DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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RE: ***EJR Determination***
Tampa General Hospital (Prov. No. 10-0128)
FYE 9/30/2009
Case No. 23-1438

Dear Ms. Webster:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request of Tampa General Hospital ("Tampa" or "Provider") and its request for expedited judicial review ("EJR") filed concurrently on June 9, 2023 to established the above-referenced individual appeal pertaining to Tampa's fiscal year ("FY") 2009. Set forth below is the decision of the Board to deny Tampa's EJR request and to dismiss Tampa's appeal.

Issue in Dispute

On June 9, 2023, Tampa filed its appeal request concerning the final rule that the Secretary of Health and Human Services ("Secretary") published in the June 9, 2023 Federal Register ("June 2023 Final Rule") as it pertains to Tampa's FY 2009 Medicare reimbursement.[1] Within minutes of filing its appeal request, Tampa filed a request for EJR.

The ***sole*** issue in this appeal is the proper treatment in the Medicare disproportionate share hospital ("DSH") calculation of days for patients who were enrolled in Medicare Advantage plans under Part C of the Medicare statute ("Part C days") in the aftermath of the *Allina* litigation discussed *infra*. Tampa contends that Part C days must be excluded in their entirety from the SSI fraction and those days must be included in the numerator of the Medicaid fraction (for patients eligible for Medicaid).[2]

Tampa is seeking EJR to challenge in Federal court the policy that the Secretary adopted in the June 2023 Final Rule which is being applied *retroactively* to certain periods prior to October 1, 2013. The Tampa estimates the amount in controversy as $1,230,772 for its FY 2009.[3]

[1] 88 Fed. Reg. 37772 (June 9, 2023).
[2] Issue Statement.
[3] 88 Fed. Reg. 37772 (June 9, 2023).

Statutory and Regulatory Background:

A. Medicare DSH Payment

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

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

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

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

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

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

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[4] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[5] *Id.*
[6] *See* 42 U.S.C. § 1395ww(d)(5).
[7] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[8] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[9] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[10] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[11] (Emphasis added.)
[12] 42 C.F.R. § 412.106(b)(2)-(3).

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

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

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

B. Establishment of Medicare Part C and Treatment of Part C Days in the DSH Calculation

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

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

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

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

> patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[16]

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

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

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

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

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

> *. . . We do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits*

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

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

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

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

There has been substantial litigation over whether enrollees in Part C plans are "entitled to benefits" under Medicare Part A when determining their placement in either the DSH Medicare or Medicaid fraction.

First, in 2011, the D.C. Circuit held that the Secretary's Part C policy in the FY 2005 IPPS Final Rule could not be applied retroactively for fiscal years 1999 through 2002, but did not address whether it could be applied to later years or whether the interpretation was reasonable.[26]

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[22] *Id.* (emphasis added).
[23] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[24] *Id*. at 47411.
[25] 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: "We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word 'or' with the word 'including' in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B)."); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff'd in part and rev'd in part*, 746 F. 3d 1102 (D.C. Cir. 2014).
[26] *Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1, 17 (D.C. Cir. 2011).

In 2014, the U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[27] vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.[28] In vacating the final rule, it reasoned that this deprived the public of adequate opportunity for notice and comment before the final rule was promulgated in 2004.[29] However, the Secretary has not acquiesced to that decision.

In 2013, the Secretary promulgated a new rule that would include Part C days in the Medicare fraction for fiscal years 2014 and beyond.[30] However, at that point, no new rule had been adopted for fiscal years 2004-2013 following the D.C. Circuit's decision in *Allina I* to vacate the 2004 rule. In 2014 the Secretary published Medicare fractions for fiscal year 2012 which included Part C days.[31] A number of hospitals appealed this action. In *Azar v. Allina Health Services* ("*Allina II*"),[32] the Supreme Court held that the Secretary did not undertake appropriate notice-and-comment rulemaking when it applied its policy to fiscal year 2012, despite having no formal rule in place.[33] There was no rule to vacate in this instance, and the Supreme Court merely affirmed the D.C. Circuit's decision to remand the case "for proceedings consistent with [its] opinion."[34] The Supreme Court did not reach the question of whether the policy to count Part C days in the Medicare fraction was impermissible or unreasonable.[35]

On August 6, 2020, the Secretary published a notice of proposed rulemaking to adopt a policy to include Part C days in the Medicare fraction for fiscal years prior to 2013.[36] On August 17, 2020, CMS issued CMS Ruling 1739-R stating that, as "CMS has announced its intention to conduct the rulemaking required by the Supreme Court's decision in Allina [II]":

> This Ruling provides notice that the Provider Reimbursement Review Board (PRRB) and other Medicare administrative appeals tribunals lack jurisdiction over certain provider appeals regarding the treatment of patient days associated with patients enrolled in Medicare Advantage plans in the Medicare and Medicaid fractions of the disproportionate patient percentage; this ruling applies only to appeals regarding patient days with discharge dates before October 1, 2013 that arise from Notices of Program Reimbursement (NPRs) that are issued before CMS issues a new final rule to govern

[27] 746 F. 3d 1102 (D.C. Cir. 2014).
[28] *Id*. at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").
[29] *Id.* at 2011.
[30] 78 Fed. Reg. 50496, 50614 (Aug. 19, 2013).
[31] *See Allina Health Services v. Price*, 863 F.3d 937, 939-940 (D.C. Cir. 2017).
[32] 139 S.Ct. 1804 (2019).
[33] *Id.* at 1817.
[34] *Id.*; *Allina Health Services v. Price*, 863 F.3d at 945.
[35] 139 S.Ct at 1814.
[36] 85 Fed. Reg. 47723 (Aug. 6, 2020).

> the treatment of patient days with discharge dates before October 1, 2013 or that arise from an appeal based on an untimely NPR under 42 U.S.C. 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for that fiscal year pre-dates the new final rule.[37]

The Secretary did not change the proposed rule and issued it in final on June 9, 2023.[38] *On the **same** day*, Tampa filed an appeal request with the Board to establish this case *and* a request for EJR to challenge this final rule. Relevant to the instant EJR Request, the June 2023 Final Rule provides the following guidance on the extent to which it is to be applied *retroactively*:

> [T]he Secretary has determined that it is in the public interest for CMS to adopt a retroactive policy for the treatment of MA patient days in the Medicare and Medicaid fractions through notice and comment rulemaking for discharges before October 1, 2013 (the effective date of the FY 2014 IPPS final rule). CMS must calculate DSH payments for periods that include discharges occurring before the effective date of the prospective FY 2014 IPPS final rule for hundreds of hospitals whose DSH payments ***for those periods are still open or have not yet been finally settled***, encompassing thousands of cost reports.[39]

Further, the June 2023 Final Rule provided the following clarification on the intent and purpose of CMS Ruling 1739-R:

> The Ruling was not intended to cut off appeal rights and will not operate to do so. It was intended to promote judicial economy by announcing HHS's response to the Supreme Court's decision in *Allina II*. After the Supreme Court made clear that CMS could not resolve the avowedly gap-filling issue of whether Part C enrollees are or are not "entitled to benefits under part A" for years before FY 2014 without rulemaking, HHS issued the Ruling [1739-R] so that providers would not need to continue litigating over DPP fractions that were issued in the absence of a valid rule. In other words, the point of the Ruling was to avoid wasting judicial, provider, and agency resources on cases in which the Secretary agreed that, after the Supreme Court's decision in *Allina II*, he could not defend such appeals of fractions issued in the absence of a valid regulation.[40]

[37] CMS Ruling 1739-R at 1-2.
[38] 88 Fed. Reg. 37772 (June 9, 2023).
[39] *Id.* at 37775 (emphasis added).
[40] 88 Fed. Reg. at 37788 (emphasis in original).

Tampa's Appeal Request and Request for EJR

A. Tampa's Appeal Request

Tampa's appeal request includes a "Statement of Jurisdiction" asserting that it has met the applicable statutory conditions for appeal because: (1) it "is dissatisfied with the Secretary's retroactive determination . . . in the June 9, 2023, *Federal Register*, to include part C days in the SSI fraction and to exclude those days from the Medicaid fraction of hospitals' DSH payment adjustments under section 1395ww(d)(5)(F) of the statue"; and (2) "the estimated amount in controversy for this appeal exceeds $10,000."[41]

The statement of issue included in Tampa's appeal request describes the issue in this appeal as concerning the proper treatment in the Medicare DSH calculation of days for Medicare Part C patients in the aftermath of the *Allina* litigation. Tampa contends that the Part C days must be included in the numerator of the Medicaid fraction and excluded from the numerator and denominator of the SSI fraction.

Tampa characterizes the relevant background facts as follows:

1. In the FY 2005 IPPS Final Rule, CMS first announced a policy change to count Part C days in the SSI fraction and to exclude those days from the numerator of the Medicaid fraction effective October 1, 2004.

2. In *Allina I*, the D.C. Circuit vacated that policy change.

3. In *Allina II*, the Supreme Court affirmed a D.C. Circuit decision that the Secretary's continued application of the same Part C days policy from the FY 2005 IPPS Final Rule in the 2012 SSI fraction published in 2015 was procedurally invalid because 42 U.S.C. § 1395hh(a)(2) required the Secretary to adopt that policy through notice-and-comment rulemaking. The Supreme Court's decision "did not address the D.C. Circuit's alternate ruling that the readopted policy was also invalid under 42 U.S.C. § 1395hh(a)(4) because the Secretary failed to engage in notice-and-comment rulemaking and the policy could not 'take effect' under the terms of the statute until after proper notice-and-comment rulemaking."[42]

4. In the June 2023 Final Rule, CMS adopted the same Part C days policy that had been vacated by *Allina I* and made it retroactive for periods prior to October 1, 2013.

Based on the above, Tampa maintains that the retroactive re-adoption of the Part C days policy in the June 2023 Final Rule "is substantively and procedurally invalid and must be set aside because it was taken without observance of procedure required by law, and it is otherwise contrary to law, arbitrary and capricious, an abuse of discretion, and unsupported by substantial

[41] Appeal Request, Statement of Jurisdiction (citations omitted).
[42] Appeal Request, Statement of Issue (citing to 139 S. Ct. at 1816).

evidence."[43]

B. Tampa's Request for EJR

Tampa has requested EJR of the "post-*Allina* retroactive Part C policy issue" because it believes it has met the requirements for a hearing before the Board, but the Board lacks the authority to decide the substantive and procedural validity of the June 2023 Final Rule.[44]

Tampa asserts that the Board has jurisdiction because:

1. "Here, the Provider is dissatisfied with the Secretary's retroactive determination (for periods prior to October 1, 2013), in the [June 2023 Final Rule] to include part C days in the SSI fraction and to exclude those days from the Medicaid fraction of hospitals' DSH payment adjustments under section 1395ww(d)(5)(F) of the statue."

2. "[T]he Provider filed its appeal within 180 days of publication of the Secretary's final determination in the *Federal Register*, and the impact of this appeal exceeds $10,000."

3. "CMS Ruling 1739-R, providing for remand of certain appeals of the Part C days issue for periods prior to October 1, 2013, does not on its face apply to this appeal because that Ruling 'applies only to appeals regarding patient days with discharge dates before October 1, 2013 that arise from Notices of Program Reimbursement (NPRs) that are issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013.'"[45]

In requesting EJR, Tampa seeks a determination that the Part C days regulation for periods prior to October 1, 2013 is invalid, and that the Part C days should be included in the Medicaid fraction instead of the Medicare fraction.[46] Specifically, Tampa describes the basis for its EJR request as follows:

> The Provider contends that the new, post-*Allina* retroactive part C days rule is substantively and procedurally invalid and must be set aside because it was adopted without observance of procedure required by law, and it is otherwise contrary to law, arbitrary and capricious, an abuse of discretion, and unsupported by substantial evidence.[47]

Tampa believes EJR is appropriate because the Board is bound by this regulation,[48] and lacks the authority to provide the relief requested.

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[43] *Id.* (referencing 4 U.S.C. § 706(2)).
[44] Provider's Petition for Expedited Judicial Review, 10 (June 9, 2023).
[45] *Id*. at 11 (quoting Ruling at 2).
[46] *Id.* at 12.
[47] *Id.* at 1.
[48] 42 C.F.R. § 405.1867.

