DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Baltimore, MD 21244
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Via Electronic Delivery

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

RE: ***Notice of Dismissal***
Regional Hospital of Scranton, Prov. No. 39-0237, FYE 04/30/2011
Case No. 19-0661

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 19-0661. Set forth below is the decision of the Board to dismiss the Provider's Disproportionate Share Hospital ("DSH") for SSI Percentage (Provider Specific).

Background

A. *Procedural History for Case No. 19-0661*

On **June 8, 2018**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end April 30, 2011. The Provider is commonly owned by Community Health Systems, Inc. ("CHS" or "Community Health").

On **December 6, 2018**, CHS filed 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 Percentage (Systemic Errors)
3. DSH – Medicaid Eligible Days[1]

After the withdrawal of Issue 3, there are two (2) remaining issues in this appeal: Issue 1 (the DSH Payment/SSI Percentage (Provider Specific)) and Issue 2 (the DSH/SSI Percentage (Systemic Errors)).

On **January 14, 2019**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

[1] The Provider withdrew this issue on October 10, 2024.

> Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the Provider will use to support its position* and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. See Board Rule 25.[2]

On **February 19, 2019**, the Medicare Contractor timely filed a Jurisdictional Challenge[3] with the Board over Issue 1, requesting that the Board dismiss this issue. The Provider filed a timely Jurisdictional Response on **March 21, 2019**.

On **July 31, 2019**, the Provider timely filed its preliminary position paper.

On **November 27, 2019**, the Medicare Contractor filed its preliminary position paper.

On **February 1, 2024**, the Board issued the Notice of Hearing and Critical Due Dates, providing among other things, the filing deadlines for the parties' final position papers. This Notice also gave the following instructions to the Provider regarding the content of its final position paper:

> Provider's Final Position Paper – *For each remaining issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *also include* ***any exhibits*** *the Provider will use to support to support its position*. *See* Board Rule 27 for more specific content requirements. If the Provider misses its due date, the Board will dismiss the cases.[4]

On **August 23, 2024**, the Provider timely filed its final position paper.

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[2] (Emphasis added.)
[3] Jurisdictional Challenges are not limited to jurisdiction *per se* as exemplified by 42 C.F.R. § 405.1840(a), (b). The Board notes that 42 C.F.R. § 405.1840 is entitled "Board Jurisdiction" but it also addresses certain claims-filing requirements such as timelines or filing deadlines. Whether an appeal request is timely filed with the Board is not a jurisdictional requirement per se, but rather it is a claims-filing requirement as the Supreme Court made clear in *Sebelius v. Auburn Reg. Med. Ctr.*, 568 U.S. 145 (2013) ("*Auburn*"). Unfortunately, following the issuance of *Auburn*, the Secretary has not yet updated § 405.1840 to reflect the clarification made by the Supreme Court in *Auburn* that distinguishes between the claims-filing requirements for a Board hearing request versus jurisdictional requirements for a Board hearing. *See also* Board Rule 4.1 ("The Board will dismiss appeals that fail *to meet the timely filing requirements* ***and/or*** *jurisdictional requirements*."); 42 C.F.R. § 405.1835(b) (addressing certain other claims-filing requirements).
[4] (Emphasis added.)

On **September 20, 2024**, the Medicare Contractor timely filed its final position paper.

On **November 5, 2024**, the Medicare Contractor filed a supplemental Jurisdictional Challenge with the Board over Issue 1, renewing its request that the Board dismiss this issue. The Provider failed to file a timely response.

On **November 12, 2024**, the Provider changed is designated representative to Mr. Ravindran of Quality Reimbursement Services, Inc. ("QRS").

B. Description of the Remaining Issues in the Appeal Request and the Commonly Owned Entities in Case No. 14-0288GC

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

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

The Issue Statement for Issue No. 2, reads:

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 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 at 42 U.S.C. § 1395ww (d)(5)(F)(vi). The Provider contends that the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") and used by the Lead MAC to settle their Cost Reports 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 the Centers for Medicare and Medicaid Services ("CMS") fail to address all the deficiencies as described in *Baystate Medical Center v. Michael O. Leavitt*, 545 F. Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37, 44 (D.D.C. 2008) and incorporates 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

[5] Issue Statement at 1 (Dec. 6, 2018).

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[6]

PRRB Case No. 14-0288GC is a Post 1498-R SSI Data Match case involving multiple providers commonly owned by Community Health. Community Health is also the owner of Regional Hospital of Scranton. The Group Issue Statement in Case No. 14-0288GC reads:

> Issue Description for DSH SSI Data Match Issue
>
> The failure of the Fiscal Intermediary and (CMS) to properly determine the ratio of patient days for patients entitled to Medicare Part A and (SSI) benefits (excluding any State supplementation) to patient days for patients entitled to Medicare Part A (Medicare Proxy or Fraction) for the Provider in its (DSH) eligibility determination and payment calculation, including any related impact on capital DSH. The Provider asserts that the Medicare Proxy is improperly understated due to a number of factors, including CMS's inaccurate and improper matching or use of data along with policy changes to determine both the number of Medicare Part A SSI patient days in the numerator of the fraction and the total Medicare Part A patient days in the denominator, as utilized in the calculation of the Medicare percentage of low income patients for DSH purposes and/or low income patient (LIP) adjustment for Inpatient Rehabilitation Facilities (IRFs) and/or IRF units.
>
> CMS's improper treatment and policy changes resulted in an underpayment to the Providers as DSH program eligible providers of services to indigent patients, and includes any other related adverse impact to DSH payments, such as reduced capital DSH payments or LIP adjustments. Also, this treatment is not consistent with Congressional intent to reimburse hospitals for treatment of indigent patients when determining DSH program eligibility and payment pursuant to 42 U.S.C. § 1395ww(d)(5)(F), 42 C.F.R. § 412.106, Medicare Intermediary Manual § 3610.15, or any other applicable statutes, regulations, program guidelines, or case law.

[6] *Id*. at 2.

> On March 22, 2006, the (PRRB) issued a decision in the Baystate case that was favorable to the provider. The PRRB identified significant flaws in the compilation of Medicare SSI days and held, among other things, that: 1) the law requires accuracy in the reporting of SSI days; 2) the PRRB has the authority to require CMS to recalculate the SSI Percentage if necessary; and 3) there would not be a significant administrative burden required to redesign CMS's computer programs and processes to more accurately identify Medicare SSI eligibility.
>
> The PRRB's decision was supported by the March 31, 2008, D.C. District Court decision which found CMS did not use the most reliable data available to determine which patient days should be counted in the SSI percentage and that such was "arbitrary and capricious." The Court additionally held that if an agency has sole possession of the information needed by an opposing party to prove its claim, then it cannot simply reject the party's allegations based upon the party's lack of proof.
>
> CMS issued Ruling 1498-R on April 28, 2010 in response to the Baystate court decision. This significant Ruling sets forth, among other things, a revised and corrected data match process CMS would use to determine Providers' appropriate Medicare proxies and overall DSH adjustments. Providers assert that errors and problems still exist in the data match process, as well as improper policy changes by CMS, which are resulting in understated DSH adjustments for Providers, including the failure to include all Dual Eligible (Medicare/Medicaid) patient days in the Medicare fraction numerator as intended by Congress or alternatively in the Medicaid fraction numerator. CMS asserts in Ruling 1498-R that such Dually Eligible/Crossover days, including such days that are Medicare Non-Covered days, are being included in the Medicare proxy for discharges occurring on or after October 1, 2004. Providers assert that all such days are not properly being captured in the Medicare proxy of the DSH and/or LIP calculation.[7]

On July 31, 2019, the Board received the Provider's preliminary position paper in 19-0661. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Provider Specific**

[7] Group Issue Statement in PRRB Case No. 14-0288GC.

> 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 based on the Provider's Fiscal Year End (April 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. CV-94-0055 (C.D. Cal June 2, 1995), the SSI entitlement of individuals can be ascertained from [s]tate 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") database, 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 completed MEDPAR data, the Provider will seek to reconcile its' records with that of CMS, and identify patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS based on the Federal Fiscal Year End (September 30) when it determined the Provider's SSI. *See Baystate Medical Center v. Leavitt,* 545 F. Supp. 2d 20 (D.D.C. 2008).[8]

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $115,000.

On August 23, 2024, the Provider submitted its final position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Provider Specific**
>
> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation.
>
> The Provider is seeking a *full and complete* set of the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination

[8] Provider's Preliminary Position Paper at 8-9 (Jul. 31, 2019).

> of the SSI percentage. *See* 65 Fed. Reg. 50,548 (2000). Although some MEDPAR data is now routinely made available to the provider community, what is provided lacks all data records necessary to fully identify all patients properly includable in the SSI fraction. The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare Fraction. **The hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra (Appellants' reply brief included as Exhibit P-37).**[9]

MAC's Contentions

Issue 1 – DSH Payment/SSI Percentage (Provider Specific)

The MAC argues that the Board lacks jurisdiction over the DSH – SSI Percentage (Provider Specific) issue. Issue 1 has three components: 1) SSI data accuracy; 2) SSI realignment; and 3) individuals who are eligible for SSI but did not receive SSI payment. The MAC contends that the first and third sub-issues should be dismissed because they are duplicative of Issue 2. The portion related to SSI realignment should be dismissed because there was no final determination over SSI realignment and the appeal is premature as the Provider has not exhausted all available remedies.[10]

The MAC argued in its supplemental Jurisdictional Challenge that the Provider violated Board Rules 25.3 and 27.2 by failing to sufficiently develop and set forth the relevant facts and arguments in its Preliminary and Final Position Papers.[11]

Provider's Jurisdictional Response

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."[12] 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."[13]

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[9] Provider's Final Position Paper at 30-31 (Aug. 23, 2024). (Emphasis added).
[10] Medicare Contractor's Jurisdictional Challenge at 1 (Feb. 19, 2019).
[11] Medicare Contractor's Jurisdictional Challenge at 4 (Nov. 5, 2024).
[12] Jurisdictional Response at 1 (Mar. 21, 2019).
[13] *Id*. at 2.

Finally, the Provider contends the Provider Specific issue is appealable "because the MAC specifically adjusted the Providers SSI percentage and the Provider is dissatisfied with the amount of DSH payments that it received for fiscal year 2011, resulting from its understated SSI percentage due to errors of omission and commission."[14]

Decision of the Board

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

As set forth below, the Board hereby ***dismisses*** the Provider's DSH Payment/SSI Percentage (Provider Specific) issue.

A. DSH Payment/SSI Percentage (Provider Specific)

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

1. *First Aspect of Issue 1*

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH – SSI Percentage (Systemic Errors) issue that was appealed in Issue No. 2.

The DSH – SSI Percentage (Provider Specific) issue in the present appeal concerns "[w]hether the Medicare Administrative Contractor ("MAC") used the correct Supplemental Security Income ("SSI") percentage in the Disproportionate Share Hospital ("DSH") calculation."[15] Per the appeal request, the Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[16] The Provider argues in its issue statement, which was included in the appeal request, that it "disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[17]

[14] *Id.*
[15] Issue Statement at 1.
[16] *Id.*
[17] *Id.*

The commonly owned entities' DSH/SSI Percentage issue in Group Case No. 14-0288GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds that the DSH Payment/SSI Percentage (Provider Specific) issue is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Issue No. 2, and common to the DSH/SSI Percentage issue being appealed by the commonly owned entities in Case No. 14-0288GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[18], the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

The Board has previously noted that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and the Provider has failed to explain how this argument is ***specific to this provider***. 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.[19] The Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 14-0288GC.

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it failed to provide any basis upon which to distinguish Issue 1 from the SSI issue in Issue 2 (or in Case No. 14-0288GC), but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. For example, it alleges that "SSI entitlement of individuals can be ascertained from State records" but fails to explain how it can, explain how that information is relevant, and whether such a review was done for purposes of the year in question consistent with its obligations under Board Rule 25.2. Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with Board Rule 25 (Aug. 29, 2018) governing the content of position papers. As explained in the Commentary to Rule 23.3 (Aug. 29, 2018), 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" 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 (Aug. 29, 2018)

[18] PRRB Rules v. 2.0 (Aug. 2018).
[19] The types of systemic errors documented in *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).

> If documents necessary to support your position are still unavailable, *identify* the missing documents, *explain why* the documents remain unavailable, *state the efforts* made to obtain the documents, *and explain when* the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.[20]

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

> https://www.cms.gov/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh.[21]

This CMS webpage describes access to DSH data ***from 1998 to 2022*** and instructs providers to send a request via email to access their DSH data."[22]

Indeed, the D.C. Circuit affirmed in *Advocate Christ Med. Ctr. v. Becerra*, 80 F.4th 346 (D.C. Cir. 2023) that "What [MMA] section 951 cannot mean is that HHS must give hospitals data that it never received from SSA in the first place. And SSA does not provide HHS with the specific codes assigned to individual patients. See 75 Fed. Reg. at 50,276." Here, the Provider does not explain what information it needs or is waiting on or claims that it should have access to or why this is not a common issue already covered by the Issue No. 2.

