DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
7500 Security Boulevard
Mail Stop: N2-19-25
Baltimore, MD 21244
410-786-2671

Via Electronic Delivery

William Galinsky
Baylor Scott & White Health
2401 South 31st St. MS-AR-M148
Temple, TX 76508

Bill Tisdale
Novitas Solutions, Inc.
707 Grant Street, Suite 400
Pittsburgh, PA 15219

RE: ***Jurisdictional Determination***
Baylor Scott & White Medical Center Lake Pointe (Prov. No. 45-0742)
FYE 05/31/2016
Case No. 21-0275

Dear Mr. Galinsky and Mr. Tisdale,

The Provider Reimbursement Review Board ("Board") has reviewed the above-captioned appeal involving Baylor Scot & White Medical Center Lake Pointe ("Provider") and finds an impediment to the Board's jurisdiction. The Provider is part of Tenet Health and, thus, is subject to the mandatory common issue relate party ("CIRP") group requirements. The pertinent facts and the Board's jurisdictional determination are set forth below.

Background

On March 8, 2019, Tenet Health requested reopening of its cost report for fiscal year ("FY") 2016 for purposes of "recalculation of the SSI percentage based on its own fiscal year dating 06/01/2015 - 5/31/2016." Tenet Health further suggested the impact of the recalculation: "Based on the analysis of routine use data, converting the SSI percentage to the hospital's fiscal year (06/01/15 - 05/31/16) will increase the SSI percentage from 5.66% to 634%."[1]

On April 18, 2018, the Medicare Contractor issued a Notice of Reopening in which it advised that the FY 2016 cost report was being reopened "[t]o update the SSI percentage and DSH payment percentage based on the Provider's request to base the SSI percentage on their cost report Fiscal Year, 5/31/2016, as calculated and approved by CMS."[2]

On March 20, 2020, the Medicare Contractor issued the Notice of Correction of Program Reimbursement (RNPR)[3] with the realigned SSI percentage (*i.e.*, realigning the SSI percentage from the federal fiscal year to the Provider's fiscal year).[4] In this regard, Audit Adjustment No. 5 was issued "[t]o update the SSI percentage and recalculate the allowable DSH percentage."[5]

[1] Exhibit C-1 attached to Medicare Contractor's Jurisdictional Challenge.
[2] Exhibit C-2 attached to Medicare Contractor's Jurisdictional Challenge.
[3] Hereafter, the Notice of Amount of Corrected Program Reimbursement will be referred to as a revised Notice of Program Reimbursement ("RNPR").
[4] Medicare Contractor's Notice of Correction of Program Reimbursement, at 1.
[5] Audit Adjustment Report, at Issue Description.

On September 17, 2020, the Provider filed an individual appeal from the RNPR,[6] to which the Board assigned Case No. 21-0275. The RNPR appeal included nine (9) issues:

1. DSH/SSI Percentage (Provider Specific)
2. DSH/SSI Percentage
3. DSH – SSI Fraction/Medicare Managed Care Part C Days
4. DSH – SSI Fraction/Dual Eligible Days
5. DSH Payment – Medicaid Eligible Days
6. DSH Payment – Medicaid Fraction/Medicare Managed Care Part C Days
7. DSH Payment – Medicaid Fraction/Dual Eligible Days
8. 2 Midnight Census IPPS Payment Reduction
9. Standardized Payment Amount[7]

The Provider transferred issues 2, 3, 4, 6, 7, and 9 to group cases. Specifically, Issue 2 was transferred to Case No. 19-2456GC, Issue 3 to Case No. 19-2457GC, Issue 4 to Case No. 19-2458GC, Issue 6 to Case No. 19-2459GC,[8] Issue 7 to Case No. 19-2460GC,[9] and Issue 9 to Case No. 19-2462GC. The Provider withdrew Issue 8 from the individual case.

The Provider referenced Audit Adjustment No. 5 from the RNPR for all issues other than the Standardized Payment Amount which the Provider indicated was self-disallowed. As noted above, Audit Adjustment No. 5 was issued to include the SSI percentage that had been realigned from the federal fiscal year to the Provider's fiscal year.[10]

On September 14, 2021, the Medicare Contractor filed a jurisdictional challenge for Issues 1 and 5. The Challenge documented that the RNPR in dispute was issued based on the Provider's request to realign the SSI percentage or fraction from the federal fiscal year to the Provider's fiscal year. In this regard, the Medicare Contractor provided copies of the Provider's Request for Reopening dated March 8, 2019 (Exhibit C-1) and the Medicare Contractor's Notice of Reopening Dated April 18, 2019 (Exhibit C-2). The Medicare Contractor essentially asserts that the Board does not have jurisdiction over Issues 1 and 5 since the Provided filed from an RPNR and the RNPR was issues as a result of the Provier's SSI realignment request and did not specifically adjust for Issues 1 or 5. As a result, the Medicare Contractor concludes that the Provider did not have a right to appeal these issues under 42 C.F.R. § 1405.1889(b) as referenced in § 405.1835(a)(1).

The Provider did not respond to the Jurisdictional Challenge within the 30 days allotted under Board Rule 44.4.3 which specifies: "Providers must file a response within thirty (30) days of the

[6] Provider's Model Form A – Individual Appeal Request.
[7] *Id.*, at Appeal Issues.
[8] Case No. 19-2459GC was closed and consolidated into Case No. 19-2457GC on July 20, 2021.
[9] A Request for Expedited Judicial Review was filed in Case No. 19-2460GC which was denied by the Board on August 3, 2022. The Board's August 3, 2022 letter also dismissed Case No. 19-2460GC as having been abandoned when the Representative failed to brief the No Pay Part A Policy as directed in the Board's June 29, 2922 Scheduling Order and Request for Information.
[10] Audit Adjustment Report, at Issue Description.

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." To date, the Provider still has not filed a response.

Board Determination

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

The Board finds that it does not have jurisdiction over any of the 8 issues included in the individual appeal request (and not withdrawn), including the previously transferred issues, because the appeal is based on the RNPR which was issued as a result of the Provider' SSI Realignment request and there was no specific adjustment for any of these 8 issues. As the Provider appealed an RNPR, its appeal rights are limited by 42 C.F.R. § 405.1889(b) as referenced in § 405.1835(a)(1) and, under this regulation, the Provider does not have the right to appeal any of these issues from the RNPR in dispute.

A. Relevant Regulations – RNPRs

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

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

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

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

> (2) Any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision.

B. The Board's Rationale

1. Rescinding and Voiding of the Transfer of Issue 9 and Dismissing That Issue

The Provider recognized in its appeal request that the RNPR did not adjust the standardized amount because it did not cite to an audit adjustment but rather claims that it self-disallowed. However, self disallowance generally pertains to the original filing of the cost report where the provider filed the cost report in accordance with the dictates of cost reporting rules and regulations. Here, *in the context of the RNPR*, the Provider did not self-disallow anything because, for purposes of the RNPR reopening, it did not file anything relating to the standardized amount or otherwise requesting adjustment of the standardized amount. In this regard, the RNRP did not specifically adjust the standardized amount. As it is clear the Provider had no right under 42 C.F.R. § 405.1889(b) (as referenced in § 405.1835(a)(1)) to appeal Issue 9 from the RNPR, the Board hereby rescinds and voids the Provider's transfer of that issue to the CIRP group under Case No. 19-2462GC and dismisses Issue 9 from this appeal.

2. Dismissal of the SSI Fraction Issues – Dismissing Issue 1 and Rescinding and Voiding of the Transfer of Issues 2, 3, and 4and Dismissing Issues 2, 3, and 4

The Provider's appeal request has stated its RNPR appeal of Issues 1 through 4 relate to the DSH SSI fraction and are each based on Audit Adjustment No. 5. As explained above, Audit Adjustment No. 5 simply reflects the inclusion of the SSI percentage that had been realigned from the federal fiscal year to the Provider's fiscal year. As explained below, this adjustment to incorporate the realigned SSI percentage did not adjust for any of the Issue 1 through 4 and, as such, it is clear the Provider had no right under 42 C.F.R. § 405.1889(b) (as referenced in § 405.1835(a)(1)) to appeal Issues 1 through 4 from the RNPR.

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[.]"[11] The reopening in this case was a result of the Provider's request to realign its SSI percentage from the federal fiscal year end to its individual cost reporting fiscal year end. Based on the Notice of Reopening, the RNPR under appeal clearly only revised the SSI percentage in order to realign it from a federal fiscal year to the provider's respective fiscal year. As described below, RNPR was being issued only to include the realigned SSI percentage where the SSI percentage was realigned from the federal fiscal year to the provider's fiscal year, *and* 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. Thus,

[11] 42 C.F.R. § 405.1889(b)(1).

the Board has consistently found that it does not have jurisdiction over RNPRs that were issued as a result of a provider's request for realignment of its SSI percentage.

As noted in 42 C.F.R. § 412.106(b)(2), CMS gathers data to be used in the SSI fraction on a month-by-month basis:

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

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

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

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

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

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

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

In other words, the determination was only being reopened to include realigned SSI percentages and CMS' realignment process (as described in the Federal Register) does ***not*** entail re-running of the data matching process that the Providers are trying to appeal (much less revise any of the SSI paid days, Part A, or Part C days included in the underlying month-by-month data). Since the only matters specifically revised in the RNPR was the adjustment to realign the SSI percentage from the federal fiscal year to the provider's fiscal year, the Board does not have jurisdiction over the RNPR appeal of the DSH SSI fraction issues included in Issues 1, 2, 3, and 4 because the Provider did not have the right under 42 C.F.R. § 405.1889(b) (as referenced in § 405.1835(a)(1)) to appeal those issues from the RNPR. Accordingly, the Board hereby: (a) rescinds and voids the transfers of Issues 2, 3, and 4 to Case Nos. 19-2456GC, 19-2457GC, and 19-2458GC respectively since there was no basis for the appeal of those issues and their ensuing transfer; and (b) dismisses Issues 1 through 4 from this appeal.

3. *Dismissal of the DSH Medicaid Fraction Issues – Dismissing Issue 5 and Rescinding and Voiding the Transfer of Issues 6 and 7 and Dismissing Issues 6 and 7*

[15] (Emphasis added.)

The Provider's appeal request has stated its RNPR appeal of Issues 5 through 7 relate to the DSH Medicaid fraction and are each based on Audit Adjustment No. 5. As explained above, Audit Adjustment No. 5 simply reflects the inclusion of the SSI percentage that had been realigned from the federal fiscal year to the Provider's fiscal year. As such, it is clear that Audit Adjustment 5 did ***not*** adjust the Medicaid fraction, much less specifically adjust the Medicaid fraction for Issues 5, 6, or 7. As such, it is clear the Provider had no right under 42 C.F.R. § 405.1889(b) (as referenced in § 405.1835(a)(1)) to appeal Issues 5 through 7 from the RNPR since there was no specific adjustment on the RNPR for those issues. Accordingly, the Board hereby: (a) rescinds and voids the transfers of Issues 6 and 7 to Case Nos. 19-2459GC and 19-2460GC respectively since there was no basis for the appeal of those issues and their ensuing transfer; and (b) dismisses Issues 5, 6 and 7 from this appeal.

*****

In conclusion, *the Board **rescinds and voids the previous transfers** of Issues 2, 3, 4, 6, 7 and 9 to CIRP groups **and dismisses** all 9 issues from the Case No. 21-0275* as the Provider did ***not*** have the right to appeal the RNPR at issue for ***any*** of these 9 issues.[16] *To this end, the Board has included the Group Representative, QRS, as a carbon copy to ensure that **the Provider's RNPR appeal** is no longer listed as a participant in the affected CIRP groups under Case Nos. 19-2456GC, 19-2457GC, 19-2458GC, 19-2459GC, 19-2460GC and 19-2462GC.*[17] In issuing this dismissal, the Board notes that its application of 42 C.F.R. § 405.1889(b) has been upheld by courts on review[18] and that the Provider had the opportunity to appeal all of these issues from the original NPR issued for FY 2016 but apparently forewent that opportunity.

As there are no remaining issues in the individual appeal, the Board hereby closes Case No. 21-0275 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.
Gregory H. Ziegler, CPA
Robert A. Evarts, Esq.
Kevin D. Smith, CPA
Ratina Kelly, CPA

For the Board:

1/3/2023

X Clayton J. Nix

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

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services
James Ravindran, Quality Reimbursement Services, Inc.

[16] As a result of this dismissal decision, Baylor Scott & White Medical Center Lake Pointe (Prov. No. 45-0742) for FYE 05/31/2016 is no longer a participant, ***based on its RNPR appeal***, in the CIRP groups under Case Nos. 19-2456GC, 19-2457GC, 19-2458GC, 19-2459GC, 19-2460GC and 19-2462GC.
[17] *See supra* note 16.
[18] *See St. Mary's of Mich. V. Azar*, No. 18-01790, 2020 WL 4049912 (D.D.C. July 20, 2020); *McLaren Flint v. Azar*, No. 18-2005, 2020 WL 2838566 (D.D.C. May 31, 2020), *Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F.Supp.3d 348 (D.D.C. 2014); *HCA Health Servs. of OK v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Board Decision* – SSI Percentage (Provider Specific)**
Naples Community Hospital
Provider Number: 10-0018
FYE: 09/30/2016
Case Number: 19-2188

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the documentation in Case No. 19-2188 in response to a jurisdictional challenge filed by the Medicare Contractor ("MAC"). The Board's decision is set forth below.

Background:

A. Procedural History for Case No. 19-2188

On June 27, 2019, Naples Community Hospital ("Provider"), appealed a Notice of Program Reimbursement ("NPR") dated December 27, 2018, for its fiscal year end ("FYE") September 30, 2016 cost reporting period. The Provider appealed the following issues:[1]

- Issue 1: DSH SSI Percentage (Provider Specific)
- Issue 2: DSH SSI Percentage
- Issue 3: DSH SSI Fraction - Medicare Managed Care Part C Days
- Issue 4: DSH SSI Fraction - Dual Eligible Days (Exhausted Part A Benefit Days, MSP Days and No-Pay Part A Days)
- Issue 5: DSH - Medicaid Eligible Days
- Issue 6: DSH – Medicaid Fraction – Medicare Managed Care Part C Days
- Issue 7: DSH – Medicaid Fraction – Dual Eligible Days (Exhausted Part A Benefit Days, MSP Days and No-Pay Part A Days)
- Issue 8: Uncompensated Care Distribution Pool
- Issue 9: Two Midnight Census IPPS Payment Reduction
- Issue 10: Standardized Payment Amount

[1] Provider's Request for Hearing, Tab 3 (June 27, 2019).

Issues 2-5, 7 and 9-10 were transferred to Group Cases on January 23, 2020. Issues 6 and 8 were withdrawn by the Provider on October 19, 2022. Therefore, Issue 1, DSH SSI Percentage (Provider Specific), is the only remaining issue.

Relevant here, the Medicare Administrative Contractor ("MAC") filed a jurisdictional challenge on April 15, 2020 regarding Issue 1. Significantly, the Provider did not file a response to the Jurisdictional Challenge within the 30 days allotted under Board Rule 44.4.3 which specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 19-2511G

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

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

> denominator. CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare 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.[2]

The Appeal Request describes Issue 2, which was transferred to group Case No. 19-2511G, as follows.

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

[2] Provider's Request for Hearing, Tab 3, Issue Statement (June 27, 2019).

> *Baystate Medical Center v. Michael O. Leavitt,* 545 F. Supp. 2d 37, 44 (D.D.C. 2008) and incorporate a new methodology inconsistent with the Medicare Statute.
>
> Providers in this case are also seeking resolution of the following additional aspects of the Medicare fraction that were not addressed in the Baystate case:
>
> 1. Availability of MEDPAR and SSA Records
> 2. Failure to adhere to required notice and comment rulemaking procedures
> 3. Fundamental problems in the SSI percentage calculation
> 4. Not in agreement with provider's records
> 5. Paid days vs. Eligible Days, and
> 6. Covered days vs. Total days.[3]

The estimated amount in controversy listed for both Issues 1 and 2 is $225,000. The group issue statement in Case No. 19-2511G, the case to which Issue 2 was transferred is as follows:

> **Statement of the Issue:**
>
> Whether the Secretary properly calculated the Provider's Disproportionate Share Hospital ("DSH")/Supplemental Security Income ("SSI") percentage, and whether CMS should be required to recalculate the SSI percentages using a denominator based solely upon covered and paid for Medicare Part A days, or alternatively, expand the numerator of the SSI percentage to include paid/covered/entitled as well as unpaid/non-covered/eligible SSI days?
>
> **Statement of the Legal Basis**
>
> The Provider(s) contend(s) that the MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute at 42 U.S.C. § 1395ww (d)(5)(F)(vi)(I). The Provider(s) further contend(s) that the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") and used by the MAC to settle their Cost Reports incorporates a new methodology inconsistent with the Medicare statute.
>
> The Providers challenge their SSI percentages based on the following reasons:
> 1. Availability of MEDPAR and SSA records,

[3] *Id.*

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

COVERED DAYS VS. TOTAL DAYS

The statutory language defines the Medicare/SSI fraction as consisting solely of days for patients who were "entitled to benefits under part A" of Medicare. The numerator includes only those Part A days for patients who are also entitled to SSI benefits. The denominator of the Medicare/SSI fraction includes all Part A days. As set forth in the statutory language above, the numerator of the Medicaid fraction consists of days of patients who were both eligible for medical assistance under Title XIX, or Medicaid, and not entitled to benefits under Part A of Title XVII, or Medicare. The denominator for the Medicaid fraction is the hospital's total patient days for the period.

CMS considers an individual to be "entitled to benefits under Part A" regardless of whether the days were "covered" or paid by Medicare. This means that now Part C days, Exhausted Benefit days, and Medicare Secondary Payer ("MSP") days are included in the denominator of the Medicare/SSI fraction even when there is no payment by Medicare, which is a departure from the treatment of these days as excluded from the Medicare/SSI fraction prior to the 2004 rule.

The Provider(s) contend(s) that if CMS includes unpaid Medicare Part A days in the denominator of the Medicare/SSI fraction, then unpaid SSI eligible patient days must be included in the numerator of the Medicare/SSI fraction, utilizing SSI payment codes that reflect the individuals' eligibility for SSI – even if the individuals did not receive SSI payments, as a matter of statutory consistency.

On June 22, 2022, the Provider filed 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 contends that the SSI percentages 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. This is based on certain data from the State of Florida and the Provider that does not support the SSI percentage issued by CMS.
>
> The Provider has worked with the State of Florida and has learned that similar to *Loma Linda Community Hospital v. Dept of Health* and Human Services, No. CVT94- 0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records.
>
> The Provider is seeking the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000, from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. *See* 65 Fed. Reg. 50,548 (2000). The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction.

The only exhibit included with the final position paper that relates to Issue 1 was Exhibit 2, which shows that the amount in controversy for the issue is $225,377. This is the same estimated amount ($225,000) that is listed as the amount in controversy for this Provider as a participant in 19-2511G.

MAC's Contentions:

In its April 15, 2020 jurisdictional challenge, the MAC asserts that, based on the language the Provider used in its appeal request, Issue 1 can be divided into three components: (1) SSI data accuracy; (2) SSI realignment; and (3) individuals who are eligible for SSI but did not receive

SSI payment.[4] With regard to components (1) and (3), the MAC asserts that these issues are duplicates of Issue 2, which was transferred to Group Case 19-2511G, "QRS CY 2016 DSH SSI Percentage Group" on January 23, 2020, and that pursuant to Board Rule 4.6, a provider may not appeal an issue from a final determination in more than one appeal.[5]

Further, the MAC first notes that the Provider's cost reporting year end is identical to the Federal fiscal year end, and this oversight leaves the MAC questioning the right the Provider is attempting to preserve in the SSI realignment component of this issue. Nonetheless, the MAC considers the SSI realignment component of this issue premature according to 42 C.F.R. § 405.1835 because the MAC has not made a determination on the realignment issue. In addition, because the Provider did not brief this issue in its preliminary position paper, the MAC asserts that the Provider has abandoned this sub-issue.[6]

Provider's Response:

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

Moreover, as quoted above, in the Provider's final position paper filed on June 22, 2022, the Provider did not address the assertion that components of Issue 1 are duplicative of Issue 2, and did not mention the realignment issue.

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. SSI Provider Specific

The analysis for Issue 1 has several relevant aspects to consider: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, which the MAC separated into two parts, (1) and (3), above, based on the Provider's description but which can both be categorized within this first aspect of Issue 1; and 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 arguing over the interpretation of

[4] MAC's Jurisdictional Challenge, at 1 (Apr. 15, 2020).
[5] *Id.* at 2.
[6] *Id.* at 2-4.

"entitled to" and "eligible for" benefits for purposes of calculating the numerator of the SSI fraction.

1. First and Third Aspects of Issue 1

The first aspect of Issue 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH SSI Percentage issue that was transferred to Case No. 19-2511G, *QRS CY 2016 DSH SSI Percentage Group*.

The Board finds that the first aspect of Issue 1 (the DSH/SSI (Provider Specific) issue) in this appeal is duplicative of Issue 2 (the DSH/SSI Percentage issue) that was transferred into Case No. 19-2511G. The first aspect of Issue 1 in the present appeal concerns "whether the Medicare Administrative Contractor used the correct [SSI] percentage in the [DSH] Calculation."[7] The Provider's legal basis for this aspect of Issue 1 is simply that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[8] Similarly, the Provider argues that "it[s] SSI percentage published by [CMS] was incorrectly computed . . ." and it ". . . [s]pecifically . . . disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[9] The DSH/SSI Percentage issue transferred to Case No. 19-2511G, similarly alleges that the Medicare Contractor and CMS improperly calculated the DSH/SSI Percentage, the DSH/SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Indeed, the Provider has the same amount in controversy for both Issue 1 and for its participation in the group appeal, namely $225,000.

Thus, the Board finds that the first aspect of Issue 1 in this appeal is duplicative of the group issue in Case No. 19-2511G, for this same provider and fiscal year. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6 (Aug. 29, 2018), the Board dismisses this aspect of the DSH/SSI (Provider Specific) issue.

In making this finding, the Board further notes that CMS regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, the provider is pursuing that issue as part of the group under Case 19-2511G. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[10] The Provider's

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

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) in its appeal request how the alleged "provider specific" errors can be distinguished from the alleged SSI Percentage issue rather than being subsumed into the SSI percentage issue appealed in Case No. 19-2511G.

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 that the Provider transferred to Case No. 19-2511G. In fact, the Provider included the same paragraph discussing this issue in both Issues 1 and 2:

> 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.

Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6 (Aug. 29, 2018), the Board dismisses this third aspect of the DSH/SSI (Provider Specific) issue.

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 Percentage issue in Case No. 19-2511G, 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 (filed on June 22, 2022) failed to comply with the Board Rule 25 (Nov. 1, 2021) (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 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.[11] This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows: "DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[12]

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

As discussed above, the Board has found that the first and third aspects of Issue 1 and the group issue in Group Case 19-2511G, 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 has dismissed these components of the DSH/SSI (Provider Specific) issue. As an alternative basis the Board dismisses Issue 1 for failure of the Provider to properly brief the issue in its position paper in compliance with Board Rules, as described above.