C. Medicare Contractor's Response

The Medicare Contractor filed an *untimely* response to the EJR Request on June 29, 2023.[49] It argues the Board has no jurisdiction over this appeal because Tampa has not demonstrated the statutorily required dissatisfaction over a final determination. The Medicare Contractor points out that 42 U.S.C. § 1395oo(a)(1)(A) requires a provider to be "dissatisfied with a final determination of the Secretary as to the amount of the payment under subsection (b) or (d) of section 1395ww of this title[,]" but the Final Rule being appealed is not "as to the amount of the payment under subsection (b) or (d) of section 1395ww."[50] It contends that the Final Rule being appealed is similar to the publication of Medicare SSI Ratios in the Federal Register, which may not be final determinations until actually used to calculate a provider's SSI Ratio.[51] It argues that the Final Rule appealed in this case simply governs the treatment of certain days in the DSH calculation, and until that policy is used to calculate a provider's DSH payment (*i.e.*, by issuing an NPR), there is no final determination "as to the amount of the payment . . ." to be dissatisfied with, which is required by 42 U.S.C. § 1395oo(a)(1)(A)(i)-(ii).[52]

The Provider did *not* file any reply or objection to the Medicare Contractor's response.

Decision of the Board

Pursuant to 42 C.F.R. § 405.1835(a)(1), an individual provider generally has a right to a hearing before the Board "with respect to a final contractor or Secretary determination ***for the provider's cost reporting period***"[53] if:

- It "is dissatisfied *with the contractor's final determination of the total amount of reimbursement* ***due the provider***, as set forth in the contractor's written notice specified under § 405.1803"[54] In other words, providers must appeal from a "final determination" that impacts payment for the period under appeal.[55]

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[49] Board Rule 42.4 (Nov. 2021) requires the Medicare Contractor to file a response to an EJR request within five (5) business days of the filing of the EJR Request. A response in this instance would have been due no later than close of business June 16, 2023.
[50] Medicare Contractor's Response to EJR Request at 2.
[51] *Id.* at 3-4 (citing *Memorial Hosp. of South Bend v. Becerra*, 2022 WL 888190 (D.D.C. 2022)).
[52] *Id.*
[53] 42 C.F.R. § 405.1835(a) (emphasis added).
[54] 42 C.F.R. § 405.1835(a)(1) (emphasis added).
[55] *See also* 42 U.S.C. § 1395oo(a)(1)(A); *Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 144-146 (D.C. Cir. 1986) (stating: "Viewing the amendments as a whole, we are inescapably drawn to the same conclusion as the District Court: § 1395oo (a) 'clearly contemplates two different kinds of appeal. One begins when the intermediary issues an NPR; the other, when the intermediary issues a notice of ***what will be paid*** *under the PPS system*.' . . . . Under PPS, in contrast, ***payment amounts*** are independent of current costs and *can be determined with finality* prior to the beginning of the cost year. Id. § 412.71(d). Thus a year-end cost report is not a report which is necessary ***in order for the Secretary to make PPS payments***, and the appeals provision applicable to PPS recipients cannot be read to require hospitals to file cost reports and await NPRs prior to filing a PRRB appeal." (emphasis added and citations omitted)).

- The request for a hearing is filed within 180 days of the date of receipt of the final determination.

- The amount in controversy is $10,000 or more.[56]

42 C.F.R. § 405.1835(b) specifically requires that a provider's request for a hearing must meet the requirements of paragraph (b), subsections (1-4), and paragraph (b)(1) specifically notes that the hearing request must include "[a] demonstration that the provider satisfies the requirements for a Board hearing as specified in paragraph (a)." Paragraph (a) states, in pertinent part, that a provider has a right to a Board hearing:

> with respect to a final … determination ***for the provider's cost reporting period***, if – (1) The provider is dissatisfied with the contractor's final *determination* of total amount *of reimbursement* ***due the provider***, as set forth in the contractor's written notice specified under § 405.1803.[57]

42 C.F.R. § 405.1801(a) defines the term "contractor determination" as including:

> (2) With respect to a hospital that receives payments for inpatient hospital services under the prospective payment system (part 412 of this chapter), the term means a final determination of the total amount of payment due the hospital, pursuant to § 405.1803 following the close of the hospital's cost reporting period, under that system for the period covered by the final determination.
>
> (3) For purposes of appeal to the Provider Reimbursement Review Board, the term is synonymous with the phrases "intermediary's final determination," "final determination of the organization serving as its fiscal intermediary," "Secretary's final determination" and "final determination of the Secretary," as those phrases are used in section 1878(a) of the Act, and with the phrases "final contractor determination" and "final Secretary determination" as those phrases are used in this subpart.

Similarly, Paragraph (b)(2) of 42 C.F.R. § 405.1835 requires certain information relative to each specific item under appeal with respect to the final determination under appeal:

> (2) *For each specific item under appeal*, a separate explanation of why, and a description of how, the provider is dissatisfied *with the specific aspects of the final . . . determination under appeal*, including an account of all of the following:

[56] 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835 – 1840.
[57] (Emphasis added.)

> (i) *Why the provider believes Medicare **payment** is incorrect for each disputed item* (or, where applicable, why the provider is unable to determine whether Medicare payment is correct because *it does not have access to underlying information **concerning the calculation of its payment***).
>
> (ii) How and why the provider believes Medicare payment must be determined differently for each disputed item.
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> (iii) If the provider self-disallows a specific item (as specified in § 413.24(j) of this chapter), an explanation of the nature and amount of each self-disallowed item, the reimbursement sought for the item, and why the provider self-disallowed the item instead of claiming reimbursement for the item.

Paragraph (a)(2) also states that a provider must demonstrate that the amount in controversy is $10,000 or more. Satisfying the criteria set out in 42 C.F.R. § 405.1835(a) is required before the Board can exercise jurisdiction over an appeal.[58]

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

Tampa is appealing from the June 2023 Final Rule and alleges that it impacts Medicare reimbursement for its FY 2009 with an estimated an amount in controversy of $1,230,772. Tampa filed its EJR request just minutes after filing its appeal request. Tampa has not, however, demonstrated that the criteria set out in 42 C.F.R. § 405.1835 have been satisfied "***for the provider's cost reporting period***[.]" The retroactive regulation being challenged is only applicable to "***to any cost reports that remain open for cost reporting periods starting before October 1, 2013***."[59] There is nothing in Tampa's request for a hearing which demonstrates that the cost report for the fiscal year at issue in this appeal remains open or has not yet been finally settled and, as such, Tampa has not demonstrated that the June 2023 Final Rule is a "final … determination ***for the***

[58] 42 C.F.R. § 405.1840(a), (b). The Board notes that 42 C.F.R. § 405.1840 is entitled "Board Jurisdiction" but it also addresses certain claim filing requirements such as timelines or filing deadlines. However, whether an appeal was timely is not a jurisdictional requirement but rather is a claim filing requirement as the Supreme Court made clear in *Sebelius v. Auburn Reg. Med. Ctr.*, 568 U.S. 145 (2013). *See also* Board Rule 4.1 ("The Board will dismiss appeals that fail *to meet the timely filing requirements **and/or** jurisdictional requirements*. Similarly, the Board notes that 42 C.F.R. § 405.1835(b) addresses claim filing requirements.

[59] *Id.* at 37775 (emphasis added).

provider's cost reporting period" which involved "*reimbursement* ***due the provider***."[60] Indeed, if the June 2023 Final Rule does not apply to Tampa's fiscal year under appeal in this case, then the actual amount in controversy would be $0. At this point, there is no evidence that suggests the Medicare Contractor has re-calculated the provider's FY 2009 DSH adjustment in accordance with the June 2023 Final Rule, nor that it has any intent to do so.

Since satisfying the criteria set out in 42 C.F.R. § 405.1835 is required before the Board can exercise jurisdiction over an appeal,[61] and since Tampa has failed to demonstrate in its hearing request that those criteria have been met for the year under appeal (*i.e*., FY 2009), the Board is permitted under § 405.1835(b) to "dismiss with prejudice the appeal or take any other remedial action it considers appropriate."[62] In this instance, the Board finds it is appropriate to deny the EJR request and dismiss the appeal ***without prejudice*** and remove it from the Board's docket. The Board finds this is an appropriate remedial action, noting that the time-period to appeal the June 2023 Final Rule does not expire until December 11, 2023. Finally, the Board notes that it never reached consideration of the Medicare Contractor's basis for its opposition since there is nothing in the record, *in the first instance*, to establish the requisite nexus between the June 2023 Final Rule and Tampa's FY 2009 Medicare reimbursement.[63] 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.[64]

Board Members Participating:

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

For the Board:

7/9/2023

X Clayton J. Nix

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

cc: Geoff Pike, First Coast Service Options, Inc. (J-N)
Wilson Leong, FSS

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[60] Consistent with the requirement that the final determination being appealed must involve "reimbursement due the provider," 42 C.F.R. § 405.1840(b)(2) requires a description of the "payment" at issue in that determination and how that payment must be determined differently. *See also* 42 C.F.R. § 405.1889(b) (addressing limited appeal rights from revised determinations).

[61] 42 C.F.R. § 405.1840(a), (b).

[62] 42 C.F.R. § 405.1835(b). The Board also reviewed the concurrently-filed EJR request to see if Tampa included the requisite information; however, it did not cure the fatal defects of its hearing request.

[63] While the Board is not ruling on the Medicare Contractor's Jurisdictional Challenge and whether its legal theory is applicable *to the case at hand*, the Board notes that it has issued a jurisdictional decision in the context of published SSI percentages and dismissed the relevant case. *See* PRRB Jurisdictional Dec., Case No. 10-0282G (Oct. 29, 2020) (*available at*: https://www.cms.gov/files/document/prrb-jurisdictional-decisions-9-1-2020-through-9-30-2020.pdf).

[64] Due to technical difficulties, this letter was not issued on Friday, July 7, 2023. While the Board issued the letter on Saturday, July 8, 2023, the issuance did not appear in the OH CDMS proceedings tab for Case No. 23-1438. As a result, the Board re-issued it on Sunday, July 8, 2023. Although this letter was issued on Sunday, the Board considers the next business day, Monday, July 10, 2023, to be the date of the Provider's receipt for purposes of determining any relevant filing deadlines.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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RE: ***Request to Reinstate & Bifurcate Group Appeal Regarding DSH Part C Days Issue***
Blumberg Ribner 2000 Independent Hospitals Dual Eligible Days Group III
Case No. 09-2241G

Dear Mr. Blumberg and Mr. Snyder:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Providers' June 2, 2016 request for Rule 41.1 Reinstatement and Bifurcation of Group Appeal regarding DSH Part C Days for the Blumberg Ribner FY 2000 Dual Eligible Days Third Group. As set forth below, the Board **denies** this request because he Providers' representative submitted it *well beyond* the three-year limit in 42 C.F.R. § 405.1885(b)(1) and the Board's Rules for requesting recission of the remand and reinstatement of the group appeal for purposes of the proposed bifurcation.

Background:

On December 10, 2010, BRI sent a request that the Board remand this group pursuant to the Centers for Medicare & Medicaid Services ("CMS") Ruling 1498-R.[1] As part of this request, BRI recognized that the group appeal "issue" was "governed" by that Ruling and, as a consequence, notified the Board that it would not be filing a preliminary position paper for the group by the January 1, 2011 deadline:

> In accordance with the PRRB's recently issued ALERT 7, [BRI] hereby *identifies the subject of this group appeal,* dual eligible days, ***as an issue governed by CMS-1498-R***. Accordingly, BRI will not be submitting a Preliminary Position Paper (PPP) by the May 1, 2011 deadline. Please notify us should the Board

[1] Ruling 1498-R was issued on April 28, 2010, by the CMS Administrator to address three specific issues regarding the calculation of the Medicare disproportionate share hospital (DSH) payment adjustment: (1) the Medicare SSI fraction data matching process issue and the method for recalculating the hospital's Medicare SSI fraction, (2) the exclusion from the DSH calculation of non-covered patient hospital days for patients entitled to Medicare Part A including days for which the patient's Part A inpatient hospital benefits were exhausted for cost reporting periods before October 1, 2004, and (3) the exclusion from the DSH calculation of the labor/delivery room (LDR) inpatient days.

