and will be granted *only for* ***good cause***." (Emphasis added.) However, the Provider did not request such a "good cause" extension of the Consolidated Final Position Paper and instead made an insufficient filing. The fact that the Representative was appointed just shortly before the deadline to file the Provider's Consolidated Final Position Paper does not in any way alter the Provider's obligations to meet the position paper content requirements. *See* Board Rule 5.2 (stating "[t]he case representative is also responsible for meeting the Board's deadlines and for timely responding to correspondence or requests from the Board or the opposing party. . . . [T]he recent appointment of a new representative will also not be considered cause for delay of any deadlines or proceedings"); Board Rule 5.5.1 ("the recent appointment of a new representative, generally will not be considered cause for delay of any deadlines or proceedings").

entitled to SSI benefits and advocating to expand that policy to include 29 additional SSA status codes.

2. Challenging the notice and comment rulemaking procedures in adopting policy on exhausted benefit days, Medicare secondary payor days and Medicare Advantage days.

3. Alleging CMS continues to make certain *Baystate* matching errors by its use of the Medicare Enrollment Database.

At the outset, the Board notes that the "Medicare Advantage days" rulemaking challenge in #2 is already covered in Issue 1 (the DSH Medicare Part C Days issue) that was part of the original appeal requests for the 4 cases and has already been disposed of by the Board when it issued its January 3, 2020 EJR determination granting EJR for Issue 1 in the 4 cases. The Board finds that all of the remaining issues raised in the Consolidated Final Position Paper are new issues because they were not included in the appeal requests originally appealed by the Provider for FYs 2008 through 2010. Moreover, they were not even included in its Preliminary Position Papers for these appeals. Rather, these issues first appear in the Consolidated Final Position Papers filed for these appeals.

In this regard, the Board notes that the subject appeals were filed with the Board in 2013 and 2014 and the regulations at § 405.1835(b) (2014) required the following:

> (b) *Contents of request for a Board hearing on final contractor determination.* The provider's request for a Board hearing . . . must be submitted in writing to the Board, and the request must include 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.
>
> (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 contractor's or Secretary's determination under appeal.
>
> (2) **An explanation (for each specific item at issue**, see paragraph (a)(1) of this section) of the provider's dissatisfaction with the contractor's or Secretary's determination, including an account of all of the following:
>
> (i) Why the provider believes Medicare payment is incorrect for each disputed item (or, where applicable, why the provider is unable to determine whether Medicare payment is correct because

> it does not have access to underlying information concerning the calculation of its payment).
>
> (ii) **How <u>and</u> why** the provider believes Medicare payment must be determined differently for each 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 sought for the item.[37]

Board Rules in effect when the appeal was filed were issued on July 1, 2009 and elaborated on this regulatory requirement as follows in pertinent part:

> **Rule 7 - Issue Statement and Claim of Dissatisfaction**
>
> For each issue under appeal, give a brief summary of the determination being appealed and the basis for dissatisfaction. (See Rule 8 for special instructions regarding multi-component disputes.)
>
> **7.1 - NPR or Revised NPR Adjustments**
> **A. Identification of Issue**: Give a concise issue statement describing
> • the adjustment, including the adjustment number,
> • why the adjustment is incorrect, and
> • how the payment should be determined differently.
>
> **B. No Access to Data**: If the Provider, through no fault of its own, does not have access to the underlying information to determine whether the adjustment is correct, describe why the underlying information is unavailable.
>
> **7.2 - Self-Disallowed Items**
> **A. Authority Requires Disallowance**
> If you claim that the item you are appealing 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,
> • give a concise issue statement describing the self-disallowed item

[37] (Bold and underline emphasis added.) The Board notes that, contrary to the Provider's assertion, the group appeal regulations are not applicable to individual appeals. The fact that an individual appeal may have more than one issue in that appeal does not obviate the Provider's obligation to identify, in the appeal request, each issue that it is appealing. To this end, the Board Rules make clear that each aspect of the DSH adjustment calculation being challenged must be identified in the appeal request. Board Rules 8.1, 8.2. Similarly, the Board Rules make clear that if a provider wishes to challenge an authority, it needs to identify that authority as part of the appeal request. Board Rule 7.2(A).

> • the reimbursement or payment sought for the item, and
> • the authority that predetermined that the claim would be disallowed.
>
> **B. No Access to Data**
> If the Provider elects to not 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.
>
> **C. Protest**
> For cost reporting periods ending on or after December 31, 2008, demonstrate how the Provider followed applicable procedures for filing a cost report under protest 42 CFR §405.1835(a)(1)(ii). . . .
>
> ## 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.).[38]

Effective August 21, 2008, Board regulations went into effect that limited the addition of issues to appeals.[39] 42 C.F.R. § 405.1835(e) (2014) provides in relevant part:

> (e) *Adding issues to the hearing request*. After filing a hearing request . . ., a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the Board, only if – . . . .
>
> (3) The Board receives the provider's request to add issues no later than 60 days after the expiration of the applicable 180–day period prescribed in paragraph (a)(3) or paragraph (c)(2) of this section.