Accordingly, *based on the record before it*, the Board finds that the DSH Payment/SSI Percentage (Provider Specific) issue in Issue 1 and the DSH/SSI Percentage (Systemic Errors) issue in Issue 2 are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same

[20] (Italics and underline emphasis added.)
[21] Last accessed Oct. 15, 2024.
[22] (Emphasis added).

final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

2. *Second Aspect of Issue 1*

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

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

* * * * *

In summary, the Board hereby dismisses the DSH Payment/SSI Percentage (Provider Specific) issue from appeal as it is duplicative of the DSH/SSI Percentage issue being appealed in Issue No. 2 and there is no final determination from which Provider can appeal the SSI realignment portion of the issue.

As the Provider is not currently participating in PRRB Case No. 14-0288GC and the DSH/SSI Percentage issue is common to the issue being appealed by the commonly owned entities in CIRP Group No. 14-0288GC, the Board is requiring the Provider to transfer the issue to PRRB Case No. 14-0288GC within ten (10) days of the date of this letter. If the Provider fails to do so, the issue will be dismissed, and the case will be closed.

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

Board Members Participating:

Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.

For the Board:

1/2/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

cc: Michael Redmond, Novitas Solutions, Inc. c/o GuideWell Source (J-L)

Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

James Ravindran
Quality Reimbursement Services, Inc.
150 N. Santa Anita Avenue, Suite 570A
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RE: ***Notice of Dismissal***
College Station Medical Center, Prov. No. 45-0299, FYE 09/30/2016
Case No. 19-2076

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 19-2076. Set forth below is the decision of the Board to dismiss the 2 remaining issues in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") for SSI Percentage (Provider Specific) and DSH Payment – Medicaid Eligible Days.

Background

A. *Procedural History for Case No. 19-2076*

On **December 27, 2018**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end September 30, 2016. The Provider is commonly owned by Community Health Systems, Inc. ("CHS").

On **June 10, 2019**, CHS filed the Provider's individual appeal request. The initial Individual Appeal Request contained nine (9) issues:

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

As the Provider is commonly owned/controlled by CHS, the Provider is subject to the mandatory common issue related party ("CIRP") group regulation at 42 C.F.R. § 405.1837(b)(1). For that reason, on **January 22, 2020**, the Provider transferred Issues 2 and 5 to CHS CIRP groups.

[1] On January 22, 2020, this issue was transferred to PRRB Case No. 19-1409GC.
[2] On December 23, 2024, the issue was withdrawn.
[3] On January 22, 2020, this issue was transferred to PRRB Case No. 19-1410GC.

As a result of the case transfers and withdraw, there are two (2) remaining issues in this appeal: Issue 1 (the DSH Payment/SSI Percentage (Provider Specific)), and Issue 3 (the DSH Payment – Medicaid Eligible Days).

On **June 17, 2019**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

> Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the Provider will use to support its position* and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. See Board Rule 25.[4]

On **September 11, 2019**, the Medicare Contractor timely filed a Jurisdictional Challenge[5] with the Board over Issues 1 and 4, requesting that the Board dismiss these issues. The Provider filed a response on **October 10, 2019**.

On **February 3, 2020**, the Provider timely filed its preliminary position paper. With respect to Issue 3, the Provider suggested that a list of Medicaid eligible days at issue was imminent by promising that one was being sent under separate cover. However, no such filing was made and no explanation was included explaining why that listing was not included with the position paper filing. Indeed, the filing failed to even provide *the material fact* of how many Medicaid eligible days are at issue and instead asserted that "[b]ased on the Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its' 2016 cost report does not reflect an accurate number of Medicaid eligible days."[6] As a result, the Provider included, as an Exhibit, the original "estimated impact" for this issue of $27,414 based on an *estimated* 50 days.

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[4] (Emphasis added.)

[5] Jurisdictional Challenges are not limited to jurisdiction *per se* as exemplified by 42 C.F.R. § 405.1840(a), (b). The Board notes that 42 C.F.R. § 405.1840 is entitled "Board Jurisdiction" but it also addresses certain claims-filing requirements such as timelines or filing deadlines. Whether an appeal request is timely filed with the Board is not a jurisdictional requirement per se, but rather it is a claims-filing requirement as the Supreme Court made clear in *Sebelius v. Auburn Reg. Med. Ctr.*, 568 U.S. 145 (2013) ("*Auburn*"). Unfortunately, following the issuance of *Auburn*, the Secretary has not yet updated § 405.1840 to reflect the clarification made by the Supreme Court in *Auburn* that distinguishes between the claims-filing requirements for a Board hearing request versus jurisdictional requirements for a Board hearing. *See also* Board Rule 4.1 ("The Board will dismiss appeals that fail *to meet the timely filing requirements* ***and/or*** *jurisdictional requirements*."); 42 C.F.R. § 405.1835(b) (addressing certain other claims-filing requirements).

[6] Provider's Preliminary Position Paper at 8 (Feb. 3, 2020).

On **February 25, 2020**, the Medicare Contractor requested from the Provider all documentation necessary to resolve Issue (DSH Payment – Medicaid Eligible Days).

On **May 28, 2020**, the Medicare Contractor filed its preliminary position paper. With regard to Issue 3, the Medicare Contractor's position paper noted that: (1) the Provider had failed to include a Medicaid eligible days listing with its position paper notwithstanding its obligation under Board Rules to file a fully developed position paper with all available documentation necessary to support its position; and (2) the Provider had failed to respond to any of the Medicare Contractor's requests for that Medicaid eligible days listing.

On **January 6, 2023**, the Medicare Contractor filed its second and final Request for DSH Package in connection with Issue 3. In this filing, the Medicare Contractor noted that, on February 25, 2020 (1st request), it had previously requested that the Provider send it a DSH package to resolve Issue 3. As no response was received, the Medicare Contractor formally filed the Final Request for DSH Package to formally request that a listing of the Medicaid eligible days at issue plus supporting documentation be provided to the Medicare Contractor within 30 days. Notwithstanding the formal request, the Provider failed to file any response to the Medicare Contractor.

As no response was received from the Provider, on **July 17, 2023**, the Medicare Contractor filed a Motion to Dismiss, requesting dismissal of DSH Medicaid Eligible Days because: (1) the Provider failed to furnish documentation in support of its claim for additional Medicaid eligible days (or explain why such documentation is unavailable); (2) the Provider failed to furnish the Medicaid eligible days listing with its preliminary position paper in violation of Board Rules 25.2.1 and 25.2.2; and (3) the Provider has effectively abandoned Issue 3. Pursuant to Board Rule 44.3, the Provider had 30 days to respond to the Motion for Dismiss. However, the Provider ***failed*** to timely respond to that Motion.

On **July 20, 2023**, the Provider changed is designated representative to Mr. Ravindran of Quality Reimbursement Services, Inc. ("QRS").

On **November 17, 2023**, almost 3 months after the deadline for responding to the Motion to Dismiss Issue 3, QRS filed a "Supplement to Position Paper/Redacted Medicaid Eligible Days Listing Submission" and added the *caveat* that the "Listing [is] *pending finalization* upon receipt of State eligibility data."[7] The Listing was 5 pages with roughly 938 Medicaid eligible days. QRS' filing did not explain why the listing of so many days (again around 938 days) was being submitted at this late date or why it was not final (*i.e.*, why it was "pending finalization") at this late date, ***more than 7 years after the fiscal year at issue had closed***. NOTE—the roughly 938 included in this belated listing is *exponentially* larger than the original *estimated* impact of 50 days included with the appeal request.

On **April 29, 2024**, the Board issued the Notice of Hearing and Critical Due Dates, providing among other things, the filing deadlines for the parties' final position papers. This Notice also gave the following instructions to the Provider regarding the content of its final position paper:

[7] (Emphasis added.)

> Provider's Final Position Paper – *For each remaining issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *also include* ***any exhibits*** *the Provider will use to support to support its position*. *See* Board Rule 27 for more specific content requirements. If the Provider misses its due date, the Board will dismiss the cases.[8]

On **November 1, 2024**, the Provider timely filed its final position paper. With respect to Issue 3, for the first time in the appeal, the Provider addresses section 1115 waiver days. QRS filed an Exhibit titled "1115 Waiver and Additional ME Days Consolidated." QRS added the *caveat* that the "Listing [is] *pending finalization* upon receipt of State eligibility data" and stated that the listing of days claimed would be submitted directly to the MAC.[9] The Listing was 45 pages with roughly 5,592 Medicaid eligible days. QRS' filing did not explain why the listing of so many days (again around 5,592 days) was being submitted at this late date or why it was not final (*i.e.*, why it was "pending finalization") at this late date, ***more than 8 years after the fiscal year at issue had closed***. NOTE—the roughly 5,592 included in this belated listing is *exponentially* larger than the original *estimated* impact of 50 days included with the appeal request AND the updated *estimated* impact of 938 days filed less than a year earlier. Per the MAC's jurisdictional challenge dated November 12, 2024, "the Provider has not submitted the unredacted listing for review to the MAC."[10]

On **November 12, 2024**, the Medicare Contractor filed a Jurisdictional Challenge with the Board over Issues 1, 3, and 4, requesting that the Board dismiss these issues. This replaced the prior Jurisdictional Challenge and renewed its Motion to Dismiss from July 17, 2023, over Issue 3. The Provider responded to the Medicare Contractor's second Jurisdictional Challenge, addressing Issue 1 & 3, on **December 19, 2024**, over 30 days past the deadline for doing so, therefore the Board will not consider the 2024 response in its decision.

Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. A provider's failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

On **November 22, 2024**, the Medicare Contractor timely filed its final position paper.

On **December 23, 2024**, the Provider file a "Redacted Medicaid Eligible days list" which purportedly is for 1115 waiver days, that total 955 days. There is no explanation as to the difference in the number of days in the listing filed November 1, 2024.

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[8] (Emphasis added.)
[9] (Emphasis added.)
[10] Medicare Contractor's Jurisdictional Challenge at 12 (Nov. 12, 2024).

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 19-1409GC - CHS CY 2016 DSH SSI Percentage CIRP Group

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

> 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 interpret 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.[11]

The Group issue Statement in Case No. 19-1409GC, to which the Provider transferred Issue No. 2, reads, in part:

> **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

[11] Provider's Individual Appeal (June 10, 2019).

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,
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.[12]

On February 3, 2020, the Board received the Provider's preliminary position paper in 19-2076. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

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 Texas and the Provider that does not support the SSI percentage issued by CMS.

The Provider has worked with the State of Texas and has learned that similar to *Loma Linda Community Hospital v. Dept of Health and Human Services*, No. CV-94-0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records.

[12] Group Appeal Issue Statement in Case No. 19-1409GC.

> 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.[13]

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $23,000.

C. Description of Issue 3 in the Appeal Request

According to its Appeal Request, the Provider asserts that all Medicaid eligible days were not included in the calculations of the DSH calculations. The Provider describes Issue 3 as:

> **Statement of Issue**
>
> Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.
>
> **Statement of the Legal Basis**
>
> The Provider contends that the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.
>
> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.
>
> Audit Adjustment Number(s): 5,6,17,S-D

[13] Provider's Preliminary Position Paper at 8-9 (Feb. 3, 2020).

Estimated Reimbursement Amount: $27,000[14]

Regarding the Medicaid eligible days issue, the Provider argues in its Preliminary Position Paper that pursuant to the Jewish Hospital case[15] and HCFA Ruling 97-2, "all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage" of the DSH payment adjustment.[16]

MAC's Contentions

Issue 1 – DSH Payment/SSI Percentage (Provider Specific)

The MAC argues that the Board lacks jurisdiction over the DSH – SSI Percentage (Provider Specific) issue. Issue 1 has three components: 1) SSI data accuracy; 2) SSI realignment; and 3) individuals who are eligible for SSI but did not receive SSI payment. The MAC contends that the first and third sub-issues should be dismissed because they are duplicative of Issue 2, which was transferred to PRRB Case No. 19-1409GC.[17]

The MAC argued the portion related to SSI realignment should be dismissed because the Provider abandoned the issue by not briefing it in the preliminary position paper and final position paper.[18] If the Board found the issue was not abandoned, the MAC argued the Board lacks jurisdiction over SSI realignment because there was no final determination over SSI realignment and the appeal is premature as the Provider has not exhausted all available remedies.[19]

Finally, the MAC argues that the entirety of the issue should be dismissed because the Provider violated Board Rules 25.2, 25.3, and 27 and 42 C.F.R. § 405.1853(b)(2) by failing to file a complete preliminary position paper.[20]

Issue 3 – DSH Payment – Medicaid Eligible Days

The MAC contends that the Provider failed to properly develop its arguments within its preliminary or final position paper in accordance with 42 C.F.R. § 405.1853(b)(2) and Board Rules 25.3, 27.1 and 27.2. The MAC argues the Provider has not submitted an unredacted Medicaid eligible days listing, which prevents them from completing a proper review.

Additionally, the MAC contends the Provider is attempting to add the Section 1115 Waiver days issue improperly and untimely. The Section 1115 Waiver days were not part of the initial appeal request and untimely added via its Final Position Paper.