2. Second Aspect of Issue 1

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

The Board also notes that the Provider's cost reporting period is the same as the federal fiscal year end, which means there is no effect of realignment in this case. Moreover, the Provider's final position paper does not address this aspect of the issue at all.

****

In summary, the Board hereby dismisses the SSI (Provider Specific) issue from this appeal as it is duplicative of the issue in Case No. 19-2511G, there is no final determination from which the Provider can appeal the SSI realignment portion of the issue, and the Provider failed to meet the Board requirements for position papers. As no issues remain pending, the Board hereby closes Case No. 19-2188 and removes it from the Board's docket.

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

Board Members:

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

For the Board:

1/3/2023

X Kevin D. Smith, CPA

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

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

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

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

RE: ***Board Decision* – SSI Percentage (Provider Specific)**
Sharon Regional Health System (Provider Number: 39-0211)
FYE 06/30/2014
Case No. 17-1648

Dear Mr. Summar:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the documentation in Case No. 17-1648 in response to a jurisdictional challenge filed by the Medicare Contractor ("MAC"). The Board's decision is set forth below.

Background:

A. Procedural History for Case No. 17-1648

On June 8, 2017, Provider appealed a Notice of Program Reimbursement (NPR) dated December 8, 2016, for its fiscal year end (FYE) June 30, 2014 cost reporting period. The Provider appealed the following issues:[1]

- Issue 1: DSH SSI Percentage (Provider Specific)
- Issue 2: DSH SSI Percentage
- Issue 3: DSH SSI Fraction - Medicare Managed Care Part C Days
- Issue 4: DSH SSI Fraction - Dual Eligible Days (Exhausted Part A Benefit Days, MSP Days and No-Pay Part A Days)
- Issue 5: DSH – Medicaid Fraction – Medicare Managed Care Part C Days
- Issue 6: DSH – Medicaid Fraction – Dual Eligible Days (Exhausted Part A Benefit Days, MSP Days and No-Pay Part A Days)
- Issue 7: DSH - Medicaid Eligible Days
- Issue 8: DSH Medicare Managed Care Part C Days
- Issue 9: DSH – Dual Eligible Days (Exhausted Part A Benefit Days, MSP Days and No-Pay Part A Days)
- Issue 10: Uncompensated Care Distribution Pool

[1] Provider's Request for Hearing, Tab 3 (June 8, 2017).

- Issue 11: 2 Midnight Census IPPS Payment Reduction

Issues 2-6 and 8-11 were transferred to Group Cases on either January 30-31, 2018 or June 30, 2018. Therefore, Issue 1, DSH SSI Percentage (Provider Specific) and Issue 7, DSH Medicaid Eligible Days, are the only remaining issues. Relevant here, the Medicare Administrative Contractor ("MAC") filed a jurisdictional challenge on April 5, 2018 regarding Issue 1.[2]

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

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

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

[2] The MAC's Jurisdictional Challenge also addressed Issue 7, among others, and argued that the MAC did not make a final determination on this issue and the Provider did not protest or self-disallow this issue. However, by letter dated December 25, 2022, Federal Specialized Services, the representative for the MAC, confirmed that the Provider is not continuing to challenge the jurisdiction over Issue 7, and that no decision over the Medicare Eligible Days issue was needed.

> applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days of care) as Medicare Part A days, yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment.[3]

The Appeal Request describes Issue 2, which was transferred to group Case No. 18-0109GC, as follows.

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

[3] Provider's Request for Hearing, Tab 3, Issue Statement (June 27, 2019).

> 37, 44 (D.D.C. 2008) and incorporate a new methodology inconsistent with the Medicare Statute.
>
> Providers in this case are also seeking resolution of the following additional aspects of the Medicare fraction that were not addressed in the Baystate case:
>
> 1. Availability of MEDPAR and SSA Records
> 2. Failure to adhere to required notice and comment rulemaking procedures
> 3. Fundamental problems in the SSI percentage calculation
> 4. Not in agreement with provider's records
> 5. Paid days vs. Eligible Days, and
> 6. Covered days vs. Total days.[4]

The estimated amount in controversy listed for both Issues 1 and 2 is $11,000. The group issue statement in Case No. 18-0109GC, the case to which Issue 2 was transferred is exactly the same as the issue statement described above for Issue 2.[5]

On November 18, 2022, the Provider filed its final position paper in Case No. 17-1648. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Calculation of the SSI Percentage**
>
> **Provider Specific**
>
> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits their calculation based on the Provider's Fiscal Year End (June 30).
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.
>
> Similar to *Loma Linda Community Hospital v. Dept of Health* and Human Services, No. CVT94- 0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records. However, at this time, the Provider has been unable to analyze the Medicare Part A data because it has not yet received the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR"), HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000, from CMS. *See* 65

[4] *Id.*
[5] Provider's Request for Hearing in PRRB Case No. 18-0109GC, Group Issue Statement (Oct. 23, 2017).

> 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 Fiscal Year End (September 30) when it determined the Provider's SSI. *See Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).

The only exhibit included with the final position paper that relates to Issue 1 was Exhibit 2, which shows that the amount in controversy for the issue is $10,705. This is the same amount that is listed as the amount in controversy for this Provider as a participant in 18-0109GC.

MAC's Contentions:

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 Issues 1 and 2. Under Board Rules, the Provider is barred from filing a duplicate SSI percentage issue. Therefore, the Board should find that the SSI percentage is one issue for appeal purposes and that Issue 1 should be dismissed."[6]

With regard to the realignment portion of Issue 1, the MAC notes:

> "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....The Provider's appeal of this...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."[7]

Provider's Response:

In response, the Provider asserts that Issues 1 and 2 represent different components of the SSI issue. The Provider asserts that Issue 2, the SSI Systemic Issue, "addresses the various errors

[6] MAC Jurisdictional Challenge, at 2 (Apr. 5, 2018).
[7] *Id.* at 3.

discussed in *Baystate Medicare 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,"[8] and lists examples of such errors. In Issue 1, the Provider asserts:

> "Provider is not addressing the errors which result from CMS' improper data matching process but is addressing the various errors and omission and commission that do not fit into the "systemic errors" category. In Baystate, the Board also considered whether, independent of these systemic errors, whether Baystate's SSI fractions were understated due to the number of days included in the SSI ratio. The Provider has analyzed Medicare Part A records and has been able to identify patients believed to be entitled to both Medicare Part A and SSI. The Provider has reason to believe that the SSI percentage determined by CMS is incorrect due to the understated days in the SSI ratio."[9]

The Provider did not address the SSI alignment portion of Issue 1 in its April 30, 2018 response to the MAC's Jurisdictional Challenge.

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. SSI Provider Specific

The analysis for Issue 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 arguing over the interpretation of "entitled to" and "eligible for" benefits for purposes of calculating the numerator of the SSI fraction.

1. First and Third Aspects of Issue 1

The first aspect of Issue 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH SSI Percentage issue that was transferred to Case No. 18-0109GC, *QRS CHS 2014 DSH SSI Percentage CIRP Group*.

[8] Provider's Jurisdictional Challenge Response at 2 (Apr. 30, 2018).
[9] *Id.*

The Board finds that the first aspect of Issue 1 (the DSH/SSI (Provider Specific) issue) in this appeal is duplicative of Issue 2 (the DSH/SSI Percentage issue) that was transferred into Case No. 18-0109GC. The first aspect of Issue 1 in the present appeal concerns "whether the Medicare Administrative Contractor used the correct [SSI] percentage in the [DSH] Calculation."[10] The Provider's legal basis for this aspect of Issue 1 is simply that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[11] Similarly, the Provider argues that "it[s] SSI percentage published by [CMS] was incorrectly computed . . ." and it ". . . [s]pecifically . . . disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[12] The DSH/SSI Percentage issue, transferred to Case No. 18-0109GC, similarly alleges that the Medicare Contractor and CMS improperly calculated the DSH/SSI Percentage, the DSH/SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Indeed, the Provider has the same amount in controversy for both Issue 1 and for its participation in the group appeal (formerly Issue 2), namely an estimated $11,000 (or $10,705).

Thus, the Board finds that the first aspect of Issue 1 in this appeal is duplicative of the group issue in Case No. 18-0109GC, for this same provider and fiscal year. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (July 1, 2015), the Board dismisses this aspect of the DSH/SSI (Provider Specific) issue.

In making this finding, the Board further notes that CMS regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, the Provider is pursuing that issue as part of the group under Case 18-0109GC. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[13] 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) in its appeal request or response to the jurisdictional challenge of how the alleged "provider specific" errors can be distinguished from the alleged SSI Percentage issue rather than being subsumed into the SSI percentage issue appealed in Case No. 18-0109GC.

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 Percentage issue in Case No. 18-0109GC, but instead refers to systemic *Baystate* data

[10] Individual Appeal Request, Issue 1.
[11] *Id.*
[12] *Id.*
[13] The types of systemic errors documented in the *Baystate* did not uniformly impact the SSI calculation for all providers but that does not may the errors any less systemic. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). *See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).

matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider's Final Position Paper (filed on November 18, 2022) failed to comply with the Board Rule 25 (Nov. 1, 2021) (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 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.[14] This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows: "DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[15]

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 that the Provider transferred to Case No. 18-0109GC. In fact, the Provider included the same paragraph discussing this issue in both Issues 1 and 2, as follows:

> 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.

Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (July 1, 2015), the Board dismisses this third aspect of the DSH/SSI (Provider Specific) issue. Moreover, the Provider did not brief this aspect of the issue in its Final Position Paper.

As discussed above, the Board has found that the first and third aspects of Issues 1 and the group issue in Group Case 18-0109GC, are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (July 1, 2015), the Board dismisses these components of the DSH/SSI (Provider Specific) issue. As an alternative basis the Board dismisses Issue 1 for failure of the Provider to properly brief the issue in its position paper in compliance with Board Rules, as described above.

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

2. Second Aspect of Issue 1

With regard to the second aspect of the DSH SSI Percentage (Provider Specific) issue—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—the MAC added Exhibit C-5 to the record with its Final Position Paper, which shows that the Provider requested SSI realignment on June 9, 2020, and that the request was granted by letter dated October 15, 2020. 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.

****

In summary, the Board hereby dismisses the SSI (Provider Specific) issue from this appeal as it is duplicative of the issue in Case No. 18-0109GC, the SSI realignment portion of the issue is now moot, and the Provider failed to meet the Board requirements for position papers. As one issue remains pending, the Medicaid Eligible Days issue, Case No. 17-1648 will remain open.

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

Board Members:

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

For the Board:

1/10/2023

X Kevin D. Smith, CPA

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
7500 Security Boulevard
Mail Stop: B1-01-31
Baltimore, MD 21244-1850
410-786-2671

Via Electronic Delivery

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

RE: ***Notice of Dismissal***
Thorek Hospital and Medical Center (Prov. No. 14-0115)
FYE 6/30/2014
PRRB Case No. 17-0667

Dear Mr. Putnam:

The Provider Reimbursement Review Board ("Board" or "PRRB") received Thorek Hospital and Medical Center's ("Provider") Individual Appeal Request on appeal December 28, 2016, appealing from a Notice of Program Reimbursement ("NPR") dated June 30, 2016. The sole issue remaining is related to Disallowance of Bad Debts. The Provider filed a Preliminary Position Paper ("PPP") on September 1, 2017, and the Medicare Contractor filed its PPP on December 15, 2017.

On March 25, 2020, the Board issued Board Alert 19 announcing temporary adjustment to the Board's processes in light of the Covid-19 public health emergency. In particular, Board Alert 19 suspended Board-set deadlines from March 13, 2020 forward. Board Alert 19 has been withdrawn effective December 7, 2022 with the issuance of Alert 23. Alert 23 announced Board-set deadlines would cease to be suspended for Board rules or instructions, or Board notices and correspondence issued on or after December 7, 2022.

The Board issued a Notice of Hearing on February 1, 2022 which set a due date for Provider's Final Position Paper ("FPP") of June 20, 2022, which was never filed. A hearing was set for September 8, 2022. On July 21, 2022, a new Notice of Hearing was issued, setting a deadline of November 24, 2022 for the Provider's FPP. The new Notice of Hearing specifically stated:

> ***Be advised that the above filing deadlines are firm and the Board has determined to specifically exempt these filing deadlines from Board Alert 19's suspension of Board filing deadlines.***

The new Notice of Hearing also set a hearing date of February 22, 2023. As of the date of this decision, the Provider has not submitted its FPP or filed any other correspondence with the Board.

Board Rule 41.2 (Nov. 2021) permits dismissal or closure of a case on the Board's own motion:

> - if it has a reasonable basis to believe that the issues have been fully settled or abandoned,
> - ***upon failure of the provider or group to comply with Board procedures or filing deadlines***,
> - if the Board is unable to contact the provider or representative at the last known address, or
> - upon failure to appear for a scheduled hearing.[1]

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

> (b) Position papers. (1) After any preliminary narrowing of the issues, the parties must file position papers in order to narrow the issues further. In each case, and as appropriate, the Board establishes the deadlines as to when the provider(s) and the contractor must submit position papers to the Board.
>
> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper must set forth the relevant facts and arguments regarding the Board's jurisdiction over each remaining matter at issue in the appeal (as described in §405.1840 of this subpart), and the merits of the provider's Medicare payment claims for each remaining issue.

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

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

[1] (Emphasis added.)

Board Rule 27.1 (Nov. 2021) notes that, "for appeals filed prior to August 29, 2018 (like the instant appeal), the final position paper remains a required filing, and *failure to timely file the final position papers may result in dismissal of the case.*"[2]

The Board is hereby dismissing case 17-0667 because the Provider has failed to meet the Board set filing deadline for Final Position Papers. The Provider was required to file its Final Position Paper by November 24, 2022 but has failed to do so, and this deadline was exempt from Alert 19.

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

Board Members:

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

For the Board:

1/11/2023

X Gregory H. Ziegler

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

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

[2] (Emphasis in original.)

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

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

RE: ***Notice of Dismissal***
SRI Summa FY 2007 Unmatched Medicaid CIRP
Case No. 14-1552GC

Dear Mr. Putnam:

The Provider Reimbursement Review Board ("Board" or "PRRB") received the group appeal request in Case No. 14-1552GC on December 5, 2013. The group was designated as fully formed on December 8, 2021 and the Providers filed their Preliminary Position Paper on April 14, 2022. The Medicare Contractor filed a Jurisdictional Challenge on July 8, 2022, and its Preliminary Position Paper on July 15, 2022.

On March 25, 2020, the Board issued Board Alert 19 announcing temporary adjustment to the Board's processes in light of the Covid-19 public health emergency. In particular, Board Alert 19 suspended Board-set deadlines from March 13, 2020 forward. Board Alert 19 has been withdrawn effective December 7, 2022 with the issuance of Alert 23. Alert 23 announced Board-set deadlines would cease to be suspended for Board rules or instructions, or Board notices and correspondence issued on or after December 7, 2022.

In response to the Jurisdictional Challenge, the Board issued a Jurisdictional Decision & Order to Cure Record on December 5, 2022, directing that the group representative respond within fifteen (15) days of the letter's signature date to cure the record for Exhibits associated with the preliminary position paper and to make the Schedule of Providers filing required under Board Rules 20 to 20.1. The Board's Order to Cure Record required a response no later than December 20, 2022 and informed you that failing to timely respond would result in the dismissal of the case. The Board's letter specifically stated:

> Be advised that the above filing deadlines are firm and the Board has determined to specifically exempt these filing deadlines from Board Alert 19's suspension of Board filing deadlines.

As of the date of this decision, the Providers' representative has not submitted the requested information or filed any other correspondence with the Board.

Board Rule 41.2 (Nov. 2021) permits dismissal or closure of a case on the Board's own motion:

- if it has a reasonable basis to believe that the issues have been fully settled or abandoned,
- ***upon failure of the provider or group to comply with Board procedures or filing deadlines***,
- if the Board is unable to contact the provider or representative at the last known address, or
- upon failure to appear for a scheduled hearing.[1]

Failure to comply with the Board's deadline for submission the requested documents can be found at 42 C.F.R. § 405.1868:

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

The Providers' representative was required to file the requested information by December 20, 2021 but has failed to do so, and this deadline was exempt from Alert 19. Accordingly, the Board hereby dismisses Case No. 14-1552GC because the Providers' representative failed to meet the Board-set deadline for curing the Exhibits associated with the preliminary position paper and to make the Schedule of Providers filing required under Board Rules 20 to 20.1.

Board Members Participating:

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

[1] (Emphasis added.)

FOR THE BOARD:

1/11/2023

X Robert A. Evarts, Esq.

Robert A. Evarts, Esq.
Board Member
Signed by: Robert A. Evarts -A

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

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

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

RE: ***Board Decision* – SSI Percentage (Provider Specific)**
Alliance Health Seminole (Provider Number 37-0229)
FYE: 03/31/2014
Case Number: 16-2192

Dear Mr. Summar:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the documentation in Case No. 16-2192 in response to a jurisdictional challenge filed by the Medicare Contractor ("MAC"). The Board's decision is set forth below.

Background:

A. Procedural History for Case No. 16-2192

On August 1, 2016, Provider appealed a Notice of Program Reimbursement (NPR) dated February 2, 2016, for its fiscal year end (FYE) March 31, 2014 cost reporting period. The Provider appealed the following issues:[1]

- Issue 1: DSH SSI Percentage (Provider Specific)
- Issue 2: DSH SSI Percentage
- Issue 3: DSH SSI Fraction - Medicare Managed Care Part C Days
- Issue 4: DSH SSI Fraction - Dual Eligible Days (Exhausted Part A Benefit Days, MSP Days and No-Pay Part A Days)
- Issue 5: DSH – Medicaid Fraction – Medicare Managed Care Part C Days
- Issue 6: DSH – Medicaid Fraction – Dual Eligible Days (Exhausted Part A Benefit Days, MSP Days and No-Pay Part A Days)
- Issue 7: DSH - Medicaid Eligible Days
- Issue 8: DSH Medicare Managed Care Part C Days
- Issue 9: DSH – Dual Eligible Days (Exhausted Part A Benefit Days, MSP Days and No-Pay Part A Days)
- Issue 10: Uncompensated Care Distribution Pool

[1] Provider's Request for Hearing, Tab 3 (Aug. 1, 2016).

- Issue 11: 2 Midnight Census IPPS Payment Reduction

Issues 2-6 and 8-11 were transferred to Group Cases on April 28, 2017. Therefore, Issue 1, DSH SSI Percentage (Provider Specific) and Issue 7, DSH Medicaid Eligible Days, are the only remaining issues. Relevant here, the MAC filed a jurisdictional challenge on May 4, 2018 regarding Issue 1.[2] The Provider did not respond to the jurisdictional challenge. Board Rule 44.4 (July 1, 2015) specifies: "The responding party must file a response within 30 days of the Intermediary's [Medicare Contractor's"] jurisdictional challenge. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 17-0578GC

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

> The Provider contends that the MAC did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the MAC's calculation of how the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations.
>
> The provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> The Provider contends that the SSI percentage issued by CMS is flawed.
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. [§] 1395(d)(5)(F)(i).
>
> The Provider also contends that CMS inconsistently interprets the term "entitled" as it is used in the statute. CMS requires SSI payment for days to be counted in the numerator but does not

[2] The MAC's Jurisdictional Challenge also addressed Issue 7, among others, and argued that the MAC did not make a final determination on this issue and the Provider did not protest or self-disallow this issue. However, by letter dated December 15, 2022, the MAC confirmed that no decision on the jurisdictional challenge of the Medicare Eligible Days issue was needed.

> require Medicare Part A payment for days to be counted in the denominator. CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days of care) as Medicare Part A days, yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment.[3]

The Appeal Request describes Issue 2, which was transferred to group Case No. 17-0578GC, as follows:

> **Statement of the Issue:**
>
> Whether the Medicare/SSl fraction used in the Medicare Disproportionate Share Hospital and LIP payment calculations accurately and correctly counted the correct number of patient days to be included in the numerator and denominator of the Medicare/SSl fraction calculation per the Medicare Statute at 42 U.S.C. § 1395ww(d)(5)(F)(vi)?
>
> **Statement of the Legal Basis**
>
> The Provider contends that the Lead MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww(d)(5)(F)(vi). The Provider contends that the SSI percentages calculated by [CMS] and used by the Lead MAC to settle their Cost Report were incorrectly computed.
>
> The Provider also contends that CMS inconsistently interprets the term "entitled" as it is used in the statute. CMS requires SSI payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the denominator. CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days of care) as Medicare Part A days, yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment.

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

> The Provider further contends that the SSI percentages calculated by [CMS] fail to address all the deficiencies as described in *Baystate Medical Center v. Michael O. Leavitt,* 545 F. Supp. 2d 37, 44 (D.D.C. 2008) and incorporate a new methodology inconsistent with the Medicare Statute.
>
> Providers in this case are also seeking resolution of the following additional aspects of the Medicare fraction that were not addressed in the Baystate case:
>
> 1. Availability of MEDPAR and SSA Records
> 2. Failure to adhere to required notice and comment rulemaking procedures
> 3. Fundamental problems in the SSI percentage calculation
> 4. Not in agreement with provider's records
> 5. Covered days vs. Total days and
> 6. Failure to adhere to required notice and comment rulemaking procedures.[4]

The estimated amount in controversy listed for both Issues 1 and 2 is $4,000. The group issue statement in Case No. 17-0578GC, the case to which Issue 2 was transferred is exactly the same as the issue statement described above for Issue 2, except that item 5, above, is listed as item 6 in the group issue statement, and item 5 is "Paid days vs. Eligible days" in the group issue statement.[5]

On November 18, 2022, the Provider filed its final position paper in Case No. 16-2192. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Calculation of the SSI Percentage**
>
> **Provider Specific**
>
> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits their calculation based on the Provider's Fiscal Year End (March 31).
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.
>
> Similar to *Loma Linda Community Hospital v. Dept of Health* and Human Services, No. CVT94- 0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State

[4] *Id.* (Items 2 and 6 are the same in the Provider's Issue Statement.)
[5] Provider's Request for Hearing in PRRB Case No. 17-0578GC, Group Issue Statement (Nov. 28, 2016).

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

The only exhibit included with the final position paper that relates to Issue 1 was Exhibit 2, which shows that the amount in controversy for the issue is $4,248. This is the same amount that is listed as the amount in controversy for this Provider as a participant in 17-0578GC.

MAC's Contentions:

The MAC asserts:

> "In Issue 1, the Provider contends that the MAC used the incorrect SSI percentage in processing 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 Issues 1 and 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...."[6]

With regard to the realignment portion of Issue 1, the MAC noted:

> "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...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

[6] MAC Jurisdictional Challenge at 2-3 (May 4, 2018).