[38] *Available at:* https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/PRRB-Instructions (last visited May 29, 2020).
[39] *See* 73 Fed. Reg. 30190 (May 23, 2008).

In practice this means that new issues had to be added to St. Dominic – Jackson Memorial Hospital's appeals no later than 240 days after receipt of the Medicare Contractor's determinations. St. Dominic – Jackson Memorial Hospital's first mention of the new issues noted above (including the notice and comment rulemaking procedures in adopting policy on exhausted benefit days and Medicare secondary payor days) was in its Consolidated Final Position Paper, which was submitted on March 11, 2020, *well after* the deadlines. The new issues discussed the Consolidated Final Position Paper are other aspects of the DSH adjustment calculation that the Provider failed to include in its appeal request or timely add to its appeal.[40] In particular, the Board notes that the issue statement for Issue 2 included in the appeal requests for the 4 cases does contain any allegation that CMS applied inconsistent or improper interpretations of the term "entitled" in the context of the Medicare fraction used in DSH adjustment calculations or was challenging a regulation as required by Board Rule 7.2. In this regard, the Board notes that Board Rule 7.2 (2015) required:

> If you claim that the item you are appealing 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,
> • give 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.

Accordingly, based on the above findings, the Board is dismissing all of the new issues in the Provider Consolidated Final Position Paper pursuant to its authority under 42 C.F.R. §§ 405.1835(b), 405.1840 and 405.1868(b).

Moreover, even if the Provider had properly and timely added all the new issues that were raised in the Consolidated Final Position Paper, the Board would still dismiss the majority of them for the Provider's failure to properly brief and develop those issues in the Consolidated Final Position Paper. More specifically, outside of #2 above, the new issues laid out in the

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[40] Indeed, the Board takes administrative notice that the rulemaking issues raised in the Consolidated Position Paper are widely known in the industry and, to this end, have been subject to much litigation at the Board and, on appeal, to federal courts. *See, e.g.*, *Metropolitan Hospital v. Sebelius*, 712 F.3d 248 (6th Cir. 2013) (issued March 27, 2013); *Catholic Health Initiatives Iowa Corporation v. Sebelius*, 718 F.3d 914 (9th Cir. 2013) (issued June 11, 2013); *Northeast Hosp. Corp. v. Sebelius*, 699 Supp. 2d 81 (D.D.C. 2010), *aff'd by*, 657 F.3d 1 (D.C. Cir. 2011); *Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75 (D.D.C. 2012), *aff'd by*, 746 F.3d 1102 (D.C. Cir. 2014); *King & Spalding Inclusion of Medicare Advantage Days in 2007 SSI Ratios v. Blue Cross Blue Shield Ass'n*, PRRB Dec. No. 2010-D38 (June 29, 2010) (this decision is an EJR determination and the Board only publishes an EJR determination as a "D-" decision when it is a seminal case); *Allina Health System 1995-2003 DSH Dual Eligible Days Group v. Blue Cross Blue Shield Ass'n*, PRRB Dec. No. 2009-D35 (July 30, 2009); *Southwest Consulting 2004 DSH Dual Eligibe Days Group, et al. v. Blue Cross Blue Shield Ass'n*, PRRB Dec. No. 2010-D36 (June 14, 2010). Similarly, the *Baystate* litigation over the matching process is well known and resulted in CMS issuing CMS Ruling 1498-R on April 28, 2010 and adopting the new data matching process in the FY 2011 IPPS final rule published on August 16, 2010. Neither the appeal request nor the preliminary position papers raise or challenges this new data matching process outside of the Mississippi Medicaid "best data available" issue. Had the Provider wished to appeal these new issues, it should have either raised them in the appeal request or timely added them.

Consolidated Final Position Paper are fact dependent and the Provider failed to fully develop the merits of those claims in compliance with the Board Rules governing the content of position papers.[41] Rather, in contravention of those Board Rules, the Consolidated Final Position Paper makes broad-brush stroke skeletal claims without support or analysis and without, where applicable, explaining why documentation or support was not available as required by Board Rule 25.2.2.[42]

* * * * *

Based on the above determinations and rulings, no issues remain in the 4 appeals. Accordingly, the Board hereby dismisses Case Nos. 13-2937, 14-0220, 14-0263 and 14-4048 and removes them from the Board's docket. Further, the Board denies the Provider's Request for EJR submitted on April 17, 2020 as the issue for which EJR was requested was ***never*** properly added to these appeals.