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[14] Appeal Request at Issue 3.
[15] *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F.3d 270 (6th Cir. 1994).
[16] Provider's Preliminary Position Paper at 7-8.
[17] Medicare Contractor's Jurisdictional Challenge at 4-6 (Nov. 12, 2024).
[18] *Id*. at 6-7.
[19] *Id*. at 7.
[20] *Id*. at 8-11.

Provider's Jurisdictional Response

The Board Rules require that Provider Response to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[21] The Provider responded to the Medicare Contractor's second Jurisdictional Challenge, addressing Issues 1 & 3, on December 19, 2024, past the deadline for doing so, therefore the Board will not consider the 2024 response in its decision.

Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. A provider's failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

Similarly, the Provider's response to the Motion to Dismiss was due within 30 days but the Provider failed to timely file a response. In this regard, Board Rule 44.3 specifies with respect to motions that "[u]nless the Board imposes a different deadline, an opposing party may send a response, with relevant supporting documentation, within 30 days from the date that the motion was sent to the Board and opposing party."

Decision of the Board

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

As set forth below, the Board hereby ***dismisses*** the Provider's two (2) remaining issues.

A. DSH Payment/SSI Percentage (Provider Specific)

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

1. *First Aspect of Issue 1*

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH – SSI Percentage (Systemic Errors) issue that was appealed in Case No. 19-1409GC.

[21] Board Rule 44.4.3, v. 2.0 (Aug. 2018).

The DSH Payment/SSI Percentage (Provider Specific) issue in the present appeal concerns "[w]hether the Medicare Administrative Contractor ("MAC") used the correct Supplemental Security Income ("SSI") percentage in the Disproportionate Share Hospital ("DSH") calculation."[22] Per the appeal request, the Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[23] The Provider argues in its issue statement, which was included in the appeal request, that it "disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[24]

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 19-1409GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds that the DSH Payment/SSI Percentage (Provider Specific) issue in Case No. 19-2076 is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 19-1409GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[25], the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

The Board has previously noted that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and the Provider has failed to explain how this argument is ***specific to this provider***. 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.[26] 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 are specific to this provider.

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it failed to provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 19-1409GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. For example, it alleges that "SSI entitlement of individuals can be ascertained from State records" but fails to explain how it can, explain how that information is relevant, and whether such a review was done for purposes of the year in question consistent with its obligations under Board Rule 25.2.[27] Moreover, the Board

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[22] Issue Statement at 1.
[23] *Id.*
[24] *Id.*
[25] PRRB Rules v. 2.0 (Aug. 2018).
[26] The types of systemic errors documented in *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).
[27] It is also not clear whether this is a systemic issue for CHS providers in the same state subject to the CIRP rules or something that is provider specific because, if it was a common systemic issue, it was required to be transferred to a CIRP group "no later than the filing of the preliminary position paper" in this case per Board Rule 12.11. The

finds that the Provider's Preliminary Position Paper failed to comply with Board Rule 25 (Aug. 29, 2018) governing the content of position papers. As explained in the Commentary to Rule 23.3 (Aug. 29, 2018), 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" 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 (Aug. 29, 2018)**
>
> If documents necessary to support your position are still unavailable, *identify* the missing documents, *explain why* the documents remain unavailable, *state the efforts* made to obtain the documents, *and explain when* the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.[28]

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

> https://www.cms.gov/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh.[29]

Provider fails to comply with its obligation under 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rules to fully brief the merits of its issue.

[28] (Italics and underline emphasis added.)

[29] Last accessed Oct. 15, 2024.

This CMS webpage describes access to DSH data ***from 1998 to 2022*** and instructs providers to send a request via email to access their DSH data."[30]

Indeed, the D.C. Circuit affirmed in *Advocate Christ Med. Ctr. v. Becerra*, 80 F.4th 346 (D.C. Cir. 2023) that "What [MMA] section 951 cannot mean is that HHS must give hospitals data that it never received from SSA in the first place. And SSA does not provide HHS with the specific codes assigned to individual patients. See 75 Fed. Reg. at 50,276." Here, the Provider does not explain what information it needs or is waiting on or claims that it should have access to or why this is not a common issue already covered by the CIRP group under Case No. 19-1409GC.

Accordingly, *based on the record before it*,[31] the Board finds that the SSI Provider Specific issue in Case No. 19-2076 and the group issue from the CHS CIRP group under Case No. 19-1409GC are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

2. *Second Aspect of Issue 1*

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

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

B. DSH Payment – Medicaid Eligible Days

1. *Section 1115 Waiver Days*

The Board finds that the section 1115 Waiver days issue is not a part of this appeal as it was not properly or timely added. The Provider failed to include section 1115 Waiver days as a cost issue in its appeal request and failed to timely and properly add this additional issue to the appeal. While the Provider appealed Medicaid eligible days, this issue is separate and distinct from the section 1115 Waiver days.

The appeal was filed with the Board in June of 2019 and the regulations required the following:

[30] (Emphasis added).
[31] Again, the Board notes that the Provider failed to respond to the Jurisdictional Challenge and the Board must make its determination based on the record before it.

> (b) *Contents of request for a Board hearing on final contractor determination.* The provider's request for a Board hearing…must be submitted in writing to the Board, and the request must include…
>
> (2) For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final…determination under appeal, including an account of…
>
> (i) Why the provider believes Medicare payment is incorrect for each disputed item...[and]
>
> (ii) How and why the provider believes Medicare payment must be determined differently for each disputed item…[32]

Board Rule 7.2.1[33] elaborated on this regulatory requirement instructing providers:

> The following information and supporting document must be submitted for each issue raised in the appeal request.
>
> - An issue title and a concise issue statement describing:
> - the adjustment, including the adjustment number,
> - the controlling authority,
> - why the adjustment is incorrect,
> - how the payment should be determined differently,
> - the reimbursement effect, and
> - the basis for jurisdiction before the PRRB.

Board Rule 8 explains that when framing issues for adjustments involving multiple components, that providers must specifically identify each item in dispute, and "…each contested component must be appealed as a separate issue and described as narrowly as possible…". The Rule goes on:

> Several examples are identified below, but these examples are not exhaustive lists of categories or issues.
>
> **A. Disproportionate Share Hospital Payments**
>
> Common examples include:
>
> …

[32] 42 C.F.R. § 405.1835(b).
[33] v. 2.0 (Aug. 2018).

- ***Section 1115 waiver days (program/waiver specific)***[34]

Effective August 21, 2008, following the appropriate notice and comment period, new Board regulations went into effect that limited the addition of issues to appeals.[35] 42 C.F.R. § 405.1835(e) provides in relevant part:

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

In practice this means that new issues had to be added to this case no later than 240 days after receipt of the contractor's determination. However, there is no evidence in the record to indicate the Provider added the section 1115 Waiver days to the case properly or timely.

In this regard, the Board notes that section 1115 Waiver days are not traditional Medicaid eligible days and indeed were only incorporated into the DSH calculation effective January 20, 2000.[36] Rather, they relate to Medicaid expansion program(s) and are only includable in the DSH adjustment calculation if they meet the requirements in 42 C.F.R. § 412.106(b)(4) relating to section 1115 Waiver days. Indeed, not every state Medicaid program has a qualifying 1115 expansion program ***and*** not every inpatient day associated with beneficiary enrolled in an 1115 waiver program qualifies to be included in the Medicaid fraction.[20] In contrast, every state has a Medicaid state plan, and every state Medicaid plan includes inpatient hospital benefits.

Specifically, § 412.106(b)(4) states in pertinent part:

> (4) *Second computation*. The fiscal intermediary determines, for the same cost reporting period used for the first computation, 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. For purposes of this second computation, the following requirements apply:
>
> (i) For purposes of this computation, a patient is deemed eligible for Medicaid on a given day only if the patient is eligible for

[34] (Bold and italic emphasis added).
[35] *See* 73 Fed. Reg. 30190 (May 23, 2008).
[36] 65 FR 47054, 47087 (Aug. 1, 2000).

> inpatient hospital services under an approved State Medicaid plan **or under a waiver authorized under section 1115(a)(2) of the Act** on that day, regardless of whether particular items or services were covered or paid under the State plan or the authorized waiver.
>
> **(ii) Effective with discharges occurring on or after January 20, 2000, for purposes of counting days under paragraph (b)(4)(i) of this section, hospitals may include all days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act**.
>
> (iii) The hospital has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.

Because the Provider did not raise the section 1115 Waiver days prior to the deadline to add issues, and it is a distinct issue, the Board finds that the issue was not properly or timely appealed. The DSH Payment – Medicaid Eligible Days issue as stated in the original appeal request cannot be construed to include section 1115 Waiver days. Additionally, there is no indication that any 1115 waiver days were included with the as-filed cost report which, if true, would make them an unclaimed cost and provide an independent basis for dismissal.

2. *Medicaid Eligible Days*

The Provider's appeal request did not include a list of the specific additional Medicaid eligible days that are in dispute in this appeal.

With regard to the filing of an individual appeal, Board Rule 7 (Support for Appealed Final Determination, Issue-Related Information and Claim of Dissatisfaction) (Aug. 2018) states:

> **No Access to Data**
>
> If the provider elects to not claim an item on the cost report because, through no fault of its own, it did not have access to the underlying information to determine whether it was entitled to payment, describe the circumstances why the underlying information was unavailable upon the filing of the cost report.

Moreover, the Provider neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2.

The MAC submitted requests for a list of additional Medicaid eligible days on February 25, 2020 and on January 6, 2023. On July 17, 2023, the MAC filed their Motion to Dismiss the Medicaid Eligible Days issue. The Provider did not submit a listing of Medicaid Eligible Days until November 17, 2023. The listing included no explanations for the delay in the submission. The Board finds the Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it could not timely produce those documents, as required by the regulations and the Board Rules.[37]

42 C.F.R. § 405.1853(b)(2)-(3) addresses the content of position papers:

> (b) *Position papers*. . . . (2) The Board has the discretion to extend the deadline for submitting a position paper. **Each position paper must set forth the relevant facts and arguments regarding** the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and **the merits of the provider's Medicare payment claims for each remaining issue.**
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. **Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board** through a schedule applicable to a specific case or through general instructions.[38]

The regulations require the parties to fully brief the merits of each issue in their position paper (including the relevant facts and legal arguments) and specify that the Board has discretion about setting the time frame for the submission of exhibits supporting the merits of the appeal.

Board Rule 25 (Aug. 2018) requires the Provider to file its complete, *fully* developed preliminary position paper with all available documentation and gives the following instruction on the content of position papers:

Rule 25 Preliminary Position Papers[39]

[37] *See also* Board's jurisdictional decision in *Lakeland Regional Health* (Case No. 13-2953, 11/20/2019), in which the Board found a Provider essentially abandoned its appeal by filing a position paper that failed to set forth the merits of its claim, explain why the agency's calculation was wrong, and identifying missing documents to support its claim and to explain why those documents remained unavailable.
[38] (Bold emphasis added.)
[39] (Underline emphasis added to these excerpts and all other emphasis in original.)

COMMENTARY:

Under the PRRB regulations effective August 21, 2008, all issues will have been identified within 60 days of the end of the appeal filing period. 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 Medicare contractor, and fifteen months for the provider's response. Therefore, preliminary position papers are expected to present fully developed positions of the parties and, therefore, require analysis well in advance of the filing deadline.

25.1 Content of Position Paper Narrative

The text of the position papers must include the elements addressed in the following sub-sections.

25.1.1 The Provider's Position Paper

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

25.2 Position Paper Exhibits

25.2.1 General

With the position papers, the parties must exchange ***all*** available documentation as exhibits to fully support your position. . . . When filing those exhibits in the preliminary position paper, ensure that the documents are redacted in accordance with Rule 1.4. Unredacted versions should be exchanged by the parties separately from the position paper, if necessary.

25.2.2 Unavailable and Omitted Documents

If documents necessary to support your position are still unavailable, identify the missing documents, explain why the

> documents remain unavailable, state the efforts made to obtain the documents, and explain when the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.
>
> **25.2.3 List of Exhibits**
>
> Parties must attach a list of the exhibits exchanged with the position paper.
>
> **25.3 Filing Requirements to the Board**
>
> Parties should file with the Board a *complete* preliminary position paper with a fully developed narrative (Rule 23.1), all exhibits (Rule 23.2), a listing of exhibits, and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. Any issue appealed, but not briefed by the Provider in its position paper will be considered withdrawn.
>
> **COMMENTARY**: Note that this is a change in previous Board practice. Failure to file a complete preliminary position paper with the Board will result in dismissal of your appeal or other actions in accordance with 42 C.F.R. § 405.1868. (*See* Rule 23.4.)

The Notice of Case Acknowledgement and Critical Due Dates issued to the Provider on June 17, 2019, included instructions on the content of the Provider's preliminary position paper consistent with the above Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

Moreover, in connection with Issue 3, Medicare regulations specifically place the burden on hospitals to provide documentation from the State to establish ***each*** *Medicaid eligible day* being claimed. Specifically, when determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(iii) places the burden of production on the provider, stating:

> The hospital has the burden of furnishing data adequate to prove eligibility for ***each*** Medicaid patient *day claimed* under this paragraph, ***and*** of *verifying with the State* that a patient was eligible for Medicaid during each claimed patient hospital day.[40]

Along the same line, 42 C.F.R. § 405.1871(a)(3) makes clear that, in connection with appeals to the Board, "the provider carrie[s the] burden of production of evidence and burden of proof by

[40] (Emphasis added.)

establishing, by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue."