> resolve this issue. The MAC requests that the PRRB dismiss this issue...."[7]

Provider's Response:

The Provider did not file a response to the May 4, 2018 jurisdictional challenge. As previously noted, Board Rule 44.4 (July 1, 2015) specifies: "The responding party must file a response within 30 days of the Intermediary's jurisdictional challenge. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

Moreover, as quoted above, in the Provider's final position paper filed on November 18, 2022, the Provider did not address the assertion that components of Issue 1 are duplicative of Issue 2, and did not mention the realignment issue.

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. SSI Provider Specific

The analysis for Issue 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 arguing over the interpretation of "entitled to" and "eligible for" benefits for purposes of calculating the numerator of the SSI fraction.

1. First and Third Aspects of Issue 1

The first aspect of Issue 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH SSI Percentage issue that was transferred to Case No. 17-0578GC, *QRS HMA 2014 DSH SSI Percentage CIRP Group*.

The Board finds that the first aspect of Issue 1 (the DSH/SSI (Provider Specific) issue) in this appeal is duplicative of Issue 2 (the DSH/SSI Percentage issue) that was transferred into Case No. 17-0578GC. The first aspect of Issue 1 in the present appeal concerns "whether the Medicare Administrative Contractor used the correct [SSI] percentage in the [DSH]

[7] *Id.*

Calculation."[8] The Provider's legal basis for this aspect of Issue 1 is simply that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[9] Similarly, the Provider argues that "it[s] SSI percentage published by [CMS] was incorrectly computed . . ." and it ". . . [s]pecifically . . . disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[10] The DSH/SSI Percentage issue transferred to Case No. 17-0578GC, similarly alleges that the Medicare Contractor and CMS improperly calculated the DSH/SSI Percentage, the DSH/SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Indeed, the Provider has the same amount in controversy for both Issue 1 and for its participation in the group appeal, namely an estimated $4,000.

Thus, the Board finds that the first aspect of Issue 1 in this appeal is duplicative of the group issue in Case No. 17-0578GC, for this same provider and fiscal year. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (July 1, 2015), the Board dismisses this aspect of the DSH/SSI (Provider Specific) issue.

In making this finding, the Board further notes that CMS regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, the Provider is pursuing that issue as part of the group under Case 17-0578GC. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[11] The Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) in its appeal request of how the alleged "provider specific" errors can be distinguished from the alleged SSI Percentage issue rather than being subsumed into the SSI percentage issue appealed in Case No. 17-0578GC.

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 Percentage issue in Case No. 17-0578GC, 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 (filed on November 18, 2022) failed to comply with the Board Rule 25 (Nov. 1, 2021) (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

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

the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" in its Final Position Paper and include *all* exhibits.

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

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

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

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 that the Provider transferred to Case No. 17-0578GC. In fact, the Provider included the same paragraph discussing this issue in both Issues 1 and 2, as follows:

> 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.

Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (July 1, 2015), the Board dismisses this third aspect of the DSH/SSI (Provider Specific) issue. Moreover, the Provider did not brief this aspect of the issue in its Final Position Paper.

As discussed above, the Board has found that the first and third aspects of Issues 1 and the group issue in Group Case 17-0578GC, 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 (July 1, 2015), the Board dismisses these components of the DSH/SSI (Provider Specific) issue. As an alternative basis the Board dismisses Issue 1 for failure of the Provider to properly brief the issue in its position paper in compliance with Board Rules, as described above.

2. Second Aspect of Issue 1

With regard to the second aspect of the DSH SSI Percentage (Provider Specific) issue—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—the MAC added Exhibit C-5 to the record with its Final Position Paper, which shows that the Notice of Provider Reimbursement was reopened following the Provider's request for SSI realignment, as indicated in a letter dated June 7, 2017, and

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

thereafter, a Notice of Correction of Program Reimbursement was issued on January 9, 2018. 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.

****

In summary, the Board hereby dismisses the SSI (Provider Specific) issue from this appeal as it is duplicative of the issue in Case No. 17-0578GC, the SSI realignment portion of the issue is now moot, and the Provider failed to meet the Board requirements for position papers. As one issue remains pending, the Medicaid Eligible Days issue, Case No. 16-2192 will remain open.

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

Board Members:

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

For the Board:

1/11/2023

X Kevin D. Smith, CPA

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

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

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

James Ravindran
Quality Reimbursement Services, Inc.
150 N. Santa Anita Avenue, Suite 570A
Arcadia, CA 91006

Dana Johnson
Palmetto GBA c/o NGS
P.O. Box 6474
Mailpoint INA101-AF-42
Indianapolis, IN 46206-6474

RE: ***Board Decision***
Novant Health UVA Prince William Medical Center (Prov. No. 49-0045)
FYE: 12/31/2006
PRRB Case Number: 15-3363

Dear Mr. Ravindran and Ms. Johnson,

The Provider Reimbursement Review Board ("Board") has reviewed the documents in the above referenced appeal and dismisses the Disproportionate Share Hospital ("DSH") Payment / Supplemental Security Income ("SSI") Percentage - Provider Specific issue for the reasons set forth below.

Pertinent Facts

On March 4, 2015, the Provider was issued a Revised Notice of Program Reimbursement ("RNPR") for fiscal year end December 31, 2006.

On August 27, 2015, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained three (3) issues:

1. DSH Payment/SSI Percentage (Provider Specific)
2. DSH – SSI Fraction/Medicare Managed Care Part C Days[1]
3. DSH – SSI Fraction/Dual Eligible Days[2]

The remaining issue is the DSH/SSI Percentage – Provider Specific Issue.

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

[1] On May 19, 2016, this issue was transferred to PRRB Case No. 13-3193GC.
[2] On May 19, 2016, this issue was transferred to PRRB Case No. 13-3191GC.

> 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.[3]

On August 27, 2015, the Provider was added via direct add to PRRB Case No. 13-3190GC, appealing the DSH/SSI – Systemic Errors issue from the same RNPR. In this appeal, the Provider described its DSH/SSI – Systemic Errors issue as whether the Secretary properly calculate the SSI percentage used to calculate their DSH payment. More specifically, Provider lists the following reasons for challenging its SSI percentage:

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

Board 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,[5] 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's 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

[3] Issue Statement at 1 (Aug. 27, 2015).
[4] Group Issue Statement in PRRB Case No. 13-3190GC (Aug. 19, 2013).
[5] As noted above, the Provider has appealed from an RNPR. 42 C.F.R. § 405.1885 provides that a Secretary or contractor determination may be reopened with respect to specific findings on matters at issue in a determination. Further, 42 C.F.R. § 405.1889 explains the effect of a cost report revision in that, "[o]nly 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." The Medicare Contractor did not challenge the Board's jurisdiction to hear the issue under appeal on the grounds that it was not adjusted in the revised NPR, nor does the Board find this is at issue in this appeal.

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.

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH SSI Percentage - Systemic Error issue that was appealed in PRRB Group Case No. 13-3190GC.

The DSH/SSI Percentage - Provider Specific issue in the present appeal concerns "whether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation."[6] The Provider's legal basis for its DSH/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)."[7] The Provider argues that "its SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . specifically disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[8]

The Provider's DSH SSI Percentage - Systemic Errors issue in group Case No. 13-3190GC 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.

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 13-3190GC. 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.[9] The Providers 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. 13-3190GC.

Accordingly, the Board finds that the remaining issue in the instant appeal and the group issue from Group Case 13-3190GC 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[10], the Board dismisses this component of the DSH/SSI (Provider Specific) issue.

---

[6] Issue Statement at 1.
[7] *Id.*
[8] *Id.*
[9] The types of systemic errors documented in the *Baystate* did not uniformly impact the SSI calculation for all providers but that does not may the errors any less systemic. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). *See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).
[10] PRRB Rules (July 2015).

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

The Board finds that, under 42 C.F.R. § 412.106(b)(3), for the determination of a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." Without this written request, the Medicare Contractor cannot issue a final determination from which the Provider can be dissatisfied with for 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. As both aspects of this issue are dismissed, the Board dismisses the DSH Payment/SSI Percentage – Provider Specific issue in its entirety. As there are no remaining issues on appeal, the case will close and be removed from the Board's docket.

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

Board Members Participating:

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

For the Board:

1/17/2023

X Kevin D. Smith, CPA

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

cc: Wilson C. Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Determination on the Consolidated EJR Request***
Scott & White 2007 DSH Part A Days CIRP Groups
Case Nos. 13-1693GC, 13-1694GC

Dear Mr. Ravindran:

On December 20, 2022, Quality Reimbursement Services ("QRS") filed a *consolidated* request for expedited judicial review ("EJR") as the group representative for Baylor Scott & White Health ("Providers") in the above-referenced common issue related party ("CIRP") group appeals. The Provider Reimbursement Review Board ("Board") has set forth below its decision on that request.

I. Procedural History / Pertinent Facts:

A. Initial Appeal Request:

On April 15, 2013, the Board received a Group Appeal Request from King & Spading, LLP (the then designated Group Representative) on behalf of the Providers. The group issue statement submitted with the group appeal request states the following, in its entirety:

> **Dual Eligible, No Part A Days**
>
> The issue in this group appeal involves the appropriate treatment in the Medicare disproportionate share hospital ("DSH") patient percentage calculation of patients who were not entitled to receive payment under Medicare Part A for their inpatient stay. Specifically, the Providers contend that the Intermediary improperly *excluded* from the Medicaid Fraction component of the disproportionate share hospital ("DSH") patient percentage calculation certain "dual-eligible" patient days for patients that were not entitled to payment by Medicare Part A (the "DSH-Dual-Eligible, No Part A Payment Days" issue). While the Providers recognize that CMS Ruling 1498-R requires the *inclusion* of such days in the Medicare Fraction (aka "SSI Ratio") component of the DSH patient percentage calculation, the Providers contend that inclusion of such days in the Medicare Fraction is contrary to the plain language of the Medicare DSH statute located at 42 U.S.C.

> § 1395ww(d)(5)(F)(vi). Under the plain language of the statute, all Dual-Eligible, No Part A Payment Days, including days for which a patient's Part A benefits were exhausted, should instead be *included* in the *Medicaid* Fraction component of the DSH patient percentage calculation. The Providers challenge the *inclusion* of the Dual-Eligible, No Part A Payment Days in the Medicare Fraction, and contend that such days should be included in the Medicaid Fraction instead.
>
> In addition, and for the same reasons, other Medicare patients who are not entitled to receive Medicare Part A payment for their inpatient stay should be *excluded* by CMS from the Medicare Fraction/SSI Ratio regardless of their eligibility for Medicaid. The *inclusion* of these "noncovered/ no Part A payment" days in the Medicare Fraction improperly dilutes the Medicare Fraction even though such days do not belong in the Medicaid Fraction for patients who are not simultaneously eligible for Medicaid. The *inclusion* of these days in the Providers' Medicare Fraction and *exclusion* of these days from the Providers' Medicaid Fraction has a negative reimbursement impact to the Providers in excess of $50,000.00.[1]

On April 26, 2013, the Board issued a Group Acknowledgement e-mail: bifurcating the case into two separate cases, one pertaining to the Medicaid fraction portion of the issue statement and the other pertaining to the Medicare or SSI fraction portion of issue statement. The Medicaid fraction was assigned to Case No. 13-1693GC entitled "Scott & White 2007 DSH Medicaid Fraction Part A Days CIRP Group. The SSI fraction was bifurcated into Case No. 13-1694GC as explained here:

> There are two distinct sub-issues in the . . . appeal request received by the Board on 4/14/13 with a requested group name of Scott & White

[1] (Italics emphasis added.) The Board recognizes that, ***only*** for the participant Trinity Medical Center, the Schedule of Providers includes behind Tab 2.D certain "self-disallowed" statements consistent with Board Rule 21(D) which states:

- Provide a copy of the matter appealed (e.g., audit adjustment report . . . .) . . . .
- For appeals of Self-Disallowed Items, you **MUST** submit a brief narrative identifying the authority that the Provider is challenging, and a copy of the cost report protested item page, if applicable. For cost reporting periods that end on or after December 31, 2008, the Provider must submit the evidence of protest. (See Rule 7.2 and 42 C.F.R. § 405.1835(a)(1)(ii)).

However, Trinity Medical Center was directly added to the group and those statements cannot expand the group issue statement (particularly since they are not filed as common to all participants in the group). *See supra* notes 159-61 and accompanying text. Moreover and most importantly, the self-disallowance descriptions were ***not included*** with the April 2013 group appeal request, but rather were only included in the Schedule of Providers that was filed *more than 3 years later*, on September 30, 2016. As a result, they have ***no*** *relevance* to determining the scope of the group appeal request and the Providers' compliance with the appeal request content requirements at 42 C.F.R. § 405.1837(c). Finally, the following excerpt from the self-disallowance description included behind Tab 2.D in Case No. 13-1693GC (pertaining to the Medicaid fraction) is simply a statement and does not, in and of itself, specifically describe what is incorrect, what should be changed, or how reimbursement should be determined differently: "The Provider contends that there are inconsistencies between the ways in which days are included in the denominator vs. numerator of the Medicare and Medicaid Proxies, respectively. The Provider maintain [*sic*] that terms such as eligible, entitled, and covered should be defined consistently in both the numerator and the denominator of the DSH calculation."

> 2007 No Part A Days CIRP Group[; *sic*] therefore the Board has set up two separate group appeals to meet the requirements of 42 C.F.R. 405.1873(a)(2). The Board has split this appeal into two group appeals to cover the two distinct legal issues described in the initial hearing request. The 2nd issue will be set up in a case entitled "Scott & White DSH SSI Fraction Part A Days CRIP Group." In the future, you should submit separate group appeals for each aspect of the Part A Days Issue.

On June 6, 2013, the Providers' Representative filed its reply to this bifurcation. The response sought reconsideration of the bifurcation because, if the Board continues to view the appealed issue as two distinct issues, other appeals brought by the Providers' Representative would need to be bifurcated. In its correspondence, the Providers' Representative specified:

> The question at issue, whether Medicare No Part A Payment Days are improperly included in the SSI Ratio and improperly excluded from the Medicaid Fraction for dual eligible patients, will be determined based on an analysis of the same legal standard: the DSH statute set out in 42 U.S.C. § 1395ww(d)(5)(F). While both the Medicare and Medicaid fractions are impacted, *the impact revolves around the **single legal question** regarding whether or not Medicare patients with exhausted Part A benefits are "entitled to Part A"* as described in the DSH statute.[2]

The Board did not take any action because it continues to view group issues statements, like the one filed here, as raising two distinct legal issues because, pursuant to 42 C.F.R. § 405.1837(a)(2), a group appeal may only contain one legal issue. As evidenced by the Ninth Circuit's decision in *Empire Health*, the invalidation of the DSH no-pay Part A days policy finalized in the FY 2005 IPPS Final Rule does not *automatically* result in no-pay Part A days involving Medicaid eligible patients being counted in the Medicaid fraction. In this regard, the Board notes that it is clear that the *class of patients* who are dual eligibles do, in fact, have Medicare Part A (*i.e.*, they are enrolled in Medicare Part A) and that, as a *patient class*, days associated with Medicare Part A beneficiaries may not be excluded *in toto* from the Medicare fraction (*i.e.*, it is undisputed that some dual eligible patients have days ***paid*** or covered under the Medicare Part A and were "entitled" to Part A benefits).[3] To this end, the Providers are asserting that only in certain ***no-pay*** Part A situations involving dual eligible beneficiaries (*e.g.*, exhausted benefits and MSP) must the days associated with this class of patients be excluded from the SSI fraction. As a result, the Board disagrees with the Providers' assertion that exclusion of days associated with these no-pay Part A situations *automatically* means such days must be counted in the Medicaid fraction and, indeed, the Ninth Circuit's decision in *Empire Health* confirms that it does not.[4] In support of its position, the Board

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[2] (Emphasis added.)

[3] This is different than Part C days where, ***as a class of days***, Part C days must be counted in either the SSI fraction or the Medicaid fraction. As explained in the 2014 holding of the D.C. Circuit in *Allina Health Servs. v. Sebelius* ("*Allina*"), 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. 746 F.3d 1102, 1108 (D.C. Cir. 2014).

[4] 958 F.3d 873 at 879-80, 886 (confirming that the policy in effect prior to October 1, 2004 excluded no-pay Part A days from both the numerator and denominator of the SSI fraction as well as from the numerator of the Medicaid

refers to the D.C. Circuit's 2013 decision in *Catholic Health Initiatives v. Sebelius*[5] and CMS Ruling 1498-R2 wherein multiple possible types of treatments/relief of no-pay dual eligible days are discussed.[6] Similarly, the relief requested by the Providers here was rejected by the Administrator in 2000 in *Edgewater Med. Center v. Blue Cross Blue Shield Ass'n*.[7] Thus, in the event the U.S. Supreme Court had upheld the Ninth Circuit's decision in *Empire Health* (and this issue were still viable), the Providers would have had to have dealt with the Ninth Circuit's reinstatement of the prior pre-October 2004 policy which excluded from the Medicaid fraction any no-pay Part A days involving patients who were also Medicaid eligible and presumably challenged the validity of the pre-October 2004 policy (whether procedurally or substantively). Accordingly, the Board continues to maintain that the legal argument in appeal request advocating for exclusion of no-pay Part A days from the SSI fraction (Case No. 13-1694GC) *is a separate and distinct issue* from the legal argument advocating inclusion of the *subset* of no-pay part A days that involve patients who are also eligible for Medicaid *into* the numerator of the Medicaid fraction (Case No. 13-1693GC).[8]

The initial group appeal request had two participants, Scott & White Healthcare and Trinity Medical Center where an amount in controversy ("AiC") was only listed for Trinity Medical Center, specifically $688,211. The group appeal request did not include an AiC for Scott & White Healthcare because "[t]he Provider had not yet received DSH reimbursement impact data for FY 2007." With regard to the AiC calculations submitted with the initial group appeal request, the Providers noted that they were waiting on corrected SSI ratios and/or their underlying data from CMS. As such, the group appeal request further stated that, for ***each*** of these participants, the Group Representative "will submit more detailed reimbursement impact when it completes an analysis of the detailed SSI Ratio data furnished by CMS in support of the SSI Ratio utilized in the relevant cost reports."[9] Notwithstanding, the Providers maintained that the initial aggregate AiC for the group exceeded $50,000.

B. Full Formation and Amount in Controversy Calculations in the Schedule of Providers

On June 23, 2016, the Group Representative certified that each of these instant CIRP groups was fully formed. No additional participants were added to the groups and, as a result, the groups were fully formed with the original two participants.

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fraction ***and*** "reinstat[ing] the prior version of 42 C.F.R. § 412.106(b)(2)(i), which embraced only "covered" patient days" because the effect of *invalidating* an agency rule is to reinstate the rule previously in force).

[5] 718 F.3d 914 (D.C. Cir. 2013).

[6] The Board takes administrative notice that some challenges to the Part A Days Policy seek only to have no-pay Part A days excluded from the SSI fraction (*i.e.*, revert back to the pre-October 2004 policy and not seek to have the subset of dual eligible days included in the numerator of the Medicaid fraction).

[7] *See Edgewater Med. Ctr. v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (June 6, 2000), *affirming*, PRRB Dec. Nos. 2000-D44, 2000-D45 (Apr. 7, 2000). *See also* 718 F.3d at 918, 921-22 (D.C. Circuit in *Catholic Health* discussing the Administrator's *Edgewater* decision and explaining that "the policy of excluding dual-eligible exhausted days from the Medicaid fraction was announced four years earlier in *Edgewater"*).

[88] As explained below in Section V(B) and V(B)(1), Case No. 13-1693GC for the Medicaid fraction is no longer a viable appeal because the Providers have effectively withdrawn its challenge to the substantive validity of the Part A Days Policy due to the U.S. Supreme Court's *Empire Health* decision and are instead only challenging the procedural validity of the Part A Days Policy. If that procedural challenge were properly part of this appeal, success on the procedural challenge would simply result in reverting back to the pre-10/1/04 policy which had no impact on the Medicaid fraction.

[9] Appeal Request at Form G: Schedule of Providers in Group, n.1 and n.4.

On September 27, 2016, the Providers' Representative was changed to QRS.

As noted above, the initial appeal request did not contain specific amount in controversy calculations because the Providers were waiting on updated SSI Ratios and/or the underlying data for those ratios. However, the first actual calculations appeared in the Schedules of Providers filed by QRS on September 30, 2016. The following are the AiCs that QRS listed for each participant included behind Tab E in the final Schedules of Providers for these two groups:

Provider	Case No 13-1693GC – AiC for each participant	Case No 13-1694GC – AiC for each participant
Scott & White Healthcare	$29,000	$157,000
Trinity Medical Center	$27,000	$ 12,000

Per the AiC calculation behind Tab E for ***each*** participant in Case No. 13-1693GC, the AiC was made using an estimated impact of 50 additional days in the numerator of the Medicaid fraction. For example, in Case No. 13-1693GC (Medicaid Fraction), the AiC for Scott & White Healthcare is listed as follows:

Impact of additional Dual Eligible/Exhausted/MSP Days

Increase in Medicaid Proxy	(1)	50 / 108,978	0.05%
DRG	(2)		$76,105,456
Multiplier	(3)		$82.50%
Net Impact	(1) x (2) x (3)		$28,807[10]

QRS did not include any explanation with regard to how these figures are derived *or, in particular, how the 50 additional days were identified or determined*. The increase in Medicaid Proxy of ***50 days*** and the multiplier of 82.50 percent are ***identical*** for each provider. Nevertheless, based on these calculations, the stated amount in controversy for this case exceeds $50,000.

Similarly, per the AiC calculation behind Tab E for ***each*** participant in Case No. 13-1694GC, the AiC was made using an "Estimated Impact of .25%." For example, in Case No. 13-1694GC (SSI Fraction), the AiC for Scott & White Healthcare is calculated as follows:

Estimated Impact of .25% (3) increase in SSI Fraction Dual Eligible Days

DRG	(1)	$76,105,456
Multiplier	(2)	82.50%
Net Impact	(1) x (2) x (3)	$156,968[11]

[10] *E.g.*, Prov. No. 45-0054.
[11] *E.g.*, Prov. No. 45-0054.

QRS did not include any explanation with regard to how these figures are derived *or, in particular, how the "Estimated Impact of .25%" was identified or determined*. The estimated impact of ***0.25 percent*** and the multiplier of 82.50 percent are ***identical*** for each provider. Nevertheless, based on these calculations, the stated amount in controversy for this case exceeds $50,000.

Accordingly, it is clear that the AiC calculations that QRS filed as part of the Final Schedules of Providers are not consistent with the Providers' promise in the group request to "submit ***more detailed*** *reimbursement impact* when it completes an analysis of the detailed SSI Ratio data furnished by CMS in support of the SSI Ratio utilized in the relevant cost reports."[12]

C. Providers' Position Papers

On April 26, 2013, the Board issue a Group Acknowledgements for each of the CIRP groups and specified that the Group Representative must advise the Board in writing when the group was fully formed and that, after receiving notice of full formation, the Board would issue a Critical Due Dates letter to set up deadlines for the submission of the Schedule of Providers and the parties' preliminary position papers.

