DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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Bruce Snyder
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RE: ***Jurisdictional Determination***
Hackensack University Medical Center (Prov. No. 31-0001)
FYE 12/31/06
Case No. 14-1327

Dear Messrs. Roth and Snyder,

The Provider Reimbursement Review Board (the "Board") has reviewed jurisdiction over the DSH – Part C Days – Medicaid Fraction issue in the above-referenced appeal. The Board's jurisdictional decision is set forth below.

Background

On December 11, 2013, the Provider filed an appeal from a Notice of Program Reimbursement ("NPR") dated June 14, 2013 with 8 issues. Two of the issues in the appeal were DSH Part C Days – Medicaid fraction and another was DSH Part C Days – Medicare SSI/Fraction. By letter dated February 12, 2018, the Provider submitted a request for Expedited Judicial Review ("EJR") of the DSH – Part C Days - Medicare/SSI Fraction issue. On March 6, 2018, the Board granted EJR for that issue.

However, the DSH – Part C Days – Medicaid Fraction remains in the appeal. The issue is described by the Provider as follows:

> Whether the Hospital's FY 2006 Medicare DSH payment was understated because the numerator of its Medicaid fraction improperly excluded inpatient hospital days attributable to Medicare Part C plan enrollee patients who were dually-eligible.[1]

Board Decision

The Board notes that the EJR request for which the Board granted EJR clearly encompassed the *complete* Part C DSH issue, *i.e.*, both the Medicare and Medicaid fractions (removal from the Medicare fraction, but required inclusion in the Medicaid fraction).[2]

[1] Provider's Combined Final Position Paper at 1.
[2] *See* Provider's Appeal Request, Issue 4, at pages 3-4.

Per the holdings in *Allina Health Servs. v. Sebelius* (746 F.3d 1102, 1108 (D.C. Cir. 2014)) ("*Allina*"), Part C days ***must*** be included in either the SSI fraction or Medicaid fraction.[3] This holding is controlling precedent for the interpretation of 42 U.S.C. § 1395ww(r)(3) because the Providers could bring suit in the D.C. Circuit.[4] Thus, the disposition of the DSH - Part C Days – Medicare/SSI Fraction issue dictates the disposition of the DSH - Part C Days – Medicaid Fraction issue, as *Allina* indicates Part C days must be counted in one fraction or the other.

As such, the Board dismisses the DSH - Part C Days – Medicaid Fraction issue from Case No. 14-1327 as it was disposed of through the EJR of the DSH - Part C Days - Medicare/SSI Fraction issue in the appeal. The case remains open as other issues remain in the appeal. The case is scheduled for hearing on July 27, 2021. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877 upon final disposition of the appeal.

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

For the Board:

7/7/2021

X Clayton J. Nix

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

cc: Wilson C. Leong, Federal Specialized Services

[3] Specifically, *Allina* states "the statute unambiguously requires that Part C days be counted in one fraction or the other (a Part C-enrolled individual is either eligible for Medicare Part A, or not)." 746 F.3d at 1108.

[4] Specifically, *Allina* states "the statute unambiguously requires that Part C days be counted in one fraction or the other (a Part C-enrolled individual is either eligible for Medicare Part A, or not)." 746 F.3d at 1108.

[5] The CMS Administrator generally has applied as controlling precedent the law of the Circuit in which the Provider is located. *See, e.g., QRS CHW DSH Labor room Days Groups v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (Apr. 13, 2009), affirming, PRRB Dec. No. 2009-D11 (Feb. 27, 2009); *St. Vincent Mercy Med. Ctr. v. Blue Cross Blue Shield 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).

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RE: **Jurisdictional Decision in Whole**
Grant Medical Center (Prov. No. 36-0017)
FYE 6/30/2011
Case No. 15-2102

Dear Mr. Flynn and Ms. Cummings,

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above-referenced individual appeal of Marion General Hospital ("Provider") in response to a Jurisdictional Challenge filed by the MAC regarding the Provider's issues in its individual appeal from its Notice of Program Reimbursement ("NPR"). The Board's decision is set forth below.

Background:

The Board received the Provider's Request for Hearing dated April 6, 2015, related to a NPR dated October 8, 2014.[1] The Provider's Request for Hearing included two issues:

1. Adjustment # 21 and 26 – Bad Debt (Indigency Determination);
2. Adjustment # N/A – Effect of prior year adjustments.[2]

On June 5, 2015, the Provider Requested to add a third issue, Dual-Eligible days in the DSH Percentage.[3] On December 3, 2015, the Provider transferred Issue #3, to the common issue related party ("CIRP") group under Case No. 16-0911GC.[4]

On March 23, 2016, the MAC filed a Jurisdictional Challenge to challenge whether the Board has jurisdiction over Issue #2.[5] The challenge centers on whether the Provider's appeal issue for the "effect from prior year adjustments" is in compliance with Medicare regulations and Board Rules. The Provider did ***not*** respond to the challenge.

On March 11, 2019, Issue #1 was transferred to the CIRP group under Case No. 19-1822GC.

[1] Provider's Request for Appeal (Apr. 6, 2015), PRRB Case No. 15-2102.
[2] *Id*., at Tab 3, Issue Statement.
[3] Provider's Request to Add Issue (Jun. 5, 2015).
[4] Provider's Request to Transfer Issue to Group Appeal (Dec. 3, 2015).
[5] MAC's Jurisdictional Challenge (Mar. 23, 2016).

MAC's Jurisdictional Challenge

The MAC argues that the Provider is not appealing any specific adjustment in the NPR. Instead, the Provider seeks to preserve its future appeal rights of this NPR in case something did occur in the preceding years' NPRs. Appeal regulations do not allow providers to file an appeal to preserve future appeal rights. The issue itself as stated by the Provider "Effect of prior year adjustments" indicates no dispute of the NPR it has appealed.

The Board elaborates the regulatory 42 C.F.R. §§ 405.1835-105.1889 requirements by issuing the Board Rules. The Board Rules require the Provider identify the specific issues, specify the basis for contending that the findings and conclusions, and show how the payment should be determined differently. The MAC contends that the provider has clearly failed to adequately identify their dispute as a specific issue. The Provider fails to follow Board Rule 7.1, Rule 7 .1 - NPR or Revised NPR Adjustments.

The MAC also asserts that the Provider has not specified any adjustment(s) it is dissatisfied within the NPR it disputes. The Provider neither specifies any adjustment to dispute, nor includes any issues pertaining to prior year adjustments in the protested item. Therefore, there was no final determination made. The MAC contends that the Provider did not preserve its appeal rights with this issue.

The MAC respectfully requests the Board dismiss this issue as it is not in compliance with 42 CFR § 405.1835 and Board Rules.

Board's Analysis and Decision

The Board finds that it does not have jurisdiction over Issue No. 2, the effect of prior year adjustments issue and dismisses the "flow-through issue" as being in violation of Board Rules.

A provider is entitled to a hearing before the Board if: (1) such provider is dissatisfied with a final determination of the Medicare Contractor as to its amount of total program reimbursement due the provider; (2) the amount in controversy is $10,000 or more; and (3) such provider files a request for a hearing within 180 days after notice of the final determination.[6] The related regulations and Board rules describe in more detail what is required in order to file a hearing request with the Board. 42 C.F.R. § 1835(b) (2015) delineates the content requirements for a request for hearing and states in pertinent part:

> (b) *Contents of request for a Board hearing on final contractor determination*. The provider's request for a Board hearing under paragraph (a) of this section must be submitted in writing 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

[6] 42 U.S.C. § 1395oo(a).

> 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 under appeal, including an account of all of the following:
>
> > (i) **Why the provider believes Medicare payment is incorrect for each disputed item** (or, where applicable, why the provider is unable to determine whether Medicare payment is correct because it does not have access to underlying information concerning the calculation of its payment).
> >
> > (ii) **How and why** the provider believes Medicare **payment must be determined differently** for each disputed item.
> >
> > (iii) If the provider self-disallows a specific item, a description of the nature and amount of each self-disallowed item and the reimbursement or payment sought for the item.
>
> (3) A copy of the contractor or Secretary determination under appeal, **and any other documentary evidence the provider considers necessary to satisfy the hearing request requirements of paragraphs (b)(1) and (b)(2) of this section**.[7]

The Board Rules state, "[f]or each issue under appeal, give a brief summary of the determination being appealed and the basis for dissatisfaction."[8] Board Rule 7.1A requires a concise issue statement describing the adjustment, including the adjustment number; why the adjustment is incorrect; and, how the payment should be determined differently.[9] Alternatively, if the Provider does not have access to the underlying information, it is to describe why that information is not available.[10] These requirements are reiterated in Model Form A, the Individual Appeal Request form, which was utilized by the Provider to file its appeal.[11] Model Form A provides that:

> The statement of the issue(s) must conform to the requirements of the regulations found at 42 C.F.R. § 405.1835 et seq. and the Board's Rules and must include: (1) a description of the issue; (2)

[7] (Bold emphasis added.)
[8] Board Rule 7 (Mar. 1, 2013).
[9] *Id*. at 7.1A.
[10] *Id*. at 7.1B.
[11] *See* Model Form A, Board Rules at 48-51.

> the audit adjustment number(s), if applicable, or other evidence required by 42 C.F.R. § 405.1835 (a)(1)(ii); (3) the amount in controversy; and (4) a statement identifying the legal basis for the appeal (with citation to statutes, regulations and/or manual provisions).[12]

The Provider did not appeal a specific issue, but rather a "flow-through effect" from any prior appeals. The Provider did not cite to any audit adjustments or specify which determination(s)/issue(s) from other appeals it was referring to. As explained in its appeal request, the Provider stated that it does not have access to the information necessary to more specifically describe the MAC's adjustments because future events, such as certain resolutions and potential re-openings, could affect such underlying data. However, the Provider's appeal request in no way "perfects" or specifically clarifies any issues and does not make any claims that permit the Board to make a determination in this case. As a result, the Board is unable to determine what issue is in dispute and finds that the appeal lacks specificity as required by 42 C.F.R § 405.1835(b) and Board Rule 7.1A. Accordingly, the Board hereby dismisses Issue 2 from the appeal.

As this was the sole remaining in the appeal, the case is now closed. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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For the Board:

7/7/2021

X Clayton J. Nix

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Chair
Signed by: PIV

cc: Edward Lau, Esq., Federal Specialized Services
Wilson Leong, Federal Specialized Services

[12] *Id*. at 50. (Section 8 of Model Form A describes the requirements for appealed issues).

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RE: ***Dismissal of Duplicate Appeal***
SRI Aurora FY 2007 SSI Fraction Medicare Part C CIRP
Case No. 10-0360GC

Dear Ms. Hartley and Mr. Putnam:

The above-referenced common issue related party ("CIRP") group appeal[1] involves the common owner Advocate Aurora Health Care ("Aurora") and includes a challenge to the inclusion of Medicare Part C days in the Medicare fraction of the disproportionate share ("DSH") percentage and/or the exclusion of Medicare Part C days for patients who are dually eligible for Medicaid from the Medicaid fraction of the DSH percentage, for patient discharges *before* October 1, 2013. In its review of the documentation, it has come to the attention of the Provider Reimbursement Review Board ("PRRB") that Aurora has already been granted EJR for these issues, for this specific Fiscal Year, and as such, the above appeal violates the Common Issue Related Party ("CIRP") regulation, is duplicative, and must be dismissed.

Background

The group appeal request for Case No. 10-0360GC was filed on January 4, 2010. On November 13, 2020, the group representative requested Expedited Judicial Review (EJR) for Case No. 10-0360GC. On November 24, 2020, the Board denied the EJR because the case was subject to remand (via CMS Ruling 1739-R) which would be received under separate cover. On March 25, 2020, the Providers' representative submitted an updated Schedule of Providers for Case No. 10-0360GC.

[1] The Providers previously requested that the Board grant expedited judicial review (EJR) for the Medicare Part C days issue under appeal in this case. The issue is now subject to CMS Ruling CMS-1739-R. The Board cannot grant the request for EJR because CMS Ruling 1739-R states the Board does not have jurisdiction over provider appeals of Medicare Advantage patient days in the Medicare and Medicaid fraction of the DSH percentage with discharge days before October 1, 2013. Pursuant to 42 C.F.R. § 405.1842(a), jurisdiction over an appeal is a prerequisite to granting a request for EJR. In addition, the ruling requires that the Board remand any otherwise jurisdictional proper challenge raising the issue to the Medicare contractor. *See* CMS Ruling CMS-1739-R at 1-2 (on the internet at https://www.cms.gov/Regulations-and-Guidance/Guidance/Rulings/CMS-Rulings).

However, Aurora had also filed two other CIRP group cases for FY 2007 for the same Part C days issue:

- Case No. 14-1576GC, *SRI Aurora FY 2007 SSI Fraction Medicare Part C CIRP*, and
- Case No. 14-1578GC, *SRI Aurora FY 2007 Medicaid Fraction Part C Days CIRP*.

At least one of the Providers in the current appeal, Case No. 10-0360GC, is included in the previous CIRP group cases.[2] The 2014 CIRP group cases appealed the following issues:

> Specifically, the MACs treated the Medicare enrollees in Part C as 'entitled to benefits' under Part A and counted them in the Medicare fraction of the DSH payment formula. The Provider Group disputes these adjustments, arguing instead that these days should be included in the Medicaid fraction. The Provider Group properly preserved this issue through the protested-item process, is dissatisfied with the amount due, and each member has timely appealed its determination, consistent with 42 U.S.C. § 1395oo(a).[3]

On November 13, 2020, the group representative certified that Case Nos. 14-1576GC and 14-1578GC were fully formed and requested EJR because the Provider Group disagreed with CMS's instruction to the Board to remand the appeals, based on CMS Ruling 1739-R.[4] The group representative argued that CMS cited to no legal authority within the Ruling authorizing remand and that such remand was counter to the Provider Group's rights to appeal to Federal court set forth in 42 U.S.C. § 1395oo.[5] The group representative further disagreed with CMS's determination that it had retroactive authority to correct the procedurally invalid and now-vacated rule adopted in 2004 and at issue for this appeal. Finally, they argued this position by CMS was inconsistent with and ignored the Supreme Court's ruling in *Azar v. Allina Health Services*, 139 S. Ct. 1804 (2019).[6]

On November 24, 2020, the Board denied the EJR request based on CMS Ruling 1739-R.[7] CMS Ruling 1739-R confirmed that the Board lacks jurisdiction over this issue and, as jurisdiction is a prerequisite for EJR, the Board denied the EJR requests. Pursuant to the Ruling, the Board must remand each "qualifying" appeal to the appropriate MAC. As such, the Board reviewed each of the fully-formed CIRP group cases to determine if the Providers had "jurisdictionally proper" appeals prior to the Ruling (*i.e.*, determine if they are ripe for remand

[2] Provider 52-0035, Aurora Sheboygan Memorial Medical Center, was previously included in both Case Nos. 14-1576GC and 14-1578GC.
[3] Request for Expedited Judicial Review (Nov. 13, 2020), Case Nos. 14-1576GC, 14-1578GC.
[4] *Id*. at 2.
[5] *Id*.
[6] *Id*.
[7] Board's Part C Days EJR Denial Letter (Nov. 24, 2020), Case Nos. 14-1576GC, 14-1578GC.

under 1739-R) and, as appropriate, remand pursuant to the Ruling. The Board remanded the two fully-formed CIRP group cases on March 9, 2021.[8]

Board's Analysis and Decision

Pursuant to 42 C.F.R. § 405.1837(b)(1), hereinafter called the CIRP regulation, commonly owned providers must pursue common issues arising in the same calendar year as part of a single CIRP group:

> Two or more providers under common ownership or control that wish to appeal to the Board a specific matter at issue that involves a question of fact or interpretation of law, regulations, or CMS Rulings that is common to the providers, and that arises in cost reporting periods that end in the same calendar year, and for which the amount in controversy is $50,000 or more in the aggregate, ***must*** *bring the appeal as a group appeal*.[9]

Subsection (e) requires that the group provider provide notice when the CIRP group is fully formed and complete.[10] *Once the group is certified as complete*, no other commonly owned providers may appeal the common issue for that year absent a Board order modifying that determination:

> When the Board has determined that a group appeal brought under paragraph (b)(1) of this section is fully formed, absent an order from the Board modifying its determination, *no other provider under common ownership or control may appeal to the Board the issue* that is the subject of the group appeal with respect to a cost reporting period that falls within the calendar year(s) covered by the group appeal.[11]

Om November 13, 2020, the group representative certified that the CIRP groups in Case Nos. 14-1576GC and 14-1578GC were complete and simultaneously requested EJR. Pursuant to this certification, any additional providers outside of these groups would be part of a duplicate case violating the CIRP regulations at 405.1837(b)(1) and (e) (and, indeed, many of the participants in Case No. 10-0360GC are also participants in Case Nos. 14-1576GC and 14-1578GC). As Case No. 10-0360GC was part of the same common ownership, for the same issue (Part C Days), and for the same fiscal year (2007), any participants within that case are in violation of 405.1837(b)(1) and (e), and thus must be dismissed.