> determine that a PPP is necessary. BRI hereby requests that the group appeal be remanded under the Standard Procedure.[2]

Consistent with BRI's request, on August 1, 2011, the Board issued a standard remand in Case No. 09-2241G remanded the dual eligible Part A days issue to the Medicare Contractor, pursuant to the CMS Ruling 1498-R:

> The above-referenced appeal includes a challenge to the exclusion of Medicare dual-eligible days (where the patient was entitled to Part A benefits but the inpatient hospital stay was not covered under Part A or the patient's Part A hospital benefits were exhausted) from the calculation of the disproportionate share (DSH) percentage for patient discharges before October 1, 2004. This issue is to be remanded to the Intermediary under the terms of the [CMS] Ruling CMS-1498-R for recalculation of the DSH payment adjustment.
>
> . . . . Consequently, the Board hereby remands the above-referenced case to the Intermediary for recalculation of the Providers' DSH adjustments. The group appeal is hereby closed and removed from the Board's docket.

Accordingly, concurrent with the remand and consistent with BRI's request for a standard remand of the case, the Board closed the case.

On June 24, 2013, BRI filed a Request to Bifurcate Dual Eligible Days Group Appeal in Two Separate Group Appeals:[3]

> At this time, the Blumberg Ribner FY 2000 Dual Eligible Days Third Group is currently pending at the PRRB. [BRI] is aware that MACs are resolving the Medicare Part C (HMO Days) Days component of the Dual Eligible Days issue. As such, we are requesting that the PRRB establish a new group appeal to be called the Blumberg Ribner FY 2000 Medicare HMO Days Third Group by transferring the Medicare Part C Days component from each Providers/Fiscal Years in the above referenced group appeal to the newly established group appeal. *After the transfer of the Medicare Part C Days component to the new group appeal is completed, the old group appeal, Blumberg Ribner FY 2000 Dual Eligible Days Third Group,* ***can be remanded***.

[2] (Emphasis added.)
[3] (Emphasis added.)

Significantly, the June 24, 2013 bifurcation request did not recognize that the case had been closed and remanded and, as such, was ***not*** a request for reinstatement.

The Board denied this request on July 26, 2013, because the appeal had already been remanded and closed:

> Upon review, the Board notes that on December 10, 2010 you requested that the Board remand the above-referenced case in accordance with CMS Ruling 1498-R under the Standard Procedure. On August 1, 2011 the Board granted you request and remanded the subject case back to the Intermediary, thereby closing the case and removing it from the Board's docket.
>
> Since the subject appeal was closed *prior to your request*, the Board hereby **denies** you request to establish a new group appeal by bifurcating the above-referenced group appeal.[4]

Additionally, the Board explained that, even if the group appeal had been open, the Board would have denied the request to bifurcation because a group can only have one issue and the Part C issue was not raised in the group appeal:

> The Board further notes that the statement of issue included in the providers' initial group appeal request does not include nor reference the Medicare Part C component of the Dual Eligible Days issue. . . . The Board's rules clearly assert that a group appeal must contain only a single issue. Board Rule 13 states:
>
> > The matter at issue must involve a single common question of fact or interpretation of law, regulation or CMS policy or ruling. A group case is not appropriate if facts that must be proved are unique to the respective Providers or if the undisputed controlling facts are not common to all group members. Likewise, a group appeal is inappropriate if the Board could make different findings for the various Providers in the group.
>
> Therefore, ***had the group appeal been open***, *the Board would have rejected your request to bifurcate the case*, as the Part C issue was not raised in this single issue group appeal.

On June 2, 2016 (almost 5 years from when the appeal was closed), BRI filed the instant request for Rule 41.1 Reinstatement and Bifurcation of Group Appeal regarding Disproportionate Share

[4] (Italics and underline emphasis added and bold emphasis in original.)

Hospital (DSH) Part C Days Issue. BRI acknowledges that the Board remanded the Providers' appeal of the dual eligible days issue. However, BRI asserts that the "Medicare Part C issue did not come within the scope of the Ruling 1498-R" and contends that:

> The Board should find that it possessed authority over the dual eligible days issue. The Board's finding that it lacked jurisdiction over, and the [1498-R] remand of, the dual eligible days issue was inappropriate because it was the intent of the Providers to appeal the Medicare Part C days issue.

The Providers request that the Board rescind its August 1, 2011 remand decision and reinstate its appeal of the dual eligible days issue.[5] The Providers request that the Board reinstate the appeal for purposes of appealing the DSH Part C days issue.[6] Significantly, the May 31, 2016 request for reinstatement and bifurcation does ***not*** discuss, identify, or otherwise reference either the Providers' prior June 24, 2013 request for bifurcation ***or*** the Board's July 26, 2013 denial of that request.

Decision of the Board:

Board Rule 46.1 (effective July 1, 2015) specifies that "[a] Provider may request reinstatement of an issue(s) or case within three years from the date of the Board's decision to dismiss the issue(s)/case." This Board Rule is consistent with 42 C.F.R. § 405.1885 (b)(2)(i), which specifies that "[a] reopening made upon request is timely only if the request to reopen is received by . . . [the] or reviewing entity . . . no later than 3 years after the date of the determination or decision that is the subject of the requested reopening."

In the instant case, the Providers are requesting that the Board rescind its August 1, 2011 remand decision and reinstate its appeal of the dual eligible days issue. As previously noted, the Board closed Case No. 09-2241G on August 1, 2011, when the Board issued its decision remanding the dual eligible Part A days issue pursuant to Ruling 1498-R. The Provider did not file their Request for Rule 41.1 Reinstatement and Bifurcation of Group Appeal Regarding DSH Part C Days Issue until June 2, 2016 which *is almost 5 years after the Board had issued the August 1, 2011 remand decision and closed the case*. Pursuant to 42 C.F.R. § 405.1885(b)(2) and Board Rule 46.1, the deadline for requesting reinstatement of the dual eligible issue was August 1, 2014 (three years from the date of the Board's decision dismissing/remanding the dual eligible days issue). The Providers' request to rescind and reinstate is ***well beyond*** the three-year limit in the Board's Rules for requesting reinstatement of an issue. As such, the Board hereby denies the Providers' request to reinstate and bifurcate.

In the alternative, even if the Board had discretion to consider BRI's belated/untimely request to reopen and rescind its August 1, 2011 remand decision , the Board would not exercise its

[5] Provider's Request for Rescission of and Bifurcation of Group Appeal Regarding DSH Part C Days Issue at 1.
[6] *Id*. at 2.

discretion to reopen the August 1, 2011 remand decision but rather would deny that request[7] because: (1) a group can only contain one issue per 42 C.F.R. § 405.1837(a); (2) the record is clear that BRI requested remand of this group appeal because "the subject of the group appeal" is "an issue governed by CMS 1498-R"; (3) had there been a separate issue, then BRI should have identified it and requested bifurcation at that time (*i.e.*, when it was requesting remand) since there can only be one issue in an optional group pursuant to 42 C.F.R. § 405.1837(a) and (b)(2); and (4) similarly, in its request for remand, BRI should have ***not*** have stated that it would "not be submitting a Preliminary Position Paper (PPP) by the January 1, 2011 deadline" but rather should have been insisting that it would be filing one for the group to otherwise brief the Part C issue which, if part of the appeal, would not have been subject to the 1498-R remand (as BRI recognized in its untimely/belated June 2, 2016 reinstatement and bifurcation request). Indeed, it is unclear why BRI waited almost 5 years from when the group appeal was remanded and closed, and it has not given any reason for such an untimely/belated request for reinstatement. Accordingly, to the extent it could have been considered part of the group appeal, the Providers abandoned the Part C issue when they submitted their December 10, 2010 request for standard remand and nowhere indicated in that request that another issue remained in the group appeal which would d have needed briefing as well as bifurcating.

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.
Kevin D. Smith, CPA
Ratina Kelly, CPA

For the Board:

7/12/2023

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services

[7] The following cases suggest that the Board's refusal to exercise its discretion to reopen under 42 C.F.R. § 405.1885(b)(2) and Board Rule 46.1 (2015) is not reviewable: *Your Home Visiting Nurse Services, Inc. v. Shalala*, 525 U.S. 449 (1999); *Palomar Med. Ctr. v. Sebelius*, 693 F.3d 1151 (9th Cir. 2012); *Michael Reese Hosp. & Med. Ctr. v. Thompson*, 427 F.3d 436 (7th Cir. 2005).

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RE: ***Request to Reinstate & Bifurcate Group Appeal Regarding DSH Part C Days Issue***
Blumberg Ribner Independent Hospitals 2001 Dual Eligible Days Third Group
Case No. 10-0502G

Dear Mr. Blumberg and Ms. Decker:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Providers' May 27, 2016 request for Rule 41.1 Reinstatement and Bifurcation of Group Appeal regarding DSH Part C Days for the Blumberg Ribner FY 2001 Dual Eligible Days Third Group. As set forth below, the Board **denies** this request because the Providers' representative, Blumberg Ribner, Inc. ("BRI"), submitted it *well beyond* the three-year limit in 42 C.F.R. § 405.1885(b)(1) and the Board's Rules for requesting recission of the remand and reinstatement of the group appeal for purposes of the proposed bifurcation.

Background:

On April 18, 2011, BRI filed for this optional group the final Schedule of Providers ("So") with supporting jurisdictional documentation as required under Board Rules upon full formation of the optional group.

On April 20, 2011, BRI filed a request that the Board remand this group pursuant to the Centers for Medicare & Medicaid Services ("CMS") Ruling 1498-R.[1] As part of this request, BRI recognized that the group appeal "issue" was "governed" by that Ruling and, as a consequence, notified the Board that it would not be filing a preliminary position paper for the group by the May 1, 2011 deadline:

> In accordance with the PRRB's recently issued ALERT 7, [BRI] hereby *identifies the subject of this group appeal*, dual eligible days, ***as an issue governed by CMS-1498-R***. Accordingly, BRI

[1] Ruling 1498-R was issued on April 28, 2010, by the CMS Administrator to address three specific issues regarding the calculation of the Medicare disproportionate share hospital (DSH) payment adjustment: (1) the Medicare SSI fraction data matching process issue and the method for recalculating the hospital's Medicare SSI fraction, (2) the exclusion from the DSH calculation of non-covered patient hospital days for patients entitled to Medicare Part A including days for which the patient's Part A inpatient hospital benefits were exhausted for cost reporting periods before October 1, 2004, and (3) the exclusion from the DSH calculation of the labor/delivery room (LDR) inpatient days.

> will not be submitting a Preliminary Position Paper (PPP) by the May 1, 2011 deadline. Please notify us should the Board determine that a PPP is necessary. BRI hereby requests that the group appeal be remanded under the Standard Procedure.[2]

Consistent with BRI's request, on December 1, 2011, the Board issued a standard remand in Case No. 10-0502G and remanded the dual eligible Part A days issue to the Medicare Contractor, pursuant to the CMS Ruling 1498-R:

> The above-referenced appeal includes a challenge to the exclusion of Medicare dual-eligible days (where the patient was entitled to Part A benefits but the inpatient hospital stay was not covered under Part A or the patient's Part A hospital benefits were exhausted) from the calculation of the disproportionate share (DSH) percentage for patient discharges before October 1, 2004. This issue is to be remanded to the Intermediary under the terms of the [CMS] Ruling CMS-1498-R for recalculation of the DSH payment adjustment.
>
> . . . . Consequently, the Board hereby remands the above-referenced case to the Intermediary for recalculation of the Providers' DSH adjustments. The group appeal is hereby closed and removed from the Board's docket.

Accordingly, concurrent with the remand and consistent with BRI's request for a standard remand of the case, the Board closed the case.

On June 27, 2013, the Board received the first "request reconsideration of remand . . . and reinstatement of appeal" from the Group Representative, in which it argued more than 1.5 years after the Board's 1498-R remand, the Medicare Contractor had yet to take any action, and therefore, the Providers could not achieve the relief they were seeking. The Providers argued that the Board should rescind its remand order and reinstate the case, or in alternative, construe the request as a request for EJR. Significantly, the request includes the following reference to Part C days:

> The Provider cannot achieve the relief they seek in a remand to the MAC. The Providers contend that persons not entitled to coverage under Medicare Part A, including persons who exhausted their coverage, who enrolled in Medicare Part C (referred to collectively as "non-covered days") or for whom Medicare was a secondary payor, should be excluded from the DSH SSI% Fraction and included in the numerator of the DSH Medicaid Fraction.