On June 16, 2016, the Providers' Representative informed the Board that each of the CIRP groups was fully formed. Accordingly, on June 23, 2016, the Board issued a Notice of Critical Due Dates in each of the CIRP groups and required the Providers to file the Schedule of Providers and their preliminary position paper by October 1, 2016. Similarly, this Notice required the Medicare Contractor to file its preliminary position paper by February 1, 2017.

On September 27, 2016, the Providers' Representative was changed to QRS. Shortly thereafter, on September 30, 2016, QRS timely filed the first page[13] of the Providers' Preliminary Position Paper in each of the CIRP groups as well as the Schedule of Providers.

On October 21, 2016, the Board sent the parties a Notice of Hearing and Critical Due Dates in each of the CIRP groups setting a hearing date of August 9, 2017 and final position paper due dates of Mary 1, 2017 for the Providers and June 1, 2017 for the Medicare Contractor. The Notice also set a deadline of July 1, 2017 for the Providers' responsive brief to the extent the

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[12] Appeal Request at Form G: Schedule of Providers in Group, n.1 and n.4 (emphasis added). The Board recognizes that, on page 9 of their final position papers filed on May 1, 2017, QRS represents that "CMS is now releasing the MEDPAR data, but the Providers have not yet been able to fully reconcile their records with that of CMS." However, it is unclear what the Providers mean by being unable to "reconcile" and did not include any explanation for that. Notwithstanding, without explanation, QRS included with the Final Position Paper filed in Case No. 13-1693GC an "eligibility listing" showing 4530 dual eligible days for one participant and 1015 dual eligible for the other participant. However, it is unclear whether any of these days are even relevant since it is unclear whether any of these dual eligible days were no-pay Part A days. Again, there is no description or explanation of what this listing shows or establishes. QRS has not filed any since 2017 on the promised reconciliation or on what the listing shows or establishes. In this regard, the EJR request is silent on the status of that reconciliation and the listing. *See infra* note 22 and accompanying text.

[13] Board Rule 25.3 (July 1, 2015) did not require the *full* Preliminary Position Papers to be filed with the Board. Instead, only a cover page, exhibit list, and statement of a good faith effort to confer were required to be filed.

Providers' wished to reply. The notice referred the parties to Board Rule 27 for the "content requirements and other information regarding the filing of final position papers."

On January 31, 2017, the Medicare Contractor timely filed its preliminary position paper in each these CIRP groups.

On May 1, 2017, QRS timely filed the Providers' Final Position Papers for each of the instant CIRP group cases.[14] The Providers' Final Position Papers are virtually identical except that the one filed in Case No. 13-1693GC focuses on the argument that no-pay Part A days "should be *excluded* from both the numerator and denominator of the Providers' Medicare fractions and ***included*** *in the Providers' Medicaid fractions* . . . . in the numerator . . . to the extent that such days are Medicaid eligible"[15] while the one in Case No. 13-1694GC simply focuses on the argument that no-pay dual eligible days "should not be ***excluded*** from both the numerator and denominator of the Providers' Medicare fractions."[16] Accordingly, the Final Position Papers argue that the Medicare Contractor's adjustments were improper and attributable to the improper inclusion of certain types of no-pay days, including Dual Eligible Days, in their SSI Ratios, which should have instead been included in their Medicaid fractions to the extent the no-pay Part A day involved a dual eligible beneficiary.[17] The Statement of Issue succinctly states that "their SSI percentages are incorrect due to the inclusion of [exhausted benefit] days in their Medicare [SSI] fractions instead of the Medicaid fractions in their DSH calculations."[18]

The Providers argue that days attributable to dual eligible patients whose Part A benefits were exhausted, or patients where Medicare Part A was a secondary payor, are not days for which these patients were "entitled to benefits under Part A" for the purposes of the DSH calculation.[19] "As a result, these days should be excluded from both the numerator and denominator of the [SSI Ratio] and included in the . . . Medicaid [fraction]. Conversely such days should be included in the numerator of the Medicaid fraction to the extent that such days are Medicaid eligible."[20]

These arguments were all presented as ***substantive*** arguments, meaning that the relevant Medicare statutory provisions mandate this outcome. The Providers did not include any arguments related to the APA and, in particular, did not challenge the ***procedural*** validity of any CMS/Secretary regulation or rulemaking.

On May 26, 2017, the Medicare Contractor timely filed its final position paper with the Board. The position paper essentially points to the 2013 decision of the Sixth Circuit in *Metropolitan Hospital v. United States Dept. of Health & Human Servs.*, 712 F.3d 248 (6th Cir. 2013). The Medicare Contractor asserts that "the [Sixth Circuit] court ruled in favor of the HHS interpretation that EB [*i.e.,* exhausted benefit] days are correctly included in the Medicare

[14] *See* Case 13-1693GC.
[15] Final Position Paper for Case No. 13-1693GC at 9 (emphasis added).
[16] Final Position Paper for Case No. 13-1694GC at 9 (emphasis added).
[17] Provider's Final Position Paper at 2 (May 1, 2017).
[18] *Id.* at 3.
[19] *Id.* at 8-9.
[20] *Id.* at 9.

fraction and rejected the Provider's contention that these days are properly included in the Medicaid fraction."[21] The Medicare Contractor also stated that the Providers misstated the facts regard MEDPAR data in that the Providers failed to recognized that Scott & White Memorial Hospital requested and received MEDPAR data for FY 2007 on March 26, 2013 and that Trinity Medical Center had not yet requested MEDPAR data for FY 2007.[22]

Shortly after that, on July 19, 2017, QRS filed a request to postpone the hearing. On July 28, 2017, the Board postponed the hearing to October 1, 2018. A series of QRS postponement requests followed by the Board rescheduling ensued in each of the CIRP groups. Currently, the hearing for each of these two groups is scheduled for January 19, 2023.

II. Issue:

As noted above, the Group Issue Statement in these group cases prior to bifurcation between the two cases can be summarized as follows:

- Case No. 13-1693GC – Dual eligible patients (Medicare & Medicaid eligible) "not entitled to Part A" are improperly *excluded* in the Medicaid fraction; and

- Case No. 13-1694GC – Non-covered (regardless of dual eligibility) and dual eligible patients (Medicare & Medicaid eligible), each "not entitled to Part A," are improperly *included* in the SSI fraction.

III. Providers' Consolidated EJR Request and the Medicare Contractor's Response:

A. The Providers' Consolidated EJR Request

On December 20, 2022, QRS filed the Providers' consolidated EJR request for the instant CIRP group appeals.[23] The Providers are seeking EJR over the following:

> [T]he Providers . . . submit this request for [EJR] regarding Providers' appeals . . . of whether patients entitled to Medicare Part A for whom no Medicare Part A payment is made and who are eligible to Title XIX should be ***excluded*** from the Medicare fraction and ***included*** in the numerator of the Medicaid fraction of the [DSH] calculation or, ***alternatively***, *whether* ***all*** *of the Providers' patients entitled to supplemental security income ("SSI") should be* ***included*** *in the DSH calculation*?[24]

[21] Medicare Contractor's Final Position Paper at 8 (May 26, 2027).
[22] *See supra* note 12.
[23] Providers' Request for Expedited Judicial Review (Dec. 20, 2022) ("EJR Request").
[24] *Id.* at 1 (emphasis added).

The Providers describe the first argument as the "Unpaid Part A Days Issue" and the "alternative" argument as the "Unpaid SSI Days Issue."[25] In support of its assertion that both the "Unpaid Part A Days Issue" and the "Unpaid SSI Days Issue" are part of the appeal, the Providers claim that they are merely "two components of a single issue" but that "if the Board finds these two issues are ***distinct*** the Providers will request that the Board bifurcate into two separate groups."[26] The issue is restated in the EJR Request as follows:

> Whether patient days associated with patients entitled to Medicare Part A for whom no Medicare Part A payment is made and who are eligible to Title XIX should be ***excluded*** from the Medicare fraction and included in the numerator of the Medicaid fraction of the Medicare Disproportionate Share Hospital ("DSH") calculation? ***Alternatively***, if "entitled" to Medicare Part A includes patients for whom no payment is made, *whether the numerator of the Medicare fraction* of the Medicare DSH percentage *should* **include** ***all*** *of the Providers' patients entitled to supplemental security income ("SSI"), as required by 42 U.S.C. § 1395ww(d)(5)(F)(vi)*.[27]

With regard to the "Unpaid Part A Days Issue," the Providers are challenging the treatment of unpaid Part A days (*e.g.*, exhausted days and Medicare secondary payor days) in the DSH calculation as set forth in the FY 2005 IPPS Final Rule published on August 11, 2004.[28] Specifically, they challenge the ***inclusion*** of these non-covered days in the Medicare fraction (Case No. 13-1694GC) and the ***exclusion*** of a certain subset of those days (where the beneficiary was also eligible for Medicaid) from the numerator of the Medicaid fraction (Case No. 13-1693GC). The Providers acknowledge that the U.S. Supreme Court has found the regulations promulgated in the FY 2005 Final Rule to be ***substantively*** valid in *Empire Health*,[29] but seek to challenge the ***procedural*** validity of these regulations which "was not decided by the Supreme Court and has not been decided outside the jurisdiction of the Ninth Circuit."[30] They argue that the promulgation of the policy in the FY 2005 IPPS Final Rule over these non-covered days failed to satisfy the requirements of the Administrative Procedure Act ("APA").[31] Specifically, the Providers argue that the final rule is not a logical outgrowth of the proposed rule in violation of 42 U.S.C. § 1395hh(a)(4).[32] The Providers also claim the new rule violates the APA because it is not a result of reasoned decision making and, therefore, should be vacated.[33]

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[25] *Id.* at 1 n.2.
[26] *Id.* (emphasis added).
[27] *Id.* at 1 (emphasis added).
[28] *Id.* at 5-6. *See* 69 Fed. Reg. 48916, 49090-99 (Aug. 11, 2004) ("FY 2005 Final Rule").
[29] *Empire Health Foundation for Valley Hospital Medical Center*, 142 S.Ct. 2354, 2368 (2022) ("*Empire Health*").
[30] EJR Request at 6-7.
[31] 5 U.S.C. §§ 551-559.
[32] EJR Request at 8-9 (citing *Ass'n of Private Sector Colleges & Univs. V. Duncan*, 681 F.3d 427, 441 (D.C. Cir. 2012)).
[33] *Id.* at 10-11.

With regard to their *alternative* argument pertaining to the "Unpaid SSI Days Issue," the Providers are seeking EJR in order to challenge the ***substantive*** validity of the policy in the FY 2011 IPPS Final Rule published on August 16, 2010[34] which establishes that determining if a patient was "entitled to SSI" is determined by three specific codes (CO1, M01, and M02). They claim that several other SSI codes should be included when determining whether a patient was "entitled to SSI" on a given day.[35] The Providers argue that "entitled to supplemental security income benefits" in the SSI Ratio should be interpreted consistently with "entitled to benefits under Medicare Part A" as argued by CMS and decided by the Supreme Court in *Empire Health*.[36]

B. Medicare Contractor's Response to Request for EJR

The Medicare Contractor did not file a response to the EJR Request. The time to do so has lapsed.[37]

IV. Statutory and Regulatory Background:

A. Adjustment for Medicare DSH

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").[38] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[39]

The statutory provisions governing IPPS contain a number of provisions that adjust reimbursement based on hospital-specific factors.[40] These cases involve 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.[41]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[42] 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.[43] The DPP is defined as the sum of two fractions expressed as percentages.[44] 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."

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[34] *Id.* at 2 (challenging the policy set forth at 75 Fed. Reg. 50041, 50280-50281 (Aug. 16, 2010)).
[35] *Id.* at 13-16.
[36] *Id.* at 12, 17-18.
[37] Board Rule 42.4 (Nov. 2021) requires a response in opposition to a request for EJR be filed within five (5) business days of the EJR request. Since the instant EJR Request was filed on December 20, 2022, a response was due no later than close of business December 28, 2022.
[38] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[39] *Id.*
[40] *See* 42 U.S.C. § 1395ww(d)(5).
[41] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[42] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[43] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[44] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).

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

> the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter . . . .[45]

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[46]

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.[47]

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.[48]

B. Accounting of Dual Eligible Days in the Medicare DSH Adjustment Calculation

In the preamble to FY 2004 IPPS proposed rule published on May 19, 2003, the Secretary reiterated that the DSH patient percentage is equal to the sum of the percentage of Medicare inpatient days attributable to patients entitled to both Medicare Part A and SSI benefits, and the percentage of total inpatient days attributable to patients eligible for Medicaid but not entitled to Medicare Part A benefits.[49] The Secretary explained that, if a patient is a Medicare beneficiary who is also eligible for Medicaid, the patient is considered dual eligible. Dual eligible patient days are included in the Medicare fraction of the DSH patient percentage, but not the Medicaid fraction. The Secretary

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[45] (Emphasis added.)
[46] 42 C.F.R. § 412.106(b)(2)-(3).
[47] (Emphasis added.)
[48] 42 C.F.R. § 412.106(b)(4).
[49] 68 Fed. Reg. 27154, 27207 (May 19, 2003).

maintained that this treatment is consistent with 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II), which specified that patients entitled to benefits under Part A are ***excluded*** from the Medicaid fraction.[50]

At the time the proposed rule was published, the policy above applied even after the patient's Medicare coverage was exhausted. More specifically, under this policy, "if a dual-eligible patient was admitted without any Medicare Part A coverage remaining, or the patient exhausted Medicare Part A coverage while an inpatient, his or her patient days were counted in the Medicare fraction before and after Medicare coverage is exhausted."[51] The Secretary maintained that this was consistent with the inclusion of Medicaid patient days even after the patient's Medicaid coverage is exhausted.[52] The Secretary then summarized his policy by stating that "our current policy regarding dual-eligible patient days is that they are counted in the Medicare fraction and excluded from the Medicaid fraction, even if the patient's Medicare Part A coverage has been exhausted."[53]

The Secretary stated that he believed that the current policy regarding dual eligible patients, counting them in the Medicare fraction and excluding them from the Medicaid fraction, even if the patient's Medicare Part A coverage had been exhausted, was consistent with 42 U.S.C § 1395ww(d)(5)(F)(vi)(II).[54] Notwithstanding, the Secretary recognized that there were other plausible interpretations and acknowledged, on a practical level, it was often difficult for Medicare contractors[55] to differentiate the days for dual eligible patients who Part A coverage had been exhausted. The Secretary explained that the degree of difficulty in differentiating the days varied from State to State depending on the manner in which States identify dual eligible beneficiaries in their list of Medicaid patient days provided to hospitals or required the MACs or hospitals undertake the identification. Underlying the Secretary's concern was the fact that there were hospitals located in States in which the beneficiaries exhausted the Medicare Part A coverage and no Part A bill may be submitted for the patients. Consequently, the relevant MACs had no data by which to verify any adjustment for these cases in the Medicaid data furnished by the hospital.[56]

In light of these concerns and to facilitate consistent handling of these days across all hospitals, the Secretary proposed in the FY 2004 IPPS proposed rule to change this policy and begin to count the patient days of dual-eligible Medicare beneficiaries whose Medicare coverage was expired in the Medicaid fraction of the DSH patient percentage.[57] Specifically, the Secretary proposed that the days of patients who have exhausted their Medicare Part A coverage would no longer be included in the Medicare fraction and, instead, would be included in the Medicaid fraction of the DSH calculation.[58] The Secretary noted that not all SSI recipients are Medicaid eligible and, therefore, it would not be automatic that the patient days of SSI recipients would be counted in the

[50] *Id.*
[51] *Id.*
[52] *Id.*
[53] *Id.* at 27207-27208.
[54] *Id.* at 27207-08.
[55] Medicare administrative contractors ("MACs") were formerly known as fiscal intermediaries or intermediaries.
[56] 68 Fed. Reg. at 27208.
[57] *Id.*
[58] *Id.*

Medicaid fraction when their Part A coverage ended. [59] Under the proposed change, before a hospital could count patient days attributable to dual eligible beneficiaries in the Medicaid fraction, the hospital would be required to submit documentation to the MAC that justified including the days in the Medicaid fraction after Medicare Part A benefits have been exhausted.[60]

When the Secretary published the FY 2004 IPPS final rule on August 1, 2003, the Secretary did not adopt and finalize the proposed policy changes regarding dual eligible days.[61] Rather, he stated that "[d]ue to the number and nature of the comments we received on our proposed policies, we are addressing the public comments in a separate document."[62]

On May 18, 2004, the Secretary provided an update. Specifically, in the preamble to the FY 2005 IPPS proposed rule published on that date, the Secretary stated that the Secretary planned to address the proposed policy changes regarding dual eligible days in the forthcoming FY 2005 IPPS final rule.[63]

In the preamble to the FY 2005 IPPS final rule published on August 11, 2004, the Secretary addressed the previously proposed policy changes and stated:

> It has come to our attention that we inadvertently misstated our ***current*** policy with regard to the treatment of certain inpatient days for dual-eligibles in the proposed rule of May 19, 2003 . . . . In that proposed rule, we indicated that a dual-eligible beneficiary is included in the Medicare fraction even after the patient's Medicare Part A hospital coverage is exhausted. That is, we stated that if a dual-eligible patient is admitted without any Medicare Part A hospital coverage remaining, or the patient exhausts Medicare Part A hospital coverage while an inpatient, the non-covered patient days are counted in the Medicare fraction. This statement was not accurate. ***Our policy has been*** that only ***covered*** patient days are included in the Medicare fraction (§ 412.106(b)(2)(i)). A notice to this effect was posted on CMS's Web site (*http://www.cms.hhs.gov/providers/hipps/dual.asp*) on July 9, 2004.[64]
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> ****
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> . . . [W]e have decided ***not*** to finalize our proposal stated in the May 19, 2003 proposed rule to include dual-eligible beneficiaries who have exhausted their Part A hospital coverage in the Medicaid fraction. Instead, ***we are adopting a policy*** *to include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the*

[59] *Id.*
[60] *Id.*
[61] 68 Fed. Reg. 45346, 45421 (Aug. 1, 2003).
[62] *Id.*
[63] 68 Fed. Reg. 28196, 28286 (May 18, 2004).
[64] 69 Fed. Reg.48916, 49098 (Aug. 11, 2004) (emphasis added).

> *beneficiary has exhausted Medicare Part A hospital coverage.* If the patient is entitled to Medicare Part A and SSI, the patient days will be included in both the numerator and denominator of the Medicare fraction. This policy will be effective for discharges occurring on or after October 1, 2004. *We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with dual eligible beneficiaries* ***in the Medicare fraction*** *of the DSH calculation*.[65]

Accordingly, the Secretary adopted a new policy to "include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage."[66] In order to effectuate this policy change, the FY 2005 IPPS final rule revised 42 C.F.R. § 412.106(b)(2)(i) by deleting the word "covered."[67] Prior to this revision, § 412.106(b)(2) (2004) had stated:

> (2) First computation: Federal fiscal year. For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS—
>
> (i) *Determines the number of* ***covered*** *patient days that—*
>
> (A) Are associated with discharges occurring during each month; and
>
> (B) Are furnished to patients who during that month were entitled to both Medicare Part A and SSI, excluding those patients who received only State supplementation . . .[68]

As a result of the revision made by the FY 2005 IPPS final rule, § 412.105(b)(2)(i) (2005) now states:

> (2) First computation: Federal fiscal year. For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS—
>
> (i) *determines the number of patient days that*--
>
> (A) Are associated with discharges occurring during each month; and
>
> (B) Are furnished to patients who during that month were entitled to both Medicare Part A and SSI, excluding those patients who received only State supplementation . . .[69]

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[65] *Id.* at 49099 (emphasis added).
[66] *Id.*
[67] *See id.* at 49099, 49246.
[68] (Emphasis added.)
[69] (Emphasis added.)

Again, the effect of this change was to adopt "a policy to include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage."[70]

Several court cases have reviewed the FY 2005 change to 42 C.F.R. § 412.106(b)(2)(i). In the first case, *Stringfellow Mem'l Hosp. v. Azar* ("*Stringfellow*"),[71] the U.S. District Court for the District of Columbia ("D.C. District Court") considered whether the FY 2005 IPPS final rule violated the Administrative Procedure Act ("APA") because the rule is procedurally defective and arbitrary and capricious.[72] The D.C. District Court concluded that the Secretary promulgated FY 2005 IPPS final rule with adequate notice and comment procedures and that the rule is *not* procedurally defective.[73] Further, the D.C. District Court found that the 2005 Final Rule was procedurally sound and the product of reasoned decision making.[74] The *Stringfellow* decision was appealed to the U.S. Court of Appeals for the D.C. Circuit ("D.C. Circuit"); however, the D.C. Circuit later dismissed it.[75] Accordingly, the D.C. District Court's decision to uphold the FY 2005 change to 42 C.F.R. § 412.106(b)(2)(i) was not otherwise altered.

In the third case, *Empire Health Found. v. Price* ("*Empire Health*"),[76] the U.S. District Court for the Eastern District of Washington ("Washington District Court") reviewed the question of "the validity" of the Secretary's FY 2005 IPPS final rule with regard to the Secretary's interpretation of the phrase "entitled to benefits under [Medicare Part A] in 42 U.S.C. § 1395ww."[77] In *Empire*, the hospital had alleged that the FY 2005 IPPS final rule amending 42 C.F.R. § 412.106(b)(2) was substantively and procedurally invalid.[78] The Washington District Court noted that the Secretary misstated the then-existing policy until approximately three days before the close of the comment period for the FY 2005 IPPS proposed rule and that the inaccuracy of the policy statement necessarily distorted the context of the proposed rule. The Washington District Court determined that, without an accurate context in which to view the Secretary's proposed rule, interested parties cannot know what to expect and have no basis on which to make comments. Further, the Washington District Court pointed out that interested parties could not have reasonably anticipated the Secretary's rulemaking contained a misstatement. Consequently, the Washington District Court found that the Secretary's notice failed to satisfy the procedural rulemaking requirements of the APA[79] and that the regulation is procedurally invalid.[80]

The U.S. Court of Appeals for the Ninth Circuit ("Ninth Circuit") reviewed the Washington District Court's decision in *Empire Health*[81] and reversed that Court's finding that the revision made by the

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[70] *Id.*
[71] 317 F. Supp. 3d 168 (D.D.C. 2018).
[72] *Id.* at 172.
[73] *Id.* at 190.
[74] *Id.* at 194.
[75] *See* 2019 WL 668282.
[76] 334 F. Supp. 3d 1134 (E.D. Wash. 2018)
[77] *Id.* at 1141.
[78] *Id.*
[79] *Id. at 1162.*
[80] *Id. at 1163*
[81] 958 F.3d 873 (9th Cir. 2020), *reh'g en banc denied* (9th Cir. Oct. 20, 2020).