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[8] Board's Part C Days Remand Letter (Mar. 9, 2021), Case Nos. 14-1576GC, 14-1578GC.
[9] 42 C.F.R. § 405.1837(b)(1) (emphasis added).
[10] 42 C.F.R. § 405.1837(e)(1).
[11] *Id*. (emphasis added).

Accordingly, the Board finds that Case No. 10-0360GC violated the CIRP regulations 42 C.F.R. § 405.1837(b)(1) and (e), and dismisses the case.[12] The Board closes the group appeal and removes it from the Board's docket.

Board Members Participating:

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For the Board:

7/12/2021

X Clayton J. Nix

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

cc: Wilson Leong, FSS

[12] The Board notes that there may be alternative bases to dismiss one or more participants in Case No. 10-0360GC had the Board not dismissed the case in its entirety. In this regard, the Board notes that one or more participants appealed from a revised NPR but may not have had the right to do so under 42 C.F.R. § 405.1889(b) as referenced in § 405.1835(a).

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RE: ***Jurisdictional Determination in Whole***
Franciscan Alliance 2010 DSH Medicare/Medicaid Fraction Part C Days CIRP Group II
Case No. 17-2271GC

Dear Ms. O'Brien Griffin:

The Provider Reimbursement Review Board ("Board") has reviewed the Franciscan Alliance 2010 DSH Medicare/Medicaid Fraction Part C Days CIRP Group II. The issue in this group is governed by Centers for Medicare & Medicaid Services ("CMS") Ruling CMS-1739-R. Under the terms of this Ruling, the Board must remand this issue to the Medicare Contractor for calculation of the DSH payment adjustment in accordance with the forthcoming final rule CMS will issue "to govern the treatment of [Medicare Part C] patient days with discharge dates before October 1, 2013." *See also* 58 Fed. Reg. 47723 (Aug. 6, 2020). In reviewing the group for the remand, the Board notes that the Medicare Contractor previously challenged the Board's jurisdiction over the two Providers in the group, both of which appealed from revised Notices of Program Reimbursement ("RNPRs"). The background of the case and the Board's determination are set forth below.

Background:

On September 25, 2017, Hall, Render, Killian, Heath & Lyman, P.C. ("Hall Render" or "Representative") filed the Franciscan Alliance 2010 DSH Medicare/Medicaid Fraction Part C Days CIRP Group II. As noted above, there are two Providers in the group, both of which appealed from RNPRs:

Provider	**FYE**
Franciscan Health Hammond (15-0004)	12/31/2010
Franciscan St. Anthony Memorial Health Center (15-0015)	12/31/2010

According to the Medicare Contractor's ("MAC") challenge dated December 17, 2019, the Providers both cited audit adjustments (#s 5 & 6)- neither of which disallowed Medicaid/Medicare Part C days. Instead, the MAC contends that both RNPRs were reopened to review Medicaid eligible days and only removed Children's Health Insurance Program ("CHIP") days.

On February 14, 2020, Hall Render filed a response to the MAC's jurisdictional review. The Representative argues that since the MAC's reopenings resulted in the Providers' Medicaid

fractions being reduced, the Board has jurisdiction over the exclusion of Part C Medicaid eligible days from the Medicaid fraction issue because there was an adjustment.

Board Decision

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

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

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

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

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

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

[1] 42 C.F.R. § 405.1889(b)(1).

Here, the Board finds that it does not have jurisdiction over Franciscan Health Hammond and Franciscan St. Anthony Memorial Health Center as participants in this group. The Providers appealed from RNPRs that were reopened for a review of Medicaid Days. The Audit Adjustments referenced in the Providers' appeal requests are Audit Adjustment Nos. 5 and 6, neither of which changed the SSI percentage.

The only manner in which the Board has determined that it has jurisdiction over the Part C days issue *in the context of a RNPR* is if: (1) the SSI percentage is specifically adjusted for Part C Days; ***or*** (2) the data match process is rerun and generates a new and different SSI percentage where the Board must necessarily assume that there was a change in the underlying month-by-month data and that the Part C days included in that month-by-month data also were changed.[2] Here, the SSI percentage clearly was not adjusted for Part C days and, unless there is evidence to the contrary (which there is not), the Board must presume the underlying Part C days data in the SSI fraction was not changed for the two Providers in this group since there was no change in their SSI percentages. The Board has considered the Representative's position that, because the MAC's reopening resulted in a change *in the **Medicaid** fraction*, the Board has jurisdiction. The Board finds, however, that the Providers are challenging the regulation promulgated in the August 11, 2004 final rule that requires the Part C days to be counted *in the **SSI** fraction* and there is no dispute about the amount or number of Part C days included in the SSI fraction itself. Accordingly, if Franciscan Health Hammond and Franciscan St. Anthony Memorial Health Center wished to appeal or contest the Part C days issue for FYE 2010, they should have appealed that issue from their original NPRs when it clearly had the right to do so since appeals of any potential future RNPRs is limited to matters "specifically revised."[3]

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[2] This second situation does ***not*** encompass a realignment of the SSI percentage because CMS does ***not*** rerun the data match process in order to effectuate a realignment but rather uses pre-existing data previously gathered on a month-by-month basis to effectuate the realignment. *See* 42 C.F.R. § 412.106(b)(2) (noting that CMS gathers data on a month-by-month basis); 75 Fed. Reg. 50042, 50279 (Aug. 16, 2010) (stating: "The SSI fractions are generally based on the Federal fiscal year; however, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived from the data match process for the two Federal fiscal years that spanned the hospital's cost reporting period.); 70 Fed. Reg. 47278, 47439 (Aug. 12, 2005) (stating: "Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period, and *the hospital **must accept** the resulting DSH percentage for that year, whether or not it is a more favorable number than the DSH percentage based on the Federal fiscal year*." (emphasis added)).

[3] For context, the Board takes administrative notice that:

1. The final rule establishing the Agency's current policy on treatment of Part C days in the SSI fraction (and the one at issue in this case) was issued on August 11, 2004 and the Agency's Part C days policy, both prior to and following the August 11, 2004 final rule, has been subject to much litigation. *See, e.g.*, *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 "D-" decision is an EJR determination. The Board does not routinely publish EJR determinations as "D-" decisions and will do so only when the EJR determination is *seminal*.).
2. Most providers filing Board appeals of the Part C days issue have done so by appealing from their original NPR,

In summary, because there was no revision to the SSI percentage in the March 27, 2017 and April 3, 2017 RNPRs that Franciscan Health Hammond and Franciscan St. Anthony Memorial Health Center appealed for FYE 2010, the audit adjustments associated with that RNPRs do not meet the requirements of the regulation for Board jurisdiction of matters revised in a revised NPR and Franciscan Health Hammond and Franciscan St. Anthony Memorial Health Center do not have a right to appeal under 42 C.F.R. §§ 405.1889(b) and 405.1835(a)(1). The Board notes that Courts have upheld the Board's application of provider's limited appeal rights under 42 C.F.R. § 405.1889(b).[4] Therefore, the Board dismisses Franciscan Health Hammond and Franciscan St. Anthony Memorial Health Center for FYE 2010 pursuant to 42 C.F.R. § 405.1889.

As an alternative basis for dismissal, the Board notes that Franciscan Alliance had two prior 2010 CIRP groups for this same issue under Case Nos. 15-1987GC and 15-1988GC (one for the Medicaid fraction and the other for the SSI fraction). *On March 16, 2017*, the Franciscan Alliance certified that the prior groups were complete with only one provider (Franciscan Health Indianapolis (Prov. No. 15-0162)) and requested transfer of the sole provider to the optional group under Case No. 16-1174G. On October 24, 2017, the Representative requested EJR in Case No 16-1174G and, on November 17, 2017, the Board granted EJR for that optional group. Notwithstanding the mandatory CIRP group requirements and the fact that a prior 2010 CIRP group had been certified complete just months earlier in March 2017, Franciscan Alliance established new *duplicate* Franciscan Alliance CIRP groups for the Part C issues on September 25, 2017 and yet also continued to pursue Franciscan Health Indianapolis' 2010 Part C issue in an optional group appeal notwithstanding the mandatory CIRP group requirements. The Board reminds the representative that 42 C.F.R. § 405.1837 states the following, in pertinent part, as the Board would have otherwise dismissed Case No. 17-2271GC based on these regulatory provisions:

> (b) *Usage and filing of group appeals* – (1) *Mandatory use of group appeals*. (i) Two or more providers under common ownership or control that wish to appeal to the Board a specific matter at issue that involves a question of fact or interpretation of law, regulations, or CMS Rulings that is common to the providers, and that arises in cost reporting periods that end in the same calendar year, and for which the amount in controversy is $50,000 or more in the aggregate, **must bring the appeal as a group appeal**.

---

regardless of whether that NPR was issued prior to or after 1498-R (including certain appeals filed pre-2010 in which the provider later requested bifurcation of the Part C days issue from dual eligible days issues emanating from the same August 11, 2004 final rule).

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

* * *

> (e) *Group appeal procedures pending full formation of the group and issuance of a Board decision*. (1) . . . The Board will determine that a group appeal brought under paragraph (b)(1) of this section is fully formed **upon a notice in writing from the group that it is fully formed**. . . . The Board determines that a group appeal brought under paragraph (b)(2) of this section is fully formed **upon a notice in writing from the group that it is fully formed**, or following an order from the Board that in its judgment, that the group is fully formed, or through general instructions that set forth a schedule for the closing of group appeals brought under paragraph (b)(2) of this section. **When the Board has determined that a group appeal brought under paragraph (b)(1) of this section is fully formed**, absent an order from the Board modifying its determination, **no other provider under common ownership or control may appeal to the Board the issue** that is the subject of the group appeal with respect to a cost reporting period that falls within the calendar year(s) covered by the group appeal.[5]

As there are no remaining participants in the group, Case No. 17-2271GC is hereby closed and removed from the Board's docket. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

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

For the Board:

7/14/2021

X Clayton J. Nix

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

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

[5] (Bold and underline emphasis added.)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Maureen O'Brien Griffin, Esq.
Hall, Render, Killian, Heath & Lyman, P.C.
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Indianapolis, IN 46204

RE: ***Response to Second Request for Corrected Remanded Providers***
LifePoint 2005 Medicare/Medicaid Fraction Part C Days CIRP Group
Case No. 16-1762GC

Dear Ms. O'Brien Griffin:

The Provider Reimbursement Review Board ("Board") has reviewed the LifePoint 2005 Medicare/Medicaid Fraction Part C Days CIRP Group which was remanded pursuant to CMS Ruling 1739R on May 27, 2021. On July 12, 2021, Hall, Render, Killian, Heath & Lyman, P.C. ("Representative") filed its *second* request for a corrected remand because a LifePoint provider was missing from the list of participants included in the remand. Accordingly, the Representative requests that the Board issue a corrected remand with an amended Schedule of Providers. Upon review of the *second* request, the Board has determined to reopen Case No. 16-1762GC and set forth below is the Board's determination on the *second* request for corrected remand.

Background:

On May 27, 2021, having received the 1739-R remand which resulted in the closure of Case No. 16-1762GC, the Representative filed its *first* request to reinstate the group because there were still two LifePoint providers awaiting the issuance of revised Notices of Program Reimbursement ("RNPRs"). On June 21, 2021, the Board denied the *first* request for reinstatement reasoning that the Medicare Contractor would be governed by 1739-R when processing the reopening for these LifePoint providers, making reinstatement unnecessary and moot. Accordingly, Case No. 16-1762GC remained closed.

On July 12, 2021, the Representative submitted a ***second*** request to reinstate that was different from the first. Specifically, the Representative requested that the Board issue a Corrected Remand Order to include Crockett Hospital (Prov. No. 44-0175; FY 11/30/2005), hereinafter "Crockett." Crockett previously filed a Direct Add Request on February 22, 2018 from a RNPR issued on August 29, 2017. With its request for correction, the Representative provided all the necessary support, including a copy of the Model Form E/Direct Add; proof of delivery; the RNPR and original NPR, & Audit Adjustment Report. Included with the support was an explanation of why the percentage on the audit adjustment report gave the appearance that the SSI ratio did not change. As noted above, the Board has reopened Case No. 16-1762GC ***solely*** for purposes of this *second* request.

Pertinent Facts for Crockett Hospital (Prov. No. 44-0175):

In its Direct Add Request, Crockett cited Audit Adjustment #3 which ". . . adjusted the SSI % and DSH % reported on the settled cost report after incorporating the latest released SSI Rate Table and calculated the DSH % in accordance with CMS Pub 15-II, Section 3430.1 and 42 CFR 413.106(d)." The SSI recipient patient days to Medicare Part A patient days remained unchanged at 8.77. In its Direct Add Request, Crockett recognized the fact that the SSI fraction remained unchanged in the RNPR and gave the following explanation of how the SSI fraction *did*, in fact, change:

> The Audit Adjustment Report gives the appearance that the SSI did not change, as the percentage used by the Medicare Contractor ("MAC") was .087 both before and after the reopening. The Audit Adjustment Report and the Medicare Cost Report use the SSI ratio rounded to *four* decimal places, i.e., to .0877. CMS's published SSI ratio is calculated to *five* decimal places in both the March, 2012 and the April, 2015 publication.
>
> CMS published revised SSI ratios for Crockett Hospital's FYE 11/30/2005 cost report in March, 2012 and again in April, 2015, to implement CMS Ruling 1498R and CMS Ruling 1498R-2, respectively. With each publication of a revised SSI ratio, the patient days that make up the SSI ratio changed. SSI days were 564 for both the March, 2012 and the April, 2015 ratios, but *Total Medicare Days* ***decreased by 2 days***, from 6433 days to 6431 days for these publication dates. These changes resulted in a change in the SSI ratio from .08767 to .08770.

Board Decision:

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

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

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

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

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

Accordingly, pursuant to 42 C.F.R. § 405.1889(b) (and § 405.1835(a)(1) which references that regulation), the Board has jurisdiction only over those matters that have been "specifically revised" in a revised determination. More specifically, when a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[2]

Here, the Board finds that it does not have jurisdiction over Crockett as a participant in this group. Crockett appealed from a RNPR that was reopened pursuant to CMS Ruling 1498R and/or 1498R-2 which, by their terms, do not encompass any Part C issues (rather they encompass only three stated issues – the SSI *Baystate* data matching issues, certain DSH non-covered dual eligible days issues, and certain DSH labor days issues). The Audit Adjustment referenced in Crockett's Direct Add Request is Audit Adjustment No. 3 which reads:

> We have adjusted the SSI % and the DSH % reported on the settled cost report after incorporating the latest released SSI Rate Table and calculated the DSH % in accordance with CMS Pub 15-II, Section 3630.1 and 42 CFR 413.106(d).

However, Crockett admits that the *only* resulting change to the SSI fraction was in the denominator to ***remove*** 2 days and Crocket does not contest this removal as this is type of adjustment that Crockett is seeking to achieve. Specifically, it is seeking to remove the block class of all Part C Days[3] (which clearly were part of the original SSI fraction) from the SSI fraction into the numerator of the Medicaid fraction as relevant.

The Board notes that the only manner in which the Board has determined that it has jurisdiction over the Part C days issue *in the context of a RNPR* is if: (1) the SSI percentage is specifically adjusted for Part C Days; ***or*** (2) the data match process is rerun and generates a new and different SSI percentage

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[1] (Emphasis added.)
[2] 42 C.F.R. § 405.1889(b)(1).
[3] The Provider is seeking to achieve the block class change in how Part C days are treated in the DSH calculation by invalidating the revisions made to 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) in the FFY 2005 IPPS final rule.

where the Board has made the *presumption* that there was a change in the underlying month-by-month data ***and*** *that the Part C days included in that month-by-month data also were changed.*[4] Only No. 2 is applicable to Crockett. However, the presumption in No. 2 is rebuttable and the record before the Board on Crockett rebuts it.