In this regard, the Board notes that the following federal court decisions had been issued and clearly confirmed that Part C days was a separate and distinct issue:

---

[2] (Emphasis added.)

- *Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1 (D.C. Cir. 2011).
- *Allina Health Servs. V. Sebelius*, 904 F. Supp. 2d 75 (D.D.C. 2012).

Notwithstanding, the Providers' first recission and reinstatement request did ***not*** request bifurcation of any Part C days issues if the Board were to grant the request recission and reinstatement.

On November 1, 2013, the Board **denied** this request to reopen/reinstate because it was bound by CMS Ruling 1498-R:

> As the Ruling deprives the Board of jurisdiction over the three issues identified therein, once the Board has determined that a provider's claim for an issue subject to the Ruling satisfies the applicable jurisdictional and procedural requirements for appeal and remands that provider/issue to the Intermediary pursuant to the Ruling, the Board no longer has authority to act on the appeal in question. *The Board **cannot reopen** a moot case* which is the result of CMS' action deeming such cases moot, as they are definition considered resolved. . . . The Board finds that its December 11, 2011 letter was nothing more than a finding that the Providers in the appeal satisfy the applicable jurisdictional and procedural requirements necessary to file an appeal before the Board, not that it retain jurisdiction over the subject matter. The *Board therefore **denies** the Providers' requests for reinstatement* and for EJR as subject matter jurisdiction is a prerequisite for EJR.[3]

The Board also addressed the oblique reference to Part C days and confirmed it was not part of the appeal:

> In addition to the Providers' request for reconsideration and EJR, the Providers also attempt to broaden the appeal to encompass Part C Days. In their reinstatement and EJR request, the Providers refer to "persons not entitled to coverage under Medicare Part A" as including those "who enrolled in Medicare Part C." Medicare Part C days is a separate issue from Medicare/Medicaid dual eligible days, which was the sole issue appealed in case number 10-0402G in the request for hearing dated February 16, 2010. *As this is a group appeal, the appeal can only have one issue, the dual eligible days issue, the Part C issue **that the Providers mention in the reconsideration request** is not part of this appeal*. Furthermore, the Providers would not be able to add an issue to an appeal after the case had been remanded and closed.[4]

[3] (Emphasis added and footnote omitted.)
[4] (Emphasis added.)

On May 27, 2016 (almost 4½ years from when the appeal was closed on December 1, 2011), BRI filed the instant request for Rule 41.1 Reinstatement and Bifurcation of Group Appeal regarding Disproportionate Share Hospital (DSH) Part C Days Issue. BRI acknowledges that the Board remanded the Providers' appeal of the dual eligible days issue. However, BRI asserts that the "Medicare Part C issue did not come within the scope of the Ruling 1498-R" and contends that:

> The Board should find that it possessed authority over the dual eligible days issue. The Board's finding that it lacked jurisdiction over, and the [1498-R] remand of, the dual eligible days issue was inappropriate because it was the intent of the Providers to appeal the Medicare Part C days issue.

The Providers request that the Board rescind its December 1, 2011 remand decision and reinstate its appeal of the dual eligible days issue.[5] The Providers request that the Board reinstate the appeal for purposes of appealing the DSH Part C days issue.[6] Significantly, the May 27, 2016 request for reinstatement and bifurcation does ***not*** discuss, identify, or otherwise reference either the Providers' prior June 27, 2013 request for rescission and reinstatement ***or*** the Board's November 1, 2013 denial of that request.

Decision of the Board:

Board Rule 46.1 (effective July 1, 2015) specifies that "[a] Provider may request reinstatement of an issue(s) or case *within three years* from the date of the Board's decision to dismiss the issue(s)/case."[7] This Board Rule is consistent with 42 C.F.R. § 405.1885 (b)(2)(i), which specifies that "[a] reopening made upon request is timely only if the request to reopen is received by . . . [the] or reviewing entity . . . *no later than 3 years* after the date of the determination or decision that is the subject of the requested reopening."[8]

In the instant case, the Providers are requesting that the Board rescind its December 1, 2011 remand decision and reinstate its appeal of the dual eligible days issue. As previously noted, the Board closed Case No. 10-0502G on December 1, 2011, when the Board issued its decision remanding the dual eligible Part A days issue pursuant to Ruling 1498-R. The Provider did not file their Request for Rule 41.1 Reinstatement and Bifurcation of Group Appeal Regarding DSH Part C Days Issue until May 27, 2016 which *is almost 4½ years* ***after*** *the Board issued its December 1, 2011 remand decision and closed the case*. Pursuant to 42 C.F.R. § 405.1885(b)(2) and Board Rule 46.1, the deadline for requesting reinstatement of the dual eligible issue was December 1, 2014 (three years from the date of the Board's decision dismissing/remanding the dual eligible days issue). The Providers' request to rescind and reinstate is ***well beyond*** the three-year limit in the Board's Rules

[5] Provider's Request for Rescission of Remand & Bifurcation of Group Appeal Regarding DSH Part C Days Issue at 1.
[6] *Id*. at 2.
[7] (Emphasis added.)
[8] (Emphasis added.)

for requesting reinstatement of an issue.[9] As such, the Board hereby denies the Providers' request to reinstate and bifurcate.

In the alternative, even if the Board had discretion to consider BRI's belated/untimely request to reopen and rescind its December 1, 2011 remand decision, the Board would not exercise its discretion to reopen the December 1, 2011 remand decision but rather would deny that request[10] because: (1) a group can only contain one issue per 42 C.F.R. § 405.1837(a); (2) the record is clear that BRI requested remand of this group appeal because "the subject of the group appeal" is "an issue governed by CMS 1498-R"; (3) had there been a separate issue, then BRI should have identified it and requested bifurcation at that time (*i.e.*, when it was requesting remand) since there can only be one issue in an optional group pursuant to 42 C.F.R. § 405.1837(a) and (b)(2); and (4) similarly, in its request for remand, BRI should have ***not*** have stated that it would "not be submitting a Preliminary Position Paper (PPP) by the May 1, 2011 deadline" but rather should have been insisting that it would be filing one for the group to otherwise brief the Part C issue which, if part of the appeal, would not have been subject to the 1498-R remand (as BRI recognized in its untimely/belated May 27, 2016 reinstatement and bifurcation request). Indeed, it is unclear why BRI waited 4 ½ years from when the group appeal was remanded and closed, and it has not given any reason for such an untimely/belated request for reinstatement. Accordingly, to the extent it could have been considered part of the group appeal, the Providers abandoned the Part C issue when they submitted their April 20, 2011 request for standard remand and nowhere indicated in that request that another issue remained in the group appeal which would d have needed briefing as well as bifurcating.

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.
Kevin D. Smith, CPA
Ratina Kelly, CPA

For the Board:

7/12/2023

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services

[9] In the alternative, the Board would deny because: (1) a group can contain only one issue; (2) on April 20, 2011, the Providers stated they would not be submitting their preliminary position paper because the group was subject to remand per CMS Ruling 1498-R remand and then *specifically requested a standard remand* of the group issue pursuant to that Ruling; (3) nowhere did that request indicate another issue remained in the group appeal which would have needed briefing as well as bifurcating; and (4) consistent with the request, the Board issued as standard remand on December 1, 2011.

[10] The following cases suggest that the Board's refusal to exercise its discretion to reopen under 42 C.F.R. § 405.1885(b)(2) and Board Rule 46.1 (2015) is not reviewable: *Your Home Visiting Nurse Services, Inc. v. Shalala*, 525 U.S. 449 (1999); *Palomar Med. Ctr. v. Sebelius*, 693 F.3d 1151 (9th Cir. 2012); *Michael Reese Hosp. & Med. Ctr. v. Thompson*, 427 F.3d 436 (7th Cir. 2005).

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RE: HCA 2005 DSH SSI Fraction Medicare Advantage Days CIRP Group
Case Number: 16-1424GC

Dear Ms. Jones and Mr. Snyder:

The above-referenced appeal 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, the Provider Reimbursement Review Board ("Board") has noted that the Common Owner of this group has already been granted EJR for this issue, for this specific Fiscal Year, and as such, the above appeal violates the Common Issue Related Party ("CIRP") statute and regulation, is a prohibited duplicate, and must be dismissed.

Background:

The group appeal request was filed (received) by the Board on April 4, 2016. It was created with one provider, and no additional providers have been added since that time.

The Board notes that HCA previously filed a CIRP group under Case No. 07-0005GC, 10/1/2004 - 2005 DSH Medicare Advantage Plan Days Group, on October 2, 2006. That appeal, which included appeals from original and revised Notices of Program Reimbursement, was pending with the Board when 16-1424GC was filed. Specifically, the original HCA 2005, 07-0005GC, case appealed the following issue:

> HCA contends that it should be allowed to count Medicare Advantage plan days in the disproportionate share ("DSH") computation. For those beneficiaries that elected Medicare Advantage ("Medicare C"), those patient days should not be counted in the Medicare fraction of the DSH formula. However, the Medicare Advantage beneficiary days would be included in the total patient days in the Medicaid fraction (denominator) For the Medicare C beneficiary who is also eligible for Medicaid, those patient days should be included in the numerator of the Medicaid

> fraction. Although CMS proposed to incorporate this methodology, 1t has not finalized the proposal. HCA is protecting its appeal rights until CMS incorporates these rules. [68 Fed. Reg. 27208 (May 19, 2003)].[1]

42 U.S.C. § 1395oo(f)(1) specifies, in pertinent part that "Any appeal to the Board or action for judicial review by providers which are under common ownership or control or which have obtained a hearing under subsection (b) must be brought by such providers as a group with respect to any matter involving an issue common to such providers." The Secretary implemented this statutory requirement at 42 C.F.R. § 405.1837(b)(1), hereinafter called the CIRP regulation, which states:

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

Subsection (e)(1) requires that the group provider provide notice that the group is fully formed and complete. Once the group is certified as complete, restrictions are placed on the ability for additional providers under common ownership to join the CIRP group:

> 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.[3]

On October 3, 2017, the group representative certified the CIRP group under Case No. 07-0005GC was complete and requested EJR for that group appeal on August 8, 2017. The Board granted EJR over the appeal on September 7, 2017. The issue statement clearly covers the inclusion of the Part C days in the SSI percentage, *and* the exclusion of the Part C days from the Medicaid fraction, which the Board has previously determined to be one issue. As the group representative confirmed the group was complete and requested the Board to grant EJR, any additional providers (or duplicate providers) outside of this group would be part of a prohibited duplicate case violating the CIRP statute and regulations at 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. §§ 405.1837(b)(1) and (e)(1) respectively. As HCA filed North Monroe in a duplicate group (Group Case No. 16-1424GC) and failed to include North Monroe in its original Group Case No. 07-0005GC prior to requesting EJR for the same issue (Part C Days) in the original

[1] Appeal Request October 2, 2006.
[2] 42 C.F.R. § 405.1837(b)(1) (emphasis added).
[3] 42 C.F.R. § 405.1837(e)(1).

group appeal, the duplicate appeal is in violation of §§ 405.1837(b)(1) and (e), and thus must be dismissed.

The Board finds that PRRB Case No. 16-1424GC violates the CIRP statute and regulations at 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. §§ 405.1837(b)(1) and (e) respectively, and dismisses the case and underlying participant. Accordingly, the Board closes the group appeal and removes it from the Board's docket.

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

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

For the Board:

7/17/2023

X Kevin D. Smith, CPA

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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Bruce Snyder
Novitas Solutions, Inc.
707 Grant Street
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Pittsburgh, PA 15219

RE: ***Board Decision* – SSI Percentage (Provider Specific)**
Opelousas General Hospital (Provider Number 19-0017)
FYE: 06/30/2013
Case Number: 16-1683

Dear Mr. Ravindran and Mr. Synder:

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the documentation in Case No. 16-1683 in response to a jurisdictional challenge filed by the Medicare Contractor ("MAC") and a request for postponement filed by the Provider. The Board's decision is set forth below.