FY 2005 IPPS Final Rule to 42 C.F.R. § 412.106(b)(2)(i) failed to satisfy the procedural rulemaking requirements of the APA.[82] Rather, the Ninth Circuit found that this revision "was a logical outgrowth of the notice and the comments received" and that it "met the APA's procedural requirements."[83] However, the Ninth Circuit then reviewed the substantive validity of this revision and determined that it was bound by the previous Ninth Circuit's 1996 decision in *Legacy Emanuel Hospital and Health Center v. Shalala* ("*Legacy Emanuel*")[84] wherein the Ninth Circuit considered the meaning of the words "entitled" and eligible in tandem as those words are used in the statutory description of the Medicaid fraction at 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II). Specifically, in *Legacy Emanuel*, the Ninth Circuit "interpreted the word 'entitled' to mean that a patient has an 'absolute right . . . to payment'" and "the word 'eligible' to mean that a patient simply meets the Medicaid statutory criteria."[85] In *Empire Health*, the Ninth Circuit noted that, in the FY 2005 IPPS Final Rule, the Secretary adopted a different meaning to "entitled" that more closely aligned with the meaning of the word "eligible."[86] Accordingly, in *Empire Health*, the Ninth Circuit held that "[b]ecause we have already construed the unambiguous meaning of 'entitled' to [Medicare]" in 42 U.S.C. § 1395(d)(5)(F)(vi), we hold that the [FY 2005 IPPS Final Rule's] contrary interpretation of that phrase is substantively invalid pursuant to APA."[87] Accordingly, the Ninth Circuit took the following actions to implement its holding:

1. It affirmed the Washington District Court's order vacating the FY 2005 IPPS Final Rule as it relates to the deletion of the word "covered" from 42 C.F.R. § 412.106(b)(2)(i); and

2. It "reinstat[ed] the version of 42 C.F.R. § 412.106(b)(2)(i) which embraced only 'covered' patient days" (*i.e.*, reinstated the rule previously in force).[88]

The Secretary appealed the Ninth Circuit decision and the U.S. Supreme Court subsequently issued its decision in *Becerra v. Empire Health Foundation*[89] ("*Empire Health"*) finding that the Secretary "correctly construes the statutory language at issue."[90]

On June 24, 2022, the U.S. Supreme Court issued its decision in *Empire Health* and found that the structure of the DSH provisions supported the Secretary, summarizing that "Counting everyone who qualifies for Medicare benefits in the Medicare fraction—and no one who qualifies for those benefits in the Medicaid fraction—accords with the statute's attempt to capture, through two separate measurements, two different segments of a hospital's low-income patient population."[91] It found that being "entitled" to Medicare benefits means meeting the basic statutory criteria, not actually receiving payment for a given day's treatment.[92] Nor did the U.S. Supreme Court find any

[82] *Id.* at 884.
[83] *Id.* at 884.
[84] 97 F.3d 1261, 1265-66 (9th Cir. 1996).
[85] 958 F.3d at 885 (citing and quoting *Legacy Emanuel*).
[86] *Id.* at 886.
[87] *Id.*
[88] *Id.*
[89] 142 S.Ct. 2354 (2022).
[90] *Id.* at 2362.
[91] *Id.*
[92] *Id.*

credence in the argument that "entitled" was modified by the statute by adding "(for such days)." Though this parenthetical does direct the Secretary to evaluate a patient's status on a given day, it does not invite an evaluation of whether a patient *received* Part A payments, but rather whether it is qualified to receive part A payments.[93] Based on the foregoing, the U.S. Supreme Court reversed the Ninth Circuit's *Empire* decision and remanded the case for further proceedings.[94]

On remand, the Ninth Circuit reviewed whether the District Court's dismissal of a separate "alternative" legal argument or challenge was proper where that dismissal was based on a finding that the alternative argument was beyond the scope of the Board's authorization of EJR.[95] The alternative argument challenges the calculation of patient days included in the numerator of the SSI fraction asserting that the Secretary's interpretation of the phrase "entitled to supplemental security benefits" is too narrow. On December 5, 2022, the Ninth Circuit determined that the District Court's dismissal was not proper and the Board's authorization encompassed the alternative argument. [96] Specifically, it noted that neither the Ninth Circuit or the Supreme Court addressed the appellant's alternative argument concerning the Secretary's calculation of patient days for those patients "entitled to supplemental security income [SSI] benefits," which also factors into the Medicare fraction.[97] The argument claims that there is an inconsistency in between "entitled to Medicare" and "entitled to SSI." As discussed above, "entitled to Medicare" Part A has been deemed to mean legally entitled to benefits, regardless of whether payment was actually made, but the Secretary's policy for SSI benefits includes those patient days only when SSI benefits are paid to an individual on a given month, not merely when they are eligible for benefits.[98] Consideration of this issue is now pending before the District Court for the Eastern District of Washington.[99]

C. The Secretary's policy on what the phrase "entitled to supplemental security income benefits" in 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I) means for purposes of the numerator of the SSI fraction used in the DSH adjustment calculation

As discussed above, the Medicare DSH adjustment is calculated using two fractions known as the Medicare fraction (also referred to as the SSI fraction or SSI ratio) and the Medicaid fraction. Pursuant to 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I), the Medicare fraction is calculated by using: (a) in the numerator, the "number of such hospital's patient days…which were made up of patients who (for such days) were ***entitled*** to benefits under part A of the subchapter and were ***entitled*** to supplementary security income benefits…under subchapter XVI of this chapter…";[100] and (b) in the denominator, the number of days of care that are furnished to patients who were

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[93] *Id.* at 2365.
[94] *Id.* at 2368.
[95] *Empire Health Found. v. Azar*, 2022 WL 17411382, *1 (9th Cir. 2022).
[96] *Id.*
[97] *Id.*
[98] *Id.*
[99] *Id.* at *2. Following the Supreme Court's remand in *Empire Health*, the district court initially dismissed this alternative argument for lack of subject matter jurisdiction. The Ninth Circuit reversed that decision and ordered the district court "to consider the argument in the first instance and to obtain supplemental briefing on the impact of the Supreme Court's ruing . . . ." *Id.*
[100] (Emphasis added.)

entitled to Medicare Part A. The Secretary incorporated this statutory provision into the regulations at 42 C.F.R. § 412.106(b)(2)(i)(B) which states:

> (2) *First computation: Federal fiscal year.* For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS –
>
> (i) Determines the number of patient days that –
>
> (A) Are associated with discharges occurring during each month; and
>
> (B) Are furnished to patients who during that month were **entitled to** both Medicare Part A (including Medicare Advantage (Part C)) and **SSI**, excluding those patients who received only State supplementation;
>
> (ii) Adds the results for the whole period; and
>
> (iii) Divides the number determined under paragraph (b)(2)(ii) of this section by the total number of days that –
>
> (A) Are associated with discharges that occur during that period; and
>
> (B) Are furnished to patients entitled to Medicare Part A (including Medicare Advantage (Part C)).[101]

The "alternative argument" in these appeals, raised in for the first time in the EJR Request, involves CMS' determination of which patients are "entitled to" both Medicare Part A and SSI benefits for purposes of the Medicare fraction of the DSH calculation.

The SSI program is a federal cash assistance program for low-income individuals who are aged, blind, or disabled,[102] administered by the Social Security Administration ("SSA"). The statutory provisions governing SSI, generally, do not use the term "entitled" to SSI benefits. Rather, the SSI statutory provisions typically refer to whether an individual is "eligible for benefits."[103] In order to be "eligible" for SSI benefits, a person must be: (1) 65 years of age or older, blind or disabled; (2) a lawful resident of the United States; (3) have limited income and resources; (4) not be fleeing to avoid prosecution for a crime or violating a condition of parole; and (5) file an application for benefits.[104]

In contrast, the Medicare program is an insurance program where an individual is automatically "entitled" to Medicare Part A when the person reaches age 65 and is entitled to Social Security

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[101] (Bold emphasis added and italics emphasis in original.) *See also* 42 U.S.C. § 1395w2(d)(5)(F)(vi)(I).
[102] 42 U.S.C. § 1382.
[103] 42 U.S.C. §§ 1381a, 1382(a) (emphasis added).
[104] 20 C.F.R. § 416.202.

benefits or becomes disabled and had been entitled to disability benefits for 24 calendar months.[105] In addition, the Medicare program provides that certain qualifying individuals with end stage renal disease are entitled to Medicare Part A.[106]

Unlike entitlement for Medicare Part A benefits, an individual who is currently eligible for SSI benefits may later become *in*eligible for SSI benefits. In this regard, SSA conducts periodic redeterminations to ensure continued eligibility[107] and may terminate,[108] suspend[109] or stop payments to individuals who are either temporarily or permanently ineligible for payment of SSI benefits.[110] In particular, SSI eligibility may be lost if a person no longer meets the basic requirements. For example, an individual may lose SSI eligibility if the individual is no longer disabled or the individual meets one of the following reasons set forth in §§ 416.207-416.216:

1. The individual fails to give the SSA permission to contact financial institutions;[111]
2. The individual fails to apply for other benefits to which the individual may be entitled;[112]
3. The individual fails to participate in drug or alcohol addiction treatment;[113]
4. The individual is absent from the United States for more than 30 days;[114] or
5. The individual becomes a resident of a public institutions or prison.[115]

In addition, under certain circumstances, SSA may not pay benefits for administrative reasons, such as removal of a representative payee, an unknown address for the beneficiary, or because of income from a previous month.[116]

After the Medicare DSH statutory provisions were enacted in 1984, CMS (then known as the Health Care Financing Administration ("HCFA")) announced that the Secretary of Health and Human Services, rather than hospitals, would be solely responsible for computation of the Medicare fraction because the data necessary to calculate the Medicare fraction is voluminous and much of this data needed to be obtained from another agency, SSA.[117] CMS noted that, as of 1986, the data sources for the computation of the Medicare fraction included approximately 11 million billing records from the Medicare inpatient discharge file and over 5 million records from the SSI file compiled by SSA.[118] To compute the Medicare fraction, CMS had to match

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[105] 42 U.S.C. § 426.
[106] 42 U.S.C. § 426-1.
[107] 20 C.F.R. § 416.204.
[108] 20 C.F.R. §§ 416.1331-1335.
[109] 20 C.F.R. §§ 416.1320-1330.
[110] 20 C.F.R. § 1320.
[111] 20 C.F.R. § 416.207.
[112] 20 C.F.R. § 416.210.
[113] 20 C.F.R. § 416.214.
[114] 20 C.F.R. § 416.215.
[115] 20 C.F.R. § 416.211.
[116] *See* SSA Program Operations Manual ("POMS") § SI 02301.201 (describing certain SSI post-eligibility events on the internet at https://secure.ssa.gov/apps10/poms.nsf/lnx/0502301201).
[117] 51 Fed. Reg. 31454, 31459 (Sept. 3, 1986).
[118] *Id.*

individual Medicare billing records to individual SSI records.[119] Considering the administrative burdens and complexity of the data matching process, CMS concluded that the Secretary would be responsible for the data matching process, which she would conduct retrospectively for every eligible Medicare hospital on a "federal fiscal year" basis—that is, based on discharges occurring in the federal fiscal year.[120] CMS notifies Medicare contractors of the SSI ratios after they are calculated. CMS currently makes this notification by posting the resulting SSI percentages on its website. Medicare contractors then use the posted SSI ratios to calculate the Medicare DSH percentage to determine each qualifying hospital's Medicare DSH payment adjustment.[121]

The Medicare DSH payment adjustment has been the subject of much litigation and, from that litigation, the following case is of particular relevance to this appeal: *Baystate v. Leavitt*, 545 F. Supp. 2d 20 *as amended* 587 F. Supp. 2d 37, 44 (D.D.C. 2008) ("*Baystate*"). In *Baystate*, the plaintiff alleged that the Secretary's process to identify and gather the data necessary to calculate each hospital's SSI ratio was deficient and the Court remanded the case to the Administrator for further action. The Board notes that this case discusses the Secretary's historical practice of basing "entitled to . . . SSI" under 42 C.F.R. § 412.106(b)(2) on actual payment of SSI cash benefits.[122]

On April 28, 2010, the Secretary through CMS acted on the *Baystate* remand order and published CMS Ruling CMS-1498-R ("Ruling 1498-R"). Specifically, the Ruling stated that CMS had implemented the *Baystate* remand order by recalculating the plaintiff's SSI fractions and Medicare DSH payment adjustments using a revised data matching process that used "updated and refined SSI eligibility data and Medicare records, and by matching individuals' records with reference to Social Security numbers (SSNs) as well as HICANs and Title II numbers."[123] The Ruling also stated that "in the FY 2011 proposed rule, CMS is proposing to adopt the same revised data matching process" for use with all hospitals and that "[i]n the forthcoming FY 2011 IPPS final rule, CMS expects to respond to public comments filed on the proposed new data matching process, make any changes to such matching process that seem appropriate, and adopt

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[119] *Id.*
[120] *Id.* at 31459–31460; 42 C.F.R. § 412.106(b).
[121] 42 C.F.R. § 412.106(b)(5); 42 C.F.R. § 405.1803.
[122] *Baystate* began with a hearing before the Board. *See Baystate Med. Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006), *modified by*, CMS Adm'r Dec. (May 11, 2006). The Board heard extensive testimony on the Secretary's then-existing data match process. This included testimony from several SSA employees on the data tapes historically sent from SSA to CMS that included "42 monthly indicators (ones and zeros) denoting the payment or non-payment of Federal SSI cash benefits during the period covered by the SSA tape." *Id.* at 11 (citations omitted). Further, this testimony established that SSA's program would "assign a '1' to a month if the CMPH field shows one of two payment codes, C01 (current pay status) or M01 (manual or forced pay), and the FAM field reflects an amount due for the month" and that "[o]therwise, the program assigns a '0' to that month." *Id.* The provider in *Baystate* contested among other things: (1) "the omission of SSI records relating to individuals who received a forced payment from an SSA filed office; (2) "the omission of SSI days associated with individuals whose SSI benefits were temporarily on hold or in suspense when SSA ran each year's SSI tape;" (3) "the omission of SSI days associated with individuals whose benefits were restored or retroactively after SSA ran each year's tape;" and (4) "the omission of individuals who were entitled to non-cash Federal SSI benefits." *Id.* at 23. The Board's discussion of these contentions confirms SSI days were counted when there was actual SSI cash benefits. *See id*. at 26-30. The CMS Administrator's decision and the ensuing decision of the D.C. District Court also contain references to the Secretary's policy. *See, e.g.,* Adm'r Dec. at 5, 16, 39, 41, 48-49; 545 F. Supp. 2d at 28-29 n.13 & n.17, 36-39.
[123] CMS-1498-R at 5.

finally a new data matching process."[124] Finally, CMS stated that it would "use that new data matching process in calculating SSI fractions and DSH payments for specific claims that are found to qualify for relief under this Ruling."[125]

Consistent with Ruling 1498-R, the Secretary published the new data matching process in the FY 2011 IPPS proposed rule published on May 4, 2010.[126] The proposed rule includes references to the Secretary's historical practice of basing "entitled to . . . SSI" under 42 C.F.R. § 412.106(b)(2) on actual payment of SSI cash benefits.[127]

The Secretary finalized that data matching process in the FY 2011 IPPS final rule published on August 16, 2010 ("FY 2011 IPPS Final Rule").[128] Significantly, in the preamble to the FY 2011 IPPS Final Rule, CMS acknowledged a public comment that: (1) requested that "CMS include both paid and unpaid days for both SSI entitlement and Medicare entitlement such that there would be consistency between the numerator and denominator of the SSI fraction"; and (2) provided examples of "several SSI codes that represent individuals who were eligible for SSI but not eligible for SSI payments, that should be included as SSI-entitled for purposes of the data match process."[129] CMS responded in detail to this comment and explained that CMS interprets SSI entitlement to correspond with any month for which an individual *receives* payment of SSI benefits. In this regard, CMS stated that the three SSI codes denoted as C01, M01, and M02 "accurately captures all SSI-entitled individuals during the month(s) they are entitled to receive SSI benefits."[130] CMS explicitly rejected the inclusion of other SSA codes because "SSI entitlement can change from time to time" and none of these codes "would be used to describe an individual who was entitled to receive SSI benefits during the month that one of these codes was used."[131] Finally, in the preamble, CMS confirms that "[t]he same data matching process [used for FY 2011 and beyond] will be used to calculate SSI fractions for cost reporting periods covered under the Ruling [1498-R]."[132]

While the new data matching process established in the preamble to the FY 2011 IPPS Final Rule was effective October 1, 2010 (*i.e.*, for FY 2011 and forward), Ruling 1498-R directed that the

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[124] *Id.*
[125] *Id.* at 5-6.
[126] 85 Fed. Reg. 23852, 24002-24007 (May 4, 2010).
[127] *See, e.g.,* 75 Fed. Reg. at 24003 (discussing SSI cash payment issues discussed in the *Baystate* decision), 24003-24004 (discussing the proposed matching process where "[t]he SSI eligibility file serves as the system of record for whether or not SSA made a payment of SSI benefits to an individual who applied for SSI"), 24004-06 (discussing the time of the matching process including how "it is important to find an appropriate balance between administrative finality (that is, the final settlement of a hospital's cost report) and the inclusion of retroactive SSI eligibility determinations and the lifting of SSI payment suspensions by using the best and latest available SSI eligibility data at the time of cost report settlement benefits").
[128] 75 Fed. Reg. 50041, 50280-50281. (Aug.f 16, 2010).
[129] *Id.* at 50280.
[130] *Id.* at 50280-50281.
[131] *Id.* This include all codes with the "S" prefix indicating a suspension of payment; codes beginning with "N" for nonpayment; code "E01" indicating that the individual had countable income which eliminated the SSI payment; and code "E02" indicating that the patient was not entitled to SSI benefits during that month but became entitled during a subsequent month.
[132] *Id.* at 50285.

Medicare contractors apply "the same, unitary relief" consisting of SSI fractions that the Secretary had calculated using the new "suitably revised" data matching process to: (1) any Medicare cost report that had not been settled; and (2) all properly pending Medicare DSH appeals of the SSI fraction data matching process issue.[133] The Ruling noted that hospitals dissatisfied with the initial or revised NPR issued using the new SSI ratios in the Medicare DSH adjustment calculation could seek administrative and judicial review provided they met the jurisdictional and procedural requirements of 42 U.S.C. § 1395oo, the Medicare regulations, and other agency rules and guidelines.[134] In the FY 2011 IPPS Final Rule, the Secretary explicitly recognized that "[t]he data matching process provisions of the Ruling would apply to . . . open cost reports for cost reporting periods beginning prior to October 1, 2010 (that is those preceding the effective date of the FY 2011 IPPS final rule)."[135]

Finally, on April 22, 2015, CMS published Ruling 1498-R2 modifying and amending Ruling 1498-R by allowing hospitals to elect whether to use new Medicare SSI fractions calculated on the basis of "total days" or "covered days" for cost reports involving patient discharges *prior* to October 1, 2004.[136]

As a result of the new regulation and new data match process, CMS calculated SSI percentages for the Providers for the fiscal year at issue.[137] In their EJR request, the Providers are challenging the adoption of the policy stated therein that only SSI paid days as represented by SSI codes S01, M01 and M02 are included in the numerator of the SSI fraction for purposes of representing days "entitled to [SSI] benefits."

V. Analysis of the EJR Request:

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

A. Jurisdiction over the Group Appeal Requests

For purposes of Board jurisdiction over a participant's appeal for cost report periods ending prior to December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming an issue as a "self-disallowed cost," pursuant to the U.S. Supreme Court's reasoning set out in *Bethesda Hospital Association v.*

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[133] CMS-1498-R at 6-7, 31.
[134] *Id.* at 28, 31.
[135] 75 Fed. Reg. at 24006.
[136] CMS-1498-R2 at 2, 6.
[137] CMS published the SSI ratios for FY 2007 on or about March 2012. SSI ratios are published and can be accessed at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.

Bowen.[138] In that case, the U.S. Supreme Court concluded that a cost report submitted in full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.[139]

Significantly, because each of the participants in Case Nos. 13-1693GC and 13-1694GC were directly added to these groups (as opposed to filing an individual appeal with a separate appeal request/issue statement and then being transferred to the group), *each participant's appeal rights can be* ***no greater than*** *those of the group appeal* (*i.e*., can be no greater than the group issue statement).

1. *Participant 1 – Scott & White Healthcare (Prov. No. 45-0054)*

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

Here, Scott & White Healthcare is a participant in Case Nos. 13-1693GC and 13-1694GC based on its appeal of the revised NPR ("RNPR") issued on October 17, 2012. The Code of Federal Regulations provides for an opportunity for a reopening of a determination and issuance of a revised determination (*e.g*., issuance of a revised NPR) at 42 C.F.R. § 405.1885 (2018), which provides in relevant part:

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

Additionally, 42 C.F.R. § 405.1889 (2013) explains the effect of a revised determination and a provider's right to appeal a revised determination:

> (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*

[138] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).
[139] *Bethesda* at 1258-59.

> 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.[140]

As described below, the Board finds that it has jurisdiction over Scott & White Healthcare as a participant in Case No. 13-1694GC (the DSH no-pay Part A days issue) but not as a participant in Case No. 13-1693GC (the DSH Medicaid fraction dual eligible days issue).

Scott & White Healthcare was directly added to the CIRP groups under Case Nos. 13-1693GC and 13-1694GC based on its appeal of its RNPR dated October 17, 2012.[141] Here, the RNPR at issue only adjusted the DSH calculation to include a new SSI fraction that was determined using the new post-*Baystate* data matching process set forth in the FY 2011 IPPS Final Rule.