The Provider admits that the SSI percentage was changed ***only*** by *removing* 2 days from the denominator of the SSI fraction (total Medicare days). The Provider is not contesting the *removal* of those 2 days. Rather, as demonstrated in the Provider's "Computation of Costs in Controversy" attached to the Direct Add Request, the Provider is requesting that: (1) 43 additional days, which are Part C days, be *removed* from the denominator of the SSI fraction: and (2) 4 Part C days be *added* to the numerator of the *Medicaid* fraction. Thus, it is clear that the Board's presumption in No. 2 above has been rebutted and that the Provider does *not* have a right to appeal under 42 C.F.R. § 405.1889(b) (as referenced in § 405.1935(a)) because Part C days were not "specifically revised" and the Provider does *not* contest any aspect of the adjustment that was actually made (indeed, the adjustment to remove the 2 days from the denominator of the SSI fraction was in the Provider's favor as the SSI fraction increased by .00003 from .08767 to .08770). To this end, as part of this appeal, the Provider seeks the *removal* of the block class of all Part C days[5] totaling 43 days from the denominator of the SSI fraction and the addition of 4 of those 43 Part C days to the Medicaid fraction (*i.e.*, these 4 days likely are attributable to the single inpatient stay of a Part C patient who was also Medicaid eligible). If Crockett Hospital wished to appeal or contest the Part C days issue for FYE 2005, it should have appealed that issue from the original NPR when it clearly had the right to do so since appeals of any potential future RNPR is limited to matters "specifically revised."[6]

---

[4] This second situation does not encompass a realignment of the SSI percentage because CMS does not rerun the data match process in order to effectuate a realignment but rather uses pre-existing data previously gathered on a month-by-month basis to effectuate the realignment. See 42 C.F.R. § 412.106(b)(2) (noting that CMS gathers data on a month-by-month basis); 75 Fed. Reg. 50042, 50279 (Aug. 16, 2010) (stating: "The SSI fractions are generally based on the Federal fiscal year; however, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived from the data match process for the two Federal fiscal years that spanned the hospital's cost reporting period.); 70 Fed. Reg. 47278, 47439 (Aug. 12, 2005) (stating: "Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period, and the hospital must accept the resulting DSH percentage for that year, whether or not it is a more favorable number than the DSH percentage based on the Federal fiscal year." (emphasis added)).

[5] *See supra* note 3.

[6] For context, the Board takes administrative notice that:

1. The final rule establishing the Agency's current policy on treatment of Part C days in the SSI fraction (and the one at issue in this case) was issued on August 11, 2004 and the Agency's Part C days policy, both prior to and following the August 11, 2004 final rule, has been subject to much litigation. *See, e.g.*, *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 "D-" decision is an EJR determination. The Board does not routinely publish EJR determinations as "D-" decisions and will do so only when the EJR determination is *seminal*.).

2. Most providers filing Board appeals of the Part C days issue have done so by appealing from their original NPR, regardless of whether that NPR was issued prior to or after 1498-R (including certain appeals filed pre-2010 in which the provider later requested bifurcation of the Part C days issue from dual eligible days issues emanating from the same August 11, 2004 final rule).

Based on the above findings, the Board dismisses Crockett Hospital because, under 42 C.F.R. §§ 405.1889(b) and 405.1835(a)(1), Crockett Hospital does not have a right to appeal the Part C issue from the RNPR. The Board notes that Courts have upheld the Board's application of provider's limited appeal rights under 42 C.F.R. § 405.1889(b).[7]

Because Crockett Hospital is no longer a participant in the subject group, the Board finds the initial listing of Providers included with the remand issued by the Board on May 19, 2021 to be correct and complete. Therefore, it unnecessary to reissue the 1739R remand for the subject group; and the Board hereby closes Case No. 16-1762GC and removes it from the Board's docket.

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

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

For the Board:

7/16/2021

X Clayton J. Nix

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

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Elliott North
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730 17th Street
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RE: ***Jurisdictional Decision***
Metropolitan Hospital Center (05-2055)
FFY 2018
PRRB Case: 20-0524

Dear Mr. North,

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

Pertinent Facts:

The Provider filed its appeal request on December 18, 2019, appealing a quality reporting decision which reduced its annual payment for FFY 2018. On December 31, 2019, the Board issued an Acknowledgement and Critical Due Dates notification which established a due date of August 14, 2020 for the Provider's Preliminary Position Paper. This notice explicitly stated that "if the Provider misses any of its due dates, the Board will dismiss the appeal." On May 18, 2020, the Board issued a Notice of Hearing which established a due date of January 18, 2021 for the Provider's Final Position Paper and set a hearing date for March 18, 2021.

On June 4, 2020, the Provider contacted the Board's staff because the designated representative no longer works there. Board staff responded via e-mail with links to resources for the Board's electronic filing system (OH CDMS), as well as contact information for the OH CDMS help desk, and explained that the designated representative would need to be changed. On October 13, 2020, Board staff followed up because the representative had not been changed and the due date for Preliminary Position Papers had passed. On January 4, 2021, Board staff once again followed up. The Provider indicated that it was still trying to change its representative, and that it would consult with its legal team on filing its Final Position Paper. On February 8, 2021, Board staff followed up again since the designated representative had not changed. To date, no response has been received.

On March 5, 2021, the Board issued a Final Notice of Hearing that was specifically exempt from Alert 19. The Notice set a due date of May 18, 2021 for the Provider's Final Position Paper and set a hearing for August 16, 2021. The Provider has still not changed its designated representative,

has not contacted or responded to Board staff since February, 2021, and has not filed any of its position papers.

Relevant Law and Analysis:

Board Rule 41.2 (Aug. 29, 2018) permits dismissal or closure of a case on the Board's own motion:

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

The regulations governing position papers can be found at 42 C.F.R. § 405.1853:

> (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.

Failure to comply with the Board's deadline for submission of its Position Paper can be found at 42 C.F.R. § 405.1868:

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

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

Similarly, the Board's Rules (August 29, 2018) further emphasize the need for the parties to meet filing deadlines. Rule 23.1 states, in pertinent part:

> To give the parties maximum flexibility and for judicial economy, the parties may choose one of the following prehearing scheduling options:
>
> - Jointly agree to a proposed Joint Scheduling Order (JSO) . . . or,
> - If the parties do not elect the JSO process, file a preliminary position paper and follow the timelines established by the Board in its acknowledgement letter.
>
> **Upon receiving an appeal request, the Board will send an acknowledgement establishing the first filing due date. By that date, the parties must take one of the options.**[1]

Rule 23.3 is accompanied with a heading that reads "Preliminary Position Papers Required if no Proposed JSO is Executed" and explains:

> If the parties do not jointly execute and file a proposed JSO by the due date, the position paper deadlines established in the acknowledgement letter will control. Both parties must file preliminary position papers that comply with Rule 25 (and exchange documentation) by their respective due dates.

Rule 23.4, "Failure to Timely File" further states:

> The Provider's preliminary position paper due date will be set on the same day as the PJSO due date; accordingly, if neither a PJSO nor the provider's preliminary position paper is filed by such date, **the case will be dismissed**.[2] If the Intermediary fails to timely file a responsive preliminary position paper by its due date, the Board will take the actions described under 42 C.F.R. § 405.1868.

Finally, Rule 23.5 related to extension requests for Preliminary Position Papers and the associated commentary states that an extension **must** be filed at least three weeks before the due date and will only be granted for good cause.

[1] Emphasis in original.
[2] Emphasis added.

Board Decision:

The Board finds that the Provider has failed to comply with the Board's procedures, specifically the filing deadlines set in this case and, further, that it has been unable to contact the provider or representative at the last known address. As such, the Board hereby closes the case and removes it from its docket.

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

Board Members Participating:

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

For the Board:

7/16/2021

X Gregory H. Ziegler

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

cc: Wilson C. Leong, Esq., Federal Specialized Services
Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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500 North Meridian St., Ste. 400
Indianapolis, IN 46204

RE: ***EJR Determination***

17-1852G	Hall Render 2013 DSH SSI Fraction Dual Eligible Days Group III
18-1678GC	Community Healthcare Sys. (IN) CY 2016 DSH SSI Ratio Dual Eligible Days Grp
18-1720GC	Indiana University CY 2015 DSH SSI Ratio Dual Eligible Days Group
18-1751GC	Franciscan Alliance CY 2015 DSH SSI Ratio Dual Eligible Days Group
19-0571G	Hall Render CY 2014 DSH SSI Fraction Dual Eligible Days III Group
19-1897G	Hall Render CY 2011 DSH SSI Ratio Dual Eligible Days Group V
19-2156GC	Beacon Health CY 2015 DSH Dual Eligible Days Group
19-2549GC	Mayo Clinic CY 2015 DSH SSI Fraction Dual Eligible Days Group
19-2564G	Hall Render CY 2015 DSH SSI Dual Eligible Days Group
19-2567GC	Thomas Health CY 2015 DSH SSI Dual Eligible Days Group
20-0124G	Spectrum Health CY 2016 DSH SSI Dual Eligible Days Group
20-1948GC	Good Shepherd Health CY 2016 DSH SSI Fraction Dual Eligible Days Group
20-2152	University of Iowa Hospital and Clinics, Provider No. 16-0058, FYE 6/30/2006
21-0200	Marion General Hospital, Provider No. 15-0011, FYE 6/30/98
21-0553GC	Thomas Health CY 2016 DSH SSI Dual Eligible Days Group

Dear Ms. Griffin:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above Providers' request for expedited judicial review ("EJR Request") received June 23, 2021 regarding the above-referenced cases.[1] The Board's determination regarding the EJR request is set forth below.

Issue for which EJR is Requested:

The Providers, in the above-referenced group and individual appeals are requesting EJR for the following issue:

[1] The Board notes that the EJR request also included the following 6 group cases:

- Case No. 13-1682GC Good Shepard Health System 2007 SSI Fraction Dual Eligible Group,
- Case No. 19-2554GC Hall Render CY 2016 DSH SSI Dual Eligible Days Group,
- Case No. 19-2599GC Hall Render CY 2017 DSH SSI Dual Eligible Days Group,
- Case No. 20-1341GC Mayo Clinic CY 2016 DSH SSI Fraction Dual Eligible Days Group,
- Case No. 20-1520G Hall Render CY 2012-2014 DSH SSI Dual Eligible Days Group, and
- Case No. 20-1901GC Truman Medical Center CY 2017 DSH SSI Dual Eligible Days Group.

The Board is concurrently addressing the request for EJR in these 6 group cases under separate cover.

> The days at issue in these appeals are days of care furnished by the Hospitals to patients who were entitled to Medicare Part A and Supplemental Security Income ("SSI") benefits. The issue presented in these appeals is whether the Intermediary erred in calculating the [SSI] percentage included in the "Medicare fraction" for purposes of calculating the Provider's [Disproportionate Share Hospital ("DSH")] payment, as required by 42 U.S.C. § 1395ww(d)(5)(F)(vi)."
>
> The Providers respectfully assert that under the rules of statutory construction CMS is *compelled to interpret "entitlement to SSI" benefits to include all inpatients who were eligible for and/or enrolled in the SSI program at the time of their hospitalization* ***and***, further, to *furnish Providers with a listing of those SSI Enrollees/Eligible patients for the relevant hospitalizations so that its DSH adjustments can be recalculated in accordance with the Medicare Act*. Furthermore, [t]he Providers seek a ruling that CMS has failed to provide the them with adequate information to allow them to check and challenge CMS'[] disproportionate patient percentage ("DPP") calculations. The Providers are entitled to this data under Section 951 of the Medicare Prescription Drug, Improvement, and Modernization Act, Pub. L. 108-173. . . . Because the summary data that CMS currently provides only gives providers the underlying data for SSI days that are limited to the three (3) SSI status codes chosen by CMS instead of the full list of the hospital's Medicare patients who are enrolled in SSI and/or eligible for SSI benefits along with their corresponding SSI status codes, and does not give the Providers any meaningful means of challenging the SSI days chosen by CMS to be used in Provider's DPP calculations, CMS continually violates its § 951 mandate . . . .[2]

Medicare Disproportionate Share Hospital (DSH) Payment Background:

The Medicare program pays inpatient hospital services based on predetermined, standardized amounts subject to certain payment adjustments under Medicare's inpatient prospective payment system ("IPPS").[3] One of these adjustments, the Medicare DSH adjustment, provides additional payments to certain qualifying hospitals that treat a disproportionate share of low income patients. [4] The Medicare DSH adjustment is calculated using two fractions known as the Medicare fraction (also referred to as the SSI fraction or SSI ratio) and the Medicaid fraction. Pursuant to 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I), the Medicare fraction is calculated by using: (a) in the numerator, the "number of such hospital's patient days…which were made up of

[2] EJR Request at 2-3 (emphasis added).
[3] 42 C.F.R. Part 412.
[4] 42 U.S.C. § 1395ww(d)(5)(F)(i)(I).

patients who (for such days) were ***entitled*** to benefits under part A of the subchapter and were ***entitled*** to supplementary security income benefits…under subchapter XVI of this chapter…";[5] and (b) in the denominator, the number of days of care that are furnished to patients who were entitled to Medicare Part A. The Secretary incorporated this statutory provision into the regulations at 42 C.F.R. § 412.106(b)(2)(i)(B) which states:

> (2) *First computation: Federal fiscal year.* For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS –
>
> (i) Determines the number of patient days that –
>
> (A) Are associated with discharges occurring during each month; and
>
> (B) Are furnished to patients who during that month were **entitled to** both Medicare Part A (including Medicare Advantage (Part C)) and **SSI**, excluding those patients who received only State supplementation;
>
> (ii) Adds the results for the whole period; and
>
> (iii) Divides the number determined under paragraph (b)(2)(ii) of this section by the total number of days that –
>
> (A) Are associated with discharges that occur during that period; and
>
> (B) Are furnished to patients entitled to Medicare Part A (including Medicare Advantage (Part C)).[6]

The dispute in these appeals involves CMS' determination of which patients are "entitled to" both Medicare Part A and SSI benefits for purposes of the Medicare fraction of the DSH calculation.

The SSI program is a federal cash assistance program for low-income individuals who are aged, blind, or disabled,[7] administered by the Social Security Administration ("SSA"). The statutory provisions governing SSI, generally, do not use the term "entitled" to SSI benefits. Rather, the SSI statutory provisions typically refer to whether an individual is "eligible for benefits."[8] In order to be "eligible" for SSI benefits, a person must be: (1) 65 years of age or older, blind or disabled; (2) a lawful resident of the United States; (3) have limited income and resources; (4) not be fleeing to avoid prosecution for a crime or violating a condition of parole; and (5) file an application for benefits.[9]

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[5] (Emphasis added.)
[6] (Bold emphasis added and italics emphasis in original.) *See also* 42 U.S.C. § 1395w2(d)(5)(F)(vi)(I).
[7] 42 U.S.C. § 1382.
[8] 42 U.S.C. §§ 1381a, 1382(a) (emphasis added).
[9] 20 C.F.R. § 416.202.