Additionally, and more generally related to accounting records and reporting requirements for providers, 42 C.F.R. § 413.24(c) describes what cost information is adequate:

> Adequate cost information must be obtained from the provider's records to support payments made for services furnished to beneficiaries. The requirement of adequacy of data implies that the data be accurate and in sufficient detail to accomplish the purposes for which it is intended.

Finally, Board Rule 41.2 permits dismissal or closure of a case on the Board's own motion:

- if it has 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 (see 42 C.F.R. § 405.1868),
- if the Board is unable to contact the provider or representative at the last known address, or
- upon failure to appear for a scheduled hearing.

On February 3, 2020, the Provider filed its preliminary position paper in which it indicated that it the eligibility listing was imminent by promising that the listing was being sent under separate cover.[41] Significantly, the position paper did ***not*** include *the material fact* of how many Medicaid eligible days remained in dispute in this case, but rather continued to reference the "estimated impact" included with its appeal request (i.e., the estimated impact of $27,414 based on an estimated 50 days). The Provider's complete briefing of this issue in its position paper is as follows:

> **Calculation of Medicaid Eligible Days**
>
> Specifically, the Provider disagrees with the MAC's calculation of the computation of the disproportionate patient percentage set forth at 42 C.F.R. § 412.106(b)(4) of the Secretary's regulations.
>
> The Sixth Circuit Court of Appeals, in *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F. 3d 270 (6th Cir. 1994), held that all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage when the DSH adjustment is calculated. Similar decisions were rendered by the Fourth, Eighth, and Ninth Circuits: *Cabell Huntington Hospital, Inc. v. Shalala,* 101 F. 3d 984 (4th Cir.

[41] Provider's Preliminary Position Paper at 8.

> 1996); *Deaconess Health Services Corp. v. Shalala,* 83 F. 3d 1041 (8th Cir. 1996), *aff'g* 912 F. Supp 478 (E.D. Mo. 1995); and *Legacy Emanuel Hospital and Health Center v. Shalala,* 97 F. 3d 1261 (9th Cir. 1996).
>
> The Centers for Medicare and Medicaid Services ("CMS", formerly HCFA) acquiesced in the above decisions and issued HCFA Ruling 97-2, which in pertinent part reads as follows:
>
> > [T]he Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to include all inpatient hospital days of service for patients who were eligible on that day for medical assistance under a state Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for these inpatient hospital services.
>
> Based on the Listing of Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its' 2016 cost report does not reflect an accurate number of Medicaid eligible days, as requested by HCFA Ruling 97-2 and the pertinent Federal Court decisions.

The Board concurs with the Medicare Contractor that the Provider is required to identify and provide documentation to prove what additional Medicaid Eligible days at issue and for which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3), Board Rule 25. Further, pursuant to 42 C.F.R. § 412.106(b)(4)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[42] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. Based on the record before the Board, the Board finds that the Provider has failed to timely provide a listing or other supporting documentation for the Medicaid Eligible Days issue as required by the controlling regulations and Board Rules. Nor has the provided any explanation as to why the documentation was absent or what caused the delay with Board Rule 25.2.2. Indeed, based on these facts plus the Provider's failure to timely respond to either Medicare Contractor's request for the listing and the Medicare Contractor's Motion to Dismiss and Jurisdictional Challenge on this issue, the Board assumes that the Provider has abandoned this issue.

The change in the designated representative to QRS does not excuse the Provider for its failure to include the information with its preliminary position paper. Board Rule 5.2 makes clear that "the recent appointment of a new representative will also not be considered cause for delay of any deadlines or proceedings."

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[42] (Emphasis added).

Based on the above, the Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and 412.106(b)(iii) and Board Rule 25 related to identifying the days in dispute and the timely submission of documentary evidence required to support its claims or describe why said evidence is unavailable, which the Provider has failed to do.[43]

Accordingly, the Board dismisses the DSH Payment – Medicaid Eligible Days issue.

* * * * *

Based on the foregoing, the Board has dismissed the two (2) remaining issues in this case – (Issues 1 and 3). As no issues remain, the Board hereby closes Case No. 19-2076 and removes it from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.

For the Board:

1/2/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

cc: Byron Lamprecht, WPS Government Health Administrators (J-5)
Wilson Leong, FSS

[43] *See also Evangelical Commty Hosp. v. Becerra*, No. 21-cv-01368, 2022 WL 4598546 at *5 (D.D.C. 2022): The Board acts reasonably, and not arbitrarily and capriciously, when it applies its "claims-processing rules faithfully to [a provider's] appeal." *Akron*, 414 F. Supp. 3d at 81. The regulations require that a RFH provide "[a]n explanation [ ]for each specific item under appeal." 42 C.F.R. § 405.1835(b)(2). The Board rules further explain that "[s]ome issues may have multiple components," and that "[t]o 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." Board Rules § 8.1. The Board rules also specifically delineate how a provider should address, as here, a challenge to a Disproportionate Share Hospital reimbursement. Board Rule 8.2 explains that an appeal challenging a Disproportionate Share Hospital payment adjustment is a "common example" of an appeal involving issues with "multiple components" that must be appealed as "separate issue[s] and described as narrowly as possible." Board Rules §§ 8.1, 8.2.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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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: ***Notice of Dismissal***
Bayfront Health Dade City, Prov. No. 10-0211, FYE 09/30/2017
Case No. 21-0261

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 21-0261. Set forth below is the decision of the Board to dismiss the remaining issue in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") for SSI Percentage (Provider Specific) payments.

Background

A. *Procedural History for Case No. 21-0261*

On **March 31, 2020**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end September 30, 2017. The Provider is commonly owned by Community Health Systems, Inc. ("CHS").

On **September 28, 2020**, CHS filed the Provider's individual appeal request. The initial Individual Appeal Request contained eight (8) issues:

1. DSH Payment/SSI Percentage (Provider Specific)
2. DSH SSI Percentage (Systemic Errors)[1]
3. DSH SSI Fraction / Medicare Managed Care Part C Days[2]
4. DSH SSI Fraction / Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)[3]
5. DSH – Medicaid Eligible Days[4]

[1] On April 27, 2021, this issue was transferred to Case No. 20-1332GC. CHS CY 2017 HMA DSH SSI Percentage CIRP Group. On September 17, 2021, Case No. 20-1332GC was consolidated with a duplicate appeal, Case No. 20-0997GC, which is the surviving SSI group in which this Provider is now a participant.
[2] On April 27, 2021, this issue was transferred to Case No. 19-2620GC.
[3] On April 27, 2021, this issue was transferred to Case No. 20-1383GC.
[4] On January 13, 2023, the Provider withdrew Issue 5 from the appeal.

6. DSH Medicaid Fraction / Medicare Managed Care Part C Days[5]
7. DSH Medicaid Fraction / Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)[6]
8. 2 Midnight Census IPPS Payment Reduction[7]

As the Provider is commonly owned/controlled by CHS, the Provider is subject to the mandatory common issue related party ("CIRP") group regulation at 42 C.F.R. § 405.1837(b)(1). For that reason, on **April 27, 2021**, the Provider transferred Issues 2, 3, 4, 6, and 7 to CHS CIRP groups.

On **April 22, 2021**, the Provider withdrew Issue 8 from the appeal and on **January 13, 2023**, the Provider withdrew Issue 5 from the appeal. As a result of the case transfers and withdrawals, there is one remaining issue in this appeal: Issue 1 (DSH – SSI Percentage Provider Specific).

On **November 23, 2020**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

> Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the Provider will use to support its position* and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. See Board Rule 25.[8]

On **May 24, 2021**, the Provider timely filed its preliminary position paper.

On **July 27, 2021**, the Medicare Contractor filed a Jurisdictional Challenge[9] with the Board over Issue 1 requesting that the Board dismiss this issue. Pursuant to Board Rule 44.4.3, the Provider

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[5] On April 27, 2021, this issue was transferred to Case No. 19-2620GC.
[6] On April 27, 2021, this issue was transferred to Case No. 20-1383GC.
[7] On April 22, 2021, the Provider withdrew Issue 8 from the appeal.
[8] (Emphasis added.)
[9] Jurisdictional Challenges are not limited to jurisdiction *per se* as exemplified by 42 C.F.R. § 405.1840(a), (b). The Board notes that 42 C.F.R. § 405.1840 is entitled "Board Jurisdiction" but it also addresses certain claims-filing requirements such as timelines or filing deadlines. Whether an appeal request is timely filed with the Board is not a jurisdictional requirement per se, but rather it is a claims-filing requirement as the Supreme Court made clear in *Sebelius v. Auburn Reg. Med. Ctr.*, 568 U.S. 145 (2013) ("*Auburn*"). Unfortunately, following the issuance of *Auburn*, the Secretary has not yet updated § 405.1840 to reflect the clarification made by the Supreme Court in *Auburn* that distinguishes between the claims-filing requirements for a Board hearing request versus jurisdictional requirements for a Board hearing. *See also* Board Rule 4.1 ("The Board will dismiss appeals that fail *to meet the timely filing requirements* ***and/or*** *jurisdictional requirements*."); 42 C.F.R. § 405.1835(b) (addressing certain other claims-filing requirements).

had 30 days in which to file a response to the Jurisdictional Challenge. However, the Provider ***failed*** to timely file a response.

On **August 20, 2021**, the Medicare Contractor filed its preliminary position paper. With regard to Issue 5, the Medicare Contractor's position paper noted that: (1) the Provider had failed to include a Medicaid eligible days listing with its position paper notwithstanding its obligation under Board Rules to file a fully developed position paper with all available documentation necessary to support its position; and (2) the Provider had failed to respond to any of the Medicare Contractor's requests for that Medicaid eligible days listing.

On **November 14, 2022**, the Medicare Contractor filed a Jurisdictional Challenge[10] with the Board over Issue 5 requesting that the Board dismiss this issue. The Provider later withdrew this issue from the appeal.

On **December 15, 2022**, the Provider changed is designated representative to Mr. Ravindran of Quality Reimbursement Services, Inc. ("QRS").

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 20-0997GC - CHS CY 2017 DSH SSI Percentage CIRP Group

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

> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> The Provider contends that the SSI percentage issued by CMS 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

[10] Jurisdictional Challenges are not limited to jurisdiction *per se* as exemplified by 42 C.F.R. § 405.1840(a), (b). The Board notes that 42 C.F.R. § 405.1840 is entitled "Board Jurisdiction" but it also addresses certain claims-filing requirements such as timelines or filing deadlines. Whether an appeal request is timely filed with the Board is not a jurisdictional requirement per se, but rather it is a claims-filing requirement as the Supreme Court made clear in *Sebelius v. Auburn Reg. Med. Ctr.*, 568 U.S. 145 (2013) ("*Auburn*"). Unfortunately, following the issuance of *Auburn*, the Secretary has not yet updated § 405.1840 to reflect the clarification made by the Supreme Court in *Auburn* that distinguishes between the claims-filing requirements for a Board hearing request versus jurisdictional requirements for a Board hearing. *See also* Board Rule 4.1 ("The Board will dismiss appeals that fail *to meet the timely filing requirements* ***and/or*** *jurisdictional requirements*."); 42 C.F.R. § 405.1835(b) (addressing certain other claims-filing requirements).

> CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395(d)(5)(F)(i) [sic].[11]

The Provider initially transferred the SSI Systems Errors issue to Case No. 20-1332GC. That group was consolidated with a duplicate appeal, Case No. 20-0997GC, which is the surviving group in which the Provider is now a participant. The Group issue Statement in Case No. 20-0997GC reads, in part:

> **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,
> 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.[12]

[11] Issue Statement at 1 (Sept. 28, 2020).
[12] Group Appeal Issue Statement in Case No. 20-0997GC.

On May 24, 2021, the Board received the Provider's preliminary position paper in 21-0261. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Provider Specific**
>
> The Provider contends that its' [sic] SSI percentage published by [CMS] was incorrectly computed because CMS failed to include 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. CV-94-0055 (C.D. Cal June 2, 1995), the SSI entitlement of individuals can be ascertained from [s]tate 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.[13]

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $10,000.

MAC's Contentions

Issue 1 – DSH Payment/SSI Percentage (Provider Specific)

The MAC argues that the Board lacks jurisdiction over the DSH – SSI Percentage (Provider Specific) issue. Issue 1 has three components: 1) SSI data accuracy; 2) SSI realignment; and 3) individuals who are eligible for SSI but did not receive SSI payment. The MAC contends that the first and third sub-issues should be dismissed because they are duplicative of Issue 2. The portion

[13] Provider's Preliminary Position Paper at 11-12 (May 24, 2021).

related to SSI realignment should be dismissed because there was no final determination over SSI realignment and the appeal is premature as the Provider has not exhausted all available remedies.[14]

Provider's Jurisdictional Response

The Board Rules require that Provider Responses to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[15] The Provider has not filed a response to the Jurisdictional Challenge over Issue 1 and the time for doing so has elapsed. Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. A provider's failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

Decision of the Board

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.