42 C.F.R. § 405.1889(b)(1) specifies that, 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[.]"[142] The reopening for Scott & White Healthcare was issued as a result of the Medicare Contractor's notice of reopening dated April 15, 2011 that was issued "[t]o revise the Medicare-SSI fraction in the DSH calculation to ensure the accurate inclusion of Medicare Advantage data submitted by providers." To this end, the audit adjustment report associated with the RNPR under appeal for Scott & White Healthcare only revised the SSI percentages to incorporate the revised SSI percentage for FY 2007 issued by CMS in March 2012[143] and the inclusion of any new Medicare Advantage data (as noted in the reopening notice) necessarily involved a post-*Baystate* re-calculation of SSI fractions *based on the new data matching process* per CMS Ruling 1498-R and the FY 2011 IPPS Final Rule.[144] As a new running of data match process occurred, neither the Board nor the Provider has any way of knowing what specific days were added and whether the added days were limited to Medicare Advantage days (here there was a 0.23 change in the SSI fraction). As a result, the Board must assume that no-pay Part A days were added to the SSI fraction as a result of the re-running of the data matching process and, thereby, assume it has jurisdiction over ***all*** no-pay Part A days included in the resulting revised SSI fraction since it is impossible to determine what days were added to the SSI fraction

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[140] (Emphasis added.)
[141] *See supra* notes 2-8 and accompanying text (explaining the group appeal request contained two separate legal issues resulting in the Board bifurcating the SSI fraction portion of the issue statement from that for the Medicaid fraction).
[142] 42 C.F.R. § 405.1889(b)(1).
[143] The new FY 2007 SSI ratios for all hospitals that CMS released in March 2012 are posted on CMS' website at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.
[144] 75 Fed. Reg. 50042, 50275-86 (Aug. 16, 2010).

as a result of the re-running of the data matching process and then to segregate any such added days from those that were in the SSI fraction included on the original NPR (from which the Provider had appeal rights but apparently forwent (*i.e.*., the Provider opted not to appeal this group issue from the original NPR and waited instead to appeal that issue from the RNPR)).[145]

Since the only matter specifically revised in the RNPR was an adjustment related to the new the SSI fraction, Scott & White Healthcare does not have a right to appeal under 42 C.F.R. §§ 405.1889(b), the DSH Medicaid Fraction Dual Eligible Days issue set forth in Case No. 13-1693GC.[146] As such, the Board hereby dismisses Scott & White Healthcare from Case No. 13-1693GC because, pursuant to § 405.1889(b) (as now referenced in § 405.1835(a)(1)), it does have the right to appeal the group issue for Case No. 13-1693GC from the RNPR at 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.[147]

2. Participant 2 – Trinity Medical Center (Prov. No. 45-0187)

Trinity Medical Center timely appealed from its original NPR dated October 16, 2012 as a direct addition to Case Nos. 13-1693GC and 13-1694GC. The Board has jurisdiction over the direct-add appeal request for Trinity Medical Center for both cases as the Provider is challenging the Secretary's policy finalized in the FY 2005 IPPS Final Rule that includes no-pay Part A days in the SSI fraction of the DSH adjustment calculation. Under *Bethesda*, Trinity Medical Center has

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[145] This is a different situation from realignment of an SSI fraction from the federal fiscal year to a provider's fiscal year because, when a realignment is performed, CMS does ***not*** re-run the data matching process. 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 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)). Accordingly, ***the realignment process*** does not change any of the data underlying the realigned SSI fraction (*e.g*., Part C days or Part A days) because that data had been previously gathered on a month-by-month basis and *there is no need for CMS to rerun the data matching process* in order to effectuate a realignment (*i.e*., realigning the SSI fraction from the federal fiscal year to the provider's fiscal year).

[146] *See* discussion *supra* notes 2-8 and accompany text (explaining the Board's bifurcation of the original group appeal into the SSI fraction and Medicaid fraction).

[147] *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).

the ability to appeal (claim dissatisfaction) with the amount of reimbursement allowed by the regulation at issue (here the policy finalized in the FY 2005 IPPS Final Rule) relative to its FY 2007 cost report submitted in compliance with the Secretary's rules and regulations. Accordingly, the Board finds jurisdiction over Participant 2, Trinity Medical Center.

3. Jurisdiction over the Groups

The Board has jurisdiction over Case No. 13-1694GC as it was timely filed, the amount in controversy for the group issue meets the minimum $50,000 threshold for a group, and there are 2 participants that were directly added to the CIRP group (the minimum number of participants).

In contrast, the Board does ***not*** have jurisdiction over the CIRP group under Case No. 13-1693GC. The CIRP group appeal was established with two participants. However, *following the dismissal of Scott & White Healthcare from Case No. 13-1693GC* (as set forth above), there is only one participant remaining in that CIRP group (and the CIRP group also now fails to meet the minimum $50,00 threshold for a group). Notwithstanding, *even if the Board had jurisdiction over the CIRP group, it would still be dismissed because, as described below,* the only issue briefed as part of the final position paper for this CIRP group was conceded/abandoned and the issues for which the Providers now seek EJR were not briefed and/or were not properly part of this group appeal in the first instance pursuant to the appeal content requirements specified in 42 C.F.R. 405.1837(c) and the fact that no issues may be added to a group appeal per 42 C.F.R. § 405.1837(f)(1)).[148]

Finally, the Board notes that Case No. 13-1693GC pertains to the Medicaid fraction but as set forth below, neither the procedural challenge to the Part A Days policy nor the substantive challenge to the SSI Days Policy impact the Medicaid fraction and, as such, this group is no longer a viable group and must be dismissed.

B. Analysis on the Scope of the EJR Request as it Relates to the Appealed Issue

The Providers suggest, in their EJR Request, that their appeals are challenging the validity of certain policies stated in both the FY 2005 and FY 2011 IPPS Final Rules.

Relative to the FY 2005 IPPS Final Rule, the Providers' EJR request challenges the procedural validity of "the policy of [CMS] to include in the DSH Medicare fraction all patients enrolled in Part A without regard to whether a Part A payment was made."[149] The Board hereinafter will refer to this as the "Part A Days Policy." Significantly, in describing this procedural challenge, the Providers recognized that the U.S. Supreme Court addressed and affirmed that the Part A Days Policy is ***substantively*** valid:

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[148] Indeed, to the extent a group appeal was improperly established with more than one issue "*common to each provider*" (emphasis added), then 42 C.F.R. § 405.1837(f)(2) requires the Board to bifurcate such additional *common* issue(s) ***before*** conducting further proceedings relative to the issue(s) subject to bifurcation. *See also* EJR request at n.2.
[149] EJR Request at 2.

> In *Empire Health Foundation v. Price*, 334 F. Supp. 3d 1134 (E.D. Wash. 2018), the District Court held that the 2004 regulation was substantively valid, but that it was procedurally invalid for failure to satisfy notice and comment rule making requirements. The decision in *Empire Health Found*. was appealed to the United States Court of Appeals for the Ninth Circuit, which reversed the District Court's holding that the 2004 regulation was procedurally invalid and held that the regulation was substantively invalid. *Empire Health Found. v. Price*, 958 F3d. 873; 2020 WL 2123363; 20 Cal. Daily Op. Serv.4283. The United States Supreme Court **reversed** the decision of the Ninth Circuit in *Xavier Becerra, Secretary of Health and Human Services v. Empire Health Foundation*, Case No. 20-1312. The Supreme Court, however, granted certiorari to review only the decision of the Ninth Circuit that the 2004 regulation was **substantively** invalid. The issue of whether the 2004 regulation is procedurally invalid, therefore, was not decided by the Supreme Court and has not been decided outside of the jurisdiction of the Ninth Circuit. (A decision of the United States District Court for the District of Columbia upheld the procedural validity of the 2004 regulation in the case of *Stringfellow Mem. Hosp. v. Azar*, 317 F. Supp. 3d 168 (D.D.C. 2018). The Providers are not located in the jurisdiction or bound by the decisions of either of these courts.)[150]

Thus, it is clear that the Providers' EJR request only seeks to challenge the ***procedural*** validity of the Part A Days Policy and that they are abandoning their challenge to the ***substantive*** validity of the FY 2005 IPPS Final Rule because *Empire Health* resolved that dispute in favor of the Secretary. Accordingly, the Board finds that the Providers have effectively withdrawn or abandoned any challenge to the substantive validity of the FY 2005 IPPS Final Rule.

Relative to the FY 2011 IPPS Final Rule, the Providers make an alternative argument that "if 'entitled' means all such Part A patients, then 'entitled' should not be limited to only three codes: C01, M01 and M02 to identify persons "entitled to SSI" as set forth in that Final Rule at 50280-81.[151] The Board hereinafter will hereinafter refer to the CMS policy adopting use of these 3 codes as the "SSI Days Policy." The Providers' EJR request sets forth a challenge to the ***substantive*** validity of the SSI Days Policy.[152]

Set forth below, the Board explains its basis for denying the EJR request and dismissing the Providers' challenges to the procedural validity of the Part A Days Policy and the substantive validity of the SSI Days Policy.

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[150] (Underline and bold emphasis added.)
[151] *Id.*
[152] The Providers' EJR request does not include any challenge to the *procedural* validity of the SSI Days Policy.

1. Dismissing Case No. 13-1693GC

Case No. 13-1693GC pertains to the Medicaid fraction but as set forth below, neither the procedural challenge to the Part A Days policy nor the substantive challenge to the SSI Days Policy impact the Medicaid fraction and, as such, this group is no longer a viable group and the EJR request does not apply to it. Only the substantive challenge to the Part A Days Policy contained a separate Medicaid fraction component but that was effectively withdrawn/conceded as explained above. Accordingly, the Board dismisses Case No. 13-1693GC.

With respect to the *procedural* challenge to the Part A Days Policy set forth in the FY 2005 IPPS Final Rule, the Board note that a successful challenge would only result in reverting back to the prior policy.[153] However, reverting back to the prior pre-October 2004 policy would not result in any changes to the Medicaid fraction because neither the current policy nor the pre-October 2004 policy included the subset of no-pay Part A days that pertain to dual eligibles in the numerator of the Medicaid fraction.[154] The only change that occurred following the FY 2005 IPPS Final Rule was the inclusion of no-pay Part A days (including those that pertain to dual eligibles) in the numerator and denominator of the SSI fraction.[155]

Even if Case No. 13-1693GC were viable, as set forth below, the Board is otherwise dismissing both the Providers' challenge to the procedural validity of the Part A Days Policy and to the substantive validity of the SSI Days Policy because they are not properly part of either Case No. 13-1693GC or Case No. 13-1694GC.

*2. Dismissing the Providers' Challenge to the **Procedural** Validity of the Part A Days Policy*

On May 1, 2017, QRS timely filed the Providers' Final Position Paper in each of these cases. Pursuant to 42 C.F.R. § 405.1853(b)(2), "[e]ach position paper must set forth the relevant facts and arguments regarding . . . the merits of the provider's Medicare payment claims for each remaining issue." Similarly, § 405.1853(b)(3) states that "[e]xhibit regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board through a schedule applicable to a specific case or through general instructions."

The Board issued Board Rules governing position papers consistent with § 405.1853(b)(2)-(3). In this regard, the Critical Due Dates Notice setting the Providers' final position paper deadline referenced the Providers to Board Rule 27 governing final position papers. In particular, this Rule (July 1, 2015 version) the following in pertinent part:

Rule 27 – Final Position Papers

27.1 – General

[153] *Empire Health*, 958 F.3d at 886 (9th Cir. 2020) (quoting *Paulsen v. Daniels*, 413 F.3d 999, 1008 (9th Cir. 2005): "The effect of invalidating an agency rule is to reinstate the rule previously in force.").
[154] *See* 958 F.3d at 879-80, 886.
[155] *Id.*

The final position paper should reflect *the refinement of the issues* from the preliminary position paper . . . .

27.2 – Content

The final position paper should address each remaining issue including, at a minimum:

a. Identification of each issue and its reimbursement impact.

b. Procedural history of the dispute.

c. A statement of facts that:

i. Indicates which facts are undisputed.

ii. Indicates, for each material disputed fact, the evidence that the party asserts supports those facts with supporting exhibits and page references.

d. Argument and Authorities – *A thorough explanation of the party's position* of how the authorities apply to the facts.

27.3 – Revised or Supplemental Final Position Papers

Except on written agreement of the parties, *revised or supplemental position papers should **not** present new positions, arguments or evidence*. However, the Board encourages revised or supplemental final position papers which, for administrative efficiency, further *narrow* the parties' positions or provide legal development (such as new case law) that has occurred since the final position paper was filed. Prior to filing such papers, the parties should contact each other to discuss the anticipated substance of such papers and anticipated objections. If a revised or supplemental position paper is filed to further refine or narrow the issues, the opposing party may file a rebuttal or reserve such rebuttal for hearing.

27.4 – Arguments Expanding the Scope of Final Position Papers

If at hearing or through a revised position paper, a party presents an argument or evidence expanding the scope of the position papers, the Board may, upon objection, exclude such arguments or evidence from consideration.[156]

[156] (Italicized and underline emphasis added.)

For further context for Board Rule 27, it is important to look at Board Rule 25 governing preliminary position papers since the final position paper is filed after preliminary position papers have been filed. Board Rule 25 (July 1, 2015 version) states in pertinent part:

Rule 25 – Preliminary Position Papers

> **COMMENTARY**: Under the Regulations effective August 21, 2008, all issues will have been identified well in advance of the due date for preliminary position papers. Unlike the prior practice, *preliminary position papers now are expected to present fully developed positions of the parties* and, therefore, require analysis well in advance of the filing deadline.
>
> To address complaints under the previous Rules that the parties have not had sufficient time to develop meaningful position papers, upon publication of these Rules, the Board will set deadlines for the first position paper generally at eight months after filing the appeal request for the Provider, twelve months for the Intermediary and fifteen months for the Provider's response. . . .

25.1 – Content:

The text of the Preliminary Position Papers must include the following:

A. Provider's Preliminary Position Paper

1. For each issue, state the material facts that support your claim.

2. Identify the controlling authority (e.g., statutes, regulations, policy, or case law) supporting your position.
3. Provide a conclusion applying the material facts to the controlling authorities.

****

25.2 – Preliminary Documents:

A. General: With the preliminary position papers, the parties must exchange *all available documentation* as preliminary exhibits to fully support your position. . . .
B. **Unavailable and Omitted Preliminary Documents**: If documents necessary to support your position are still unavailable, identify the missing documents, explain why the documents remain unavailable, state the efforts made to obtain the documents, and

> explain when the documents will be available. Once the documents become available, promptly forward them to the opposing party.
>
> **C. Preliminary Documentation List**: Parties must attach a list of the exhibits exchanged with the preliminary position paper.
>
> **25.3 – Filing Requirements to Board**
>
> Parties should file with the Board only (1) the cover page of the preliminary position paper, (2) the preliminary documentation list, and (3) a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. Do not file any other documents with the Board.[157]

Similarly, the following Commentary at Board Rule 23.3 (July 1, 2015 version) discussing preliminary position papers and proposed joint scheduling orders ("JSOs") is also relevant[158]:

> **COMMENTARY**: The Regulations and these Rules impose preliminary position paper requirements that are more stringent than in the past. *Full development* of the parties' positions fosters efficient use of the administrative review process and due process. The due dates have been extended to give the parties a better opportunity to develop their case. Because the date for adding issues will have expired and transfers are severely limited, *the Board expects preliminary position papers to be fully developed* and include all available documentation necessary *to give the parties a thorough understanding of their opponent's position*. **CAUTION: Unless the parties demonstrate good cause (e.g., subsequent case law or documents were unavailable through no fault of the party offering the documents), *new* arguments and documents not included in the preliminary position paper may be excluded at the hearing**.

The Board notes that neither the initial Group Issue Statement filed to establish the instant CIRP group nor Final Position Papers filed therein contain any challenges or references to a *procedural* defect in the promulgation of the Part A Days Policy as finalized in the FY 2005 IPPS Rule. In particular, there is no mention of notice and comment, the APA, or that any action taken was arbitrary and capricious. Rather, the arguments in the Group Issue Statement and Final Position Papers are entirely focused on the ***substantive*** validity of the policy and whether it is in accordance with the Medicare statute (which was precisely the issue decided in the Supreme

[157] (Italics and underline emphasis added.)
[158] (Italics and underline emphasis added to Commentary quote.)

Court's recent *Empire Health* decision and conceded by the Providers in their EJR request). As noted above, § 405.1853(b)(2) requires position papers to set forth "the merits of the provider's Medicare payment claims for each remaining issue" and, consistent with that requirement, Board Rules 25 and 27 require fully developed positions of the parties in position papers so the Board and the parties may have a thorough understanding of the other party's position and that new arguments made subsequent to the filing of position papers may be excluded. Thus, any challenge to the ***procedural*** validity of the FY 2005 IPPS Rule and resulting regulations should have been included in the Providers' Final Position Paper, but there is no discussion whatsoever of any procedural defects to that rule or regulation. Accordingly, pursuant to its authority under § 405.1868(a)-(b), the Board dismisses the ***new*** *procedural* defect argument made in the Providers' consolidated EJR request and denies the EJR request relative to that argument for failure of the Providers to comply with the Board regulations and Rules governing position papers and raising new arguments following completion of the position paper process.

*3. Dismissing the Providers' Challenge to the **Substantive** Validity of the SSI Days Policy*

In the consolidated EJR Request, Providers also seek to challenge the ***substantive*** validity of the SSI Days Policy as set forth in the FY 2011 IPPS Rule. The Board notes that neither the original Group Issue Statement or Final Position Paper contain any reference to the FY 2011 IPPS Rule or the interpretation of "entitled to supplemental security benefits under Medicare Part A" within the SSI Ratio. Accordingly, as described below, the Board dismisses the Providers' challenge to the substantive validity of the SSI Days Policy because it was not included in the group appeal request in compliance with the following content requirements for group appeal requests specified in 42 C.F.R. § 405.1837(c), because it was not briefed in the Providers' Final Position Papers, and because § 405.1837(f)(1) specifies that issues may not be added to a group appeal.

The Secretary sets for the regulations governing group appeals at 42 C.F.R. § 405.1837. The Secretary confirms at § 405.1837(a)(2) that a group appeal may only "involve[] ***a single*** question of fact or ***interpretation*** *of law, regulations*, or CMS Rulings that is common to each provider in the group."[159] The Secretary give the following content requirements for group appeal request in § 405.1837(c):

> (c) *Contents of request for a group appeal.* The request for a Board hearing as a group appeal must be submitted in writing to the Board, and **the request must include all of the following**:
>
> (1) A demonstration that the request satisfies the requirements for a Board hearing as a group appeal, as specified in paragraph (a) of this section.
>
> (2) **An explanation** (for each specific item at issue) **of each provider's dissatisfaction** with the final contractor or Secretary determination under appeal, **including** an account of -

[159] (Emphasis added.)

> (i) **Why** the provider believes Medicare **payment is incorrect** for each disputed item;
>
> (ii) **How and why** the provider believes Medicare **payment must be determined differently** for each disputed item; and
>
> (iii) If the provider self-disallows a specific item (as specified in § 413.24(j) of this chapter), **an explanation of the nature and amount of each self-disallowed item**, **the reimbursement sought for the item**, and why the provider self-disallowed the item instead of claiming reimbursement for the item.
>
> (3) A copy of each final contractor or Secretary determination under appeal, and any other documentary evidence the providers consider to satisfy the hearing request requirements of paragraphs (c)(1) and (c)(2) of this section, and a precise description of the one question of fact or interpretation of law, regulations, or CMS Rulings that is common to the particular matter at issue in the group appeal.
>
> (4) A statement that -
>
> (i) The providers believe they have satisfied all of the requirements for a group appeal hearing request under paragraph (a) of this section and requesting the Board to proceed to make jurisdictional findings in accordance with § 405.1840; or
>
> (ii) The Board is requested to defer making jurisdictional findings until the providers request the findings in accordance with paragraph (e)(2) of this section.[160]

Finally, the Secretary confirms in § 405.1837(f)(1) that "[a]fter the date of receipt by the Board of a group appeal hearing request under paragraph (c) of this section, a provider may ***not add*** *other questions of fact or law to the appeal*, regardless of whether the question is common to other members of the appeal . . . ."[161]

The Group Issue Statement filed for the instant CIRP groups focuses on in the interpretation of "not entitled to benefits" as it relates to dual eligible and non-covered patient days in the DSH calculation:

> The issue in this group appeal involves the appropriate treatment in the Medicare [DSH] patient percentage calculation of patients who were not entitled to receive payment under Medicare Part A for

[160] (Bold and underline emphasis added.)
[161] (Emphasis added.)

> their inpatient stay. Specifically, the Providers contend that the Intermediary improperly ***excluded*** from the Medicaid Fraction component of the [DSH] patient percentage calculation certain "dual-eligible" patient days for patients that were not entitled to payment by Medicare Part A (the "DSH—Dual Eligible, No Part A Payment Days" issue). While the Provider recognized that CMS Ruling 1498-R requires inclusion of such days in the Medicare Fraction (aka "SSI Ratio") component of the DSH patient percentage calculation, the Providers contend that ***inclusion*** of such days in the Medicare Fraction is contrary to the plain language of the Medicare DSH statute located at 42 U.S.C. § 1395(d)(5)(F)(vi). . . . The Providers challenge the ***inclusion*** of the Dual Eligible No Part A Payment Days in the Medicare Fraction, and contend all such days should be included in the Medicaid Fraction instead.
>
> In addition, and for the same reasons, other Medicare patients who are not entitled to receive Medicare Part A payment for their inpatient stay should be ***excluded*** by CMS from the Medicare Fraction/SSI Ratio regardless of their eligibility for Medicaid.[162]

This was affirmed in the Providers' letter to the Board dated June 6, 2013, which specifically stated that "the impact revolves around ***the single legal question*** regarding *whether or not Medicare patients with exhausted Part A benefits are* ***'entitled to Part A'*** as described in the DSH statute."[163] The Board finds that, under the § 405.1837(c) content requirements, the Group Issue Statement does not encompass the Providers' challenge to the SSI Days Policy because if failed to specify it was dissatisfied with the SSI Days Policy ***and***, *relative to the SSI Days Policy*: (a) explain "why … Medicare payment is incorrect" under the SSI Days Policy; (b) "[h]ow and why the provider believes Medicare payment must be determined differently" from the SSI Days Policy; (c) since the Provider self-disallowed the SSI Days issue, explain the "nature and amount" of the SSI days issue and "the reimbursement sought" for the SSI days issue.[164] Indeed,

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[162] (Emphasis added.)
[163] (Emphasis added.)
[164] The Board notes that the appeal request only contained one amount in controversy ("AiC") calculation and that this AiC calculation was only related to the Providers' challenge to the Part A Days Policy whereby the Provider was seeking to exclude no-pay Part A days from the numerator and denominator of the SSI fraction and include the subset of those days involving dual eligible in the numerator of the Medicaid fraction. This calculation and the resulting AiC amount are distinctly different than any AiC that would be associated with the Providers' challenge in the EJR request to the SSI Days Policy because the Providers' challenge to the SSI Days Policy merely seeks to increase only the SSI entitled days included in the numerator of the SSI fraction. Moreover, neither the Providers' EJR request nor the Providers' Schedule of Providers includes a separate AiC calculation for the Providers' challenge in the EJR request to the SSI Days Policy. This is a separate bases for dismissal pursuant to 42 C.F.R § 405.1839. In this regard, since the challenge to the SSI Days Policy is a separate issue, it must separately meet the $50,000 minimum threshold for a group appeal as made clear by the following excerpt from subsection (b)(2):

> (2) *Aggregation of claims*. (i) For purposes of satisfying the amount in controversy requirement, group members are not allowed to aggregate claims involving different issues.
> (A) A group appeal must involve a single question of fact or interpretation of law, regulations, or CMS Ruling that is common to each provider (as described in § 405.1837(a)(2) of this subpart).

the Group Issue Statement for these CIRP groups does not even reference SSI or SSI benefits much less include the requisite amount in controversy calculation for this separate issue as required by 42 C.F.R. § 405.1839.[165] Similarly, the Providers' Final Position Paper's Statement of Issue frames the case only as the contention that their "SSI percentages are incorrect due to the ***inclusion*** of [exhausted benefits] days in their [SSI Ratios] instead of the Medicaid fractions on of their DSH calculations."[166]

Furthermore, the Board notes that, per § 405.1837(a)(2), a group appeal may only contain "a single . . . interpretation of law, regulations, or CMS Rulings" and that, per § 405.1837(f)(1), the Providers may not add issues to a group appeal. Here, the Providers' challenge to the SSI Days Policy is clearly based on a separate, "alternative" interpretation of *different* statutory provisions governing the DSH adjustment calculation and involves a *different* class of days (SSI days).[167] Thus, per § 405.1837(a)(2) and § 405.1837(f)(1), the Providers may not expand the scope of the CIRP group appeals by filing an EJR request that would add an "alternative" legal interpretation to challenge the substantive validity *a totally* ***different*** *policy*, namely the SSI Days Policy.