In contrast, the Medicare program is an insurance program where an individual is automatically "entitled" to Medicare Part A when the person reaches age 65 and is entitled to Social Security benefits or becomes disabled and had been entitled to disability benefits for 24 calendar months.[10] In addition, the Medicare program provides that certain qualifying individuals with end stage renal disease are entitled to Medicare Part A.[11]

Unlike entitlement for Medicare Part A benefits, an individual who is currently eligible for SSI benefits may later become *in*eligible for SSI benefits. In this regard, SSA conducts periodic redeterminations to ensure continued eligibility[12] and may terminate,[13] suspend[14] or stop payments to individuals who are either temporarily or permanently ineligible for payment of SSI benefits.[15] In particular, SSI eligibility may be lost if a person no longer meets the basic requirements. For example, an individual may lose SSI eligibility if the individual is no longer disabled or the individual meets one of the following reasons set forth in §§ 416.207-416.216:

1. The individual fails to give the SSA permission to contact financial institutions;[16]
2. The individual fails to apply for other benefits to which the individual may be entitled;[17]
3. The individual fails to participate in drug or alcohol addiction treatment;[18]
4. The individuals is absent from the United States for more than 30 days;[19] or
5. The individual becomes a resident of a public institutions or prison.[20]

In addition, under certain circumstances, SSA may not pay benefits for administrative reasons, such as removal of a representative payee, an unknown address for the beneficiary, or because of income from a previous month.[21]

After the Medicare DSH statutory provisions were enacted in 1984, CMS (then known as the Health Care Financing Administration ("HCFA")) announced that the Secretary of Health and Human Services, rather than hospitals, would be solely responsible for computation of the Medicare fraction because the data necessary to calculate the Medicare fraction is voluminous and much of this data needed to be obtained from another agency, SSA.[22] CMS noted that, as of

[10] 42 U.S.C. § 426.
[11] 42 U.S.C. § 426-1.
[12] 20 C.F.R. § 416.204.
[13] 20 C.F.R. §§ 416.1331-1335.
[14] 20 C.F.R. §§ 416.1320-1330.
[15] 20 C.F.R. § 1320.
[16] 20 C.F.R. § 416.207.
[17] 20 C.F.R. § 416.210.
[18] 20 C.F.R. § 416.214.
[19] 20 C.F.R. § 416.215.
[20] 20 C.F.R. § 416.211.
[21] *See* SSA Program Operations Manual ("POMS") § SI 02301.201 (describing certain SSI post-eligibility events on the internet at https://secure.ssa.gov/apps10/poms.nsf/lnx/0502301201).
[22] 51 Fed. Reg. 31454, 31459 (Sept. 3, 1986).

1986, the data sources for the computation of the Medicare fraction included approximately 11 million billing records from the Medicare inpatient discharge file and over 5 million records from the SSI file compiled by SSA.[23] To compute the Medicare fraction, CMS had to match individual Medicare billing records to individual SSI records.[24] Considering the administrative burdens and complexity of the data matching process, CMS concluded that the Secretary would be responsible for the data matching process, which she would conduct retrospectively for every eligible Medicare hospital on a "federal fiscal year" basis—that is, based on discharges occurring in the federal fiscal year.[25] CMS notifies Medicare contractors of the SSI ratios after they are calculated. CMS currently makes this notification by posting the resulting SSI percentages on its website. Medicare contractors then use the posted SSI ratios to calculate the Medicare DSH percentage to determine each qualifying hospital's Medicare DSH payment adjustment.[26]

The Medicare DSH payment adjustment has been the subject of much litigation and, from that litigation, the following case is of particular relevance to this appeal: *Baystate v. Leavitt*, 545 F. Supp. 2d 20 *as amended* 587 F. Supp. 2d 37, 44 (D.D.C. 2008) ("*Baystate*"). In *Baystate*, the plaintiff alleged that the Secretary's process to identify and gather the data necessary to calculate each hospital's SSI ratio was deficient and the Court remanded the case to the Administrator for further action. The Board notes that this case discusses the Secretary's historical practice of basing "entitled to . . . SSI" under 42 C.F.R. § 412.106(b)(2) on actual payment of SSI cash benefits.[27]

On April 28, 2010, the Secretary through CMS acted on the *Baystate* remand order and published CMS Ruling CMS-1498-R ("Ruling 1498-R"). Specifically, the Ruling stated that CMS had implemented the *Baystate* remand order by recalculating the plaintiff's SSI fractions and Medicare DSH payment adjustments using a revised data matching process that used "updated and refined SSI eligibility data and Medicare records, and by matching individuals'

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[23] *Id.*
[24] *Id.*
[25] *Id.* at 31459–31460; 42 C.F.R. § 412.106(b).
[26] 42 C.F.R. § 412.106(b)(5); 42 C.F.R. § 405.1803.
[27] *Baystate* began with a hearing before the Board. *See Baystate Med. Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006), *modified by*, CMS Adm'r Dec. (May 11, 2006). The Board heard extensive testimony on the Secretary's then-existing data match process. This included testimony from several SSA employees on the data tapes historically sent from SSA to CMS that included "42 monthly indicators (ones and zeros) denoting the payment or non-payment of Federal SSI cash benefits during the period covered by the SSA tape." *Id.* at 11 (citations omitted). Further, this testimony established that SSA's program would "assign a '1' to a month if the CMPH field shows one of two payment codes, C01 (current pay status) or M01 (manual or forced pay), and the FAM field reflects an amount due for the month" and that "[o]therwise, the program assigns a '0' to that month." *Id.* The provider in *Baystate* contested among other things: (1) "the omission of SSI records relating to individuals who received a forced payment from an SSA filed office; (2) "the omission of SSI days associated with individuals whose SSI benefits were temporarily on hold or in suspense when SSA ran each year's SSI tape;" (3) "the omission of SSI days associated with individuals whose benefits were restored or retroactively after SSA ran each year's tape;" and (4) "the omission of individuals who were entitled to non-cash Federal SSI benefits." *Id.* at 23. The Board's discussion of these contentions confirms SSI days were counted when there was actual SSI cash benefits. *See id.* at 26-30. The CMS Administrator's decision and the ensuing decision of the D.C. District Court also contain references to the Secretary's policy. *See, e.g.,* Adm'r Dec. at 5, 16, 39, 41, 48-49; 545 F. Supp. 2d at 28-29 n.13 & n.17, 36-39.

records with reference to Social Security numbers (SSNs) as well as HICANs and Title II numbers."[28] The Ruling also stated that "in the FY 2011 proposed rule, CMS is proposing to adopt the same revised data matching process" for use with all hospitals and that "[i]n the forthcoming FY 2011 IPPS final rule, CMS expects to respond to public comments filed on the proposed new data matching process, make any changes to such matching process that seem appropriate, and adopt finally a new data matching process."[29] Finally, CMS stated that it would "use that new data matching process in calculating SSI fractions and DSH payments for specific claims that are found to qualify for relief under this Ruling."[30]

Consistent with Ruling 1498-R, the Secretary published the new data matching process in the FY 2011 IPPS proposed rule published on May 4, 2010.[31] The proposed rule includes references to the Secretary's historical practice of basing "entitled to . . . SSI" under 42 C.F.R. § 412.106(b)(2) on actual payment of SSI cash benefits.[32]

The Secretary finalized that data matching process in the FY 2011 IPPS final rule published on August 16, 2010 ("FY 2011 IPPS Final Rule").[33] Significantly, in the preamble to the FY 2011 IPPS Final Rule, CMS acknowledged a public comment that: (1) requested that "CMS include both paid and unpaid days for both SSI entitlement and Medicare entitlement such that there would be consistency between the numerator and denominator of the SSI fraction"; and (2) provided examples of "several SSI codes that represent individuals who were eligible for SSI but not eligible for SSI payments, that should be included as SSI-entitled for purposes of the data match process."[34] CMS responded in detail to this comment and explained that CMS interprets SSI entitlement to correspond with any month for which an individual *receives* payment of SSI benefits. In this regard, CMS stated that the three SSI codes denoted as C01, M01, and M02 "accurately captures all SSI-entitled individuals during the month(s) they are entitled to receive SSI benefits."[35] CMS explicitly rejected the inclusion of other SSA codes because "SSI entitlement can change from time to time" and none of these codes "would be used to describe an individual who was entitled to receive SSI benefits during the month that one of these codes was used."[36] Finally, in the preamble, CMS confirms that "[t]he same data matching process

[28] CMS-1498-R at 5.
[29] *Id.*
[30] *Id.* at 5-6.
[31] 85 Fed. Reg. 23852, 24002-24007 (May 4, 2010).
[32] *See, e.g.,* 75 Fed. Reg. at 24003 (discussing SSI cash payment issues discussed in the *Baystate* decision), 24003-24004 (discussing the proposed matching process where "[t]he SSI eligibility file serves as the system of record for whether or not SSA made a payment of SSI benefits to an individual who applied for SSI"), 24004-06 (discussing the time of the matching process including how "it is important to find an appropriate balance between administrative finality (that is, the final settlement of a hospital's cost report) and the inclusion of retroactive SSI eligibility determinations and the lifting of SSI payment suspensions by using the best and latest available SSI eligibility data at the time of cost report settlement benefits").
[33] 75 Fed. Reg. 50041, 50280-50281. (Aug. 16, 2010).
[34] *Id.* at 50280.
[35] *Id.* at 50280-50281.
[36] *Id.* This include all codes with the "S" prefix indicating a suspension of payment; codes beginning with "N" for nonpayment; code "E01" indicating that the individual had countable income which eliminated the SSI payment; and code "E02" indicating that the patient was not entitled to SSI benefits during that month but became entitled during a subsequent month.

[used for FY 2011 and beyond] will be used to calculate SSI fractions for cost reporting periods covered under the Ruling [1498-R]."[37]

While the new data matching process established in the preamble to the FY 2011 IPPS Final Rule was effective October 1, 2010 (*i.e.*, for FY 2011 and forward), Ruling 1498-R directed that the Medicare contractors apply "the same, unitary relief" consisting of SSI fractions that the Secretary had calculated using the new "suitably revised" data matching process to: (1) any Medicare cost report that had not been settled; and (2) all properly pending Medicare DSH appeals of the SSI fraction data matching process issue.[38] The Ruling noted that hospitals dissatisfied with the initial or revised NPR issued using the new SSI ratios in the Medicare DSH adjustment calculation could seek administrative and judicial review provided they met the jurisdictional and procedural requirements of 42 U.S.C. § 1395oo, the Medicare regulations, and other agency rules and guidelines.[39] In the FY 211 IPPS Final Rule, the Secretary explicitly recognized that "[t]he data matching process provisions of the Ruling would apply to . . . open cost reports for cost reporting periods beginning prior to October 1, 2010 (that is those preceding the effective date of the FY 2011 IPPS final rule)."[40]

Finally, on April 22, 2015, CMS published Ruling 1498-R2 modifying and amending Ruling 1498-R by allowing hospitals to elect whether to use new Medicare SSI fractions calculated on the basis of "total days" or "covered days" for cost reports involving patient discharges *prior* to October 1, 2004.[41]

As a result of the Rulings, new regulation, and new data match process, CMS calculated SSI percentages for the Providers for all of fiscal years at issue in this CIRP group appeal.[42] The Providers have appealed original NPRs a based on the methodology articulated in the preamble, *i.e.*, use only the three SSI codes to denote SSI eligibility.

Providers' Request for EJR:

The Providers assert that, under the rules of statutory construction, the Secretary is compelled to interpret "entitled to SSI" benefits to include all inpatients who were enrolled in the SSI program at the time of their hospitalization. The Providers point out that, overtime, the Secretary has expanded the definition of entitled to benefits, but the expanded definition did not address the rift between Medicare Part A beneficiaries and SSI beneficiaries who are described in the DSH statute as "entitled to benefits." The Providers explain that the Secretary continues to construe "entitled to [SSI] benefits" narrowly. In order to be counted in the Medicare fraction numerator of the DSH calculation, an SSI enrollee must actually have received a cash payment from the Social Security Administration ("SSA") for the month in question. The Providers contend that

[37] *Id.* at 50285.
[38] CMS-1498-R at 6-7, 31.
[39] *Id.* at 28, 31.
[40] 75 Fed. Reg. at 24006.
[41] CMS-1498-R2 at 2, 6.
[42] CMS published the SSI ratios for FY 2012 on or about June 12, 2014. SSI ratios are published and can be accessed at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.

this action excludes SSI enrollees otherwise qualified for and receiving non-cash benefits under the SSI program.[43]

The Providers note that, in administering the SSI program, SSA assigns each beneficiary a Patient Status Code ("PSC"). The codes are made up of two elements: a single letter code reflecting payment status and a numeric code indicating the reason for the payment status. Of the 77 PSC codes used by SSA, the Secretary announced in the FY 2011 IPPS Final Rule that only three PSC codes, C01, M01 and M02, are counted as "entitlement" for purposes of the DSH statute.[44] Thus, the Providers allege the exclusion of the other 74 codes used by SSA to determine payment status result in a significant number of SSI enrollees being excluded from the numerator of the Medicare fraction for reasons that have no bearing on their eligibility for or entitlement to SSI benefits. The Providers believe that the SSI enrollees remain entitled to SSI regardless of whether cash payment is received in the month of hospitalization.

Further, the Providers assert in their request for EJR that CMS should provide the Providers with a listing of those SSI enrollees for the relevant hospitalizations so that they can ensure that their DSH adjustments were calculated in accordance with the DSH statute. The Providers state that they are seeking a ruling that CMS has failed to furnish the Providers with adequate information to allow them to check and meaningfully challenge CMS' disproportionate patient percentage ("DPP") calculations which they are entitled to under § 951 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 ("MMA").[45]

Decision of the Board:

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

A. Jurisdiction

The participants that comprise the group appeals within this EJR determination, have filed appeals involving fiscal years 1998 through 2016 (all cost reporting periods in this determination started before 1/1/16).

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 Hospital*

[43] 75 Fed. Reg. at 50275-86.
[44] *Id.* at 50281.
[45] Pub. L. 108-173, § 951, 117 Stat. 2066, 2427 (2003).

Association v. Bowen ("*Bethesda*").[46] 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.[47]

On August 21, 2008, new regulations governing the Board were effective.[48] Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hospital v. Burwell* ("*Banner*").[49] 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.[50]

The Secretary did not appeal the decision in *Banner* and decided to 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.

(1) Case No 17-1852G: # 3 Memorial Healthcare (Prov. No. 23-0121, FYE 12/31/13)

In this case, both parties have filed jurisdictional briefs regarding the appeal. On December 11, 2018, the Medicare Administrative Contractor (MAC) noted that the issue appealed in Case No. 17-1852GC was:

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[46] 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.).
[47] *Bethesda*, 108 S. Ct. at 1258-59.
[48] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[49] 201 F. Supp. 3d 131 (D.D.C. 2016).
[50] *Id.* at 142.

> Whether the Medicare DSH calculation was understated due to the failure of CMS and the MAC to properly include all dual eligible days, including all dual eligible days that are Medicare Non-Covered Days, which include but are not limited to Medicare Exhausted Days and Medicare Secondary Payor days, in the numerator of the Medicare or Medicaid Fraction of the DSH percentage as applicable pursuant to 42 U.S.C. § 1395ww(d)(5)(F).

The MAC maintains that the issue statement above is different from that which was briefed in the Providers' preliminary position paper. The issue in the preliminary position paper was:

> Whether the Medicare DSH reimbursement calculations were understated due to CMS' and the MAC's failure to include all patient days for patients who were eligible for and enrolled in the SSI program, but may not have received SSI payment for the month in which they received services from the Providers in the numerator of the Medicare fraction as required by 42 U.S.C. § 1395ww(d)(5)(F)(vi).

The MAC contends that these issue statements are entirely different issues (i.e. dual eligible days v. SSI percentage systemic errors) and that change is not permitted in accordance with 42 C.F.R. § 405.1837 and Board Rule 13.

The MAC also contends that Provider # 3 Memorial Healthcare (provider no. 23-0121, FYE 12/31/13) was improperly transferred to this group appeal. The MAC alleges that the Provider did not appeal the issue in dispute, dual eligible days-SSI fraction in its individual appeal. Rather, the Provider appealed the Medicaid fraction-Medicare Advantage days, Medicaid fraction-Exhausted Days, Medicare Fraction-Medicare Advantage Days and Medicare Fraction-SSI percentage.

The Group Representative refutes the MAC's argument that the issue morphed between the appeal request and the initial arguments in the preliminary position paper by stating that the MAC only included the first paragraph of the appeal request and not the entire issue statement. Further, the Providers assert in their position paper they tried to succinctly boil down a much longer and broader issue statement from the original appeal request and focus on what should be presented at a hearing. The Providers maintain that they have always used a more refined issue statement in their position papers and that the preliminary position paper address and argues the Providers' entire issue statement.

The Group Representative also contends that Provider #3 Memorial Healthcare was properly transferred to this group. The Representative argues that issue statements should be, and are, broadly written especially where providers do not have access to the data that CMS used to more narrowly describe the issues and the bases for their appeals statement. The Group Representative believes that the broadly written issue statement in Memorial Healthcare's original hearing request

covers all potential problems or concerns that the Providers had with how CMS was excluding numerous dual eligible or SSI/dual eligible days.