Background

A. *Procedural History for Case No. 16-1683*

Opelousas General Hospital appealed a Notice of Program Reimbursement ("NPR") dated November 25, 2015, for its fiscal year end June 30, 2013. On May 24, 2016, the Provider filed an individual appeal request which contained the following issues:

1. DSH Payment/SSI Percentage (Provider Specific)
2. DSH Payment/SSI Percentage (Systemic Errors)[1]
3. DSH Payment-Medicare Managed Care Part C Days/SSI Fraction[2]
4. DSH Payment-Dual Eligible Days/SSI Fraction[3]
5. DSH Payment – Medicaid Eligible Days
6. DSH Payment- Medicare Managed Care Part C Days/Medicaid Fraction[4]

[1] On January 18, 2017, this issue was transferred to Case No. 16-1141G.
[2] On January 18, 2017, this issue was transferred to Case No. 16-1143G.
[3] On January 18, 2017, this issue was transferred to Case No. 16-1142G.
[4] On January 18, 2017, this issue was transferred to Case No. 16-1144G.

7. DSH Payment- Dual Eligible Days/Medicaid Fraction[5]
8. Outlier Payments-Fixed Loss Threshold

All of the issues except the following three issues were transferred to optional group cases: Issue 1, DSH Payment/SSI Percentage (Provider Specific), Issue 5, DSH Payment- Medicaid Eligible Days and Issue 8, Outlier Payments-Fixed Loss Threshold.

On May 14, 2018, the Medicare Contractor filed a Jurisdictional Challenge regarding Issue 1, DSH Payment/SSI Percentage (Provider Specific), Issue 5, DSH Payment- Medicaid Eligible Days, Issue 6, DSH Payment- Medicare Managed Care Part C Days/Medicaid Fraction, Issue 7, DSH Payment- Dual Eligible Days/Medicaid Fraction, and Issue 8, Outlier Payments-Fixed Loss Threshold. The Provider filed a response to the Medicare Contractor's Jurisdictional Challenge on June 7, 2018.

On August 16, 2018, Issue 8, Outlier Payments-Fixed Loss Threshold was transferred to Case No. 17-1837G. And on March 15, 2023, Issue 5, DSH Payment- Medicaid Eligible Days issue was withdrawn by the Provider. After the six transfers and the withdrawal, one issue remains: Issue 1, DSH Payment/SSI Percentage (Provider Specific) issue.

On June 16, 2023, the Provider filed a request to postpone the July 21, 2023, hearing pending the settlement of the last remaining issue, the DSH Payment/SSI Percentage (Provider Specific) issue. The postponement request stated:

> Quality Reimbursement Services, Inc. ("QRS"), as the designated representative for the above referenced appeal, hereby requests that the Provider Reimbursement Review Board ("PRRB" or "Board") hearing for PRRB Case Number 16-1683 currently scheduled for July 21, 2023, be postponed pending the settlement of the last remaining issue, SSI Provider Specific.
>
> This postponement is requested pending the implementation of the Final Rule, [CMS-1739-F] Medicare Program; Treatment of Medicare Part C Days in the Calculation of a Hospital's Medicare Disproportionate Patient Percentage. On June 7, 2023, CMS issued the final rule on DSH Part C days, which, (1) places Part C days in the Medicare Fraction, and (2) is given retroactive effect for discharges prior to October 1, 2013. The rule states that upon the rule becoming effective (which is 60 days after publication in the Federal Register), CMS will commence issuing initial and revised NPRs that have been held pending the issuance of the final rule.
>
> The effect of the Final Rule directly impacts the SSI Provider Specific (Realignment) issue and, the Provider maintains that, once implemented, this final rule will allow for the resolution of this issue. Accordingly, this appeal hearing should be postponed pending the implementation of the final rule.

[5] On January 18, 2017, this issue was transferred to Case No. 16-1145G.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 16-1141G

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

> [T]he MAC did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. §1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations.
>
> The Provider contends that its' [sic] SSI percentage published by the Centers for Medicare and Medicaid Services ("CMS") was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> The Provider 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 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.[6]

The amount in controversy was listed as $44,319.[7]

In the DSH SSI percentage issue in the group, Case No. 16-1141G, which includes the Provider in this case, and the same fiscal year, the Providers assert that:

> The Providers contend that the Lead MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute 42 U.S.C. §1395ww(d)(5)(F)(i). The Providers further contend that the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") and used by the Lead MAC to settle their Cost Report does not address all the deficiencies as described in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20, *as*

[6] Provider's Individual Appeal Request, Issue 1 Issue Statement (May 24, 2016).
[7] *Id.*

> *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.[8]

The amount in controversy for Opelousas General Hospital, Provider No. 19-0017, in Case No. 16-1141G is $44, 319, the same amount as Issue 1, DSH Payment/SSI Percentage (Provider Specific) issue in the Provider's individual appeal.

On April 12, 2023, the Provider filed its final position paper. The following is the Provider's ***complete*** position on Issue 1, DSH Payment SSI Percentage (Provider Specific) set forth therein:

> **Calculation of the SSI Percentage**
>
> The Provider contends that the MAC's determination of Medicare Reimbursement for DSH payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww(d)(5)(F)(i). The Provider contends that the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") and used by the 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 the Centers for Medicare and Medicaid Services ("CMS") was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation.
>
> The Provider is seeking a full and complete set of the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, HHS/HCFAIOIS, 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

[8] Group Appeal Request, Statement of the Issue (Feb. 29, 2016).

> (2000). Although some MEDPAR data is now routinely made available to the provider community, what is provided lacks all data records necessary to fully identify all patients properly includable in the SSI fraction. The Provider believes that upon completion of this review it will be entitled to a correction of those 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. The hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra (Appellants' reply brief included as Exhibit P-2).[9]

The exhibit included with the final position paper that relates to Issue 1, DSH Payment/SSI Percentage (Provider Specific) is Exhibit P-1, which shows that the amount in controversy for the issue is $44, 319. This is the same amount that is listed as the amount in controversy for this Provider as a participant in Case No. 16-1141G.

MAC's Jurisdictional Challenge

Issue 1 – DSH SSI Percentage (Provider Specific)

The MAC argues that the Board lacks jurisdiction over the DSH SSI Percentage - Provider Specific issue for two reasons. The MAC argues that the appeal is premature:

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

[9] Provider's Final Position Paper at 7-8 (April 12, 2023).
[10] MAC Jurisdictional Challenge at 3 (May 14, 2018).

In addition, the MAC argues Issue 1, the DSH Payment/SSI Percentage (Provider Specific) issue and Issue 2, the DSH Payment/SSI Percentage (Systemic Errors) issue are considered the same issue by the Board. The MAC asserts:

In issue 1 the Provider contends that the MAC used the incorrect SSI percentage in processing its DSH payment. In issue 2 the provider contends that the Secretary improperly calculated its SSI percentage. The Provider is making the same argument, as the MAC is required to use the SSI ratio provided by CMS. Essentially, the Provider contends that the SSI ratio applied to its cost report was incorrect; the SSI ratio is the underlying dispute in both issue 1 and issue 2. Under Board Rules, the Provider is barred from filing a duplicate SSI percentage issue. Therefore, the PRRB should find that the SSI percentage is one issue for appeal purposes and that issue 1 should be dismissed consistent with recent jurisdictional decisions.

The MAC cites several past Board decisions to that end.[11]

Provider's Response

On June 7, 2018, the Provider filed a response to the MAC's jurisdictional challenge. The Provider contends each of the appealed SSI issues are separate and distinct issues and that the Board should find jurisdiction over Case No. 16-1683. The Provider maintains appeal Issues 1 and 2 represent different components of the SSI issue, which was specifically adjusted during the audit. Since these specific appeal issues represent different aspects/components of the SSI issue, the Board should find jurisdiction over the both the SSI Systemic and SSI Provider Specific/Realignment issues.

The Provider asserts the SSI Systemic issue addresses the various errors discussed in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008), in CMS' calculation of the disproportionate payment percentage which result in the MEDPAR not reflecting all individuals who are eligible for SSI. The Provider contends these systemic errors are the result of the CMS' improper policies and data matching process. The Provider maintains in the SSI Provider Specific issue it is not addressing the errors which result from CMS' improper data matching process but is addressing the various errors of omission and commission that do not fit into the "systemic errors" category. The Provider asserts it has analyzed Medicare Part A records and has been able to identify patients believed to be entitled to both Medicare Part A and SSI. The Provider maintains it has reason to believe that the SSI percentage determined by CMS is incorrect due to the understated days in the SSI ratio. Therefore, the Board should find jurisdiction over the SSI Provider Specific issue in the instant appeal.

The Provider contends this is an appealable issue because the MAC specifically adjusted the Provider's SSI percentage and the Provider is dissatisfied with the amount of the DSH payments that it received for fiscal year 2013, resulting from its understated SSI percentage due to errors of omission and commission. [12]

[11] *Id*. at 2.
[12] Provider Jurisdictional Response at 2 (June 7, 2018).

Board Analysis and Decision

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

A. DSH SSI Percentage (Provider Specific)

The Board finds that it does not have jurisdiction over the DSH Payment/SSI Percentage (Provider Specific) issue. The jurisdictional analysis for Issue No. 1 has three 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, 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period, and 3) the Provider incorporating the arguments form *Advocate Christ*[13] into its appeal.

1. First and Third Aspects of Issue 1

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage— in the present appeal concerns "[w]hether the Medicare Administrative Contractor ("MAC") used the correct Supplemental Security Income ("SSI") percentage in the Disproportionate Share Hospital calculation."[14] The Provider's legal basis for its DSH Payment/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)."[15] The Provider argues that "its' [sic] SSI percentage published by the Centers for Medicare and Medicaid Services ("CMS") was incorrectly computed . . . ." and it ". . . disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[16]

The Provider's DSH Payment/SSI Percentage (Systemic Errors) issue in group Case No. 16-1141G also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds the DSH Payment/SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH Payment/SSI Percentage (Systemic Errors) issue in Case No. 16-1141G. Because the issue is duplicative, and duplicative issues appealed from the same final determination are

[13] The Provider has included the Appellants' Reply Brief in *Advocate Christ Med. Ctr. v. Becerra*, No. 22-5214 (D.C. Cir.), which is on appeal from the decision in *Advocate Christ Med. Ctr. V. Azar*, 17-cv-1519 (TSC), 2022 WL 2064830, (D.D.C. June 8, 2022).
[14] Provider's Individual Appeal Request, Issue 1 Issue Statement (May 24, 2016).
[15] *Id.*
[16] *Id.*

prohibited by PRRB Rule 4.5[17], the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

In making this finding, the Board further notes that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, the Provider is pursuing that issue as part of the group under Case 16-1141G. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[18] The Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 16-1141G.

To this end, the Board also reviewed the Provider's Final Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 16-1141G, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider's Final Position Paper failed to comply with the Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" in its Final Position Paper and include *all* exhibits.

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

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

[17] PRRB Rules v. 1.3 (July 2015).
[18] The types of systemic errors documented in the *Baystate* decision did not uniformly impact the SSI calculation for all providers but that does not make the errors any less systemic. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). *See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).

> Act (also known as FOIA requests), or similar requests for information pending with a state Medicaid agency.

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

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

This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows:

> DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal.[21]

Accordingly, the Board finds that the remaining issue in the instant appeal and the group issue from Group Case 16-1141G are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

Additionally, in its Final Position Paper, the Provider stated "The [Provider] hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra (Appellants' reply brief included as Exhibit P-2)." The Board finds that this purported argument does not comply with the regulations and Board rules to fully develop the Provider's position in the Final Position Paper, because the Provider merely lists a case name and does not explain further what the arguments are that it would like to incorporate into this appeal.

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[20] Last accessed July 12, 2023.

[21] Emphasis added.

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

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.[22]

Therefore, the Board finds that the Provider did not comply with the Final Position Paper regulations and Board rules with respect to the purported *Advocate Christ* argument, and dismisses that portion of the issue.

1. Second Aspect of Issue 1

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

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

B. Postponement Request

The Board also denies the postponement request, as the last issue has been dismissed. The only impact the final rule may have on this appeal, is that it "should" eliminate the hold on NPRs and RNPRs and allow for SSI realignment requests to be implemented. However, the Board has found that issue to be premature, as the record does not indicate that realignment has been requested.

****

In summary, the Board hereby dismisses the DSH Payment/SSI Percentage (Provider Specific) issue from this appeal as it is duplicative of the issue in Case No. 16-1141G and there is no final determination from which the Provider can appeal the SSI realignment portion of the issue. As no issues remain pending, the Board hereby denies the Provider's Postponement Request and closes Case No. 16-1683 and removes it from the Board's docket.

[22] (Emphasis added).