Even if the Providers' challenge to the SSI Days Policy were encompassed within the EJR request, the Board would find that it was abandoned because it was not briefed in the Providers' position papers for these cases. As discussed more fully above, the final position paper must include a fully set forth the merits of the party's position on ***each*** issue so the opposing party and the Board have a thorough understanding of the party's position on ***each*** issue. Here it is clear that the Providers' Final Position Paper does not include any challenge to the SSI Days Policy. In particular, there absolutely no discussion of the phrase "entitled to supplemental security benefits", its interpretation, or the FY 2011 IPPS Rule in the Providers' Final Position Papers (or elsewhere in the record for these group cases) prior to the EJR Request being filed in these cases. Nor do the amounts in controversy calculations, whether with the initial group appeal request submitted in 2013 or the Schedules of Providers submitted in 2017, contain ***any*** reference to these SSI entitled days or the impact of including them in the numerator of the Medicare fraction, which is the relief they seek in their EJR Request.

Accordingly, based on the above multiple separate and independent reasons, the Board dismisses the Providers' challenge in the EJR request to the validity of the SSI Days Policy and denies the Providers' EJR request as it relates to that challenge since it was never properly part of this appeal.

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[165] *See supra* note164 (discussing the lack of an AiC for the SSI Days issue as a separate bases to dismiss that issue).
[166] Provider's Final Position Paper at 3 (emphasis added).
[167] The alternative argument is substantively different than the Providers' original challenge to the substantive validity of the Part A Days Policy and, as such, is separate and distinct as highlighted by the fact that the alternative argument would impacts very different components of the DSH calculation, involves a different class of days (SSI days), focuses on a different statutory phrase "entitled to social security income benefits," and seeks to interpret the word "entitled" as used in that phrase in a different/opposite manner. *See* Board Rule 8 (March 1, 2013 version) (stating at Rule 8.1: "Some issue may have multiple components. To comply with the regulatory requirement to specifically identify the items in dispute, each contested component must be appealed as a separate issue and described as narrowly as possible using the applicable format outlined in Rule 7.") (noting that at Rule 8.2 that DSH cases are an example of an issue with multiple components).

In summary, the Board has jurisdiction over the group and participants in Case No. 13-1694GC. However, with respect to Case No. 13-1693GC, the Board dismisses Scott & White Healthcare from Case No. 13-1693GC which pertains to the Medicaid fraction because, pursuant to 42 C.F.R. § 405.189(b), the Provider did not have the right to appeal the Medicaid fraction issue from the RNPR at issue since that RNPR did not adjust the Medicaid fraction, much less adjust dual eligible days in the Medicaid fraction. As a result, of this dismissal, the Board does not have jurisdiction over Case No. 13-1693GC since, following that dismissal, the group no longer meets the minimum amount in controversy for a group and no longer has the minimum number of participants for a group. Notwithstanding the Board further dismissed Case No. 13-1693GC, in its entirety, because it is no longer a viable appeal since neither procedural challenge to the Part A Days Policy nor the substantive challenge to the SSI Days Policy has any relevance to the Medicaid fraction as stated in the consolidated EJR request.

Regardless of the jurisdictional findings and the non-viability dismissal of Case No. 13-1693GC, the Board dismisses both Case No 13-1693GC and 13-1694GC pursuant to its authority under 42 C.F.R. §§ 405.1868(a)-(b) and 405.1837(c) because:

1. Relative to the Part A Days Policy stated in the FY 2005 IPPS Final Rule, the Board finds:

    a. The Providers' consolidated EJR request for Case No. 13-1693GC and 13-1694GC effectively withdraws/abandons the Provider's challenge to the ***substantive*** validity of the Part A Days Policy (as stated in the group appeal request and briefed in their Final Position Papers) because the Providers conceded in their EJR request that the U.S. Supreme Court resolved that dispute in *Empire Health* in favor of the Secretary; and

    b. The Providers' consolidated EJR request challenge to the procedural validity of the Part A Days Policy is not properly part of either Case Nos. 13-1693GC or 13-1694GC since it was not briefed in the Providers' Final Position Papers filed in those cases.

2. Relative to the SSI Days Policy stated in the FY 2011 IPPS Final Rule, the Board finds that:

    a. The Provider's challenge to the SSI Days Policy is a separate and distinct legal issue since per 42 C.F.R. § 405.1837(a)(2) specifies that a group appeal can only involve "***a single*** question of fact or ***interpretation of law***, regulations, or CMS Rulings that is common to each provider in the group."[168]

    b. The Providers' group issue statement for Case Nos. 13-1693GC and 13-1694GC did not encompass any challenge to the SSI Days Policy based on the content requirements for group appeal requests stated in 42 C.F.R. § 405.1837(c) and failed to include an amount in controversy for this separate issue as required by 42 C.F.R. § 405.1839; and

    c. The Providers did not brief their challenge to the SSI Days Policy in their Final Position Paper notwithstanding the requirements in 42 C.F.R. § 405.1853(b)(2)-(3) and Board

[168] (Emphasis added.)

Rules 25 and 27 that a party must fully brief the merits of their position on each in issue in their position paper; and

d. The Providers may not add an issue to a group appeal per 42 C.F.R. § 405.1837(f)(1).

Accordingly, the Board hereby **dismisses** Case Nos. 13-1693GC and 13-1694GC, in their entirety, **denies** the EJR requests as it relates to the Part A Days and SSI Days Policies, and removes them from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

FOR THE BOARD:

1/18/2023

X Clayton J. Nix

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

James Ravindran
Quality Reimbursement Services, Inc.
150 N. Santa Anita Avenue, Suite 570A
Arcadia, CA 91006

RE: ***Board Decision* – SSI Percentage (Provider Specific)**
Covenant Medical Center (Provider Number: 16-0067)
FYE: 06/30/2013
Case Noumber: 17-0514

Dear Mr. Ravindran,

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

Background:

A. *Procedural History for Case No. 17-0514*

On May 23, 2016, the Provider was issued a Notice of Program Reimbursement ("NPR") for its fiscal year end June 30, 2013.

On November 17, 2016, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained six (6) issues:

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

The remaining issue is the DSH/SSI Percentage – Provider Specific Issue.

[1] On July 26, 2017, this issue was transferred to PRRB Case No. 16-1834GC.
[2] On July 26, 2017, this issue was transferred to PRRB Case No. 16-1838GC.
[3] On July 26, 2017, this issue was transferred to PRRB Case No. 16-1837GC.
[4] On January 11, 2023, this issue was withdrawn by the Group Representative.
[5] On July 26, 2017, this issue was transferred to PRRB Case No. 16-1835GC.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 16-1834GC

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

> The Provider contends that its SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> . . .
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[6]

Provider described its DSH/SSI – 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. Paid days vs Eligible days,
3. Not in agreement with provider's records,
4. Fundamentals problems in the SSI percentage calculation,
5. Covered days vs Total days, and
6. Failure to adhere to required notice and comment rulemaking procedures.[7]

The Provider also transferred its Issue 2 – DSH/SSI Percentage to the CIRP group under Case Number 16-1834GC, *QRS WFHC 2013 DSH SSI Percentage CIRP Group*, on July 26, 2017. The Group Issue Statement for that case is identical to the DSH/SSI Percentage issue in case 17-0514.

MAC'S Contentions:

On April 19, 2018, the MAC filed a Jurisdictional Challenge. The MAC argues that the Board lacks jurisdiction over the DSH SSI% - Provider Specific issue for two reasons. First, the MAC argues that the appeal is premature:

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[6] Issue Statement at 1 (Nov. 17, 2016).
[7] *Id*. at 2.

> The MAC contends that this issue is suitable for reopening, but it is not an appealable issue. The decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election, not a MAC determination. The hospital must make a formal request, through its MAC, to CMS in order to receive a realigned SSI percentage. For the respective fiscal year, once the hospital elects to use its own fiscal year end, it is bound by that decision, regardless of reimbursement impact.[8]

In addition, the MAC argues the DSH SSI% - Provider Specific issue and the DSH SSI% - Systemic issue are considered the same issue by the Board, and cites several past Board decisions to that end.[9]

Provider's Response:

The Provider filed a Jurisdictional Response on May 17, 2018. In it, the Provider argues that the issues are not duplicative because "issues #1 and 2 represent different components of the SSI issue, which was specifically adjusted during the audit."[10] Additionally, the Provider argues that the issue is not duplicative because the Provider is "not addressing the errors which result from CMS' improper data matching process but is addressing the various errors of omission and commission that do not fit into the "systemic errors" category."[11]

Finally, the Provider contends the Provider Specific issue is appealable "because the MAC specifically adjust the Providers SSI percentage and the Provider is dissatisfied with the amount of DSH payments that it received for fiscal year 2013, resulting from its understated SSI percentage due to errors of omission and commission."[12]

Board Analysis and Decision:

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

A. SSI Provider Specific

The analysis for Issue Number 1 has two relevant aspects to consider: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used

[8] Jurisdictional Challenge at 4 (Apr. 19, 2018).
[9] *Id*. at 2.
[10] Jurisdictional Response at 2 (May 17, 2018).
[11] *Id*. at 3.
[12] *Id*.

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 1 (the DSH/SSI (Provider Specific) issue) —the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of Issue 2 (the DSH/SSI issue) which was transferred to Case Number 16-1834GC. This first aspect of Issue 1 in the present appeal concerns "whether the Medicare Administrative Contractor used the correct [SSI] percentage in the [DSH] Calculation."[13] The Provider's legal basis for this aspect of Issue 1 is simply that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[14] Similarly, the Provider argues that "it[s] SSI percentage published by [CMS] was incorrectly computed . . ." and it ". . . [s]pecifically . . . disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[15] Issue 2, transferred to group Case No. 16-1834GC, similarly alleges that the Medicare Contractor and CMS improperly calculated the DSH/SSI Percentage, the DSH/SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F)(i).

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 Number 16-1834GC. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[16] The Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) 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 Number 16-1834GC.

Accordingly, the Board must find that Issue 1 and the group issue in Group Case Number 16-1834GC, are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (2015), the Board dismisses this component of the DSH/SSI (Provider Specific) issue. As an alternative basis, the Board dismisses Issue 1 for failure of the Provider to properly brief the issue in its position paper in compliance with Board Rules.

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[13] Individual Appeal Request, Issue 1.
[14] *Id.*
[15] *Id.*
[16] The types of systemic errors documented in the *Baystate* did not uniformly impact the SSI calculation for all providers but that does not may the errors any less systemic. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). *See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).

2. Second Aspect of Issue 1

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

Conclusion:

The Board dismisses Issue 1, the DSH/SSI (Provider Specific) issue, in its entirety, from this appeal. As there are no remaining issues on appeal, the case is closed and removed from the Board's docket.

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

Board Members Participating:

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

For the Board:

1/26/2023

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
Byron Lamprecht, WPS Government Health Administrators (J-8)

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

Eric Volk
Wipfli LLP
201 W. North River Dr., Ste. 400
Spokane, WA 99201

John Bloom
Noridian Healthcare Solutions
P.O. Box 6722
Fargo, ND 58108

RE: ***Jurisdictional Determination – Electronic Health Records***
Frances Mahon Deaconess Hospital (Prov. No. 27-1316)
FYE 06/30/2014
Case No. 17-2106

Dear Messrs. Volk and Bloom:

The Provider Reimbursement Review Board (the "Board") has reviewed jurisdiction in response to the Medicare Contractor's Jurisdictional Challenge in the above-referenced appeal. The Board's jurisdictional decision is set forth below.

Background

On August 18, 2017, the Board received the Provider's Appeal Request related to a revised Notice of Program Reimbursement ("RNPR") dated February 20, 2017.[1] The Provider is a critical access hospital ("CAH") and the Provider's Issue Statement included the following description of the Electronic Health Record ("EHR") Payment issue:

> Frances Mahon Deaconess Hospital (provider) asserts its dissatisfaction with the Fiscal Intermediary's (auditor) Adjustment #4, Reference 7 disallowing a material amount of Health Information Technology (HIT) cost, which is the basis for claiming an Electronic Health Record (EHR) Incentive program payment, for which the auditor described as non-allowable for EHR and that some of the cost related to Electronic Medical Records (EMR) instead of EHR.
>
> Initially, the provider submitted $1,474,653 in HIT cost that originally finalized with the 2014 cost report with an NRP date of 8/12/2015; however, *that cost report was reopened to consider an* ***additional*** *$277,826 in HIT cost* that was first submitted with the 2015 cost report. The intermediary determined that this cost actually belong in the previous reporting period. *Of that additional cost, the intermediary* ***only*** *allowed $113,827*. This effectively disallowed

[1] Provider's Request for Appeal (Aug. 18, 2017).

> $163,999 in HIT cost, which equated to a reduction of the provider's total potential EHR payment of $112,678. The net amount allowed was $1,55,480 . . . . Of the $163,999 in cost that was disallowed, the provider did agree that $6,300 included with asset #2293 did not meet capitalization requirements as it related to an annual subscription.
>
> The *disallowed* assets included the following:
>
> A. #2293 Software, IMO-Intelligent Medical Objects (SnoMed Codes): $20,708 . . . .
> B. 2310 Software, Data Repository: $50,631 . . . .
> C. #2260 Software, Emergency Department Module of Meditech: $73,260 . . . .
> D. #2265 Software, Interface Engine – Cloverleaf: $19,400 . . . .
>
> Considering all of the above, the provider is proposing the following adjustment:
>
> Increase S-2, Line 168, column 1 from $1,588,480 to $1,746,179[. *sic*]

On December 1, 2022, the Medicare Contractor filed a Jurisdictional Challenge asserting that administrative review of the Provider's appeal is precluded by statute and regulation.

The Provider has not filed a response within the time allotted under Board Rules. In this regard, Board Rule 44.4.3 states:

> 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*.[2]

Medicare Contractor's Position

On December 1, 2022, the Medicare Contractor ("MAC") filed a Jurisdictional Challenge. The MAC notes that the Provider is a CAH and argues that the Board lacks jurisdiction over the CAH EHR/HIT Incentive Payment issue as administrative and judicial review of the Provider's CAH EHR/HIT issue is precluded by 42 U.S.C. § 1395f(l)(5) and the regulations at 42 C.F.R. § 495.106(f). To further strengthen this argument, the Medicare Contractor pointed out prior Board decisions, such as the September 16, 2020 Jurisdictional Decision in Case No. 19-1379, where the Board has previously determined that it lacked jurisdiction over a similar EHR/HIT issue.[3]

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[2] (Emphasis added.)
[3] Medicare Contractor's Jurisdictional Challenge at 4 (Dec. 1, 2022); Exhibit C-2 (copy of the jurisdictional decision in Case No. 19-1379).

Board Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2008), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

The Board finds that it does not have jurisdiction over the EHR payment issue in the above-referenced appeal because administrative and judicial review of the payment is precluded by 42 U.S.C. § 1395f(l)(5) and 42 C.F.R. § 495.106(f).

42 U.S.C. § 1395f(l) provides for incentives for adoption and meaningful use of certified EHR technology by CAHs. In particular, § 1395f(l)(5) states the following:

> **(5) There shall be no administrative or judicial review under section 1395ff of this title, section 1395*oo* of this title, or otherwise, of--**
>
> (A) *the methodology and standards for determining* the amount of payment and *reasonable cost* under paragraph (3) and payment adjustments under paragraph (4), including selection of periods under section 1395ww(n)(2) of this title for determining, and making estimates or using proxies of, inpatient-bed-days, hospital charges, charity charges, and Medicare share under subparagraph (D) of section 1395ww(n)(2) of this title;
>
> (B) the methodology and standards for determining a meaningful EHR user under section 1395ww(n)(3) of this title as would apply if the hospital was treated as an eligible hospital under section 1395ww(n) of this title, and the hardship exception under paragraph (4)(C);
>
> (C) the specification of EHR reporting periods under section 1395ww(n)(6)(B) of this title as applied under paragraphs (3) and (4); and
>
> (D) *the identification of costs* for purposes of paragraph (3)(C).[4]

The regulations at 42 C.F.R. § 495.106(f) also precludes administrative and judicial review under sections 1869 or 1878 of the Social Security Act, or otherwise, of the following as it relates to EHR/HIT payments to CAHs:

[4] (Italics and underline emphasis added.)

> (1) *Methodology and standards for determining* the amount of payment, *the reasonable cost*, and adjustments described in this section including selection of periods for determining, and making estimates or using proxies of, inpatient-bed-days, hospital charges, charity charges, and the Medicare share percentage as described in this section;
>
> (2) Methodology and standards for determining if a CAH is qualifying CAH under this section;
>
> (3) Specification of EHR reporting periods, cost reporting periods, payment years, and fiscal years used to compute the CAH incentive payments as specified in this section; and
>
> (4) ***Identification of <u>the reasonable costs</u>*** *used to compute the CAH incentive payment* under paragraph (c) of this section including any reconciliation of the CAH incentive payment amount made under paragraph (d) of this section.[5]

Here, the Provider is clearly challenging the methodology that the Medicare Contractor used to identify and determine what HIT costs were "reasonable costs" for its FYE 2015 cost report on reopening for purposes of the CAH's EHR/HIT payment. On reopening, the Provider explains that it submitted an additional $277,826 in HIT cost, of which the Medicare Contractor only allowed $113,827. The Provider contends that the Medicare Contractor should have allowed additional HIT costs as qualifying "reasonable costs." However, the Provider's contentions clearly challenge to the methodology and standards that the Medicare Contractor used to identify and determine the allowable HIT "reasonable costs' and these contentions are precluded from administrative and judicial review by the plain reading of both 42 U.S.C. § 1395f(l)(5) and 42 C.F.R. § 495.106(f).[6] Accordingly, the Board agrees with the Medicare Contractor's Challenge which the Provider did ***not*** contest/oppose.

In summary, the Board concludes that it does not have jurisdiction over the EHR issue in the above-referenced appeal because judicial and administrative review of the issue appealed is precluded by statute and regulation. Accordingly, the Board dismisses this issue from the appeal. As there are no other issues pending, the Board hereby closes the case and removes it from the Board's docket.

---

[5] (Emphasis added.)

[6] The only aspect that a CAH may appeal relates to "the statistical and financial amounts from the Medicare cost report used to determine the CAH incentive payment." 75 Fed. Reg. 44314, 44464 (July 28, 2010). *See also* 77 Fed. Reg. 53968, 54113 (Sept. 4, 2012). Consistent with the statutory and regulatory preclusion provisions, these appeal rights can only relate to the total inpatient bed days and charges used to compute the Medicare share percentage as used in the EHR/HIT payment calculation to the extent they are otherwise appealable in the context of other Medicare reimbursement issues. However, such statistical/financial amounts are not at issue in this case and, as such, this small carve out is not applicable here.

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

Board Members:

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

For the Board:

1/26/2023

X Clayton J. Nix

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Dylan Chinea
Toyon Associates, Inc.
1800 Sutter Street, Suite 600
Concord, CA 94520-2546

Lorraine Frewert, Appeals Coordinator
Noridian Healthcare Solutions (J-E)
P.O. Box 6782
Fargo, ND 58108-6782

RE: ***Jurisdictional Determination in Part*** **for Salinas Valley Memorial Hospital (Provider Number 05-0334) FYE 6/30/2017 as a participant in:**

Toyon Associates CY 2017 Accuracy of CMS Developed SSI Ratio Group Case Number: 20-0956G, and

Toyon Associates CY 2017 DSH Medicare Part C - SSI Ratio/DE Part C - Medicaid Ratio Group; Case Number: 20-2047G

Dear Mr. Chinea and Ms. Frewert:

The Provider Reimbursement Review Board ("Board") has reviewed correspondence dated August 20, 2021 from Toyon Associates, Inc. ("Toyon" or "Representative") requesting that the status of the referenced fully-formed optional groups be reopened to allow the addition of a Provider, Salinas Valley Medical Center (05-0334) ("Salinas Valley" or "Provider") appealing from a revised determination.[1] The pertinent facts with regard to the Provider's appeal and the jurisdictional determination of the Board, are set forth below.

Pertinent Facts re: SSI Group, Case No. 20-0956G:

On February 6, 2020, Toyon filed a request to establish the ***optional*** group under Case No. 20-0956G entitled the "Toyon Associates CY 2017 Accuracy of CMS Developed SSI Ratio Group" with two Providers.

Salinas Valley was transferred to the *optional* group from its individual appeal, Case No. 20-0861 on February 6, 2020.[2]

The group issue statement for Case No. 20-0956G indicates that the optional group is appealing "Whether the SSI Ratio developed by CMS is calculated accurately?" Specifically, the optional group is challenging:

> [T]he SSI percentage developed by CMS and utilized by the Medicare Administrative Contractor (MAC) in their updated

[1] Case No. 20-2047G was not fully formed at the time it filed the request to be directly added to the group, but has subsequently been deemed complete.
[2] The individual appeal was filed from receipt of the original Notice of Program Reimbursement ("NPR") dated August 13, 2019.

> calculation of the Medicare Inpatient Prospective Payment System's DSH payment. The group contends that CMS failed to disclose the underlying patient data of their calculation proving the SSI ratio is calculated in the manner prescribed by CMS Ruling 1498-R. In short the accuracy of CMS' updated SSI ratio is in question.

Between February, 2020 and July, 2020, additional participants were transferred into the optional group before it was designated to be "fully-formed" on February 6, 2021, a year after its formation.

The request for the "Direct Add" of Salinas Valley from receipt of its revised NPR was filed on August 20, 2021.

Pertinent Facts re: Medicare Part C Days Group, Case No. 20-2047G:

On September 9, 2020, Toyon filed the ***optional*** group under Case No. 20-2047G entitled the "Toyon Associates CY 2017 DSH Medicare Part C - SSI Ratio/DE Part C - Medicaid Ratio Group." On September 18, 2020, Salinas Valley was transferred to the *optional* group from its individual appeal, Case No. 20-0861.

The group issue statement indicates that the group is appealing:

> [T]he SSI percentage and the Medicaid percentage utilized by the MAC in its calculation of the Medicare DSH payment. Contrary to the MAC's calculations, all Medicare Part C days should be removed from the SSI ratio calculation and all dual eligible Medicare Part C days should be included in the numerator of the Medicaid Ratio calculation.