As set forth below, the Board hereby ***dismisses*** the Provider's only remaining issue.

A. DSH Payment/SSI Percentage (Provider Specific)

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

1. *First Aspect of Issue 1*

The first aspect of Issue No. 1—the Provider's disagreement with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH – SSI Percentage (Systemic Errors) issue that was appealed in Case No. 20-1332GC.

The DSH – SSI Percentage (Provider Specific) issue in the present appeal concerns "[w]hether the Medicare Administrative Contractor ("MAC") used the correct Supplemental Security Income ("SSI") percentage in the Disproportionate Share Hospital ("DSH") calculation."[16] Per the appeal request, the Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in

[14] Medicare Contractor's Jurisdictional Challenge at 9 (Jul. 27, 2021).
[15] Board Rule 44.4.3, v. 2.0 (Aug. 2018).
[16] Issue Statement at 1.

accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[17] In its issue statement that was included in the appeal request, the Provider argues that it "disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[18]

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 20-0997GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds that the DSH Payment/SSI Percentage (Provider Specific) issue in Case No. 21-0261 is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 20-0997GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[19], the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

The Board has previously noted that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and the Provider has failed to explain how this argument is ***specific to this provider***. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[20] Accordingly, the Provider's reference to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, Provider has failed to sufficiently distinguish (by sufficient explanation or evidence) how the alleged "provider specific" errors averred in Issue 1 are distinguished from the alleged "systemic" issues argued in Issue 2, and why those alleged "provider specific" errors should not be subsumed into the "systemic errors" issue appealed in Case No. 20-0997GC.

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it failed to provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 20-0997GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. For example, it alleges that "SSI entitlement of individuals can be ascertained from State records" but fails to explain how that information is relevant and whether such a review was done for purposes of the year in question consistent with its obligations under Board Rule 25.2.[21] Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with Board Rule 25 (Aug. 29, 2018) governing the content of

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[17] *Id.*
[18] *Id.*
[19] PRRB Rules v. 2.0 (Aug. 2018).
[20] The types of systemic errors documented in *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).
[21] It is also not clear whether this is a systemic issue for CHS providers in the same state subject to the CIRP rules or something that is provider specific because if it was a common systemic issue it was required to be transferred to a CIRP group "no later than the filing of the preliminary position paper" in this case per Board Rule 12.11. The Provider fails to comply with its obligation under 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rules to fully brief the merits of its issue.

position papers. As explained in the Commentary to Rule 23.3 (Aug. 29, 2018), 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" 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 (Aug. 29, 2018)**
>
> If documents necessary to support your position are still unavailable, *identify* the missing documents, *explain why* the documents remain unavailable, *state the efforts* made to obtain the documents, *and explain when* the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.[22]

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") as explained on the following webpage:

> https://www.cms.gov/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh.[23]

This CMS webpage describes access to DSH data ***from 1998 to 2022*** and instructs providers to send a request via email to access their DSH data."[24]

---

[22] (Italics and underline emphasis added.)
[23] Last accessed Oct. 15, 2024.
[24] (Emphasis added).

Accordingly, *based on the record before it*,[25] the Board finds that the SSI Provider Specific issue in Case No. 21-0261 and the group issue from the CHS CIRP group under Case No. 20-0997GC are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

2. *Second Aspect of Issue 1*

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

Under 42 C.F.R. § 412.106(b)(3), the applicable regulation 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 . . . ." Moreover, without this written request, the Medicare Contractor cannot issue a final determination with which the Provider can be dissatisfied for Board 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 dismisses this aspect of the appeal.

* * * * *

Based on the foregoing, the Board has dismissed the only remaining issue in this case – (Issue 1). As no issues remain, the Board hereby closes Case No. 21-0261 and removes it from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.

For the Board:

1/3/2025

X Shakeba DuBose

Shakeba DuBose, Esq.
Board Member
Signed by: PIV

cc: Byron Lamprecht, WPS Government Health Administrators (J-5)
Wilson Leong, FSS

[25] Again, the Board notes that the Provider failed to respond to the Jurisdictional Challenge of Issue 1 and the Board must make its determination based on the record before it.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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RE: ***Board Decision* – DSH Payment/SSI Percentage (Provider Specific) & Medicaid Eligible Days Issues**
Lower Keys Medical Center (Provider No. 10-0150)
FYE 09/30/2018
Case No. 22-1200

Dear Mr. Ravindran and Mr. Lamprecht,

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

Background:

A. *Procedural History for Case No. 22-1200*

On **February 7, 2022**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end September 30, 2018.

On **July 25, 2022**, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained five (5) issues:

1. DSH Payment/SSI Percentage (Provider Specific)
2. DSH/SSI Percentage (Systemic Errors)[1]
3. DSH Payment – Medicaid Eligible Days
4. DSH Payment – Medicare Managed Care Part C Days (SSI Fraction & Medicaid Fraction)[2]
5. DSH Payment – Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days, Eligible SSI Days for Which No Payment Was Made) – (SSI Fraction)[3]

The Provider is commonly owned/controlled by Community Health Systems, Inc. (hereinafter "CHS") and, thereby, is subject to the mandatory CIRP group regulation at 42 C.F.R.

[1] On February 1, 2023, this issue was transferred to PRRB Case No. 21-1206GC.
[2] On February 1, 2023, this issue was transferred to PRRB Case No. 20-2149GC.
[3] On February 1, 2023, this issue was transferred to PRRB Case No. 21-0066GC.

§ 405.1837(b)(1). For that reason, on **February 1, 2023**, the Provider transferred Issues 2, 4 and 5 to Community Health groups. As a result, there are two (2) remaining issues in this appeal: Issue 1 (DSH Payment/SSI Percentage (Provider Specific)) and Issue 3 (DSH Payment – Medicaid Eligible Days).

On **July 27, 2022**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

> Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the Provider will use to support its position* and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. *See* Board Rule 25.[4]

On **July 29, 2022**, the Medicare Contractor requested from the Provider all documentation necessary to resolve Issue 3 (DSH Payment – Medicaid Eligible Days).

On **February 8, 2023**, the Medicare Contractor requested for the second and final time from the Provider all documentation necessary to resolve Issue 3 (DSH Payment – Medicaid Eligible Days.

On **March 20, 2023**, the Provider timely filed its preliminary position paper.

On **May 12, 2023**, the Medicare Contractor timely filed its preliminary position paper.

On **June 7, 2023**, the Medicare Contractor filed a jurisdictional challenge, requesting the dismissal of Issues 1 and 3. The Provider filed a Jurisdictional Response on **August 4, 2023**.[5]

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

In their Individual Appeal Request, Provider summarizes its DSH Payment/SSI Percentage (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.
>
> . . .

[4] (Emphasis added).
[5] The Jurisdictional Response was not timely filed.

> 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]

The group issue statement in Case No. 21-1206GC, CHS CY 2018 DSH SSI Percentage CIRP Group, to which the Provider transferred Issue 2 reads, in part:

> **Statement of the Issue:**
>
> Whether the Secretary properly calculated the Provider's [DSH]/[SSI] percentage, and whether CMS should be required to recalculate the SSI percentages using a denominator based solely upon covered and paid for Medicare Part A days, or alternatively, expand the numerator of the SSI percentage to include paid/covered/entitled as well as unpaid/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 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). The Provider(s) further contend(s) that the SSI percentages calculated by [CMS] and used by the MAC to settle their Cost Reports incorporates a new methodology inconsistent with the Medicare statute.
>
> The Providers challenge their SSI percentages based on the following reasons:
>
> 1. Availability of MEDPAR and SSA records,
> 2. 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.[7]

[6] Issue Statement at 1 (July 25, 2022).
[7] Group Issue Statement, Case No. 21-1206GC.

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $14,535.

On March 20, 2023, the Provider filed its preliminary position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

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

C. Description of Issue 3 in the Appeal Request

According to its Appeal Request, the Provider asserts that all Medicaid eligible days were not included in the calculations of the DSH calculations. The Provider describes Issue 3 as:

> **Statement of Issue**
>
> Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.
>
> **Statement of the Legal Basis**

[8] Provider's Preliminary Position Paper at 9-10 (Mar. 20, 2023).

> The Provider contends that the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.
>
> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.
>
> Audit Adjustment Number(s): 5,25,41,S-D
>
> Estimated Reimbursement Amount: $26,447[9]

Regarding the Medicaid eligible days issue, the Provider argues in its Preliminary Position Paper that pursuant to the *Jewish Hospital* case[10] and HCFA Ruling 97-2, "all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage" of the DSH payment adjustment.[11]

MAC's Contentions

Issue 1 – DSH Payment/ SSI Percentage (Provider Specific)

The MAC argues that the Board lacks jurisdiction over the DSH – SSI Percentage (Provider Specific) issue for three reasons. First, the MAC argues that the SSI realignment portion of the issue has been abandoned by the Provider:

> The Provider fails to note that its cost reporting year end is identical to the federal fiscal year end. This oversight leaves the MAC questioning the right the Provider is attempting to preserve.
>
> The MAC contends that the Provider has abandoned the issue of SSI realignment and, therefore, it should be considered withdrawn. The Provider did not brief this issue within its preliminary position paper PRRB Rule 25.3 addresses issues that are not briefed in a provider's position paper. In relevant part, this rule states:

[9] Appeal Request at Issue 3.
[10] *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F.3d 270 (6th Cir. 1994).
[11] Provider's Preliminary Position Paper at 8-9.

> Any issue appealed, but not briefed by the Provider in its position paper will be considered withdrawn.[12]

Failing that, the MAC argues the realignment sub-issue is premature:

> The decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election. It is not a final intermediary determination. A hospital must make a formal request to CMS in order to receive a realigned SSI percentage. Once the hospital elects to use its own fiscal year end, it is bound by that decision, regardless of reimbursement impact.
>
> . . .
>
> The Provider's appeal of this item is premature. The Provider has not formally requested to have its SSI percentage realigned in accordance with 42 C.F.R. § 412.106(b)(3). The Provider has not exhausted all available remedies prior to requesting a PRRB appeal to resolve this issue. The MAC requests that the PRRB dismiss this issue consistent with recent jurisdictional decisions.[13]

In addition, the MAC argues the DSH – SSI Percentage (Provider Specific) issue and the DSH – SSI Percentage (Systemic Errors) issue are considered the same issue by the Board.[14]

Finally, the MAC argues "the Provider did not file a **complete** preliminary position paper in accordance with 42 C.F.R. § 405.1853 and Board Rules 25.2 and 25.3."[15] The MAC posits that the Provider "failed to sufficiently develop and set forth the relevant facts and regarding the merits of its claim in its Preliminary Position Paper."[16] Specifically the MAC avers:

> Within its Provider's Preliminary Position Paper, the Provider makes the broad allegation that "The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation" yet offers no evidence or analysis to demonstrate that CMS calculated its SSI percentage inaccurately. The Providers failed to include any evidence to establish the material facts in this case relating to inaccuracies in the SSI Percentage calculation at issue or any evidence pertaining to the alleged systemic SSI ratio data match errors like those referenced in the *Baystate* case. The Provider merely repeats their appeal request

[12] Jurisdictional Challenge at 6 (June 7, 2023).
[13] *Id*. at 7.
[14] *Id*. at 5-6.
[15] *Id*. at 8.
[16] *Id*. at 10.

> which itself is a verbatim recitation of the deficiencies that the Board found in the *Baystate* case.[17]

Issue 3 – DSH Payment – Medicaid Eligible Days

The MAC requests that the Board find the Provider abandoned the DSH – Medicaid Eligible Days issue arguing:

> The MAC contends that the Provider was in violation of Board Rule 25.3 when it failed to sufficiently develop and set forth the relevant facts and arguments regarding the merits of its claim in its preliminary position paper. Moreover, the Provider neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2. Accordingly, the DSH – Medicaid Eligible Days issue should be dismissed.
>
> Within its Provider's preliminary position paper, the Provider makes the broad allegation, ". . . the Provider contends that the total number of days reflected in its' [sic] 2018 cost report does not reflect an accurate number of Medicaid eligible days. . ." The Provider has failed to include any evidence to establish the material facts in this case relating to inaccuracies in the Medicaid Percentage calculation at issue. The Provider merely repeats their appeal request.[18]

Provider's Jurisdictional Response

Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record." The MAC filed its Jurisdictional Challenge on June 7, 2023. The Provider filed a response on August 4, 2023, after the July 7, 2023 deadline. As a result of the late filing, the Board will not consider the Provider's Jurisdictional Response.

Board Analysis and Decision:

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

As set forth below, the Board hereby dismisses the Provider's Issue No. 1.

[17] *Id*.
[18] *Id*. at 12.

A. DSH Payment/SSI Percentage (Provider Specific)

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

1. First Aspect of Issue 1

The first aspect of Issue No. 1—the Provider's disagreement with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH/SSI Percentage (Systemic Errors) issue that was appealed in PRRB Case No. 21-1206GC.