The Board finds that the MAC is not on point with respect to the group issue under appeal in Case No. 17-1852G. The issue did not change from the submission of the hearing request and the submission of the preliminary position paper. The submission of a truncate issue statement from the initial appeal is misleading as the last sentence of the issue statement clearly confirms the issue that is the subject of both the position paper and the EJR request:

> The Providers dispute CMS's position that only Dual Eligible Days, and DE MNC Days, that are also SSI days go in the Medicare numerator of the DSH calculation. Since Medicare interprets "entitled" to Medicare as "eligible" for Medicare, and thus their basis for SSI and allow all Dual Eligible Days, including all such DE MNC Days, that are "eligible" for SSI which includes days where the patient may only be receiving their SSI medical benefit/Medicaid, to be included in the DHS Medicare numerator.

Accordingly, when the entire issue statement and the preliminary position paper are reviewed, the Board concludes that the issue has not changed.

With respect to # 3 Memorial Healthcare (Prov. No. 23-0121, FYE 12/31/13), the Board hereby ***dismisses*** the Provider from the case because the SSI issue that was appealed was ***not*** the issue for which EJR has been requested. The complete description of the issue in Memorial Healthcare's individual appeal was:

> Statement of the Issue:
> The intermediary ***erred*** by incorrectly calculating the SSI percentage for inclusion in the "Medicare fraction" for purposes of the calculation of the provider's disproportionate share payment.
>
> Brief Description of the Issue
>
> The Provider believes the Intermediary's calculation of the Providers' [sic] Medicare disproportionate share hospital (DSH) payments contains ***errors*** in the calculation of the SSI percentage for purposes of 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II) and 42 C.F.R. § 412.106(b).
>
> Audit Adjustment Numbers:
> Audit Adjustment numbers 41
>
> Amount in Controversy:

> The Provider believes that its DSH reimbursement should correctly reflect an accurate SSI percentage for purposes of the "Medicare fraction". The correct value of this adjustment is not able to be fully calculated from the information currently available to the provider, but is in execess of $10,000. The documents or data relating to CMS's calculation of the adjustment to the DSH payment that were utilized in CMS's calculation as required by DHS are, to the best of the Provider's knowledge, solely in the possession of CMS.
>
> Legal Basis for Appeal:
> The Provider believes that inclusion of ***correct*** data and calculation of the SSI percentage for purposes of the disproportionate share hospital (DSH) payment is supported by the plain language of 42 U.SC. § 1395ww(d)(5)(F)(vi)(II) and 42 C.F.R. § 412.106(b).

The Board finds that this issue statement does not comply with 42 C.F.R § 405.1835(b) or Board Rule 8.1. Under 42 C.F.R. § 405.1835(b)(2) (2013), a provider's written request for hearing must contain, "*for each **specific** item at issue,"* a separate explanation of why, and a description of how, the provider is dissatisfied with the *specific* aspects of the final determination under appeal:

> (b) *Contents of request for a Board hearing*. The provider's request for a Board hearing must be submitted in writing to the Board, and the request **must include the elements described in paragraphs (b)(1) through (b)(4) of this section**. If the provider submits a hearing request that does not meet the requirements of 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. . . .
>
> (2) An explanation (**for each specific item at issue**, see paragraph (a)(1) of this section) of the provider's dissatisfaction with the intermediary's or Secretary's determination under appeal, **including an account of all of the following**:
>
> (i) Why the provider believes Medicare payment is incorrect **for each disputed item** (or, where applicable, why the provider is unable to determine whether Medicare payment is correct because it does not have access to underlying information concerning the calculation of its payment).
>
> (ii) How and why the provider believes Medicare payment must be determined differently **for each disputed item**.[51]

[51] (Bold emphasis added.)

> (iii) If the provider self-disallows a specific item, a description of the nature and amount of **each self-disallowed item** and the reimbursement or payment sought **for the item**

Accordingly, the regulations prescribe that if a provider submits a hearing request that *does not* meet the requirements of (b)(1), (2), or (3), the Board may dismiss the appeal with prejudice or take any other remedial action it considers appropriate.[52]

In keeping with the above-quoted regulation's specificity requirement, the Board's Rules in effect at the time that the Provider filed its RFHs stated the following:

> **Rule 8—Framing Issues for Ajdustment 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.)[53]

The Provider describes a very vague, *non-specific* SSI Percentage issue. Even when considering its further description and legal basis, the issue remains vague and overly broad. When considering the specificity of the "contents" requirements in 42 C.F.R. § 405.1835(b), the Board finds the Provider's issue statement in the request for hearing to be deficient because it failed to meet the "contents" requirements in subsection (b)(2). More specifically, this issue statement generically refers to "errors" in the SSI calculation, but fails to include any description of the alleged "errors" (*e.g.*, describe a mechanical implementation error or a statutory interpretation error) much less explain "*why* . . Medicare payment is incorrect for *each* disputed item" or "*how* and *why* Medicare payment must be determined differently for *each* disputed item." Similarly, it fails to comply with Board Rule 8.1: "to *specifically identify* the items in dispute" and describe each item "as narrowly as possible." The Board notes that, by the time the Provider filed its request for hearing *in August 2016*, there had been much litigation and several Agency publications describing certain systemic errors in the data matching process used to calculate SSI percentages:

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[52] 42 C.F.R. § 405.1835(b).
[53] Board Rule 8 (March 1, 2013 & July 1, 2015) (italics and underline emphasis added).

1. *Baystate Med. Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. 2006-D20 (Mar. 17, 2006), *rev'd by* CMS Adm'r Dec. (May 11, 2006).

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

3. CMS Ruling 1498-R (April 28, 2010); and

4. 75 Fed. Reg. 50042, 50275-85 (Aug. 16, 2010) (adopting a new data matching process post *Baystate* that, among other things, restated CMS' policy that SSI entitlement is based on only 3 specified SSI PSCs).

5. *Catholic Health Initiatives Iowa Corp. v. Sebelius*, 718 F.3d 914 (D.C. Cir. 2013) (reviewing the agency's interpretation of the phrase "entitled to benefits" as used in 42 U.S.C. § 1395ww(d)(5)(F)(vi) and, consistent with its 2011 decision in *Northeast Hospital Corp v. Sebelius*, 657 F.3d 1 (D.C. Cir. 2011) found that the Secretary's interpretation that that an individual is "entitled to benefits" under Medicare when he meets the basic statutory criteria for Medicare Part A was a reasonable and permissible interpretation of that phrase (718 F.3d at 920)).

However, ***none*** of these documents nor the detailed alleged errors or issues described within these documents are referenced in the request for hearing. The vague reference to "inclusion of correct data" in the "Legal Basis for the Appeal" section does nothing to cure this deficiency. Similarly, the vague reference in the "Amount in Controversy" section of Issue 4 to certain documents solely in CMS' possession does nothing to cure this deficiency (particularly when the very issue that is the subject of the EJR is a legal issue). Specifically, Providers' inability to calculate the amount in controvery because "documents or data relating to CMS's calculation of the adjustment to the DSH payment that were utilized in CMS's calculation of the adjustment . . . are, to the best of the Provider[s'] knowledge, solely in the possession of CMS" does nothing to cure this deficiency. Thus, the Board concludes that the Provider's description of its SSI Percentage issue does not comply with the regulatory specificity requirements (or related Board Rules) mandated for a Board hearing.

The Board Rules specifically state that the SSI dual eligible days issue must be clearly identified as a DSH issue that is being appealed and states that issues must be narrowly defined, not broadly as the Group Rep suggests. The hearing request does not specifically identify the dual eligible days issue as the subject of the appeal, as required.

Based on the above findings, the Board ***dismisses*** # 3 Memorial Healthcare (Prov. No. 23-0121, FYE 12/31/13) from Case No. 17-1852G for failure to appeal the group issue as well as the

issue for which EJR has been requested. Since jurisdiction over an appeal is a prerequisite to granting a request for EJR, the Board hereby denies Memorial Healthcare's request for EJR.[54]

(2) Case No. 19-2564G Hall Render CY 2015 DSH SSI Dual Elgible days Group

On December 8, 2020, the MAC notified the Board that the Group Representative had failed to sign three certfications when it added the following 4 participants to this group case:

> # 1 Baxter Regional Medical Center (Prov. No. 04-0027, FYE 12/31/),
> #3 Spectrum Health Butterworth Campus (Prov. No. 23-0038, FYE 6/30/15),
> #4 Caromont Regional Medical Center (provider number 34-0032, FYE 6/30/15); and
> #6 Christus Good Shepherd Medical Center-Longview, (Prov. No. 45-0037, FYE 9/30/15).

The Group Representative responded stating that it had complied with the Office of Hearings Case and Document Management System (OH CDMS) External User Manual[55] when adding the Providers.

The Board finds that the Group Representative completed the proper certifications for adding the providers through OH CDMS to Case No. 19-2564G. Section 3.3.3.2 of the OH CDMS External User Manual requires only a single certification when adding providers to a group appeal. The Board finds that the appeals of # 1 Baxter Regional Medical Center (Prov. No. 04-0027, FYE 12/31/), #3 Spectrum Health Butterworth Campus (Prov. No. 23-0038, FYE 6/30/15), #4 Caromont Regional Medical Center (Prov. No. 34-0032, FYE 6/30/15), and #6 Christus Good Shepherd Medical Center-Longview (Prov. No. 45-0037, FYE 9/30/15) were correctly certified when the Providers were added to the appeal.

(3) Case No. 19-1897G Hall Render CY 2011 DSH SSI Ratio Dual Eligible Days Group V

In Case No. 19-1897G, the MAC filed a jurisdictional challenge contending that the Providers have morphed the issue statement from the time the appeal request was submitted and the preliminary position paper was filed. Further, the MAC alleges the two of the Providers, # 1 Indiana University Health Morgan Hospital (Provider No. 15-0038) and # 3 Gundersen Lutheran Medical Center (Prov. No. 52-0087) have open appeals containing the same issue—Case Nos. 17-2000G (Hall Render 2010-2011 DSH Post 498R SSI Data Match Group IV) ***and*** 19-0936G (Hall Render CY 2011-2012 Post 1498R SSI Data Match Group IV Group).

The Providers responded to the issue of the issue morphing by stating that the MAC failed to include the full issue statement from the initial appeal request in its brief. The Providers state that the issue statement is clear: the issue is Dual Eligible Days or where do the Dual Eligible days belong—do they belong in the numerator of the Medicare or Medicaid fraction of the DSH percentage. The Providers state that when they filed their preliminary position paper, to the

[54] *See* 42 C.F.R. § 405.1842(a).
[55] This manual appears on the internet at https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview.

same arguments as the Board considered in the Hall Render Optional & CIRP DSH Dual/SSI appeals resulting in PRRB Decs. 2017-D11 and D12. The Providers maintain that it defined the issue in their preliminary position paper as:

> The days at issue in these group appeals are the days of care furnished by the Hospitals to patients who were eligible for and/or entitled to Medicare Part A and Supplemental Security Income benefits. The issue presented in these appeals is whether the Providers' Medicare [DSH reimbursement calculations were understated due to [CMS'] and the [MAC's] failure to include all patient days for patients who were eligible for and enrolled in the SSI program but may not have received an SSI 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 . . . .

The Providers maintain that the MAC had no authority to manipulate the issue statement by truncating it to convince the Board that preliminary position paper deals with a different issue.

The Providers also contend that the cases cited above as duplicative are not, rather they deal with two different issues. The SSI data match issue is a technical issue which alleges that there are still errors that exist with CMS' revised matching process developed in response to Baystate, and therefore does not properly capture all SSI eligible individuals. The SSI Dual Eligible Days issue is rooted in the legal arguments related to CMS' interpretation of the DSH statute, particularly the Medicare fraction, and CMS' policy decisions in which the term "entitlement" to Medicare Part A broadly interprets the term "entitlement" very narrowly with respect to SSI benefits and the failure to use the 77 Payment status codes.

The Board finds that the Providers' issue, as filed in this case and in the EJR request, has not changed. Once again, the MAC did not include the full issue statement from the CN 19-1878GC and the EJR request when it submitted its objection to jurisdiction. The issues are substantially the same in both documents. In fact, the last sentence confirms the issue that is the subject of both the position paper and the EJR request confirms the issue that is the subject of both the position paper and the EJR request:

> The Providers dispute CMS's position that only Dual Eligible Days, and DE MNC Days, that are also SSI days go in the Medicare numerator of the DSH calculation. Since Medicare interprets "entitled" to Medicare as "eligible" for Medicare, and thus their basis for SSI and allow all Dual Eligible Days, including all such DE MNC Days, that are "eligible" for SSI which includes days where the patient may only be receiving their SSI medical benefit/Medicaid, to be included in the DHS Medicare numerator.

The Provider's preliminary position paper also includes the SSI entitlement-eligibly issue as evidenced by the title of sub-argument 2: "CMS's Policy of Counting Only SSI Eligible Patients SSA Coded As C01, M01, and M02 in the Medicare Fraction Numerator Must Be Rejected Because It Violates the DSH Statute."

Further the issue in the in Case Nos. 17-2000G and 19-0936G involve the data match process found to be deficient in *Baystate*. In the current case, the Providers dispute CMS's position that only dual eligible days, and dual eligible non-covered day are entitled to Medicare as "eligible" for Medicare as the basis for including the additional days in the Medicare fraction. The Providers believe that all dual eligible days, including dual eligible non-covered days , that are eligible for SSI which includes days where the patient may only be receiving the SSI medical benefit/Medicaid, should be included in the DSH Medicare numerator. These are not duplicative cases.

(4) Jurisdiction and Appropriate Cost Report Claim Summary for the Remaining Participants

Based on its review of the record, the Board finds that each of the remaining participants in the these cases (individual and group), who filed from NPRs beginning ***prior to*** January 1, 2016, filed timely and proper appeals. In this regard, the Board finds that the above Providers are governed by *Bethesda* or CMS Ruling CMS-1727-R and that the above Providers' appeals are permitted as they are challenging the substantive and procedural validity of a regulation. Further, with respect to the Providers who filed from revised NPRs, the Board finds that the SSI percentage issue was adjusted by the revised NPRs as required for Board jurisdiction under 42 C.F.R. § 405.1889.

The participants' documentation in all of the EJR requests shows that the estimated amount in controversy exceeds $50,000 in each group, as required for a group appeal.[56] The individual appeals exceed the $10,000 estimated amount in controversy as required 42 C.F.R. § 405.1835. Based on the above, the Board finds that it has jurisdiction for the above-captioned appeals 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. Analysis Regarding the Appealed Issue

As discussed above, the Secretary revised the SSI data match process in light of the *Baystate* decision through notice and comment in the form of an uncodified regulation. First, the Secretary issued CMS Ruling 1498-R on April 28, 2010, authorizing remands of pending appeals of the SSI data match issue to recalculate the SSI fraction based on a *revised* data match.[57] The Secretary also stated in the Ruling that, where cost reports had not been settled, those providers

[56] *See* 42 C.F.R. § 405.1837.
[57] CMS Ruling 1498-R at 27.

SSI fraction would be calculated using the *revised* data match process to be published through rulemaking.[58]

Contemporaneous with CMS Ruling 1498-R[59] the Secretary published a proposed IPPS rule[60] which proposed to adopt a revised data process for cost reports covered by Ruling 1498-R ***and*** for cost reports beginning on or after October 1, 2010. The Secretary adopted this proposed rule as part of the 2011 Final IPPS Rule in which the Secretary explained that:

> . . . we used a revised data matching process . . . that comports with the court's decision [in *Baystate* to recalculate the hospitals SSI fractions]. As the revised data matching process was completed using SSI eligibility data compiled between 13 and 16 years beyond the fiscal years at issue in the *Baystate* case, we believe any issues associated with retroactive determinations of SSI eligibility and the lifting of payment suspensions had been long since resolved. Furthermore, because we believe that the revised match process used to implement the *Baystate* decision addressed all of the concerns found by the court, in the FY 2011 IPPS/LTCH PPS proposed rule we proposed to use the same revised data matching process for calculating hospitals' SSI fractions for FY 2011 and subsequent fiscal years.[61]

Then she announced that:

> We have adopted the proposed data matching process for FY 2011 and beyond as final. The only modification we are making to the proposed matching process is adopting a policy to exclude a record from the data matching process if we find a HICAN in the MedPAR file that we are not able to locate in the EDB[62]which is an extremely unlikely situation as noted in the prior discussion in this final rule. We are adopting this additional step in our validation process to respond to public comment and provide even more assurances that our data matching process will yield accurate SSI fractions and capture all Medicare beneficiaries who were entitled to SSI at the time of their inpatient hospital stay. The same data matching process will be used to calculate SSI fractions for cost reporting periods covered under the ruling.[63]

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[58] *Id.* at 31.
[59] *Id.* at 5.
[60] 75 Fed. Reg. 23852, 24002-07.
[61] 75 Fed. Reg. at 50277.
[62] (Medicare) Enrollment Database.
[63] 75 Fed. Reg. at 50285.