As in Case 20-0956G, additional participants were transferred into the optional group until the group was designated to be complete a year later, on September 10, 2021. As in Case No. 20-0956G, the request for "Direct Add" from receipt of the RNPR for Salinas Valley was filed on August 20, 2021. In Case No. 20-2047G, however, it was received prior to the group's closure.

Pertinent Facts re: Salinas Valley's Revised NPR:

As noted in the facts above, on August 20, 2021, Toyon requested that the Board reopen the status of Case No. 20-0956G to allow the direct addition of Salinas Valley and requested the direct add of Salinas Valley to Case 20-2047G. In both instances, Salinas Valley is appealing from its realignment-related Revised NPR ("RNPR"). In the direct add requests, Toyon contends that the days used to calculate the revised SSI Ratio for the calendar year ("CY") 8/31/2017 DSH entitlement were changed due to the realignment.

Based on a review of the supporting documentation, it is noted that:

- On July 8, 2020, Toyon filed a Reopening Request for Salinas Valley "request[ing] a

recalculation of its SSI ratio based on its cost reporting period rather than the federal fiscal year." This reopening request was made "pursuant to 42 CFR 412.106(b)(3)" which is the regulation governing requests to realign the SSI ratio (as used in the DSH adjustment calculation) from the federal fiscal year to a provider's fiscal year.

- On August 7, 2020, the Medicare Contractor issued the Notice of Reopening "To adjust the SSI ratio used to calculate the provider's disproportionate share adjustment based on the data from the hospital's actual cost reporting period *rather than the federal fiscal year* and to amend the disproportionate share adjustment to account for the change in SSI ratio."[3]
- The RNPR was issued on March 1, 2021. The Provider appealed Adjustment #s 8, 16, 17 and 19 from the RNPR – however, these adjustment numbers actually refer to the original adjustment report. Adjustment #4 on the revised adjustment report adjusted the SSI percentage from 10.05 to the realigned amount of 10.23.

Board's Determination:

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

The Board finds that it does not have jurisdiction over Salinas Valley for both previously transferred issues, because the appeal is based on the RNPR which was issued as a result of the Provider' SSI Realignment request and there was no specific adjustment for either the SSI accuracy or the Part C days issues. As the Provider appealed an RNPR, its appeal rights are limited by 42 C.F.R. § 405.1889(b) as referenced in § 405.1835(a)(1) and, under this regulation, the Provider does not have the right to appeal any of these issues from the RNPR in dispute.

A. Relevant Regulations – RNPRs

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

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

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

> (a) If a revision is made in a Secretary or contractor determination or a decision by a reviewing entity after the determination or

[3] (Emphasis added.)

> 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.[4]

B. The Board's Rationale

The Provider's appeal request states that the RNPR audit adjustments were issued to reflect the inclusion of the SSI percentage that had been realigned from the federal fiscal year to the Provider's fiscal year. As explained below, this adjustment to incorporate the realigned SSI percentage did not adjust the SSI Data Accuracy issue or the Part C Days issue, and it is clear the Provider has no right under 42 C.F.R. § 405.1889(b) (as referenced in § 405.1835(a)(1)) to appeal either issue from the RNPR.

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[.]"[5] The reopening, in this case, was a result of the Provider's request to realign its SSI percentage from the federal fiscal year end to its individual cost reporting fiscal year end. Based on the Notice of Reopening, the RNPR under appeal clearly only revised the SSI percentage in order to realign it from a federal fiscal year to the provider's respective fiscal year. As described below, the RNPR was being issued only to include the realigned SSI percentage where the SSI percentage was realigned from the federal fiscal year to the provider's fiscal year, and 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. Thus, the Board has consistently found that it does not have jurisdiction over RNPRs that were issued as a result of a provider's request for realignment of its SSI percentage.

As noted in 42 C.F.R. § 412.106(b)(2), CMS gathers data to be used in the SSI fraction on a month-by-month basis:

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

[4] (Emphasis added.)
[5] 42 C.F.R. § 405.1889(b)(1).

> (A) Are associated with discharges occurring **during each month**; and
>
> (B) Are furnished to patients who **during that month** were entitled to both Medicare Part A (including Medicare Advantage (Part C)) and SSI, excluding those patients who received only State supplementation;
>
> (ii) Adds the results for the whole period; and
>
> (iii) Divides the number determined under paragraph (b)(2)(ii) of this section by the total number of days that -
>
> (A) Are associated with discharges that occur during that period; and
>
> (B) Are furnished to patients entitled to Medicare Part A (including Medicare Advantage (Part C)).[6]

The data matching process by which CMS gathers this monthly data is described in the FY 2011 IPPS Final Rule.7 As described in the Federal Register, under the realignment process, CMS calculates the SSI fraction using the previously-gathered data for the months included in the published SSI fractions from the 2 Federal fiscal years that encompass the hospital's cost reporting period:

1. *75 Fed. Reg. 50042, 50279 (Aug. 16, 2010)*.—"[W]e publish these [SSI fraction] data for every hospital based on the Federal fiscal year but, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived *from the data match process* ***for the two Federal fiscal years that spanned the hospital's cost reporting period***."[8]

2. *70 Fed. Reg. 47278, 47439 (Aug. 12, 2005)*.—"Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period,

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

> and *the hospital* ***must accept*** *the resulting DSH percentage for that year, whether or not it is a more favorable number than the DSH percentage based on the Federal fiscal year. . . .*
>
> Beginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108–173), we will arrange to furnish, consistent with the Privacy Act, MedPAR LDS data for a hospital's patients eligible for both SSI and Medicare at the hospital's request, regardless of whether there is a properly pending appeal relating to DSH payments. *We will make the information available for either the Federal fiscal year or, if the hospital's fiscal year differs from the Federal fiscal year, for the* ***months*** ***included in the 2 Federal fiscal years that encompass the hospital's cost reporting period***. Under this provision, *the hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year.* The data set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year."[9]

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

In other words, the determination was only being reopened to include realigned SSI percentages and CMS' realignment process (as described in the Federal Register) does not entail re-running of the data matching process that the Providers are trying to appeal (much less revise any of the SSI paid days, Part A, or Part C days included in the underlying month-by-month data). Since the only matter specifically revised in the RNPR was the adjustment to realign the SSI percentage from the federal fiscal year to the provider's fiscal year, the Board does not have jurisdiction over the RNPR appeal of the DSH SSI fraction issues in both group appeals for Salinas Valley because the Provider did not have the right under 42 C.F.R. § 405.1889(b) (as referenced in § 405.1835(a)(1)) to appeal those issues from the RNPR.

Finally, the Board notes that Board Rule 19.5 (consistent with 42 C.F.R. § 405.1837(e)(1)) specifies: "The Board has discretion to grant or deny a request to join a fully formed group." In conclusion, the Board declines to exercise its discretion and hereby ***denies*** Toyon's request to reopen the status of the two optional groups, Case Nos. 20-0956G and 20-2047G to allow the ***direct*** addition of Salinas Valley's RNPR appeal because the Board finds the Provider does not

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

have the right to appeal the RNPR at issue under 42 C.F.R. §§ 405.1889(b)and 405.1835(a)(1).[10]

The Board also notes that the Provider has already previously appealed these two issues *from its original NPR* where: (a) it was transferred to Case No. 20-0956G for the SSI Accuracy Issue and to Case No. 20-2047G for the Medicare Part C Days issue and is still an active participant in both group cases based on the *original NPR* appeals.

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

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

For the Board:

1/30/2023

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, Inc.

[10] The Board notes that the Provider filed requests to be directly added to 2 existing fully formed groups (as opposed to filing individual appeal requests and then asking for the optional groups to be reopened so that the provider could be transferred from an individual appeal to those optional groups). But they also filed an individual appeal, 21-1651, with the same issues, on August 30, 2021, 10 days after the requests to direct add to this group appeal. The Board has already denied transfers to these group appeals from the individual appeal in a letter dated July 1, 2022, utilizing the same dismissal rationale that was outlined in this determination.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
7500 Security Boulevard
Mail Stop: B1-01-31
Baltimore, MD 21244-1850
410-786-2671

Via Electronic Delivery

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

RE: ***Notice of Dismissal***
River Regional Medical Corp. (Prov. No. 25-0031)
FYE 6/30/2011
PRRB Case No. 16-0050

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board" or "PRRB") received River Regional Medical Corp.'s ("Provider's") Individual Appeal Request on October 16, 2015, appealing from a Notice of Program Reimbursement ("NPR") dated April 20, 2015. The two issues remaining are: (1) DSH/SSI Percentage (Provider Specific) and (2) DSH Medicaid Eligible Days. The Provider filed a Preliminary Position Paper ("PPP") on June 28, 2016, and the Medicare Contractor filed its PPP on October 31, 2016.

On March 25, 2020, the Board issued Board Alert 19 announcing temporary adjustment to the Board's processes in light of the Covid-19 public health emergency. In particular, Board Alert 19 suspended Board-set deadlines from March 13, 2020 forward. Board Alert 19 has been withdrawn effective December 7, 2022 with the issuance of Board Alert 23. Board Alert 23 announced Board-set deadlines would cease to be suspended for Board rules or instructions, or Board notices and correspondence issued on or after December 7, 2022.

In this case, the Board issued a revised Notice of Hearing on December 12, 2022, following the issuance of Alert 23, which set a due date for the Provider's Final Position Paper ("FPP") of January 18, 2023, which was never filed. A hearing was set for April 18, 2023.

As of the date of this decision, the Provider has not submitted its FPP or filed any other correspondence with the Board. Board Rule 41.2 (Nov. 2021) permits dismissal or closure of a case on the Board's own motion:

- if it has a reasonable basis to believe that the issues have been fully settled or abandoned,
- ***upon failure of the provider or group to comply with Board procedures or filing deadlines***,

- if the Board is unable to contact the provider or representative at the last known address, or
- upon failure to appear for a scheduled hearing.[1]

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

> (b) Position papers. (1) After any preliminary narrowing of the issues, the parties must file position papers in order to narrow the issues further. In each case, and as appropriate, the Board establishes the deadlines as to when the provider(s) and the contractor must submit position papers to the Board.
>
> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper must set forth the relevant facts and arguments regarding the Board's jurisdiction over each remaining matter at issue in the appeal (as described in §405.1840 of this subpart), and the merits of the provider's Medicare payment claims for each remaining issue.

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

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

Board Rule 27.1 (Nov. 2021) provides that, "for appeals filed prior to August 29, 2018 (like the instant appeal), the final position paper remains a required filing, and *failure to timely file the final position papers may result in dismissal of the case.*"[2]

---

[1] (Emphasis added.)

[2] (Emphasis in original.) FPPs are optional for new appeals filed on or after August 29, 2018, which under the Board Rules in effect for those appeals, the parties must file a **complete** preliminary position paper. Board Rule 25.3 (v 3.1 Nov. 2021). In this case, the parties did not file complete preliminary position papers in compliance with the Board Rules in effect at the time the appeal request was filed. Board Rule 25.3 (v 1.3, July 2015)

Further, the revised Notice of Hearing issued on December 12, 2022, states at the end of the paragraph on the Provider's Final Position Paper that "[i]f the Provider misses its due date, the Board will dismiss the case[]." The revised Notice of Hearing was issued after Board Order No. 3 withdrew Alert 19, and in that Order, it was clearly indicated that the Board will cease suspending deadlines and will hold parties to the deadline specified in *any* Board issued notice or correspondence issued on or after December 7, 2022.

The Board is hereby dismissing case 16-0050 because the Provider has failed to meet the Board-set filing deadline for its FPP. The Provider was required to file its FPP by January 18, 2023, but failed to do so. Case No. 16-0050 is dismissed and removed from the Board's docket.

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

Board Members:

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

For the Board:

1/30/2023

X Gregory H. Ziegler

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
7500 Security Boulevard
Mail Stop: B1-01-31
Baltimore, MD 21244-1850
410-786-2671

Via Electronic Delivery

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

RE: ***Notice of Dismissal***
Merit Health River Region (Prov. No. 25-0031)
FYE 6/30/2013
PRRB Case No. 16-1674

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board" or "PRRB") received Merit Health River Region's ("Provider's") Individual Appeal Request on May 23, 2016, appealing from a Notice of Program Reimbursement ("NPR") dated November 24, 2015. The two issues remaining are: (1) DSH/SSI Percentage (Provider Specific) and (2) DSH Medicaid Eligible Days. The Provider filed a Preliminary Position Paper ("PPP") on January 26, 2017, and the Medicare Contractor filed its PPP on June 1, 2017.

On March 25, 2020, the Board issued Board Alert 19 announcing temporary adjustment to the Board's processes in light of the Covid-19 public health emergency. In particular, Board Alert 19 suspended Board-set deadlines from March 13, 2020 forward. Board Alert 19 has been withdrawn effective December 7, 2022 with the issuance of Board Alert 23. Board Alert 23 announced Board-set deadlines would cease to be suspended for Board rules or instructions, or Board notices and correspondence issued on or after December 7, 2022.

In this case, the Board issued a revised Notice of Hearing on December 12, 2022, following the issuance of Alert 23, which set a due date for the Provider's Final Position Paper ("FPP") of January 18, 2023, which was never filed. A hearing was set for April 18, 2023.

As of the date of this decision, the Provider has not submitted its FPP or filed any other correspondence with the Board. Board Rule 41.2 (Nov. 2021) permits dismissal or closure of a case on the Board's own motion:

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

- upon failure to appear for a scheduled hearing.[1]

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

> (b) Position papers. (1) After any preliminary narrowing of the issues, the parties must file position papers in order to narrow the issues further. In each case, and as appropriate, the Board establishes the deadlines as to when the provider(s) and the contractor must submit position papers to the Board.
>
> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper must set forth the relevant facts and arguments regarding the Board's jurisdiction over each remaining matter at issue in the appeal (as described in §405.1840 of this subpart), and the merits of the provider's Medicare payment claims for each remaining issue.

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

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

Board Rule 27.1 (Nov. 2021) provides that, "for appeals filed prior to August 29, 2018 (like the instant appeal), the final position paper remains a required filing, and *failure to timely file the final position papers may result in dismissal of the case.*"[2]

---

[1] (Emphasis added.)
[2] (Emphasis in original.) FPPs are optional for new appeals filed on or after August 29, 2018, which under the Board Rules in effect for those appeals, the parties must file a complete preliminary position paper. Board Rule 25.3 (v 3.1 Nov. 2021). In this case, the parties did not file complete preliminary position papers in compliance with the Board Rules in effect at the time the appeal request was filed. Board Rule 25.3 (v 1.3, July 2015).

Further, the revised Notice of Hearing issued on December 12, 2022, states at the end of the paragraph on the Provider's Final Position Paper that "[i]f the Provider misses its due date, the Board will dismiss the case[]." The revised Notice of Hearing was issued after Board Order No. 3 withdrew Alert 19, and in that Order, it was clearly indicated that the Board will cease suspending deadlines and will hold parties to the deadline specified in *any* Board issued notice or correspondence issued on or after December 7, 2022.

The Board is hereby dismissing case 16-1674 because the Provider has failed to meet the Board-set filing deadline for its FPP. The Provider was required to file its FPP by January 18, 2023, but failed to do so. Case No. 16-1674 is dismissed and removed from the Board's docket.

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

Board Members:

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

For the Board:

1/30/2023

X Gregory H. Ziegler

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

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

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

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

Byron Lamprecht
WPS Government Health Administrators
2525 N. 117th Avenue, Suite 200
Omaha, NE 68164

RE: ***Jurisdictional Decision*** **– SSI Realignment**
LifePoint 2012 Medicare/Medicaid Fraction Medicare Advantage Days CIRP Group
Case Number: 14-3465GC

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

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the jurisdictional documentation in the common issue related party ("CIRP") group under Case No. 14-3465GC. The Board's decision is set forth below.

Background

The group appeal request was filed on May 14, 2014, and originally entitled *LifePoint 2012 SSI Fraction Medicare Advantage Days CIRP Group*. Simultaneously filed was PRRB Case No. 14-3464GC, entitled *LifePoint 2012 Medicaid Fraction Medicare Advantage Days CIRP Group*. On July 19, 2017, the Providers requested bifurcation and consolidation to accomplish the following:

1) To consolidate two DSH Medicare Advantage cases into one single group; and

2) Bifurcate the Inpatient Rehabilitation Units out of the existing two Medicare Advantage cases into a newly formed mandatory group.[1]

On July 26, 2017, the Board bifurcated the rehab portion of the providers in the group appeals and transferred them to newly formed Case No. 17-1880GC, *LifePoint 2012 Rehab LIP Medicare/Medicaid Medicare Advantage Days CIRP*.[2] Also, the Board consolidated the *LifePoint 2012 DSH Medicaid Fraction Medicare Advantage Days CIRP Group*, Case Number 14-3464GC into the *LifePoint 2012 DSH SSI Fraction Medicare Advantage Days CIRP Group*, Case Number 14-3465GC. Case Number 14-3464GC was closed, and the group name for Case

[1] Providers' Request for Bifurcation (Jul. 19, 2017), PRRB Case No. 14-3465GC.
[2] PRRB Case Nos. 17-1880GC, et al., were closed on October 24, 2018, as the providers' IRF-LIP issue was dismissed by the Board pursuant to the ruling in *Mercy*.

Number 14-3465GC was modified to the current name, *LifePoint 2012 Medicare/Medicaid Fraction Medicare Advantage Days CIRP Group*.

The group currently contains over 30 providers, two of which appealed from original NPRs *and,* as permitted, separately appealed from revised NPRs ("RNPRs") that were issued subsequent to requests for SSI realignment:

- Provider No. 18-0066 – Logan Memorial Hospital (FYE 2/29/2012)
  - Adjustment No. 2: "To update the SSI% in accordance with CMS' SSI realignment calculation."
- Provider No. 01-0118 – Vaughan Regional Medical Center (FYE 6/30/2012)
  - Adjustment Nos. 1, 2: "To update the Provider's SSI percentage based on CMS recalculation of the Provider's SSI % based on the provider's fiscal year instead of the federal fiscal year;" and, "To update the DSH payment factor… as part of updating the provider's SSI%...."

Both providers requested cost report reopenings to realign their SSI percentages on December 14, 2015, resulting in the issuance of revised NPRs.[3]

Board's Analysis and Decision

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

As the two Providers at issue appealed RNPRs, their appeal rights are limited by 42 C.F.R. § 405.1889(b) as referenced in § 405.1835(a)(1) and, under this regulation, the two Providers do not have the right to appeal from the RNPRs in dispute.

A. Relevant Regulations – RNPRs

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

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

[3] *See* Provider's Request to Realign SSI percentage (Dec. 14, 2015); *Id*. (documents included among the requests to add respective providers to group appeal).

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

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

B. The Board's Rationale

The Providers' appeal requests have stated that the RNPRs' audit adjustments for both Logan and Vaughn (Audit Adjustments 2, and 1 and 2, respectively) were issued to reflect the inclusion of the SSI percentage that had been realigned from the federal fiscal year to the Provider's fiscal year. As explained below, this adjustment to incorporate the realigned SSI percentage did not adjust the Part C Days issue, and it is clear that the Providers have no right under 42 C.F.R. § 405.1889(b) (as referenced in § 405.1835(a)(1)) to appeal the Part C days issue from the RNPRs.

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[.]"[5] The reopenings in this case were a result of the Providers' requests to realign their SSI percentage from the federal fiscal year end to their individual cost reporting fiscal year ends. Based on the Notice of Reopening, the RNPRs under appeal clearly only revised the SSI percentage in order to realign it from a federal fiscal year to the providers' respective fiscal years. As described below, RNPRs were being issued only to include the realigned SSI percentage where the SSI percentage was realigned from the federal fiscal year to the providers' fiscal year, and 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. Thus, the Board has consistently found that it does not have jurisdiction over RNPRs that were issued as a result of a provider's request for realignment of its SSI percentage.

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[4] *See also St. Mary's of Mich. V. Azar*, No. 18-01790, 2020 WL 4049912 (D.D.C. July 20, 2020); *McLaren Flint v. Azar*, No. 18-2005, 2020 WL 2838566 (D.D.C. May 31, 2020), *Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F.Supp.3d 348 (D.D.C. 2014); *HCA Health Servs. of OK v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994).
[5] 42 C.F.R. § 405.1889(b)(1).

As noted in 42 C.F.R. § 412.106(b)(2), CMS gathers data to be used in the SSI fraction on a month-by-month basis:

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

The data matching process by which CMS gathers this *monthly* data is described in the FY 2011 IPPS Final Rule.[7] As described in the Federal Register, under the realignment process, CMS calculates the SSI fraction using the *previously-gathered* data for the months included in the published SSI fractions for the 2 Federal fiscal years that encompass the hospital's cost reporting period:

1. *75 Fed. Reg. 50042, 50279 (Aug. 16, 2010)*.—"[W]e publish these [SSI fraction] data for every hospital based on the Federal fiscal year but, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived *from the data match process* ***for the two Federal fiscal years that spanned the hospital's cost reporting period***."[8]

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

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

   Beginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108–173), we will arrange to furnish, consistent with the Privacy Act, MedPAR LDS data for a hospital's patients eligible for both SSI and Medicare at the hospital's request, regardless of whether there is a properly pending appeal relating to DSH payments. *We will make the information available for either the Federal fiscal year or, if the hospital's fiscal year differs from the Federal fiscal year, for the **months included in the 2 Federal fiscal years that encompass the hospital's cost reporting period***. Under this provision, *the hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the 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."[9]

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

In other words, the determination was only being reopened to include realigned SSI percentages and CMS' realignment process (as described in the Federal Register) does not entail re-running of the data matching process that the Providers are trying to appeal (much less revise any of the SSI paid days, Part A, or Part C days included in the underlying month-by-month data). Since the only matters specifically revised in the revised NPRs were the adjustments to realign the SSI percentage from the federal fiscal year to the provider's fiscal year, the Board does not have jurisdiction over the revised NPR appeals of the DSH Part C days issue for Logan Memorial and Vaughn Regional because the Provider did not have the right under 42 C.F.R. § 405.1889(b) (as referenced in § 405.1835(a)(1)) to appeal those issues from the RNPR. 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.[10]

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[9] (Emphasis added.)

[10] *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).

In conclusion, the Board is dismissing the two participants who appealed from SSI realigned NPR's, Provider No. 18-0066 – Logan Memorial Hospital (FYE 2/29/2012), and Provider No. 01-0118 – Vaughan Regional Medical Center (FYE 6/30/2012), because they do not have the right to appeal their revised NPRs at issue under 42 C.F.R. § 405.1889 for the DSH Part C days issue. The Board notes that both providers do have valid appeals from their original NPRs pending in this group appeal. The remaining providers will be remanded pursuant to CMS Ruling 1739-R under separate cover.

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

Board Members Participating:

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

For the Board:

1/30/2023

X Kevin D. Smith, CPA

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

cc: Wilson Leong, Federal Specialized Services