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

Board Members Participating:

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

For the Board:

7/17/2023

X Kevin D. Smith, CPA

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

cc: Wilson Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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RE: ***Board Decision***
Genesys Regional Medical Center (Provider Number: 23-0197)
FYE: 6/30/2014

as a participant in Group Case Number: 15-0053GC

Dear Ms. Elias,

The Provider Reimbursement Review Board ("Board") has reviewed the documents in the above-referenced appeal and dismisses the provider Genesys Regional Medical Center in accordance with the decision of the Board, which is set forth below.

Pertinent Facts:

The Common Issue Related Party ("CIRP") Group appeal was established on October 9, 2014, appealing the DSH Payment / SSI Fraction Medicare Managed Part C Days issue for PRRB Case No. 15-0053GC. Genesys Regional Medical Center was directly added to the appeal on March 16, 2018, appealing from a Revised Notice of Program Reimbursement ("RNPR") dated September 21, 2017.

Attached to Genesys Regional Medical Center's Model Form E – Request to Join an Existing Group Appeal: Direct Appeal from Final Determination was the RNPR and the associated Audit Adjustment Report. The Audit Adjustment Report showed an adjustment to the cost report "to include the hospital's Realignment SSI percentage as calculated by CMS . . ."

Board Decision:

The Code of Federal Regulations provides for an opportunity for a reopening and RNPR at 42 C.F.R. § 405.1885, 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 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]

Further, this regulatory limitation is cross-referenced in the provider's right to a hearing in 42 C.F.R. § 405.1835(a) as follows:

> (a) *Right to hearing on final contractor determination*.
> A provider . . . has a right to a Board hearing, as a single provider appeal, with respect to a final contractor or Secretary determination for the provider's cost reporting period, if -
>
> (1) The provider is dissatisfied with the contractor's final determination of the total amount of reimbursement due the provider, as set forth in the contractor's written notice specified under § 405.1803. **Exception**: If a final contractor determination is reopened under § 405.1885, **any review by the Board must be limited solely to those matters that are specifically revised in the contractor's revised final determination** (§§ 405.1887(d), 405.1889(b), and the "Exception" in § 405.1873(c)(2)(i)).
>
> (2) The amount in controversy (as determined in accordance with § 405.1839) must be $10,000 or more.
>
> (3) Unless the provider qualifies for a good cause extension under § 405.1836, the date of receipt by the Board of the provider's

[1] 42 C.F.R. § 405.1889(b).

> hearing request must be no later than 180 days after the date of receipt by the provider of the final contractor or Secretary determination.[2]

The Board finds that it does not have jurisdiction over the Part C Days issue in this appeal from Genesys Regional Medical Center because the RNPR was issued as a result of the Provider's SSI Realignment request and did not make any adjustments related to the Part C days issue. Thus, the provider does not have the right to appeal under 42 C.F.R. § 405.1889(b) as referenced in § 405.1835(a)(1).

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[.]"[3] The reopening in this case was a result of the Providers' request to realign their SSI percentage from the federal fiscal year end to their individual cost reporting fiscal year end. The audit adjustments (#5) associated with the RNPR under appeal clearly only revise the SSI percentage in order to realign it from a federal fiscal year to the provider's fiscal year. More specifically, the realignment process (as described in the Federal Register) does not change any of the underlying data that is gathered on a month-by-month basis since CMS does not rerun the data matching process in order to effectuate a realignment.[4] In other words, the determination was only being reopened to include the realigned SSI percentage and CMS' realignment process (as described in the Federal Register) does ***not*** entail re-running of the data matching process that the Provider is trying to appeal (much less revise any of the Part C days included in the underlying month-by-month data). Since the only matter specifically revised in Genesys Regional Medical Center's RNPR was the adjustment related to realigning the SSI percentage from federal fiscal year to the Provider's fiscal year, the Provider does not have a right to appeal under 42 C.F.R.

---

[2] (Emphasis added).
[3] 42 C.F.R. § 405.1889(b)(1).
[4] CMS describes the matching process that it uses as part of the FY 2011 IPPS final rule published on August 16, 2010. *See* 75 Fed. Reg. 50042, 50275-85 (Aug. 16, 2010). However, CMS does not utilize or re-run the data match process when it issues a realigned SSI percentage. Rather, when CMS conducts the realignment process, all of the underlying data which has already been gathered on a month-by-month basis through that data matching process remains the same. The realigned SSI percentage simply reflects a different 12-month time period being used. *See* 42 C.F.R. § 412.106(b)(2) (noting that CMS gathers data on a month-by-month basis). The realignment solely takes the SSI data for each provider and the total Medicare days for each provider (previously accumulated on a month-by-month basis and used in the original CMS published SSI percentages) and reports it based on the provider's cost reporting period instead of the September 30 FFY. *See also* 75 Fed. Reg. 50042, 50279 (Aug. 16, 2010) (stating: "The SSI fractions are generally based on the Federal fiscal year; however, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived from the data match process for the two Federal fiscal years that spanned the hospital's cost reporting period.); 70 Fed. Reg. 47278, 47439 (Aug. 12, 2005) (stating: "Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period, and *the hospital **must accept** the resulting DSH percentage for that year, whether or not it is a more favorable number than the DSH percentage based on the Federal fiscal year*." (emphasis added)).

§§ 405.1889(b) and 405.1835(a)(1) for the Part C Days issue. In making this ruling, the Board notes that its application of 42 C.F.R. § 405.1889(b) has been upheld by courts on review.[5]

The Board finds that it does not have jurisdiction over Genesys Regional Medical Center's RNPR appeal and therefore dismisses the Provider from the appeal.

The remaining Providers in PRRB Case 15-0053GC will be remanded pursuant to CMS Ruling 1739-R under separate cover.

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

Board Members Participating:

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Robert A. Evarts, Esq.
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For the Board:

7/18/2023

X Kevin D. Smith, CPA

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

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Board Decision* – SSI Percentage (Provider Specific)**
Alliance Health Woodward (Provider Number: 37-0002)
FYE: 05/31/2017
Case Number: 20-0432

Dear Messrs. Summar and Lamprecht:

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the documentation in Case No. 20-0432. The Board's decision is set forth below.

Background:

A. *Procedural History for Case No. 20-0432*

On May 14, 2019, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end May 31, 2017.

On November 8, 2019, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained five (5) issues:

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

The Provider is subject to the mandatory rules governing common issue related party ("CIRP") groups at 42 C.F.R. § 405.1837(b)(1) since the Provider is owed by Community Health Systems. Accordingly, on June 15, 2020, the Provider transferred issues to various CIRP group appeals, including Issue 2, DSH/SSI Percentage (Systemic Issues) to Case No. 20-0997GC, CHS CY

[1] On June 15, 2020, this issue was transferred to PRRB Case No. 20-0997GC.
[2] This issue was withdrawn on March 2, 2023.
[3] This issue was withdrawn on May 4, 2021.
[4] On June 15, 2020, this issue was transferred to PRRB Case No. 20-0999GC.

2017 DSH SSI Percentage CIRP Group. The last remaining issue is the DSH Payment/SSI Percentage (Provider Specific) issue.

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

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

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

The Provider described its DSH/SSI Percentage (Systemic Errors) issue, which has been transferred to a group appeal, as whether the Medicare/SSI Fraction used to calculate their DSH payment accurately and correctly counted the number of patient days to be included therein. More specifically, Provider lists the following reasons for challenging its SSI percentage:

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

On June 29, 2020, the Provider submitted its preliminary position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

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

[5] Issue Statement at 1 (Nov. 8, 2019).
[6] *Id*. at 2.

> all patients that were entitled to SSI benefits in their calculation based on the Provider's Fiscal Year End (May 31).
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.
>
> Similar to *Loma Linda Community Hospital v. Dept of Health and Human Services*, No. CV-94-0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records. However, at this time, the Provider has been unable to analyze the Medicare Part A data because it has not yet received the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR"), HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000 from CMS. *See* 65 Fed. Reg. 50,548 (2000). 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). Upon release of the complete MEDPAR data, the Provider will seek to reconcile its' records with that of CMS, and identify patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS based on the Federal Fiscal Year End (September 30) when it determined the Provider's SSI. *See Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).[7]

MAC'S Contentions:

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

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

[7] Provider's Preliminary Position Paper at 8-9 (Jun. 29, 2020).

> all available remedies for this issue. The MAC requests that the Board dismiss this issue consistent with other jurisdictional decisions.[8]

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

Provider's Response:

The Provider has not filed a response to the Jurisdictional Challenge or Motion to Dismiss and the time for doing so has elapsed. The Board Rules require that Provider Responses to the MAC's Jurisdictional Challenge must filed within thirty (30) days of the filing of the Jurisdictional Challenge.[10] Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

Board Analysis and Decision:

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

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

1. First Aspect of Issue 1

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage— in the present appeal concerns "[w]hether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation."[11] The Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance

[8] Jurisdictional Challenge at 6-7 (Oct. 9, 2020).
[9] *Id*. at 4-6.
[10] Board Rule 44.4.3, v. 3.1 (Nov. 2021).
[11] Issue Statement at 1.

with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[12] The Provider argues that "its SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[13]

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 20-0997GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds the DSH Payment/SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 20-0997GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[14], the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

In making this finding, the Board further notes that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, the Provider is pursuing that issue as part of the group in Case 20-0997GC. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[15] The Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 20-0997GC.

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

---

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

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

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

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

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

[16] Last accessed February 24, 2023.

This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows:

> DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal.[17]

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

2. Second Aspect of Issue 1

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

The Board finds that, under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." Without this written request, the Medicare Contractor cannot issue a final determination with which the Provider can be dissatisfied for appeal purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding DSH SSI Percentage realignment. Therefore, the Board finds that it lacks jurisdiction in this aspect of the appeal and this aspect of Issue 1 is dismissed.

****

In summary, the Board hereby dismisses the DSH Payment/SSI Percentage (Provider Specific) issue, in its entirety, from this appeal as it is duplicative of the issue in Case No. 20-0997GC and there is no final determination from which the Provider can appeal the SSI realignment portion of the issue. As no issues remain pending, the Board hereby closes Case No. 20-0432 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.

[17] Emphasis added.

Board Members Participating:

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Ratina Kelly, CPA

For the Board:

7/19/2023

X Kevin D. Smith, CPA

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

cc: Wilson Leong, Federal Specialized Services

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RE: ***Duplicate FY 2017 Part C CIRP Groups – Fairview Health***

Specifically: Healtheast Woodwinds Hospital (Provider Number 24-0213) as a participant in

21-1187GC Fairview Health CY 2017 HealthEast DSH Medicaid Fraction Medicare HMO Days
21-1188GC Fairview Health CY 2017 HealthEast DSH Medicare/SSI Fraction Medicare HMO Days
21-1172GC Fairview Health CY 2017 Medicare-SSI Fraction for Medicare HMO Days CIRP Group
21-1174GC Fairview Health CY 2017 2017 Medicaid Fraction for Medicare HMO Days CIRP Group

Dear Ms. Del Santro and Ms. VanArsdale:

The Provider Reimbursement Review Board (the "Board") has reviewed the common issue related party ("CIRP") groups, Case Nos. 21-1187GC and 21-1188GC, which each include only a single provider, Healtheast Woodwinds Hospital ("Woodwinds"/ "Provider") and related CIRP groups for the same calendar year ("CY") and issue under Case No. 21-1172GC and 21-1174GC. The pertinent facts with regard to these groups and the Board's dismissal of related groups are set forth below.

Pertinent Facts:

On March 31, 2021, Fairview Health Services ("Fairview Health"/ "Representative") filed the "Fairview Health CY 2017 2017 Medicare-SSI Fraction for Medicare HMO Days CIRP Group" (Case No. 21-1172GC) and the Fairview Health CY 2017 Medicaid Fraction for Medicare HMO Days CIRP Group (Case No. 21-1174GC). The groups were formed with the Direct Add of Fairview Lakes Medical Center ("Fairview Lakes"/Prov. No. 24-0050) from a 10/2/2020 NPR. 21-1174GC was withdrawn and closed on February 13, 2023. 21-1172GC is open, and the group is not yet fully formed.