The Secretary did not incorporate the above new policy involving the revised data match process into the Code of Federal Regulations. However, it is clear from the language in the final IPPS rule, as set forth above, that the Secretary intended to bind the regulated parties and establish a binding data match process to be used by the Medicare Contractors in calculating (or recalculating) the SSI fractions for all hospitals pursuant to 42 C.F.R. § 412.106(b)(2).

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 "Uncodified SSI Data Match Regulation." Indeed, this finding is consistent with the Secretary's obligations under 42 U.S.C. § 1395hh(a)(2) to promulgate any "substantive legal standard governing . . . the payment of services" as a regulation."[64] Moreover, it is clear that the Uncodified SSI Data Match Regulation specifies which PSC codes determine SSI entitlement for purposes of calculating SSI fractions under 42 C.F.R. § 412.106(b)(2).

Pursuant to 42 C.F.R. § 405.1867, the Board is bound to apply the statutory and regulatory provisions governing the Medicare program. Consequently, the Board finds that it is bound by the Uncodified SSI Data Match Regulation published in the FY 2011 Final Rule and the Board does not have the authority to grant the relief sought by the Providers, namely invalidating the Uncodified SSI Data Match Regulation which they allege fails to include all of the PSC codes used by SSA to determine SSI eligibility. As a result, the Board finds that EJR is appropriate for the issue for the calendar year under appeal in this CIRP group appeal.

C. Board's Decision Regarding the EJR Request

The Board makes the following findings:

1) Provider # 3 Memorial Healthcare (Prov. No. 23-0121, FYE 12/31/13) from Case No. 17-1852G is dismissed for failure to appeal the group issue as well as the issue for which EJR has been requested. Since jurisdiction over an appeal is a prerequisite to granting a request for EJR, the Board hereby denies Memorial Healthcare's request for EJR;

2) It has jurisdiction over the matter for the subject years and that the remaining participants in these cases (2 indvidual appeals for 16-0058 (6/30/2006 and 15-0011 (6/30/1998) plus the participants listed on the schedules of poviders attached to this decision) are entitled to a hearing before the Board;

3) Based upon the participants' assertions regarding FY 2011 Final IPPS Rule there are no findings of fact for resolution by the Board;

[64] 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 . . . ."

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

5) It is without authority to decide the legal question of whether the Uncodified SSI Data Match Regulation as adopted in the preamble to the FY 2011 Final IPPS Rule is valid.

Accordingly, the Board finds that the question of the validity of the Uncodified SSI Data Match Regulation (as adopted in the preamble to the 2011 Final IPPS Rule) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for EJR for the issue and the subject years. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute, the Board hereby closes these cases.

Board Members Participating:

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

For the Board:

7/22/2021

X Clayton J. Nix

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

cc: Byron Lamprecht, WPS
Cecile Huggins, Palmetto GBA
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RE: ***Jurisdictional Determination***
Margaret R. Pardee Memorial Hospital (Prov. No. 34-0017)
FYEs 9/30/09, 9/30/10, 9/30/11
Case Nos. 14-2646, 15-1348, 15-1352

Dear Mr. Roth and Ms. Johnson,

The Provider Reimbursement Review Board (the "Board") has reviewed jurisdiction over the DSH Part C Days – Medicaid Fraction issue in the above-referenced appeals. The Board's jurisdictional decision is set forth below.

Background

The Provider filed individual appeals with the Board as follows:

- Case No. 14-2646 – February 24, 2014 appealing an NPR dated August 30, 2013
- Case No. 15-1348 - February 6, 2015 appealing an NPR dated August 11, 2014
- Case No. 15-1352 – February 6, 2015 appealing an NPR dated October 9, 2014

One of the remaining issues in each of the appeals is DSH Part C Days – Medicaid Fraction, described by the Provider as follows:

> Whether the Hospital's Medicare DSH payments for FYs 2009, 2010 through 2012 were understated because the numerator of the Medicaid fraction improperly excluded inpatient hospital days attributable to dually-eligible Medicare Part C plan enrollee patients.[1]

Each of the appeals previously contained the DSH Part C Days – Medicare/SSI Fraction issue described as follows:

> Whether the Hospital's Medicare DSH Payment was understated because its Medicare/SSI Fraction improperly included inpatient hospital days attributable to Medicare Part C enrollee patients.[2]

[1] Provider's Combined Final Position Paper at 13.
[2] Provider's Combined Final Position Paper at 1.

The DSH Part C Days – Medicare/SSI Fraction issue was transferred to the following 3 optional group appeals and, subsequently in early 2018, were granted expedited judicial review ("EJR"):

- Case No. 14-2646 – transferred to Case No. 18-0847G – HLB FY 2009 DSH Part C Days Medicare/SSI Fraction Group (EJR granted 3/1/1/8)
- Case No. 15-1348 – transferred to Case No. 18-0794G – HLB FY 2010 DSH Part C Days Medicare/SSI Fraction Group (EJR granted 2/26/18)
- Case No. 15-1352 – transferred to Case No. 18-0911G – HLB FY 2011 DSH Part C Days Medicare/SSI Fraction Group (EJR granted 3/1/18)

Board Decision

The Board notes that the EJR requests for which the Board granted EJR clearly, as well as the Board's EJR decision itself, encompassed the complete Part C DSH issue, *i.e.*, both the Medicare and Medicaid fractions. Per the holdings in *Allina Health Servs. v. Sebelius* (746 F.3d 1102, 1108 (D.C. Cir. 2014)) ("*Allina*"), Part C days ***must*** be included in either the SSI fraction or Medicaid fraction.[3] Thus, the disposition of the DSH Part C Days – Medicare/SSI Fraction issue dictates the disposition of the DSH Part C Days – Medicaid Fraction issue, as *Allina* indicates Part C days must be counted in one fraction or the other.

As such, the Board hereby dismisses the DSH Part C Days – Medicaid Fraction issue from PRRB Case Nos. 14-2646, 15-1348, and 15-1352 as this issue was disposed of through the Board's EJR of the DSH Part C Days - Medicare/SSI Fraction Groups under Case Nos. 18-0847G, 18-0794G, and Case No. 18-0911G. The cases remain open as other issues remain in each appeal. The cases are scheduled for hearing on September 22, 2021. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877 upon final disposition of the appeals.

Board Members Participating:

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Robert A. Evarts, Esq.
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For the Board:

7/27/2021

X Clayton J. Nix

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Chair
Signed by: PIV

cc: Wilson C. Leong, Federal Specialized Services

[3] Specifically, *Allina* states "the statute unambiguously requires that Part C days be counted in one fraction or the other (a Part C-enrolled individual is either eligible for Medicare Part A, or not)." 746 F.3d at 1108.

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RE: ***Jurisdictional Determination***
Johnston Memorial Hospital (Prov. No. 34-0090)
FYEs 9/30/10, 9/30/11, 9/30/12, 9/30/13
Case Nos. 15-1347, 15-0720, 17-0347, 18-1099

Dear Mr. Roth and Ms. Johnson,

The Provider Reimbursement Review Board (the "Board") has reviewed jurisdiction over the DSH Part C Days – Medicaid Fraction issue in the above-referenced appeals. The Board's jurisdictional decision is set forth below.

Background

The Provider filed individual appeals with the Board as follows:

- Case No. 15-1347 – February 6, 2015 appealing an NPR dated August 11, 2014
- Case No. 15-0720 – December 16, 2014 appealing an NPR dated June 19, 2014
- Case No. 17-0347 – November 8, 2016 appealing an NPR dated May 19, 2016
- Case No. 18-1099 – March 22, 2018 appealing an NPR dated September 26, 2017

One of the remaining issues in each of the appeals is DSH Part C Days – Medicaid Fraction, described by the Provider as follows:

> Whether the Hospital's Medicare DSH payments for FYs 2010, 2011, 2012, and 2013 were understated because the numerator of the Medicaid fraction improperly excluded inpatient hospital days attributable to dually-eligible Medicare Part C plan enrollee patients.

Each of the appeals previously contained the DSH Part C Days – Medicare/SSI Fraction issue described as follows:

> Whether the Hospital's Medicare DSH Payment was understated because its Medicare/SSI Fraction improperly included inpatient hospital days attributable to Medicare Part C enrollee patients.

The DSH Part C Days – Medicare/SSI Fraction issue was transferred to the following 3 optional group appeals and, subsequently in early 2018, the Board granted expedited judicial review ("EJR"):

- Case No. 15-1347 – transferred to Case No. 18-0794G – HLB FY 2010 DSH Part C Days Medicare/SSI Fraction Group (EJR granted 2/26/18)
- Case No. 15-0720 – transferred to Case No. 18-0911G – HLB FY 2011 DSH Part C Days Medicare/SSI Fraction Group (EJR granted 3/1/18)
- Case No. 17-0347 – transferred to Case No. 18-0912G – HLB FY 2012 DSH Part C Days Medicare/SSI Fraction Group (EJR granted 3/1/18)

Similarly, on May 10, 2019, the Board granted EJR over the DSH Part C Days – Medicare/SSI Fraction issue in Case No. 18-1099.

Case Nos. 15-1347, 15-0720 and 17-0347 are scheduled for hearing on October 19, 2021. Case No. 18-1099 is not yet scheduled for hearing

Board Decision

The Board notes that the EJR requests for which the Board granted EJR, as well as the Board's EJR decision itself, clearly encompassed the complete Part C DSH issue, *i.e.*, both the Medicare and Medicaid fractions. Per the holdings in *Allina Health Servs. v. Sebelius* (746 F.3d 1102, 1108 (D.C. Cir. 2014)) ("*Allina*"), Part C days ***must*** be included in either the SSI fraction or Medicaid fraction.[1] Thus, the disposition of the DSH Part C Days – Medicare/SSI Fraction issue dictates the disposition of the DSH Part C Days – Medicaid Fraction issue, as *Allina* indicates Part C days must be counted in one fraction or the other.

As such, the Board hereby dismisses the DSH Part C Days – Medicaid Fraction issue from PRRB Case Nos. 15-1347, 15-0720, and 17-0347 as this issue was disposed of through the Board's EJR of the 3 DSH Part C Days - Medicare/SSI Fraction Groups (Case Nos. 18-0794G, 18-0911G, and 18-0912G) ***and*** the Board's EJR of the DSH Part C Days – Medicare/SSI Fraction issue in individual Case No. 18-1099. The 4 individual cases remain open as other issues remain in each appeal. Case Nos. 15-1347, 15-0720 and 17-0347 are scheduled for hearing on October 19, 2021. Case No. 18-1099 is not yet scheduled for hearing. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877 upon final disposition of the appeals.

Board Members Participating:

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For the Board:

7/27/2021

X Clayton J. Nix

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Chair
Signed by: PIV

cc: Wilson C. Leong, Federal Specialized Services

[1] Specifically, *Allina* states "the statute unambiguously requires that Part C days be counted in one fraction or the other (a Part C-enrolled individual is either eligible for Medicare Part A, or not)." 746 F.3d at 1108.

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RE: ***Own Motion Expedited Judicial Review***
Discovery Healthcare Consulting Group 2011-2014 LVPA Appeals
Case Nos. 14-3006G, 14-4019G, 16-1059G, 16-2520

Dear Messrs. Morris and Leong,

The Provider Reimbursement Review Board ("Board") has reviewed the records in the four (4) above-referenced appeals involving fiscal years 2011 to 2014. On May 17, 2021, the Board requested comments from the parties because it is considering, on its own motion, whether expedited judicial review ("EJR") is appropriate. Having received each party's comments, the decision of the Board is set forth below.

Pertinent Facts:

In these cases, the Providers receive Medicare reimbursement under the inpatient prospective payment system ("IPPS") and, during the relevant years at issue, also qualified for an additional payment under IPPS known as Low Volume Payment Adjustment ("LVPA"). For the fiscal years at issue, CMS used MedPAR data in determining whether a hospital qualified for an LVPA. In this regard, 42 C.F.R. § 412.101(b)(2)(ii) (2014) states:[1]

> (2) In order to qualify for this adjustment [*i.e.*, an LVPA], a hospital ***must*** *meet the following criteria*: . . .
>
> (ii) For FY 2011 through FY 2014, and the portion of FY 2015 before April 1, 2015, a hospital must have fewer than 1,600 Medicare discharges, as defined in paragraph (a) of this section, during the fiscal year, *based on the hospital's Medicare discharges from the most recently available MedPAR data as determined by CMS*, and be located more than 15 road miles, as defined in paragraph (a) of this section, from the nearest ''subsection (d)'' (section 1886(d) of the Act) hospital.[2]

[1] As discussed *infra*, the policy was codified in the regulation in 2011, but the regulation as amended in 2014 includes the comprehensive requirements for all of the fiscal years at issue.
[2] (Emphasis added.)

For the fiscal years at issue, the number of discharges recorded for a provider not only determined whether it *qualified* for an LVPA, but also directly impacted the *amount* of its LVPA, with a lower number of discharges generally corresponding to a higher LVPA.[3] The Providers are appealing whether CMS' "use of a Hospital's Medicare discharges from the most recently available (*i.e.*, two-year-old) Medicare Provider Analysis and Review (MEDPAR) data complies with the statutory requirement that a hospital qualify for [an LVPA] for a fiscal year based on contemporaneous discharges from the same fiscal year, where CMS' use of two-year-old MEDPAR data results in a lower computed LVPA amount."[4]

CMS' LVPA policy to use MedPAR data was initially set forth in the FY 2011 IPPS Final Rule[5] and codified at 42 C.F.R. § 412.101(b)(ii).[6] The Providers are challenging the policy by appealing the impact it had on their Notices of Program Reimbursement ("NPRs"). The Providers argue that, in 2010, CMS changed the source it uses to calculate discharges (when evaluating a hospital's LVPA) from "the hospitals' most recently submitted cost report" to "the most recently available MEDPAR data as determined by CMS."[7] They note that, as a result of this policy change, CMS based FYs 2011-2013 on updates of the hospitals' FY 2009-2011 MedPAR data, respectively; and that, in 2014, CMS continued to apply this policy by using FY 2012 MedPAR data.[8]

More importantly, the Providers claim their LVPA computation was negatively impacted because, for the fiscal years at issue, the number of discharges credited to a provider not only determined if they qualified for a LVPA, but additional percentage increases to the LVPA were provided on a sliding scale for providers with a lower number of discharges.[9] Specifically, §§ 3125 and 10314 of the Patient Protection and Affordable Care Act ("ACA")[10] amended 42 U.S.C. 1395ww(d)(12)(D) to introduce a linear sliding scale in determining an LVPA for a qualifying provider:

> (D) TEMPORARY APPLICABLE PERCENTAGE INCREASE.—For discharges occurring in fiscal years 2011 and 2012, the Secretary shall determine an applicable percentage increase for purposes of subparagraph (A) using a continuous linear sliding scale ranging from 25 percent for low volume hospitals with 200 or fewer discharges of individuals entitled to, or enrolled for, benefits under part A in the fiscal year to 0 percent for low-volume hospitals with greater than [1,600] discharges of such individuals in the fiscal year.[11]

[3] *See* 42 U.S.C. §1395ww(d)(12)(D); 42 C.F.R. §412.101(c).
[4] Provider Final Position Paper at 2.
[5] 75 Fed. Reg. 50241 (Aug. 16, 2010).
[6] *See also* 78 Fed. Reg. 50496 (Aug. 19, 2013); 79 Fed. Reg. 15024 (Mar. 18, 2014); 79 Fed. Reg. 49854 (Aug. 22, 2014).
[7] Provider Final Position Paper at 6 (citing 75 Fed. Reg. 50241 (Aug. 16, 2010) (copy at Exhibit P-7)).
[8] *Id.* at 6-7 (citing 79 Fed. Reg. 15024 (Mar. 18, 2014) (copy at Exhibit P-8)).
[9] *Id.* at 2-6 (citing 42 U.S.C. §1395ww(d)(12)(D); 42 C.F.R. §412.101(b), (c)).
[10] Pub. L. 111-148, 124 Stat. 119, 425, 944 (2010).
[11] *Id.* Section 3125 capped the allowable number of discharges at 1,500 in order to qualify for an LVPA, but § 10314 increased that number to 1,600. Furthermore, while the ACA implemented this sliding scale for FYs 2011 and 2012, subsequent legislation extended it to the other fiscal years at issue in this case. *See, e.g.*, American Taxpayer

Soon thereafter, the Secretary set forth a continuous linear sliding scale equation to determine the LVPA for low-volume hospitals of more than 200 and less than 1,600 discharges and modified 42 C.F.R. § 412.101(c)(2) accordingly:[12]

> (c) *Determination of the adjustment amount*. The low-volume adjustment for hospitals that qualify under paragraph (b) of this section is as follows for the applicable fiscal year: . . . .
>
> (2) For FY 2011 and FY 2012, the adjustment is as follows:
>
> (i) For low-volume hospitals with 200 or fewer Medicare discharges (as defined in paragraph (a) of this section), the adjustment is an additional 25 percent for each Medicare discharge.
>
> (ii) For low-volume hospitals with Medicare discharges (as defined in paragraph (a) of this section) of more than 200 and fewer than 1,600, the adjustment for each Medicare discharge is an additional percent calculated using the formula [(4/14)—(number of Medicare discharges/5600)]. The "number of Medicare discharges" is determined as described in paragraph (b)(2)(ii) of this section.[13]

The Secretary later updated the regulation to reflect the extension of this linear sliding scale beyond FYs 2011 and 2012 to encompass up to the portion of FY 2015 before April 1, 2015.[14] Thus, for providers that qualified for an LVPA, the lower the discharges (so long as they exceed 200), the higher the LVPA.