The DSH Payment/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."[19] Per the appeal request, the Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[20] The Provider argues that "its'[sic] SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[21]

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 21-1206GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds that the DSH Payment/SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 21-1206GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[22], the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

The Board has previously noted that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and the Provider has failed to explain how this argument is ***specific to this provider***. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may

[19] Issue Statement at 1.
[20] *Id.*
[21] *Id.*
[22] PRRB Rules v. 3.1 (Nov. 2021).

impact the SSI percentage for each provider differently.[23] Accordingly, Provider's reference to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, Provider has failed to sufficiently distinguish (by sufficient explanation or evidence) how the alleged "provider specific" errors averred in Issue 1 are distinguished from the alleged "systemic" issues argued in Issue 2, and why those alleged "provider specific" errors should not be subsumed into the "systemic errors" issue appealed in Case No. 21-1206GC.

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 21-1206GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with the Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" in its Preliminary Position Paper and include *all* exhibits.

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

> **25.2.2 Unavailable and Omitted Documents**
>
> *If documents necessary to support your position are still unavailable,* then provide the following information in the position papers:
>
> 1. Identify the missing documents;
> 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.[24]

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

[23] The types of systemic errors documented in *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).
[24] (Emphasis added).

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/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh.[25]

This CMS webpage describes access to DSH data ***from 1998 to 2022*** and instructs providers to send a request via email to access their DSH data."[26]

Accordingly, *based on the record before it*, the Board finds that the remaining issue in the instant appeal and the group issue from Group Case 21-1206GC are the same issue.[27] Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

Additionally, in its Preliminary Position Paper, the Provider states, "The [Provider] hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra [sic] (Appellants' reply brief included as Exhibit P-3)." The Board finds that this incorporation by reference does not comply with the regulatory and Board rule requirements to *fully* develop the Provider's position in the Preliminary Position Paper. Particularly, 42 C.F.R. § 405.1853 provides in pertinent part:

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.[28]

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[25] Last accessed August 14, 2024.
[26] Emphasis added.
[27] Moreover, even if it were not a prohibited duplicate, it was not properly in the individual appeal because it is a common issue that would be required to be in a CHS CIRP group per 42 C.F.R. § 405.1837(b)(1).
[28] (Emphasis added).

An incorporation of arguments by reference from a different case simply fails to do so. Accordingly, the Board dismisses that portion of the issue as well.

2. Second Aspect of Issue 1

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

Under 42 C.F.R. § 412.106(b)(3), the applicable regulation 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 . . . ." Moreover, without this written request, the Medicare Contractor cannot issue a final determination with which the Provider can be dissatisfied for Board appeal purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding DSH SSI Percentage *realignment*. Therefore, in accordance with 42 C.F.R. § 405.1835(a)(1), the Board dismisses this aspect of the appeal.

B. DSH Payment – Medicaid Eligible Days

According to its Appeal Request, the Provider asserts that all Medicaid eligible days were not included in the calculations of the DSH calculation. The Provider states Issue 3 as:

> **Statement of the Issue**
>
> Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.
>
> **Statement of the Legal Basis**
>
> The Provider contends that the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.
>
> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.[29]

[29] Individual Appeal Request, Issue 3.

When determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days that affect the percentage), 42 C.F.R. § 412.106(b)(4)(iii), which places the burden of production on the provider states in pertinent part:

> The hospital has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.

Additionally, and more generally related to accounting records and reporting requirements for providers, 42 C.F.R. § 413.24(c) describes what cost information is adequate:

> Adequate cost information must be obtained from the provider's records to support payments made for services furnished to beneficiaries. The requirement of adequacy of data implies that the data be accurate and in sufficient detail to accomplish the purposes for which it is intended.

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

> The provider must support the determination being appealed and the basis for its dissatisfaction for each issue under appeal. *See* subsections below and Rule 8 for special instructions regarding multi-component disputes.
>
> If the provider, through no fault of its own, does not have access to the underlying information to determine whether the adjustment is correct, describe why the underlying information is unavailable.

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

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. *Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a*

> *timeframe to be decided by the Board through a schedule applicable to a specific case or through general instructions*.[30]

Similarly, with regard to position papers,[31] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[32] This requirement is consistent with 42 C.F.R. § 405.1853(b)(3). Also consistent with that regulation, Board Rule 25.2.2 provides the following instruction on the content of position papers as it relates to unavailable documentation/exhibits:

> *If documents necessary to support your position are still unavailable,* then provide the following information in the position papers:
>
> 1. Identify the missing documents;
> 2. Explain why the documents remain unavailable;
> 3. State the efforts made to obtain the documents; and
> 4. Explain when the documents will be available.
>
> Once the documents become available, ***promptly*** forward them to the Board and the opposing party.[33]

Finally, Board Rule 41.2 permits dismissal or closure of a case on the Board's own motion:

> - if it has a reasonable basis to believe that the issues have been fully settled or abandoned;
> - upon failure of the provider or group to comply with Board procedures or filing deadlines (*see* 42 C.F.R. § 405.1868);
> - if the Board is unable to contact the provider or representative at the last known address; or
> - upon failure to appear for a scheduled hearing.

Relative to a Medicaid Eligible Days determination, it is well-established that adequate data to prove eligibility for each Medicaid patient day claimed is a complete and accurate (i.e., auditable) Medicaid eligible days listing, which upon timely submission by a provider, a MAC can examine to make applicable adjustments.

This appeal was initiated on February 7, 2022 (nearly 3 years ago), and at that time, the Provider did not include a list of additional Medicaid eligible days they expect to be included in their Medicaid percentage and DSH computations with their appeal request. Subsequently, the Provider's preliminary position paper indicated that it would be sending the eligibility listing under

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[30] (Emphasis added).
[31] The minimum requirements for Final Position Paper narratives and exhibits are the same as those for Preliminary Position Papers. *See* Board Rule 27.2.
[32] (Emphasis added).
[33] (Emphasis added).

separate cover.[34] ***To-date, no listing has been provided—even after the MAC requested the listing on three (3) occasions***. Accordingly, the Provider has abandoned the issue by failing to properly develop its arguments and provide supporting documents, and by failing to explain why it cannot produce those documents, as required by the regulations and the Board Rules.[35] Specifically, the Board finds that the Provider has failed to satisfy the requirements of Board Rules 25.2.1 and 25.2.2 and 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) related to identifying the days in dispute and the submission of documentary evidence required to support its claims or describe why said evidence is unavailable. The Board takes administrative notice that it has made similar dismissal in other cases involving CHS providers.[36]

****

In summary, the Board hereby dismisses the DSH Payment/SSI Percentage (Provider Specific) issue from this appeal as it is duplicative of the issue in Case No. 21-1206GC and because the purported realignment portion of the issue is premature in absence of a properly submitted written realignment request subject to a final determination from which the Provider can appeal. The Board also dismisses the DSH Payment - Medicaid Eligible Days issue as the Provider failed to meet the Board requirements for submitting fully developed and complete position papers in compliance with 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25. As no issues remain pending, the Board hereby closes Case No. 22-1200 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:

Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.

For the Board:

1/3/2025

X Shakeba DuBose

Shakeba DuBose, Esq.
Board Member
Signed by: PIV

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

[34] Provider's Preliminary Position Paper at 9.
[35] *See also* Board's jurisdictional decision in *Lakeland Regional Health* (Case No. 13-2953, 11/20/2019), in which the Board found a Provider essentially abandoned its appeal by filing a position paper that failed to set forth the merits of its claim, explain why the agency's calculation was wrong, and identifying missing documents to support its claim and to explain why those documents remained unavailable.
[36] An example of a CHS individual provider case in which the Board dismissed for failure of the Provider to provide a listing of Medicaid eligible days include, but are not limited to: Case No. 22-0676 (dismissed by Board letter dated December 7, 2022 based on a MAC July 13, 2022 request for dismissal of the Medicaid eligible days issue for failure to file Medicaid eligible days listing with the preliminary position paper).

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

RE: ***Board Jurisdictional Determination***

Asante Health System CY 2008 Part C Days Retroactive Final Rule CIRP Group
PRRB Case No. 25-0563GC

Asante Health System CY 2009 Part C Days Retroactive Final Rule CIRP Group
PRRB Case No. 25-0564GC

Asante Health System CY 2010 Part C Days Retroactive Final Rule CIRP Group
PRRB Case No. 25-0562GC

Asante Health System CY 2011 Part C Days Retroactive Final Rule CIRP Group
PRRB Case No. 25-0565GC

Asante Health System CY 2012 Part C Days Retroactive Final Rule CIRP Group
PRRB Case No. 25-0635GC

Asante Health System CY 2013 Part C Days Retroactive Final Rule CIRP Group
PRRB Case No. 25-0586GC

Specifically, as participants:
Asante Three Rivers Medical Center (Prov. No. 38-0002) and
Asante Rogue Regional Medical Center (Prov. No. 38-0018)

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (the "Board") has reviewed the above-captioned common issue related party ("CIRP") groups and finds an impediment over one or more of the participants in each group. The pertinent facts regarding the deficient provider(s) and the Board's determination are set forth below.

Background:

In **November 2024**, Quality Reimbursement Services, Inc. ("QRS") filed separate groups on behalf of Asante Health System for the Part C Days Retroactive Final Rule issue for calendar

years ("CYs") 2008 through 2013. All six groups were established in the Office of Hearings Case and Document Management System ("OH CDMS") with a single provider: Asante Health Three Rivers Medical Center ("Asante Three Rivers"/Prov. No. 38-0002), which filed from revised Notices of Program Reimbursement ("RNPRs") as follows:

Case No.	CY	Filed Date	RNPR Date
25-0563GC	2008	11/1/2024	5/6/2024
25-0564GC	2009	11/1/2024	5/6/2024
25-0562GC	2010	11/1/2024	5/6/2024
25-0565GC	2011	11/1/2024	5/6/2024
25-0635GC	2012	11/6/2024	7/29/2024
25-0586GC	2013	11/4/2024	5/6/2024

On **November 12, 2024**, QRS directly added an additional provider, Asante Rogue Regional Medical Center ("Asante Rogue"/Prov. No. 38-0018) to five of the six groups - Case Nos. 25-0563GC, 25-0564GC, 25-0565GC, 25-0635GC and 25-0586GC. In each group, Asante Rogue appealed from RNPRs that were all purportedly dated May 17, 2024. Again, instead of submitting copies of the RNPRs for Asante Rogue, QRS uploaded copies of the HCRIS Report as the final determinations for each CY.[1]

Board Determination:

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

Further, 42 C.F.R. § 405.1835(b), indicates that a Provider's appeal may be dismissed if it does not include . . . "A copy of the final contractor or Secretary determination under appeal and any other documentary evidence the provider considers necessary to satisfy the hearing request requirements . . . ". Including the actual determination with the appeal request is critical for a myriad of reasons, including to determine whether the Provider meets the claim filing requirements specified in 42 C.F.R. § 405.1835.

In the case of Asante Three Rivers and Asante Rogue as participants in these CIRP groups (Case Nos. 25-0562GC, 25-0563GC, 25-0564GC, 25-0565GC, 25-0635GC and 25-0586GC), the HCRIS DSH Report is NOT considered a final determination and, therefore, the Direct Adds of these Providers are technically deficient. In addition, the Board notes that QRS has previously been put on notice that additions of deficient Providers (i.e., participants that do not include the proper final determinations) will be dismissed for failure to meet the requirements of 42 C.F.R. § 405.1835. Because the Representative failed to submit the required copies of the final determinations under appeal in the subject cases (i.e., RNPRs), the Board finds that Asante Three

[1] Asante Rogue was not directly added to Case No. 25-0562GC.

Rivers and Asante Rogue do not meet the regulatory requirements for filing an appeal (in this case directly adding to the groups). Accordingly, the Board finds dismissal is appropriate under § 405.1835(b) and Board Rules and hereby dismisses Asante Three Rivers and Asante Rogue from the six groups. As there are no other participants in Case Nos. 25-0562GC, 25-0563GC, 25-0564GC, 25-0565GC, 25-0635GC and 25-0586GC, the Board hereby dismisses the six groups.

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:
Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.

For the Board:

1/3/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services
Dean Wolfe, Noridian Healthcare Solutions (J-F)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

James Ravindran
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150 N. Santa Anita Avenue, Suite 570A
Arcadia, CA 91006

RE: ***Notice of Dismissal***
Fannin Regional Hospital, Prov. No 11-0189, FYE 12/31/2016
Case No. 20-0320

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 20-0320. Set forth below is the decision of the Board to dismiss the remaining issue in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") payment for SSI Percentage (Provider Specific).

Background

A. *Procedural History for Case No. 20-0320*

On **April 23, 2019,** the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end December 31, 2019. The Provider is commonly owned by Quorum Health ("Quorum").

On **October 22, 2019,** Quorum filed the Provider's individual appeal request. The initial Individual Appeal Request contained five (5) issues:

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

As the Provider is commonly owned/controlled by Quorum, the Provider is subject to the mandatory common issue related party ("CIRP") group regulation at 42 C.F.R. § 405.1837(b)(1).

[1] On May 21, 2020, this issue was transferred to Case No. 19-1503GC.
[2] On December 23, 2024, this issue was withdrawn by the Provider.
[3] On August 21, 2023, this issue was withdrawn by the Provider.
[4] On May 21, 2020, this issue was transferred to Case No. 19-1504GC.