On April 6, 2021, Fairview Health filed the "Fairview CY 2017 ***HealthEast*** DSH Medicaid Fraction Medicare HMO Days CIRP Group" (Case No. 21-1187GC) and the "Fairview Health CY 2017 ***HealthEast*** DSH Medicare\SSI Fraction HMO Days CIRP Group" (Case No. 21-1188GC). Both groups (which include "**HealthEast**" in the group names) were formed with the Direct Add of

Woodwinds (Prov. No. 24-0213).[1] The Representative letter that accompanied the Direct Add was filed on the same Fairview Health letterhead that was used for the participant in Case 21-1172GC.

On January 12, 2023, both Case Nos. 21-1187GC and 21-1188GC were designated to be fully formed with only a single participant.

Board Determination:

The Board notes that the issue that is the subject of the ***four*** Fairview Health-HealthEast group appeals, involves the inclusion/exclusion of Medicare Advantage Part C Days in the Medicare and Medicaid fractions of the disproportionate share hospital ("DSH") adjustment. Per the 2014 holding of the D.C. Circuit in *Allina Health Servs. v. Sebelius* ("*Allina*"),[2] 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.[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] The Board finds that, under the *Allina* holding, the disposition of the Medicare Part C Days in the DSH calculation is a *single* issue because disposition of Part C days in the SSI Fraction issue dictates the disposition of the Medicare Part C Days in the Medicaid Fraction (and vice versa).

Based on the holding in *Allina*, the Board finds that the issues in Case No. 21-1187GC, 21-1188GC, 21-1172GC and 21-11744GC are duplicates.

42 U.S.C. § 1395oo(f)(1) specifies, in pertinent part that "Any appeal to the Board or action for judicial review by providers which are under common ownership or control or which have obtained a hearing under subsection (b) must be brought by such providers as a group with respect to any matter involving an issue common to such providers." The Secretary implemented this statutory requirement at 42 C.F.R. § 405.1837(b)(1), hereinafter called the CIRP regulation, which states:

> 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,

[1] Based on an internet search, the Minneapolis-based Fairview merged with the St. Paul-based HealthEast in 2017.
[2] 746 F.3d 1102, 1108 (D.C. Cir. 2014).
[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] 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).

must bring the appeal as a group appeal.[5]

On February 11, 2023, the group representative withdrew 21-1174GC Fairview Health CY 2017 2017 Medicaid Fraction for Medicare HMO Days CIRP Group with no indication as to why it was being withdrawn.[6] The Board adjudicated that closure on February 13, 2013. As the group representative withdrew one of the four duplicate appeals, any additional providers (or duplicate providers) outside of this group would be part of a prohibited duplicate case violating the CIRP statute and regulations at 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. §§ 405.1837(b)(1) and (e)(1) respectively.

The Board finds that PRRB Cases 21-1172GC, 21-1187GC and 21-1188GC violate the CIRP statute and regulations at 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. §§ 405.1837(b)(1) and (e), respectively, and dismisses those cases and any underlying participants. Accordingly, the Board closes the group appeals and removes them from the Board's docket.

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

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

For the Board:

7/20/2023

X Kevin D. Smith, CPA

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

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

[5] 42 C.F.R. § 405.1837(b)(1) (emphasis added).
[6] This withdrawal is inconsistent with the Providers' action for prior year Part C issues where both fractions were withdrawn. Specifically for 2015 and 2016, the Provider withdrew each of these companion appeals in late January or early February, 2023. For 2015, Case Nos. 19-0611GC and 19-0614GC were withdrawn on January 20, 2023. For 2016, Case Nos. 21-0959GC and 21-0960GC were withdrawn on February 11, 2023.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
7500 Security Boulevard
Mail Stop: B1-01-31
Baltimore, MD 21244
410-786-2671

Via Electronic Delivery

Kimberly Jones Appeals Analyst II
HCA Healthcare, Inc.
2000 Health Park Dr., 2-North
Brentwood, TN 37027

RE: ***Dismissal for Untimely Filing***
Tristar Ashland City Medical Center (Prov. No. 44-1311)
FYE 05/31/2020
Case No. 23-0101

Dear Ms. Jones:

Pursuant to 42 C.F.R. § 405.1868, the Provider Reimbursement Review Board ("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 provision of section 1878 of the Act and of the regulations. The Board's powers include the authority to take appropriate actions in response to the failure of a party to comply with Board rules and orders. Specifically, if a provider fails to meet a filing deadline or other requirement established by the Board in a rule or order, the Board may dismiss the appeal with prejudice.

The Provider filed an appeal in the above referenced cases on October 19, 2022. The Board issued a Case Acknowledgement and Critical Due Date Notice on October 20, 2022, setting the Provider's Preliminary Position Paper deadline for June 16, 2013. The Board re-issued the Critical Due Dates letter on March 21, 2023, which again stated the deadline was June 16, 2013. Each of these notices confirmed that "[i]f the Provider misses any of its due dates, the Board will dismiss the appeal."

On June 14, 2023, HCA Healthcare, Inc. ("HCA") attempted to file its preliminary position paper narrative, a list of exhibits, a good faith statement and 5 exhibits. However, each of these 8 documents was flagged and quarantined as potentially infected by CMS' anti-virus scanning and, as a result, the filing was not completed (*i.e.*, it is not part of the record for this case) because the documents are not downloadable/accessible due to the documents being flagged and quarantined as infected.

Accordingly, on June 20, 2023, the Board issued a Request for Information ("RFI") notification and advised HCA Healthcare, Inc. ("HCA") that all 8 of the documents it uploaded on June 14, 2023 were flagged as potentially infected by CMS' anti-virus scanning. The Board noted that the flags may occur when there is an embedded link or macro in the document or it is password protected. The RFI requested HCA to resubmit a new version of these documents to complete the Board's record by July 17, 2023 and that failure to do so by the deadline would result in the Board taking action in accordance with 42 C.F.R. § 405.1868.

42 C.F.R. § 405.1868 states:

> (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.[1]

HCA has failed to *properly* file its preliminary position paper by the June 16, 2023 deadline since it was flagged and quarantined as being infected with a virus and, as such, is not accessible/ downloadable. Notwithstanding, the Board provided HCA an opportunity to cure its defective submission within 31 days (*i.e.*, by Monday, July 17, 2023) and this request was set up in OH CDMS showing that a response was required from HCA by Monday, July 17, 2023. However, HCA failed to either respond and/or cure its ***defective*** position paper submission within the prescribed 31-day period. As a result, it is clear that HCA has failed to *properly* file its preliminary position paper, notwithstanding the 31-day period prescribed by the Board to cure the defective filing, and the Board hereby dismisses the appeal pursuant to its authority under 42 C.F.R. § 405.1868. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

7/20/2023

X Clayton J. Nix

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

cc: Wilson C. Leong, Federal Specialized Services
Cecile Huggins, Palmetto GBA (J-J)

[1] Emphasis an added.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Wade Jaeger
Sutter Health
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Lorraine Frewert
Noridian Healthcare Solutions
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Fargo, ND 58108-6782

RE: ***Dismissal of Duplicate Appeal***
Group Name: *Sutter Health 2010 DSH – SSI Ratio Part C Days CIRP Group*
Case Number: 16-2465GC

Dear Mr. Jaeger and Ms. Frewert:

The above-referenced common issue related party ("CIRP") group appeal for Sutter Health ("Sutter") 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. The Provider Reimbursement Review Board ("PRRB" or "Board") has noted that the Common Owner of this group, Sutter Health, has already been adjudicated via 1739-R Remand for the issue under appeal, and for this specific Fiscal Year. As such, the above CIRP group appeal violates the CIRP regulation, is duplicative, and must be dismissed.

Background

The Board received the Group Representative's Request for Hearing dated September 15, 2016, to establish the above mentioned CIRP group. The CIRP group appeal request contained the following issue statement regarding the appealed Part C Days issue:

> *[W]hether patient days associated with Medicare Part C Managed Care Days (and other days not covered or paid under Medicare Part A) should be included in the Medicare SSI percentage.*

In reviewing the documentation for jurisdiction, it was noted that the common owner of this group had already appealed the Part C days issue for this specific fiscal year, in another group case. Specifically, Case No. 18-0303GC Sutter Health 2010 DSH Medicaid Eligible Part C Days CIRP Group was remanded to the Medicare Contractor on April 7, 2023. This case includes a similar issue statement.[1]

[1] Group Issue Statement Case No. 18-0303GC (Dec. 1, 2017).

> *"The Provider contends CMS' new interpretation of including Medicare Dual Eligible Part C Days in the SSI ratio issued on March 16, 2012 is tantamount to retroactive rule making which the D.C. Circuit held impermissible in the Northeast Hospital decision…..The Provider maintains the position all unpaid Medicare Dual Eligible Part C Days should be included in the Medicaid patient day ratio of the Medicare DSH and LIP payment calculations."*

Each of the participants in Case No. 16-2456GC are also participants in Case No. 18-0303GC.

Board's Analysis and Decision

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

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

Board Rule 4.6.2 also addresses duplicate filings:

> *A provider may not appeal an issue from a single final determination in more than one appeal.*

Per the 2014 holding of the D.C. Circuit in *Allina Health Servs. v. Sebelius* (746 F.3d 1102, 1108 (D.C. Cir. 2014)) ("*Allina*"),[3] 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.[4] 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.[5] 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.

---

[2] 42 C.F.R. § 405.1837(b)(1).
[3] 746 F.3d 1102, 1108 (D.C. Cir. 2014).
[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. 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).

Thus, PRRB Case No. 16-2465GC and 18-0303GC are duplicate appeals and PRRB appeal 18-0303GC was previously disposed of through the 1739-R Remand of that appeal to the Medicare Contractor. Case No. 16-2465GC is a duplicate appeal of the same Part C DSH issue in violation of the CIRP regulations at 42 C.F.R. § 405.1837(b)(1) and (e) and the PRRB Rule involving duplicate appeals, 4.6.1.

As such, the Board dismisses the DSH Part C Days appeal PRRB Case No. 16-2465GC because the issue was disposed of through the 1739-R Remand of Case No. 18-0303GC, and because Case No. 16-2465GC violated the CIRP regulations at 42 C.F.R. § 405.1837(b)(1) and (e), as well as the duplicate appeal PRRB Rule 4.6.2.

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

Board Members Participating:

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

For the Board:

7/24/2023

X Kevin D. Smith, CPA

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

cc: Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Board Decision* – SSI Percentage (Provider Specific)**
Northside Medical Center (Provider Number: 36-0141)
FYE: 12/31/2013
Case Number: 17-0163

Dear Mr. Ravindran and Ms. Cummings:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the documentation in Case No. 17-0163. The Board's decision is set forth below.

Background:

A. *Procedural History for Case No. 17-0163*

On April 20, 2016, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end December 31, 2013.

On October 19, 2016, the Board received the Provider's Individual Appeal Request, which contained two (2) issues:

1. DSH Payment/SSI Percentage (Provider Specific)
2. DSH Payment – Medicaid Eligible Days

On April 25, 2018, the Medicare Administrative Contractor ("Medicare Contractor" or "MAC") filed a jurisdictional challenge, contending that the Board does not have jurisdiction over either issue in this appeal. The Provider filed a response to the jurisdictional challenge on May 25, 2018.

Thereafter, on July 5, 2023, the Medicare Contractor filed a motion to dismiss the Medicaid Eligible Days issue. On July 21, 2023, the Medicare Contractor filed a second jurisdictional challenge, to only the Medicaid Eligible Days issue, and noted that it maintained its position in the April 25, 2018, jurisdictional challenge with regard to the SSI Percentage (Provider Specific) issue.

On July 25, 2023, the Provider withdrew the Medicaid Eligible Days issue. Consequently, the only remaining issue is the DSH Payment/SSI Percentage (Provider Specific) issue (Issue 1). Therefore, this decision addresses only the April 25, 2018, jurisdictional challenge to Issue 1.

B. ***Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 15-2694GC***

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

> The Provider contends that the MAC did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations.
>
> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> * * *
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.
>
> The Provider also contends that CMS inconsistently interprets the term "entitled" as it is used in the statute. CMS requires SSI payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the denominator. CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days of care) as Medicare Part A days, yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment.[1]

[1] Issue Statement at 1 (Oct. 19, 2016).