The Providers contend that, while the law governing LVPAs, 42 U.S.C. § 1395ww(d)(12)(A), "does not specify the source CMS must use to compute hospital discharges," it "does appear to require to require that the LVPA payment calculated for a fiscal year should relate to the discharges occurring in the same fiscal year and not an earlier fiscal year."[15] In further support of the contention that using older MedPAR data for 2011 through 2014 is less accurate and violates the statute's requirements, the Providers note that, prior to 2010, CMS used discharges from the applicable year's cost report.[16]

Relief Act of 2012, Pub. L. 112-240, § 605, 126 Stat. 2313, 2349 (2013); Pathway for SGR Reform Act, Pub. L. 113-67, § 1105, 127 Stat. 1165, 1197 (2013); Protecting Access to Medicare Act of 2014, Pub. L. 113-93, § 105, 128 Stat. 1040, 1042 (2014).

[12] 75 Fed. Reg. 50014, 50239-50725 (Aug. 16, 2010).

[13] 42 C.F.R. § 412.101(c)(2) (2011). The regulation was also updated to reflect the extension of this linear sliding scale beyond FYs 2011 and 2012. *See* 79 Fed. Reg. 49853, 49998-50001 (Aug. 22, 2014).

[14] *See* 79 Fed. Reg. 49853, 49998-50001 (Aug. 22, 2014).

[15] Provider Final Position Paper at 7.

[16] *Id*.

Ultimately, the Providers contend that "patient discharge data used to determine low volume qualification for a given fiscal year should be based on source data from the same fiscal year."[17] MedPAR data from two years prior is not contemporaneous and, more specifically, not representative of the actual patient discharges occurring during the applicable fiscal year.

The Medicare Contractor argues that the Board should uphold the Medicare Contractor's LVPA calculations at issue in these appeals because it simply followed the methodology that (as the Providers acknowledge) was promulgated and announced via two Federal Register notices.

Own Motion EJR and Comments:

The Providers did not request EJR, but the Board may initiate its own motion for EJR if it makes a finding that is has jurisdiction to conduct a hearing on the issue and that it lacks the authority to decide a legal question relevant to the issue.[18] In its May 17, 2021 letter requesting comments, the Board found that it has jurisdiction over the providers in each of the four appeals at issue.

In the May 17, 2021 letter, the Board noted that the following legal question was presented in the Providers' final position paper:

> whether CMS' "use of a Hospital's Medicare discharges from the most recently available (i.e., two-year-old) Medicare Provider Analysis and Review (MEDPAR) data complies with the statutory requirement that a hospital qualify for Low Volume Payment Adjustment (LVPA) for a fiscal year based on contemporaneous discharges from the same fiscal year, where CMS' use of two-year-old MEDPAR data results in a lower computed LVPA amount."[19]

The Board noted that 42 C.F.R. § 412.101(c)(2)(ii) (2014) appeared to be the regulation used in calculating the Providers' LVPAs. Significantly, this regulation specifies that "[t]he 'number of Medicare discharges' is determined as described in paragraph (b)(2)(ii) of this section" which in turn states the determination of its specific number of Medicare discharges be "based on the hospital's Medicare discharges from the most recently available MedPAR data as determined by CMS." Accordingly, based on the Providers' final position paper, the Board concluded in the May 17, 2021 letter that the Providers are ultimately challenging *the mandate in 42 C.F.R. § 412.101(c)(2)(ii)* that, for the years at issue, its specific number of Medicare discharges as used in the sliding scale equation for the LVPA calculation must be determined under § 412.101(b)(2) (*i.e.*, must be determined "based on the hospital's Medicare discharges from the most recently available MedPAR data as determined by CMS").

On June 6, 2021, the Providers' Representative submitted its comments with regard to the proposed EJR. The Providers' Representative did not dispute the Board's assessment of the

[17] *Id.* at 8.
[18] 42 C.F.R. § 405.1842(c)(1).
[19] Provider Final Position Paper at 2.

Provider's appeal and the regulation in dispute; but rather, he agreed that the Board has jurisdiction and that the Board cannot grant the relief sought by the Providers. Likewise, the Medicare Contractor submitted its comments to the Board on July 13, 2021, and did not object to the Provider's position that the Board is without the authority to decide the issue in these cases.

Board's Decision Regarding EJR:

The Board finds that:

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

2) Based upon the participants' assertions regarding the Providers' Low Volume Payment Adjustment, 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 mandate in 42 C.F.R. § 412.101(c)(2)(ii) that, for the years at issue, the specific number of Medicare discharges as used in the sliding scale equation for the LVPA calculation must be determined under § 412.101(b)(2) (*i.e.*, per (b)(2)(ii), must be determined "based on the hospital's Medicare discharges from the most recently available MedPAR data as determined by CMS") is valid.

Accordingly, the Board finds that the Providers' challenge of the validity of 42 C.F.R. § 412.101(c)(2)(ii) (2014) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants expedited judicial review on its own motion for the issue and the subject years. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute, the Board hereby closes each of the four cases.

Board Members Participating:

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Gregory H. Ziegler, CPA
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Susan A. Turner, Esq.
Kevin D. Smith, CPA

For the Board:

7/27/2021

X Clayton J. Nix

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

Enclosures: Schedules of Providers

cc: Bill Tisdale, Novitas Solutions, Inc. (J-H)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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RE: ***Jurisdictional Challenge***
Hartford Hospital (Prov. No. 07-0025)
FYE 09/30/2008
Case No. 14-3544

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the jurisdictional documents in the above referenced appeal. Set forth below is the Board's determination.

Pertinent Facts:

On May 21, 2014, the Board received Provider's Individual Appeal Request appealing their December 26, 2013 Notice of Program Reimbursement ("NPR") for fiscal year ending September 30, 2008. The initial appeal contained nine (9) issues.

- Issue 1: Disproportionate Share Hospital (DSH) Supplemental Security Income (SSI) Percentage (Provider Specific)
- Issue 2: DSH SSI (Systemic Errors)[1]
- Issue 3: DSH Medicaid Eligible Days[2]
- Issue 4: DSH Medicare Part C Days – SSI Fraction[3]
- Issue 5: DSH Medicare Part C Days – Medicaid Fraction[4]
- Issue 6: DSH – Medicaid Eligible Labor Room Days[5]
- Issue 7: DSH Dual Eligible Days – SSI Fraction[6]
- Issue 8: DSH Dual Eligible Days – Medicaid Fraction[7]
- Issue 9: DSH – Medicaid Eligible Patient Days - Connecticut State Administered General Assistance[8]

All issues except Issue 1 have been transferred to group appeals or withdrawn. The sole issue remaining in the appeal is Issue 1, the DSH/SSI Provider Specific issue.

[1] The Provider transferred this issue to Group Case No. 15-1154GC in a letter dated 01/16/2015.
[2] The Provider withdrew this issue in a letter dated 07/13/2018. *See* Exhibit C-3.
[3] The Provider transferred this issue to Group Case No. 15-1155GC in a letter dated 01/16/2015.
[4] The Provider transferred this issue to Group Case No. 15-1156GC in a letter dated 01/16/2015.
[5] The Provider withdrew this issue by way its Preliminary Position Paper dated 01/28/2015. See Exhibit C-2.
[6] The Provider transferred this issue to Group Case No. 15-1175GC in a letter dated 01/16/2015.
[7] The Provider transferred this issue to Group Case No. 15-1175GC in a letter dated 01/16/2015.
[8] The Provider transferred this issue to Group Case No. 13-3415G in a letter dated 09/16/2014.

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

> The provider contends that its SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.
>
> The Provider *is seeking SSI data* from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[9]

The Provider's appeal request describes Issue 2, the DSH/SSI issue as follows:

> The Providers contend that the Lead MAC's determination of Medicare Reimbursement for the DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww(d)(5)(F)(i). The Providers further contend that the SSI percentages calculated by [CMS] and used by the Lead MAC to settle their Cost Report does not address all of the deficiencies descried in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37, 44 (D.D>C. 2008) and incorporates a new methodology inconsistent with the Medicare statute.
>
> The Providers challenge their SSI percentages based on the following reasons:
>
> 1. *Availability of MEDPAR and SSA records*,
> 2. Paid days vs. Eligible Days,
> 3. *Not in agreement with provider's records*,
> 4. Fundamental problems in the SSI percentage calculation,
> 5. Covered days vs. Total days and
> 6. Failure to adhere to required notice and comment rulemaking procedures.[10]

[9] Individual Appeal Request, Issue 1 (emphasis added and citation omitted).
[10] *Id.* at Issue 2 (emphasis added).

The Provider transferred Issue 2 to a common issue related party ("CIRP") group appeal for DSH/SSI Systemic Errors under Case No. 15-1154GC. The group issue statement for Case No. 15-1154GC is virtually identical to the above description of Issue 2.

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

> The Provider contends that the Lead MAC's determination of Medicare Reimbursement for DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww(d)(5)(F)(i). The Provider contends that the SSI percentages calculated by [CMS] and used by the Lead MAC to settle their Cost Report was incorrectly computed because of the following reasons:
>
> **Provider Specific**
>
> The Provider contends that its' [*sic*] SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation. This is based on certain data from the State of Connecticut and the Provider that does not support the SSI percentage issued by CMS.
>
> The Provider has worked with the State of Connecticut and has learned that similar to *Loma Linda Community Hospital v. Dept. of Health and Human Servs.*, No. CV-94-0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records.
>
> *The Provider is seeking* Medicare Provider Analysis and Review ("MEDPAR") database, HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000, from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. *See* 65 Fed. Reg. 50,548 (2000). The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' [*sic*] SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction.[11]

[11] (Underline emphasis added.)

The only exhibit included with the final position paper that relates to Issue 1 was Exhibit 2. This exhibit estimates that Issue 1 impacts the SSI percentage by +0.25% but does not include any explanation or basis for this estimate.

On July 1, 2021, the Board received a jurisdictional challenge filed on behalf of the Medicare Contractor which argued that the Board lacks jurisdiction over the DSH/SSI Provider Specific issue because it is duplicative of the issue which was transferred to Case No. 15-1154GC. They also argue that the decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election, not an appealable Medicare Contractor determination, and since the Provider did not request an SSI realignment, appealing this issue is premature since there was no final determination.[12] The Provider did not respond to the Jurisdictional Challenge.

Board Decision

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

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

A. First Aspect of Issue 1

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH SSI Percentage (Systemic Errors) issue that was transferred to Group Case No. 15-1154GC.

The Board finds that the first aspect of Issue 1 (the DSH SSI Percentage (Provider Specific) issue) in this appeal is duplicative of Issue (the DSH SSI Percentage (Systemic Errors) issue) that was transferred to Case No. 15-1154GC. The first aspect of Issue 1 in the present appeal concerns "whether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital Calculation."[13] The Provider's legal basis for this aspect of Issue 1 is simply that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[14] Similarly, the Provider argues that "its SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ."

[12] *Medicare Administrative Contractor's Jurisdictional Challenge* (July 1, 2021).
[13] Individual Appeal Request, Issue 1.
[14] *Id.*

and it ". . . specifically disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[15] Issue 2 transferred to the group under Case No. 15-1154GC similarly alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F) and 42 C.F.R. § 412.106. Thus, the Board finds that the first aspect of Issue 1 in this appeal is duplicative of Issue 2 transferred to Case No. 15-1154GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (2013), the Board dismisses this aspect of the DSH/SSI Percentage (Provider Specific) issue.

In making this finding, the Board further notes that CMS regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, as this provider is part of a chain, the Provider would be required by the CIRP regulations to pursue that challenge with related providers in a CIRP group appeal and, to that end, is pursuing that issue in Case No. 15-1154GC. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[16] Provider is misplaced in referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 15-1154GC.

To this end, the Board also reviewed the Provider's Final Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from Issue 2 but instead refers to systemic *Baystate* data matching issues that are the subject of Issue 2. Moreover, the Board finds that the Provider's Final Position Paper failed to comply with the Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions."[17] Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" in its Final Position Paper and include *all* exhibits. The Board recognizes that 7+ years earlier, the Provider stated in its May 21, 2014 appeal that it was "seeking *SSI data* from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in

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[15] *Id.*

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

[17] (Emphasis added.) Similarly, the Commentary at Board Rule 25 states that position papers "are expected to present ***fully developed*** positions of the parties" and Board Rule 25.3 states: "Parties should file with the Board a *complete* preliminary position paper *with a* ***fully developed*** *narrative* (Rule 23.1), ***all*** *exhibits* (Rule 23.2), 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."

their determination of the SSI percentage."[18] However, the Provider simply states again it is "seeking [MEDPAR 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" but fails to give any update on those efforts over the past 7+ years when it filed its final position paper on June 2, 2021 in direct violation of Board Rule 25.2.2 (as applied via Board Rule 27.2):

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

Similarly, the Provider references "certain data from the State of Connecticut and the Provider that does not support the SSI percentage issued by CMS" as the basis for its broad allegation that "CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation." But fails to fully develop what the alleged data establishes, much less enter the alleged data into the record for examination by the opposing party or the Board.

Accordingly, the Board must find that Issues 1 and 2 are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (2015), the Board dismisses this component of the DSH SSI Percentage (Provider Specific) issue. In the alternative, the Board would dismisses Issue 1 due to the Provider's failure to properly brief the issue in its Final Position Paper in compliance with Board Rules.

B. Second Aspect of Issue 1

The second aspect of the DSH SSI Percentage (Provider Specific) issue involves the Provider's request to preserve its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period. Under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." Without this written request, the Medicare Contractor cannot issue a final determination from which the Provider can be dissatisfied with for appealing purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding DSH SSI Percentage realignment. Accordingly, the second aspect of Issue 1 is premature and the Board hereby dismisses it from Case No. 14-3544.

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[18] (Emphasis added.)