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.
Charlotte F. Benson, CPA
Gregory H. Ziegler, CPA
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

For the Board:

5/29/2020

X Clayton J. Nix

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

cc: Wilson C. Leong, Federal Specialized Services

[41] This does not even address the lack of discussion on controlling authorities as required under Board Rules governing the content of position papers. For example, the Board's decision in *Pomona Valley Hosp. Med. Ctr. v. Noridian Healthcare Solutions*, PRRB Dec. No. 2018-D50 (Sept. 21, 2018) (hereinafter "*Pomona Valley*") could be relevant since the Board reviewed whether California Medicaid program records can be used as a substitute for SSI data and leads to more accurate SSI fractions. The *Pomona Valley* case was appealed to D.C. District Court on November 27, 2018 and is still pending. *Pomona Valley Hosp. Med. Ctr. v. Azar* No. 18-02763 (D.D.C. filed Nov. 27, 2018).

[42] *See supra* notes 29 – 36 and accompanying text.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Nathan Summar
Community Health Systems, Inc.
4000 Meridian Blvd.
Franklin, TN 37067

Justin Lattimore
Novitas Solutions, Inc.
707 Grant St., Ste. 400
Pittsburgh, PA 15219

RE: ***Jurisdictional Decision***
Tomball Regional Medical Center (Prov. No. 45-0670)
FYE 6/30/2013
Case No. 17-0511

Dear Mr. Summar and Mr. Lattimore:

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the jurisdictional documentation in Case No. 17-0511, based on the Medicare Contractor's ("MAC") April 19, 2018, Jurisdictional Challenge. The Board finds that it does not have jurisdiction to hear the Provider's issues as set forth below.

Background

On November 18, 2016, the Board received the Provider's request to appeal the Revised Notice of Program Reimbursement ("RNPR") dated June 1, 2016 for the fiscal year ("FY") 2013.[1] The Provider's appeal request contained the following issue statements:

> **Issue 1: Disproportionate Share Hospital Payment/Supplemental Security Income Percentage (Provider Specific)**
>
> The Provider contends that its SSI percentage published by the Centers for Medicare and Medicaid Services ("CMS") was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation… 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….

[1] Provider's Request for Appeal (Nov. 18, 2016).

Issue 2: Disproportionate Share Hospital Payment - Medicaid Eligible Days

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.[2]

The Medicare Administrative Contractor ("MAC") filed a formal jurisdictional challenge on April 19, 2018.

MAC's Contentions

A. SSI Provider Specific

The MAC asserts that Issue 1 should be dismissed because it is duplicative of an issue in another appeal.[3] Furthermore, the MAC contends the Issue 1 includes the Provider's subsidiary appeal over SSI Realignment.[4] The MAC insists that the SSI realignment is a hospital election, and that the hospital is bound by its choice, regardless of reimbursement impact.[5] Finally, the Provider's appeal is immature as it has not formally requested to have its SSI realigned, or exhausted all available remedies before requesting an appeal.[6]

B. Medicaid Eligible Days

In regards to Issue 2, the MAC contends that the adjustments the Provider cited as sources of dissatisfaction (Adjustments 4 and 5) dealt solely with updating the SSI percentage. Further, these adjustments did not render a final determination concerning Medicaid ratio issues.[7] As there is the determination in regards to Medicaid Eligible Days, the Provider has not reserved its right to claim dissatisfaction for these issues as self-disallowed items.[8]

Provider's Response to the Jurisdicitonal Challenge

The Provider did ***not*** file a response to the Medicare Contractor's Jurisdictional Challenge dated April 19, 2018. Per Board Rule 44.4.3, "Providers must file a response within 30 days of the Medicare contractor's jurisdictional challenge. Failure to respond will result in the Board making a jurisdictional determination with the information in the record."

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[2] *Id.*, at Ex. 3 (Issue Statement).
[3] Medicare Administrative Contractor's Jurisdictional Challenge at 2.
[4] *Id*.
[5] *Id*.
[6] *Id*.
[7] *Id*.
[8] *Id.* at 6.

Board Determination

As set forth below, the Board is dismissing the SSI Percentage Provider Specific issue and Medicaid Eligible Days issue.

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2016), a provider has a right to a hearing before the Board with respect to specific items claimed on a timely filed cost report if: (1) it is dissatisfied with the final determination of the Medicare contractor; (2) the amount in controversy is $10,000 or more (or $50,000 for a group); and (3) the request for a hearing is filed within 180 days of the date of receipt of the final determination.[9] In this case, the Provider appealed from a Revised NPR, the amount exceeds $10,000, and the appeal was timely filed.