For that reason, on **May 21, 2020**, the Provider transferred Issue 2 to PRRB Case No. 19-1503GC and Issue 5 to Case No. 19-1504GC.

On **November 13, 2019,** the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

> Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the Provider will use to support its position* and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. See Board Rule 25.[5]

On **August 11, 2020,** the Medicare Contractor filed a Jurisdictional Challenge[6], requesting dismissal of Issues 1 and 4. Pursuant to Board Rule 44.3, the Provider had 30 days to respond to the Jurisdictional Challenge. However, the Provider ***failed*** to timely respond to the Jurisdictional Challenge.

On **September 23, 2020,** the Medicare Contractor timely filed its preliminary position paper.

On **August 18, 2023**, the Provider changed is designated representative to Mr. Ravindran of Quality Reimbursement Services, Inc. ("QRS").

On **August 21, 2023**, the Provider withdrew Issue 4 – Uncompensated Care ("UCC") Distribution Pool from the appeal.

On **December 19, 2024**, the Provider filed its final position paper.

On **December 23, 2024**, the Provider withdrew Issue 3 – DSH – Medicaid Eligible Days from the appeal.

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[5] (Emphasis added.)

[6] Jurisdictional Challenges are not limited to jurisdiction *per se* as exemplified by 42 C.F.R. § 405.1840(a), (b). The Board notes that 42 C.F.R. § 405.1840 is entitled "Board Jurisdiction" but it also addresses certain claims-filing requirements such as timelines or filing deadlines. Whether an appeal request is timely filed with the Board is not a jurisdictional requirement per se, but rather it is a claims-filing requirement as the Supreme Court made clear in *Sebelius v. Auburn Reg. Med. Ctr.*, 568 U.S. 145 (2013) ("*Auburn*"). Unfortunately, following the issuance of *Auburn*, the Secretary has not yet updated § 405.1840 to reflect the clarification made by the Supreme Court in *Auburn* that distinguishes between the claims-filing requirements for a Board hearing request versus jurisdictional requirements for a Board hearing. *See also* Board Rule 4.1 ("The Board will dismiss appeals that fail *to meet the timely filing requirements* ***and/or*** *jurisdictional requirements*."); 42 C.F.R. § 405.1835(b) (addressing certain other claims-filing requirements).

As a result of the case transfers and withdrawn issues, there is one remaining issue in this appeal: Issue 1 - DSH/SSI (Provider Specific).

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 19-1503GC - Quorum Health CY 2010 & CY 2016 DSH SSI Percentage CIRP Group

In their Individual Appeal Request, the 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 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) [sic].[7]

The Group issue Statement in Case No. 19-1503GC, to which the Provider transferred Issue No. 2, reads, in part:

> **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

[7] Issue Statement at 1 (Nov. 13, 2019).

> 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,
> 2. Paid days vs. Eligible days,
> 3. Not in agreement with provider's records,
> 4. Fundamental problems in the SSI percentage calculation,
> 5. Covered days vs. Total days and
> 6. Failure to adhere to required notice and comment rulemaking procedures.[8]

On December 19, 2024, the Board received the Provider's final position paper in Case No. 20-0320. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Provider Specific**
>
> The Provider contends that its SSI percentage published by the Centers for Medicare and Medicaid Services ("CMS") was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation.
>
> The Provider is seeking a *full and complete* set of the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. See 65 Fed. Reg. 50,548 (2000). Although some MEDPAR data is now routinely made available to the provider community, what is provided lacks all data records necessary to fully identify all patients properly includable in the SSI fraction. The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction. The hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra (Appellants' reply brief included as Exhibit P-3).[9]

[8] Group Appeal Issue Statement in Case No. 19-1503GC.
[9] Provider's Final Position Paper at 7-8 (Dec. 19, 2024).

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $6,000.

MAC's Contentions

Issue 1 – DSH/SSI (Provider Specific)

The MAC argues that the Board lacks jurisdiction over the DSH/SSI (Provider Specific) issue. Issue 1 has three components: 1) SSI data accuracy; 2) SSI realignment; and 3) individuals who are eligible for SSI but did not receive SSI payment. The MAC contends that the first and third sub-issues should be dismissed because they are duplicative of Issue 2. The portion related to SSI realignment should be dismissed because there was no final determination over SSI realignment and the appeal is premature as the Provider has not exhausted all available remedies.[10]

Provider's Jurisdictional Response

The Board Rules require that Provider Responses to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[11] The Provider has not filed a response to the Jurisdictional Challenge and the time for doing so has elapsed. Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. A provider's failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

Decision of the Board

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.

As set forth below, the Board hereby ***dismisses*** the Provider's only remaining issue.

A. DSH/SSI (Provider Specific)

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

[10] Medicare Contractor's Jurisdictional Challenge at 2 (Aug. 11, 2020).
[11] Board Rule 44.4.3, v. 2.0 (Aug. 2018).

1. *First Aspect of Issue 1*

The first aspect of Issue No. 1—the Provider disagreement with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH – SSI Percentage (Systemic Errors) issue that was appealed in Case No. 19-1503GC.

The DSH/SSI Percentage (Provider Specific) issue in the present appeal concerns "[w]hether the Medicare Administrative Contractor ("MAC") used the correct Supplemental Security Income ("SSI") percentage in the Disproportionate Share Hospital ("DSH") calculation."[12] Per the appeal request, the Provider's legal basis for its DSH/SSI (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[13] In its issue statement that was included in the appeal request, the Provider argues that it "disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[14]

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 19-1503GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds that the DSH/SSI (Provider Specific) issue in Case No. 20-0320 is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 19-1503GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[15], the Board dismisses this aspect of the DSH/SSI (Provider Specific) issue.

The Board has previously noted that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and the Provider has failed to explain how this argument is ***specific to this provider***. 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] Accordingly, the Provider's reference to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, Provider has failed to sufficiently distinguish (by sufficient explanation or evidence) how the alleged "provider specific" errors averred in Issue 1 are distinguished from the alleged "systemic" issues argued in Issue 2, and why those alleged "provider specific" errors should not be subsumed into the "systemic errors" issue appealed in Case No. 19-1503GC.

To this end, the Board also reviewed the Provider's Final Position Paper to see if it further clarified Issue 1. However, it failed to provide any basis upon which to distinguish Issue 1 from the SSI

[12] Issue Statement at 1.
[13] *Id.*
[14] *Id.*
[15] PRRB Rules v. 2.0 (Aug. 2018).
[16] The types of systemic errors documented in *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).

issue in Case No. 20-1332GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. For example, it alleges that "SSI entitlement of individuals can be ascertained from State records" but fails to explain how it can, explain how that information is relevant, and whether such a review was done for purposes of the year in question consistent with its obligations under Board Rule 25.2.[17] Moreover, the Board finds that the Provider's Final Position Paper failed to comply with Board Rule 25 (Dec. 15, 2023) governing the content of position papers. As explained in the Commentary to Rule 23.3 (Dec. 15, 2023), 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" 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 (Dec. 15, 2023)**
>
> 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.[18]

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*

[17] It is also not clear whether this is a systemic issue for Quorum providers in the same state subject to the CIRP rules or something that is provider specific because if it was a common systemic issue it was required to be transferred to a CIRP group "no later than the filing of the preliminary position paper" in this case per Board Rule 12.11. The Provider fails to comply with its obligation under 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rules to fully brief the merits of its issue.

[18] (Italics and underline emphasis added.)

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") as explained on the following webpage:

> https://www.cms.gov/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh.[19]

This CMS webpage describes access to DSH data ***from 1998 to 2022*** and instructs providers to send a request via email to access their DSH data."[20]

Accordingly, *based on the record before it*,[21] the Board finds that the SSI Provider Specific issue in Case No. 20-0320 and the group issue from the CHS CIRP group under Case No. 19-1503GC are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH/SSI (Provider Specific) issue.

2. *Second Aspect of Issue 1*

The second aspect of the DSH/SSI (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.

Under 42 C.F.R. § 412.106(b)(3), the applicable regulation 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 . . . ." Moreover, without this written request, the Medicare Contractor cannot issue a final determination with which the Provider can be dissatisfied for Board 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 dismisses this aspect of the appeal.

* * * * *

Based on the foregoing, the Board has dismissed the remaining issue in this case Issue 1: DSH/SSI (Provider Specific). As no issues remain, the Board hereby closes Case No. 20-0320 and removes it from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

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[19] Last accessed Dec. 27, 2024.
[20] (Emphasis added).
[21] Again, the Board notes that the Provider failed to respond to the Jurisdictional Challenge and the Board must make its determination based on the record before it.

Board Members Participating:

Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.

For the Board:

1/3/2025

X Shakeba DuBose

Shakeba DuBose, Esq.
Board Member
Signed by: PIV

cc: Byron Lamprecht, WPS Government Health Administrators (J-5)
Wilson Leong, FSS

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Via Electronic Delivery

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150 N. Santa Anita Avenue, Suite 570A
Arcadia, CA 91006

RE: ***Board Jurisdictional Determination***

VCH CY 2010 Part C Days Retroactive Final Rule CIRP Group
PRRB Case No. 25-0500GC

Specifically, as participants:
Ascension Via Christi Hospitals Wichita, Inc. (Prov. No. 17-0122)
Ascension Via Christi Hospitals Manhattan, Inc. (Prov. No. 17-0142)
Via Christi Hospital Pittsburg (Prov. No. 17-0006)

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (the "Board") has reviewed the above-captioned common issue related party ("CIRP") group and finds an impediment over the three participants in the group. The pertinent facts regarding the deficient providers and the Board's determination are set forth below.

Background:

On **October 29, 2024**, Quality Reimbursement Services, Inc. ("QRS") filed a group on behalf of Via Christi Health, Inc. for the Part C Days Retroactive Final Rule issue for calendar year ("CY") 2010. The group was established in the Office of Hearings Case and Document Management System ("OH CDMS") with two providers:

- Ascension Via Christi Hospitals Wichita, Inc. ("VCH Wichita"/Prov. No. 17-0122) and
- Ascension Via Christi Hospitals Manhattan, Inc. ("VCH Manhattan"/Prov. No. 17-0142),

Both Providers filed from revised Notices of Program Reimbursement ("RNPRs") that were dated May 2, 2024. However, instead of QRS uploading copies of the RNPRs, it uploaded copies of the HCRIS Report as final determination support for each provider.

On **October 31, 2024**, QRS directly added an additional provider to the group, Via Christi Hospital Pittsburg ("VCH Pittsburg"/Prov. No. 17-0006). This Direct Add was filed from a RNPR allegedly dated May 7, 2024, but again QRS uploaded a copy of the HCRIS Report.

Board Determination:

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

Further, 42 C.F.R. § 405.1835(b), indicates that a Provider's appeal may be dismissed if it does not include . . . "A copy of the final contractor or Secretary determination under appeal and any other documentary evidence the provider considers necessary to satisfy the hearing request requirements . . . ". Including the actual determination with the appeal request is critical for a myriad of reasons, including to determine whether the Provider meets the claim filing requirements specified in 42 C.F.R. § 405.1835.

In the case of VCH Wichita, VCH Manhattan and VCH Pittsburg as participants in the CIRP group, the HCRIS DSH Report is ***not*** considered a final determination and, therefore, the Direct Adds of these Providers are deficient. In addition, the Board notes that QRS has previously been put on notice that additions of deficient Providers (i.e., participants that do not include the proper final determinations) will be dismissed for failure to meet the requirements of 42 C.F.R. § 405.1835. Because the Representative failed to submit the required copies of the final determinations under appeal in Case No. 25-0500GC (i.e., RNPRs), the Board finds that VCH Wichita, VCH Manhattan and VCH Pittsburg do not meet the regulatory requirements for filing an appeal (in this case directly adding to the group). Accordingly, the Board finds dismissal is appropriate under § 405.1835(b) and Board Rules and hereby dismisses VCH Wichita, VCH Manhattan and VCH Pittsburg. As there are no other participants in Case No. 25-0500GC, the Board hereby dismisses the group.

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:
Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.

For the Board:

1/3/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services
Byron Lamprecht, WPS Government Health Administrators (J-5)

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

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

RE: ***Notice of Dismissal***
Eastern New Mexico Medical Center, Prov. No. 32-0006, FYE 05/31/2016
Case No. 19-1314

Dear Mr. Summar:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 19-1314. Set forth below is the decision of the Board to dismiss the 3 remaining issues in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") for SSI Percentage (Provider Specific), Medicaid Eligible Days, and Uncompensated Care ("UCC") payments.

Background

A. *Procedural History for Case No. 19-1314*

On **August 17, 2018**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end May 31, 2016. The Provider is commonly owned by Community Health Systems, Inc. ("CHS").

On **February 5, 2019**, CHS filed the Provider's individual appeal request. The initial Individual Appeal Request contained five (5) issues:

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

[1] On September 23, 2019, this issue was transferred to Case No. 19-1409GC.
[2] On May 14, 2023, the Medicare Contractor filed a Motion to Dismiss over Issue 3.
[3] On September 23, 2019, this issue was transferred to Case No. 19-1410GC.