As the Provider is commonly owned by Community Health Systems, on April 26, 2016, Northside Medical Center was directly added to Group Appeal Request in Case No. 15-2694GC, *Community Health Systems*[2] *Post 1498-R 2013 DSH SSI Data Match CIRP,* was filed on May 22, 2015. The Providers described the issue in Group Case 15-2694GC, as the failure of CMS "to properly determine the ratio of patient days for patients entitled to Medicare Part A and Supplemental Security Income (SSI) benefits (excluding any State supplementation) to patient days for patients entitled to Medicare Part A (Medicare Proxy or Fraction) for the Provider in its Disproportionate Share Hospital (DSH) eligibility determination and payment calculation."[3] The Providers assert that "the Medicare Proxy is improperly understated due to a number of factors, including CMS' inaccurate and improper matching or use of data along with policy changes to determine both the number of Medicare Part A SSI patient days in the numerator of the fraction and the total Medicare Part A patient days in the denominator, as utilized in the calculation of the Medicare percentage of low income patients for DSH purposes."[4] The Providers assert that "this treatment is not consistent with Congressional intent to reimburse hospitals for treatment of indigent patients when determining DSH program eligibility and payment pursuant to 42 U.S.C. § 1395ww(d)(5)(F), 42 C.F.R. § 412.106, Medicare Intermediary Manual § 3610.15, or any other applicable statutes, regulations, program guidelines, or case law."[5]

The Providers refer to the Board's decision in the Baystate case, wherein the Board identified "significant flaws in the compilation of Medicare SSI days," and noted that the Board's decision was supported by the March 31, 2008 D.C. District Court decision.[6] The D.C. District Court found that CMS did not use the most reliable data available to determine which patient days should be counted in the SSI percentage, among other things. The Providers note that CMS issued Ruling 1498-R on April 28, 2010, in response to the *Baystate* court decision, which sets forth a revised and corrected data match process. The Providers assert that "errors and problems still exist in the data match process, as well as improper policy changes by CMS, which are resulting in understated DSH adjustments for Providers."[7]

On May 22, 2023, in Case No. 17-0163, the Provider submitted its final position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Calculation of the SSI Percentage**
>
> The Provider contends that the 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

[2] The Provider is owned by Community Health Systems, which is the parent organization that filed group Case No. 15-2694GC. The Provider is subject to the mandatory rules governing common issue related party ("CIRP") groups at 42 C.F.R. § 405.1837(b)(1).
[3] PRRB Case No. 15-2694GC, Group Issue Statement (Sept. 4, 2018).
[4] *Id.*
[5] *Id.*
[6] *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). *See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).
[7] PRRB Case No. 15-2694GC, Group Issue Statement (Sept. 4, 2018).

> contends that the SSI percentage calculated by [CMS] and used by the MAC to settle their Cost Report was incorrectly computed because of the following reasons:
>
> **Provider Specific**
>
> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation.
>
> The Provider is seeking a *full and complete* set of the the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. *See* 65 Fed. Reg. 50,548 (2000). Although some MEDPAR data is now routinely made available to the provider community, what is provided lacks all data records necessary to fully identify all patients properly includable in the SSI fraction. The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' SSI percentage based on CMS' admission in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction. The hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v. Xavier Becerra (Appellants' reply brief included as Exhibit P-3).[8]

MAC's Contentions:

In its jurisdictional challenge filed on April 25, 2018, the MAC first notes that, based on the Provider's language in its appeal request, "the Provider is essentially arguing two sub-issues: (1) the accuracy of the SSI percentage, and (2) the question of SSI realignment."[9] The MAC argues that the Board lacks jurisdiction over both of these issues in the DSH Payment/SSI Percentage (Provider Specific) issue for the following reasons. First, the MAC argues that with regard to sub-issue (1), the Provider has "failed to show that the SSI percentage is not accurate,"[10] including failing "to supply any supporting documentation or SSI analysis showing how the SSI percentage used for its DSH calculation is in error."[11] Further, the Provider has

[8] Provider's Final Position Paper at 8-9 (May 22, 2023).
[9] Medicare Contractor's Jurisdictional Challenge at 2 (April 25, 2018).
[10] *Id.*
[11] *Id.*

duplicated its appeal of the SSI percentage in group case 15-2694GC to which the Provider was directly added on August 25, 2016. In accordance with Board Rule 4.5, a provider may not appeal an issue from a final determination in more than one appeal.

With regard to sub-issue (2), the MAC asserts that the Provider did not brief this issue in its preliminary paper and the MAC therefore considers the issue abandoned. In addition, "the MAC considers that an appeal of SSI realignment is premature according to 42 C.F.R. § 405.1835 as the MAC has not made a determination regarding the realignment issue."[12]

In its jurisdictional challenge filed on July 21, 2023, the MAC indicated that it maintains its position in its April 25, 2018 jurisdictional challenge, and therefore did not address this issue in its July 21, 2023 filing. However, the MAC did note that, subsequent to its filing of the 2018 jurisdictional challenge, the Provider requested and received SSI realignment with a Revised Notice of Program Reimbursement issued on January 2, 2020, rendering sub-issue (2) moot.

Provider's Response:

In its May 25, 2018, response, the Provider asserts with regard to sub-issue (1) that under Board Rule 8.1, some issues may have multiple components, and that "each contested component must be appealed as a separate issue and described as narrowly as possible."[13] The Provider asserts that the two issues in the two cases (17-0163 and 15-2694GC), represent different components of the SSI issue, and that the Board should find jurisdiction over both. The Provider refers to the SSI issue in 15-2694GC as the SSI Systemic issue, addressing various errors discussed in *Baystate*, which are the result of CMS' improper policies and data matching process, which also covers CMS Ruling 1498-R.

The Provider asserts that the SSI Provider Specific issue in the instant case, 17-0163, "is not addressing the errors which result from CMS' improper data matching process but is addressing the various errors of omission and commission that do not fit into the "systematic errors" category."[14] In *Baystate,* the Provider asserts that the Board also considered, independent of the systematic errors, whether Baystate's SSI fractions were understated due to the number of days included in the SSI ratio. The Provider asserts that it has reason to believe that the SSI percentage determined by CMS is incorrect due to the understated days in the SSI ratio, and that once these patients are identified, the Provider contends that it will be entitled to a correction of these errors of omission to its SSI percentage.

The Provider did not address sub-issue (2) on SSI realignment in its response.

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[12] *Id.*
[13] Provider's Response to Jurisdictional Challenge at 1 (May, 25, 2018).
[14] *Id.* at 2.

Board Analysis and Decision:

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

The Board finds that it does not have jurisdiction over the DSH Payment/SSI Percentage (Provider Specific) issue. The jurisdictional analysis for Issue No. 1 has four 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, 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period, 3) the Provider arguing over the interpretation of "entitled to" and "eligible for" benefits for purposes of calculating the numerator of the SSI fraction, and 4) the Provider incorporating the arguments from *Advocate Christ*[15] into its appeal.

1. *First, Third and Fourth Aspects 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 (Data Match) issue that the Provider is pursuing in PRRB Case No. 15-2694GC.

The DSH Payment/SSI Percentage (Provider Specific) issue in the present appeal concerns "[w]hether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation."[16] The Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[17] The Provider argues that "its SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[18]

The Provider's DSH/SSI Percentage (Data Match) issue in group Case No. 15-2694GC 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.

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[15] The Provider has included the Appellants' Reply Brief in *Advocate Christ Med. Ctr. v. Becerra*, No. 22-5214 (D.C. Cir.), which is on appeal from the decision in *Advocate Christ Med. Ctr. v. Azar*, 17-cv-1519 (TSC), 2022 WL 2064830, (D.D.C. June 8, 2022).
[16] Issue Statement at 1.
[17] *Id.*
[18] *Id.*

Thus, the Board finds the DSH Payment/SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH/SSI Percentage (Data Match) issue in Case No. 15-2694GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6,[19] the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

In making this finding, the Board further notes that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, the Provider is pursuing that issue as part of the group under Case No. 15-2694GC. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[20] The Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged data matching issue appealed in Case No. 15-2694GC.

To this end, the Board also reviewed the Provider's Final Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 15-2694GC, but instead refers to *Baystate* issues, generally, which are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider's Final Position Paper failed to comply with the Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 and explain the nature of any alleged "errors" in its Final Position Paper and include *all* exhibits.

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

> 25.2.2 Unavailable and Omitted Documents If documents necessary to support your position are still unavailable, then provide the following information in the position papers:
> 1. Identify the missing documents;
> 2. Explain why the documents remain unavailable;
> 3. State the efforts made to obtain the documents; and
> 4. Explain when the documents will be available.

---

[19] Board Rule 4.6 (v. 2.0, Aug. 29, 2018). This version of the Board Rules is cited within since the Group Case 15-2694GC was filed on September 4, 2018.

[20] The types of systemic errors documented in the *Baystate* did not uniformly impact the SSI calculation for all providers but that does not make the errors any less systemic. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. 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).

> Once the documents become available, promptly forward them to the Board and the opposing party. Common examples of unavailable documentation include pending discovery requests, pending requests filed under the federal Freedom of Information Act (also known as FOIA requests), or similar requests for information pending with a state Medicaid agency.

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

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

The CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows:

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

The Provider indicates that the data made available "lacks all data records necessary to fully identify all patients properly includable in the SSI fraction"[23] but does not explain how the data provided is deficient. Instead, CMS' website explains that what is provided is the same data set CMS uses to calculate the Medicare fractions.

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[21] Last accessed February 24, 2023.
[22] Emphasis added.
[23] Provider's Final Position Paper at 9.

In summary, the Board finds that the remaining issue in the instant appeal and the group issue from Group Case 15-2694GC are the same issue. Duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6.[24] Moreover, as mentioned above, the Provider is subject to the mandatory rules governing common issue related party ("CIRP") groups at 42 C.F.R. § 405.1837(b)(1) and is therefore pursuing the SSI Accuracy issue in the Group Case 15-2694GC. For these reasons, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue from the instant appeal (Case No. 17-0163).

The Board also finds that the third aspect of Issue 1, the Provider arguing over the interpretation of "entitled to" and "eligible for" benefits for purposes of calculating the numerator of the SSI fraction is duplicative of the issue in group case 15-2694GC. In the group case, the Providers describe the issue as the failure of CMS "to properly determine the ratio of patient days for patients entitled to Medicare Part A and Supplemental Security Income (SSI) benefits (excluding any State supplementation) to patient days for patients entitled to Medicare Part A (Medicare Proxy or Fraction) for the Provider in its Disproportionate Share Hospital (DSH) eligibility determination and payment calculation."[25] While this aspect of the issue is not stated exactly the same in both appeal requests, the group issue can be read to subsume this issue, and therefore, the Board finds that this aspect of Issue 1 is also duplicative of the issue in group Case No. 15-2694GC.

Additionally, in its Final Position Paper, the Provider stated "The [Provider] hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra (Appellants' reply brief included as Exhibit P-3)." The Board finds that this purported argument does not comply with the regulations and Board rules to fully develop the Provider's position in the Final Position Paper, because the Provider merely lists a case name and does not explain further what the arguments are that it would like to incorporate into this appeal.

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

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.[26]

Therefore, the Board finds that the Provider did not comply with the Final Position Paper regulations and Board Rules with respect to the purported *Advocate Christ* argument and dismisses that portion of the issue.

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[24] Board Rule 4.6 (v. 2.0, Aug. 29, 2018).
[25] PRRB Case No. 15-2694GC, Group Issue Statement (Sept. 4, 2018).
[26] Emphasis added.

2. Second Aspect of Issue 1

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

The MAC added Exhibit C-3 to the record with its Final Position Paper, which shows that the Provider requested SSI realignment on March 25, 2019, and that the request was granted by letter dated March 26, 2019. Further, the Amended Notice of the amount of Medicare program reimbursement based on the Provider's cost reporting fiscal period end of December 31, 2013, was issued on January 2, 2020. *See* Exhibit C-3 at C-00035. Therefore, the Provider's request to preserve its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting year is now moot, as this request was made and granted. For this reason, the Board dismisses this aspect of Issue 1.

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In summary, the Board hereby dismisses the DSH Payment/SSI Percentage (Provider Specific) issue from this appeal as it is duplicative of the issue in Case No. 15-2694GC and the SSI realignment portion of the issue is moot. As no issues remain pending, the Board hereby closes Case No. 17-0163 and removes it from the Board's docket.

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

Board Members Participating:

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For the Board:

7/31/2023

X Kevin D. Smith, CPA

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

cc: Wilson Leong, Federal Specialized Services