A. SSI Percentage – Provider Specific

The Board finds that it does not have jurisdiction over the SSI Provider Specific issue. The SSI Provider Specific Issues is Issue 1 in the appeal request. In the issue statement for Issue 1 in the individual appeal, the Provider contends that the SSI percentage published by CMS was incorrectly computed because CMS failed to include all patients entitled to SSI benefits in the Provider's DSH calculation. Based on the scant record before it,[10] the Board finds that this issue is duplicative of the DSH SSI Data Match issue that the Provider directly added to Case No. 15-2694GC on September 29, 2016. The Providers in that CIRP Group challenge their SSI percentages because of disagreement over how the SSI percentage is calculated and contend that CMS has not properly computed the SSI percentage because it failed to include all patients entitled to SSI benefits in the calculation.

Pursuant to Board Rule 4.6.1, "A provider may not appeal an issue from a single determination in more than one appeal." Therefore, the Board finds that the SSI Provider specific issue is duplicative of the issue the Provider is appealing in the group appeal and hereby dismisses this aspect of the SSI Provider specific issue.

In its SSI Provider Specific issue statement, the Provider also asserts that it "preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period." Under 42 C.F.R. § 412.106(b)(3), "if 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 a written request, the Medicare Contractor cannot even issue a final determination from which the Provider could be dissatisfied for purposes of appeal. Therefore, the Board finds that it does not have jurisdiction over the realignment portion of the Provider's SSI Provider Specific issue.

---

[9] Board Rule 4.4.1 (Aug. 29, 2018); 42 C.F.R. § 405.1835.

[10] In making this finding, the Board notes that it has been two years since the Medicare Contractor filed its jurisdictional challenge. Per Board Rule 44, a response from the Provider was due within 30 days but, even at this late date, the Provider still has not responded. As a result, the Provider forwent its opportunity to present argument or additional information on how the issues may have been different and, per Board Rule 44.4.3, the Board had to rely on the scant record before it in making its findings.

B. Medicaid Eligible Days

The Code of Federal Regulations provides for an opportunity to reopen and revise determinations and an RNPR is an example of this. In this regard, 42 C.F.R. § 1885 states in relevant part:

> (a) *General*. (1) A Secretary determination, an intermediary determination, or a decision by a reviewing entity (as described in § 405.1801(a) of this subpart) **may be reopened**, for findings on matters at issue in a determination or decision, by CMS (with respect to Secretary determinations), by the intermediary (with respect to intermediary determinations) or by the reviewing entity that made the decision (as described in § 405.1885(c) of this subpart). . . .
>
> (5) If a matter is reopened and a revised determination or decision is made, a revised determination or decision is appealable **to the extent provided in § 405.1889 of this subpart**.[11]

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

> (a) If a revision is made in a Secretary or intermediary determination or a decision by a reviewing entity after the determination or decision is reopened as provided in § 405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the provisions of 42 C.F.R. §§ 405.1811, 405.1834, 405.1835, 405.1837, 405.1875, 405.1877 and 405.1885 of this subpart are applicable.
>
> (b)(1) ***Only*** *those matters that are* ***specifically revised*** *in a revised determination or decision are within the scope of any appeal of the revised determination or decision.*
>
> (b)(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.[12]

In accordance with these regulations, a Provider can only appeal items that were specifically adjusted in the revised cost report. The MAC contends that the adjustments the Provider cited as sources of dissatisfaction (Adjustments Nos. 4 and 5) dealt solely with updating the ***SSI***

[11] (Bold emphasis added.)
[12] (Emphasis added.)

percentage,[13] and that these adjustments did not render a final determination concerning ***Medicaid*** *ratio* issues.[14] The Board agrees. Adjustment Nos. 4 and 5 are the RNPR adjustments cited by the Provider for this issue but Adjustment No. 4 was to update the SSI percentage and Adjustment 5 was to update the DSH calculation based on the new SSI percentage. No adjustment was made to the Medicaid ratio.

As the RNPR is a distinct determination and no adjustments were made to the Medicaid Eligible Days, the Board finds that, pursuant to 42 C.F.R. § 405.1885(b), it does not have jurisdiction over the Medicaid eligible days issue and dismisses the issue from this case.

Conclusion

The Board has dismissed both the SSI Provider Specific and Medicaid Eligible Days issues in this case. As there are no longer any issues remaining in the case, the Board hereby closes Case No. 17-0511 and removes it from the Board's docket.

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

Board Members Participating:

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

For the Board:

5/29/2020

X Clayton J. Nix

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

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

[13] *Id*. at Tab 4, Audit Adjustments (Adjustment 4 modified the percentage of SSI recipient patient days to Medicare Part A patient days. Adjustment 5 changed the allowable DSH percentage.).
[14] MAC's Jurisdictional Challenge, at 2 (Apr. 19, 2018).