In summary, as all other issues have been transferred or withdrawn, Issue 1 is the sole remaining issue in this case and the Board hereby dismisses Issue 1 in its entirety. In this regard, the Board recognizes that the Provider briefed Issue 3, the Medicaid Eligible days issue, in its Final Position Paper filed on June 2, 2021; however, the Board's records reflect that the Provider withdrew this issue by letter dated July 13, 2018 and the Board has not reinstated this issue.[19] Accordingly, as Issue 1 was the last issue remaining in the appeal, the Board hereby closes the case and removes it from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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Robert A. Evarts, Esq.
Susan A. Turner, Esq.
Kevin D. Smith, CPA

For the Board:

7/28/2021

X Clayton J. Nix

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

cc: Wilson C. Leong, Esq., Federal Specialized Services
Danelle Decker, National Government Services, Inc. (J-K)

[19] Indeed, the Provider has not requested reinstatement and the 3-year time period in which the Board could potentially reinstate the issue has since tolled.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

James C. Ravindran
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RE: ***Jurisdictional Decision***
Hartford Hospital (Prov. No. 07-0025)
FYE 09/30/2010
Case No. 15-1831

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the jurisdictional documents in the above-referenced appeal. Set forth below is the Board's determination to dismiss the issue.

Pertinent Facts:

On March 16, 2015, the Board received Provider's Individual Appeal Request appealing their September 16, 2014 Notice of Program Reimbursement ("NPR") for fiscal year ending September 30, 2010. The initial appeal contained eight (8) issues.

- Issue 1: Disproportionate Share Hospital (DSH) Supplemental Security Income (SSI) Percentage (Provider Specific)
- Issue 2: DSH SSI Percentage[1]
- Issue 3: DSH Medicare Part C Days – SSI Fraction[2]
- Issue 4: DSH Dual Eligible Days – SSI Fraction[3]
- Issue 5: DSH – Medicaid Eligible Days[4]
- Issue 6: DSH Medicare Part C Days – Medicaid Fraction[5]
- Issue 7: DSH Dual Eligible Days – Medicaid Fraction[6]
- Issue 8: DSH – Medicaid Eligible Patient Days - Connecticut State Administered General Assistance[7]

All issues *except* Issue 1 have been transferred to group appeals or withdrawn. The issue remaining in the appeal is Issue 1, the DSH/SSI Provider Specific issue.

[1] The Provider transferred this issue to Group Case No. 15-2384G in a letter dated 11/02/2015. See Exhibit C-2.
[2] The Provider transferred this issue to Group Case No. 15-2387G in a letter dated 11/02/2015. See Exhibit C-2.
[3] The Provider transferred this issue to Group Case No. 15-2385G in a letter dated 11/02/2015. See Exhibit C-2.
[4] The Provider withdrew this issue in a letter dated 07/13/2018. See Exhibit C-4.
[5] The Provider transferred this issue to Group Case No. 15-2388G in a letter dated 11/02/2015. See Exhibit C-2.
[6] The Provider transferred this issue to Group Case No. 15-2386G in a letter dated 11/02/2015. See Exhibit C-2.
[7] The Provider transferred this issue to Group Case No. 14-4130G in a letter dated 09/29/2015. See Exhibit C-3.

In the appeal request, Provider summarizes Issue 1 (the DSH/SSI – Provider Specific issue) as follows:

> The provider contends that its SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.
>
> The Provider *is seeking SSI data* from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[8]

he Provider's appeal request describes Issue 2, the DSH/SSI issue as follows:

> The Providers contend that the Lead MAC's determination of Medicare Reimbursement for the DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww(d)(5)(F)(i). The Providers further contend that the SSI percentages calculated by [CMS] and used by the Lead MAC to settle their Cost Report does not address all of the deficiencies descried in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37, 44 (D.D>C. 2008) and incorporates a new methodology inconsistent with the Medicare statute.
>
> The Providers challenge their SSI percentages based on the following reasons:
>
> 1. *Availability of MEDPAR and SSA records*,
> 2. Paid days vs. Eligible Days,
> 3. *Not in agreement with provider's records*,
> 4. Fundamental problems in the SSI percentage calculation,
> 5. Covered days vs. Total days and
> 6. Failure to adhere to required notice and comment rulemaking procedures.[9]

[8] Individual Appeal Request, Issue 1 (emphasis added and citation omitted).
[9] *Id.* at Issue 2 (emphasis added).

The Provider transferred Issue 2 to a common issue related party ("CIRP") group appeal for DSH/SSI Systemic Errors under Case No. 15-2384G. The group issue statement for Case No. 15-2384G is virtually identical to the above description of Issue 2.

On June 13, 2021, the Provider filed its final position paper and the following is the Provider's ***complete*** position on Issue 1 for the "Calculation of the SSI Percentage" that is set forth therein:

> The Provider contends that the Lead MAC's determination of Medicare Reimbursement for DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww(d)(5)(F)(i). The Provider contends that the SSI percentages calculated by [CMS] and used by the Lead MAC to settle their Cost Report was incorrectly computed because of the following reasons:
>
> **Provider Specific**
>
> The Provider contends that its' [*sic*] SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation. This is based on certain data from the State of Connecticut and the Provider that does not support the SSI percentage issued by CMS.
>
> The Provider has worked with the State of Connecticut and has learned that similar to *Loma Linda Community Hospital v. Dept. of Health and Human Servs.*, No. CV-94-0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records.
>
> The Provider is seeking Medicare Provider Analysis and Review ("MEDPAR") database, HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000, from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. *See* 65 Fed. Reg. 50,548 (2000). The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' [*sic*] SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction.[10]

[10] (Underline emphasis added.)

The only exhibit included with the final position paper that relates to Issue 1 was Exhibit 2. This exhibit estimates that Issue 1 impacts the SSI percentage by +0.25% but does not include any explanation or basis for this estimate.

On July 1, 2021, the Board received a jurisdictional challenge filed on behalf of the Medicare Contractor which argued that the Board lacks jurisdiction over Issue 1 (the DSH/SSI Provider Specific issue) because it is duplicative of the issue which was transferred to Case No. 15-2384G. They also argue that the decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election, not an appealable Medicare Contractor determination, and since the Provider did not request an SSI realignment, appealing this issue is premature since there was no final determination.[11]

Board Decision

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

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

A. First Aspect of Issue 1

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH SSI Percentage (Systemic Errors) issue that was transferred to Group Case No. 15-2384G.

The Board finds that the first aspect of Issue 1 (the DSH SSI Percentage (Provider Specific) issue) in this appeal is duplicative of Issue 2 (the DSH SSI Percentage (Systemic Errors) issue) that was transferred to Case No. 15-2384G. The first aspect of Issue 1 in the present appeal concerns "whether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital Calculation."[12] The Provider's legal basis for its DSH/SSI (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[13] Similarly, the Provider argues that "its SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly

[11] Medicare Administrative Contractor's Jurisdictional Challenge (July 1, 2021).
[12] Individual Appeal Request, Issue 1.
[13] *Id.*

computed . . . .” and it “. . . specifically disagrees with the [Medicare Contractor]’s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary’s Regulations.”[14]

The Provider’s Issue 2 which was transferred to the group under Case No. 15-2384G also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F) and 42 C.F.R. § 412.106. Thus, the Board finds that the first aspect of Issue 1 in this appeal is duplicative of Issue 2 in Case No. 15-2384G. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (Mar. 1, 2013), the Board dismisses this aspect of the DSH/SSI Percentage (Provider Specific) issue.

In making this finding, the Board further notes that CMS regulation interpretation for the SSI percentage is clearly not “specific” to only this provider. Rather, it applies to all SSI calculations and, to that end, is pursuing that issue as part of the group under Case No. 15-2384G. Further, any alleged “systemic” issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[15] Provider is misplaced in referring to Issue 1 as “Provider Specific” and keeping it in an individual appeal. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged “provider specific” errors can be distinguished from the alleged “systemic” issue rather than being subsumed into the “systemic” issue appealed in Case No. 15-2384G.

To this end, the Board also reviewed the Provider’s Final Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from Issue 2 but instead refers to systemic *Baystate* data matching issues that are the subject of Issue 2. Moreover, the Board finds that the Provider’s Final Position Paper failed to comply with the Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers “to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties’ positions.”[16] Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged “errors” in its Final Position Paper and include *all* exhibits. The Board recognizes that 6+ years earlier, the Provider stated in its March 16, 2015 appeal that it was “seeking *SSI data* from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in

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[14] *Id.*

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

[16] (Emphasis added.) Similarly, the Commentary at Board Rule 25 states that position papers “are expected to present ***fully developed*** positions of the parties” and Board Rule 25.3 states: “Parties should file with the Board a *complete* preliminary position paper *with a* ***fully developed*** *narrative* (Rule 23.1), ***all*** *exhibits* (Rule 23.2), 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.”

their determination of the SSI percentage."[17] However, the Provider simply states again it is "seeking [MEDPAR 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" but fails to give any update on those efforts over the past 6+ years when it filed its final position paper on June 13, 2021 in direct violation of Board Rule 25.2.2 (as applied via Board Rule 27.2):

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

Similarly, the Provider references "certain data from the State of Connecticut and the Provider that does not support the SSI percentage issued by CMS" as the basis for its broad allegation that "CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation." But fails to fully develop what the alleged data establishes, much less enter the alleged data into the record for examination by the opposing party or the Board.

Accordingly, the Board must find that Issues 1 and 2 are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (2015), the Board dismisses this component of the DSH SSI Percentage (Provider Specific) issue. In the alternative, the Board would dismisses Issue 1 due to the Provider's failure to properly brief the issue in its Final Position Paper in compliance with Board Rules.

B. Second Aspect of Issue 1

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

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In summary, as all other issues have been transferred or withdrawn, Issue 1 is the sole remaining issue in this case and the Board hereby dismisses Issue 1 in its entirety. Accordingly, as Issue 1

[17] (Emphasis added.)

was the last issue remaining in the appeal, the Board hereby closes the case and removes it from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

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7/28/2021

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RE: ***Jurisdictional Determination***
John C. Lincoln Health Network 2011 DSH-SSI Part C Days CIRP Group
Case No. 14-3801GC

Dear Messrs. Taylor and Bloom:

The above-referenced common issue related party ("CIRP") group appeal for the John C. Lincoln Health Network ("Lincoln") includes a challenge to the inclusion of Medicare Part C days in the Medicare fraction of the disproportionate share ("DSH") percentage and/or the exclusion of Medicare Part C days for patients who are dually eligible for Medicaid from the Medicaid fraction of the DSH percentage, for patient discharges *before* October 1, 2013. As set forth below, the Board finds the above Lincoln CIRP group case is duplicative of another Lincoln CIRP group case, and dismisses the appeal.

Background:

Case No. 14-3801GC was established based on the Group Representative's Request for Hearing filed on July 16, 2014 and relating to original Notices of Program Reimbursement ("NPR") issued in 2014.[1] The providers in Case NO. 14-3801GC appealed the following issue:

> The Provider disputes the inclusion of MA days in the SSI ratio and requests these days along with the additional identified dual-eligible Medicare/Medicaid days should be included in the Medicaid ratio [emphasis added] Since this issue impacts both the SSI ratio and the Medicaid ratio, the Provider is appealing both….[2]

Case No. 14-3801G consists of only two Providers: John C. Lincoln – North Mountain (Prov. No. 03-0014); and John C. Lincoln – Deer Valley (Prov. No. 03-0092).

The following year, on February 25, 2015, Quality Reimbursement Services, Inc. ("QRS") established a separate Lincoln CIRP group appeal under Case No. 15-1625GC entitled "QRS

[1] Providers' Request for Appeal in Case No. 14-3801GC (Jul. 16, 2014).
[2] *Id*. at Tab 3, Issue Statement.

John C. Lincoln HN 2011 Medicaid Fraction Medicare Managed Care Pt. C Days CIRP Group." The group issue statement in Case No. 15-1625GC reads, in part:

> The Provider contends that the MAC's treatment of the MA days is not in accordance with the DSH statute at 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II). The MAC failed to include patients days applicable to MA patients who were also eligible for Medicaid in the Medicaid fraction of the DSH payment adjustment, and instead included those days in the SSI or Medicare fraction.[3]

On June 26, 2019, QRS requested EJR in Case No. 15-1625GC, for the following issue:

> [W]hether Medicare Advantage Days ("Part C Days") should be removed from the disproportionate share hospital adjustment ("DSH Adjustment") Medicare fraction and added to the Medicaid Fraction.[4]

Subsequently, on July 18, 2019, the Board granted EJR in Case No. 15-1625GC and closed the appeal. There was one Provider in the CIRP group appeal at the time the Board granted EJR and closed the appeal: John C. Lincoln – North Mountain Hospital (Prov. No. 03-0014) which is also a participant in Case No. 14-3801GC.

Board's Analysis and Decision:

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

> Two or more providers under common ownership or control that wish to appeal to the Board a specific matter at issue that involves a question of fact or interpretation of law, regulations, or CMS Rulings that is common to the providers, and that arises in cost reporting periods that end in the same calendar year, and for which the amount in controversy is $50,000 or more in the aggregate, ***must*** *bring the appeal as a group appeal*.[5]

Subsection (e) requires that the group provider provide notice that the group is fully formed and complete.[6] Once the group is certified as complete, restrictions are placed on the ability for additional providers under common ownership:

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[3] Providers' Request for Appeal in Case No. 15-1625GC (Fe. 25, 2015).
[4] Request for Expedited Judicial Review (Jun. 26, 2019), PRRB Case no. 09-1980GC; *Id*., PRRB Case No. 15-1625GC.
[5] 42 C.F.R. § 405.1837(b)(1) (emphasis added).
[6] 42 C.F.R. § 405.1837(e)(1).

> When the Board has determined that a group appeal brought under paragraph (b)(1) of this section is fully formed, absent an order from the Board modifying its determination, *no other provider under common ownership or control may appeal to the Board the issue that is the subject of the group appeal* with respect to a cost reporting period that falls within the calendar year(s) covered by the group appeal.[7]

On June 26, 2020, QRS certified that the Lincoln CIRP group under Case No. 15-1625GC was complete and simultaneously requested EJR. Pursuant to this certification, any additional Lincoln providers outside of this CIRP group for the same issue and year would be part of a duplicate case, violating the CIRP regulations at 405.1837(b)(1) and (e). As the CIRP group under Case No. 14-3801GC is for the *same* chain, for the *same* issue (Part C Days), ***and*** for the *same* fiscal year (2011), any providers within Case No. 14-3801GC are in violation of 405.1837(b)(1) and (e), and thus must be dismissed.

Furthermore, the Board notes that the group EJR request for which the Board previously granted EJR clearly encompassed the ***complete*** Part C DSH issue, *i.e.*, both the Medicare and Medicaid fractions. Per the 2014 holding of the D.C. Circuit in *Allina Health Servs. v. Sebelius* ("*Allina*"),[8] the DSH statute at 42 U.S.C. § 1395ww(d)(5)(F)(vi) "*unambiguously requires*" that Part C days be included in either the SSI fraction or Medicaid fraction.[9] This holding is controlling precedent for the interpretation of 42 U.S.C. § 1395ww(r)(3) because the Providers could bring suit in the D.C. Circuit.[10] Thus, the disposition of the DSH Part C Days – Medicare/SSI Fraction issue dictates the disposition of the DSH Part C Days – Medicaid Fraction issue, as *Allina* indicates Part C days must be counted in one fraction or the other.

As such, the Board dismisses Case No. 14-3801GC because the DSH Part C Days issue in this CIRP group is duplicative of the issue that was disposed of through the EJR of Case No. 15-1625GC. The Board recognizes that Case No. 14-3801GC had more participants than Case No. 15-1625GC. However, the Representative in Case No. 15-1625GC certified that Case No. 15-1625GC was complete (i.e., there were no other Lincoln provider that had the same issue for the same year) and the Board disposed of the CIRP group by granting EJR. Accordingly, the Board further finds that Case No. 14-3801GC violated the CIRP regulations 42 C.F.R. § 405.1837(b)(1) and (e), and dismisses the CIRP group case in its entirety.

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[7] *Id*. (emphasis added).
[8] 746 F.3d 1102, 1108 (D.C. Cir. 2014).
[9] Specifically, *Allina* states "the statute unambiguously requires that Part C days be counted in one fraction or the other (a Part C-enrolled individual is either eligible for Medicare Part A, or not)." 746 F.3d at 1108.
[10] 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).

The Board hereby closes Case No. 14-3801GC and removes it from the Board's docket. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

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cc: Wilson Leong, FSS