As the Provider is commonly owned/controlled by CHS, the Provider is subject to the mandatory common issue related party ("CIRP") group regulation at 42 C.F.R. § 405.1837(b)(1). For that reason, on **September 23, 2019**, the Provider transferred Issues 2 and 5 to CHS CIRP groups. As a result of the case transfers, there are three (3) remaining issues in this appeal: Issue 1 (the DSH – SSI Percentage Provider Specific), Issue 3 (the DSH – Medicaid Eligible Days), and Issue 4 (UCC Distribution Pool).

On **March 5, 2019**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

> Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the Provider will use to support its position* and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. See Board Rule 25.[4]

On **October 2, 2019**, the Provider timely filed its preliminary position paper. With respect to Issue 3, the Provider suggested that a list of Medicaid eligible days at issue was imminent by promising that one was being sent under separate cover. However, no such filing was made and no explanation was included explaining why that listing was not included with the position paper filing. Indeed, the filing failed to even provide *the material fact* of how many Medicaid eligible days are at issue and instead asserted that "[b]ased on the Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its' 2016 cost report does not reflect an accurate number of Medicaid eligible days." As a result, the Provider included, as an Exhibit, the original "estimated impact" for this issue of $77,558 based on an *estimated* 150 days.

On **December 31, 2019**, the Medicare Contractor timely filed a Jurisdictional Challenge[5] with the Board over Issues 1 and 4 requesting that the Board dismiss these issues. Pursuant to Board

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[4] (Emphasis added.)

[5] Jurisdictional Challenges are not limited to jurisdiction *per se* as exemplified by 42 C.F.R. § 405.1840(a), (b). The Board notes that 42 C.F.R. § 405.1840 is entitled "Board Jurisdiction" but it also addresses certain claims-filing requirements such as timelines or filing deadlines. Whether an appeal request is timely filed with the Board is not a jurisdictional requirement per se, but rather it is a claims-filing requirement as the Supreme Court made clear in *Sebelius v. Auburn Reg. Med. Ctr.*, 568 U.S. 145 (2013) ("*Auburn*"). Unfortunately, following the issuance of *Auburn*, the Secretary has not yet updated § 405.1840 to reflect the clarification made by the Supreme Court in *Auburn* that distinguishes between the claims-filing requirements for a Board hearing request versus jurisdictional requirements for a Board hearing. *See also* Board Rule 4.1 ("The Board will dismiss appeals that fail *to meet the timely filing requirements* ***and/or*** *jurisdictional requirements*."); 42 C.F.R. § 405.1835(b) (addressing certain other claims-filing requirements).

Rule 44.4.3, the Provider had 30 days in which to file a response to the Jurisdictional Challenge. The Provider timely filed a response on January 29, 2020.

On **January 24, 2020**, the Medicare Contractor filed its preliminary position paper. With regard to Issue 3, the Medicare Contractor's position paper noted that: (1) the Provider had failed to include a Medicaid eligible days listing with its position paper notwithstanding its obligation under Board Rules to file a fully developed position paper with all available documentation necessary to support its position; and (2) the Provider had failed to respond to any of the Medicare Contractor's requests for that Medicaid eligible days listing.

On **January 3, 2023**, the Medicare Contractor filed a Request for DSH Package in connection with Issue 3. In this filing, the Medicare Contractor noted that over four years had elapsed since Provider's end of cost reporting period in question. The Provider did not file a response to this request. Notwithstanding the formal request, the Provider failed to file any response to the Medicare Contractor.

As no response was received from the Provider, on **May 14, 2023**, the Medicare Contractor filed a Motion to Dismiss, requesting dismissal of DSH Medicaid Eligible Days because: (1) the Provider failed to furnish documentation in support of its claim for additional Medicaid eligible days (or explain why such documentation is unavailable); (2) the Provider failed to furnish the Medicaid eligible days listing with its preliminary position paper in violation of Board Rules 25.2.1 and 25.2.2; and (3) the Provider has effectively abandoned Issue 3. Pursuant to Board Rule 44.3, the Provider had 30 days to respond to the Motion for Dismiss. However, the Provider ***failed*** timely respond to that Motion.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 19-1409GC - CHS CY 2016 DSH SSI Percentage CIRP Group

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

> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation[.]
>
> The Provider contends that the SSI percentage issued by CMS 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).[6]

The Group issue Statement in Case No. 19-1409GC, to which the Provider transferred Issue No. 2, reads, in part:

> **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,
> 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.[7]

On October 2, 2019, the Board received the Provider's preliminary position paper in 19-1314. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

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[6] Issue Statement at 1 (Feb. 5, 2019).
[7] Group Appeal Issue Statement in Case No. 19-1409GC.

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 based on the Provider's Fiscal Year End (May 31). The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.
>
> Similar to *Loma Linda Community Hospital v. Dept. of Health and Human Services,* No. CV-94-0055 (C.D. Cal June 2, 1995), the SSI entitlement of individuals can be ascertained from [s]tate 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") database, 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 completed MEDPAR data, the Provider will seek to reconcile its' records with that of CMS, and identify patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS based on the Federal Fiscal Year End (September 30) when it determined the Provider's SSI. *See Baystate Medical Center v. Leavitt,* 545 F. Supp. 2d 20 (D.D.C. 2008).[8]

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $25,974.

MAC's Contentions

Issue 1 – DSH Payment/SSI Percentage (Provider Specific)

The MAC argues that the Board lacks jurisdiction over the DSH – SSI Percentage (Provider Specific) issue. Issue 1 has three components: 1) SSI data accuracy; 2) SSI realignment; and 3) individuals who are eligible for SSI but did not receive SSI payment. The MAC contends that the first and third sub-issues should be dismissed because they are duplicative of Issue 2. The portion related to SSI realignment should be dismissed because there was no final determination over SSI realignment and the appeal is premature as the Provider has not exhausted all available remedies.[9]

[8] Provider's Preliminary Position Paper at 12-13 (Oct. 2, 2019).
[9] Medicare Contractor's Jurisdictional Challenge at 3 (Dec. 31, 2019).

Issue 3 – DSH Payment – Medicaid Eligible Days

The MAC contends that the Provider failed to properly develop its arguments within its preliminary position paper in accordance with 42 C.F.R. § 405.1853(b)(2) and Board Rule 25. The MAC argues the Provider has not submitted a Medicaid eligible days listing and therefore, requests the Board dismiss the issue.[10]

Issue 8 – UCC Distribution Pool

The MAC argues "that the Board does not have jurisdiction over the UCC DSH payment issue because jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2)."[11] The MAC also contends that this issue is a duplicate of PRRB Case No. 16-0769GC and should therefore be dismissed.[12]

Provider's Jurisdictional Response

The Board Rules require that Provider Responses to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[13] The Provider timely filed a response to the Medicare Contractor's jurisdictional challenge on January 29, 2020.

In its response, the Provider asserted the following arguments:

> **SSI – Provider Specific**
>
> FSS, on behalf of the Medicare Administrative Contractor ("MAC") WPS Government Health Administrators, challenges the Board's jurisdiction, stating that the Provider does not have a right to a hearing before the Board on the DSH/SSI realignment issue because it is duplicative of the SSI Systemic issue. However, Provider contends that FSS is incorrect. 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. 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. See Baystate Medical Center v. Leavitt, 545 F. Supp. 2d 20 (D.D.C. 2008). 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

[10] Medicare Contractor's Motion to Dismiss at 14-15 (May 14, 2023).
[11] Medicare Contractor's Jurisdictional Challenge at 3 (Dec. 31, 2019).
[12] *Id*.
[13] Board Rule 44.4.3, v. 2.0 (Aug. 2018).

> determined by CMS is incorrect due to the understated days in the SSI ratio. Therefore, the Board should find jurisdiction over the SSI provider specific issue in the instant appeal.
>
> Accordingly, this is an appealable item because the MAC specifically adjusted the Provider's SSI percentage and the Provider is dissatisfied with the amount of DSH payments that it received for fiscal year 2016, because of its understated SSI percentage due to errors of omission and commission.
>
> **UCC Distribution Pool**
>
> **Duplicate Issue:**
> The MAC states that it "appears" Providers are violating PRRB Rule 4.6.2 which states "appeals of the same issue from distinct determinations must be pursued in a single appeal". Providers have appealed from the Federal Register dated August 22, 2014, August 17, 2015 and from the NPR. In this instance, Provider's appeals in PRRB CN 15- 1134GC, CN 16-0769GC and 19-1314 are from separate and distinct determinations, and appeal rights associated with Federal Register Publications vary from those of appeal rights based upon NPRs. Therefore, Provider contends there is no conflict with PRRB Rule 4.6.2, and Providers wish to preserve their appeal rights for both types of appeals.
>
> **Jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2).**
> [R]eview by this Board of the uninsured patient percentage is not barred by 42 U.S.C. § 1395ww(r)(3), because such percentages may not be computed on estimates. Moreover, the provisions of 42 U.S.C. § 1395ww(r)(3) reflect intent by Congress to put administrative review on the same footing as judicial review. The ban on judicial review does not apply in connection with mandamus type claims, challenges to regulations, and constitutional challenges. Accordingly, this Board also has jurisdiction over this appeal.

Similarly, the Provider's response to the Motion to Dismiss regarding Issue 3 was due within 30 days, but the Provider failed to timely file a response. In this regard, Board Rule 44.3 specifies with respect to motions that "[u]nless the Board imposes a different deadline, an opposing party may send a response, with relevant supporting documentation, within 30 days from the date that the motion was sent to the Board and opposing party."

Decision of the Board

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.

As set forth below, the Board hereby ***dismisses*** the Provider's three (3) remaining issues.

A. DSH Payment/SSI Percentage (Provider Specific)

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

1. *First Aspect of Issue 1*

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH – SSI Percentage (Systemic Errors) issue that was appealed in Case No. 19-1409GC.

The DSH – SSI Percentage (Provider Specific) issue in the present appeal concerns "[w]hether the Medicare Administrative Contractor ("MAC") used the correct Supplemental Security Income ("SSI") percentage in the Disproportionate Share Hospital ("DSH") calculation."[14] Per the appeal request, the Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[15] The Provider argues in its issue statement, which was included in the appeal request, that it "disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[16]

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 19-1409GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds that the DSH Payment/SSI Percentage (Provider Specific) issue in Case No. 19-1314 is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 19-1409GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by

[14] Issue Statement at 1.
[15] *Id.*
[16] *Id.*

PRRB Rule 4.6[17], the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

The Board has previously noted that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and the Provider has failed to explain how this argument is ***specific to this provider***. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[18] The Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors are specific to this provider.

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it failed to provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 19-1409GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. For example, it alleges that "SSI entitlement of individuals can be ascertained from State records" but fails to explain how it can, explain how that information is relevant, and whether such a review was done for purposes of the year in question consistent with its obligations under Board Rule 25.2.[19] Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with Board Rule 25 (Aug. 29, 2018) governing the content of position papers. As explained in the Commentary to Rule 23.3 (Aug. 29, 2018), 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" 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 (Aug. 29, 2018)**
>
> 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.

[17] PRRB Rules v. 2.0 (Aug. 2018).
[18] The types of systemic errors documented in *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).
[19] It is also not clear whether this is a systemic issue for CHS providers in the same state subject to the CIRP rules or something that is provider specific because, if it was a common systemic issue, it was required to be transferred to a CIRP group "no later than the filing of the preliminary position paper" in this case per Board Rule 12.11. The Provider fails to comply with its obligation under 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rules to fully brief the merits of its issue.

> Once the documents become available, promptly forward them to the Board and the opposing party.[20]

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

> https://www.cms.gov/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh.[21]

This CMS webpage describes access to DSH data ***from 1998 to 2022*** and instructs providers to send a request via email to access their DSH data."[22]

Indeed, the D.C. Circuit affirmed in *Advocate Christ Med. Ctr. v. Becerra*, 80 F.4th 346 (D.C. Cir. 2023) that "What [MMA] section 951 cannot mean is that HHS must give hospitals data that it never received from SSA in the first place. And SSA does not provide HHS with the specific codes assigned to individual patients. See 75 Fed. Reg. at 50,276." Here, the Provider does not explain what information it needs or is waiting on or claims that it should have access to or why this is not a common issue already covered by the CIRP group under Case No. 19-1409GC.

Accordingly, *based on the record before it*, the Board finds that the SSI Provider Specific issue in Case No. 19-1314 and the group issue from the CHS CIRP group under Case No. 19-1409GC are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

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[20] (Italics and underline emphasis added.)
[21] Last accessed Nov. 1, 2024.
[22] (Emphasis added).

2. *Second Aspect of Issue 1*

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

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

B. DSH Payment – Medicaid Eligible Days

The Provider's appeal request did not include a list of the specific additional Medicaid eligible days that are in dispute in this appeal in either the initial appeal or the position papers.

With regard to the filing of an individual appeal, Board Rule 7 (Support for Appealed Final Determination, Issue-Related Information and Claim of Dissatisfaction) (Aug. 2018) states:

> **No Access to Data**
>
> If the provider elects to not claim an item on the cost report because, through no fault of its own, it did not have access to the underlying information to determine whether it was entitled to payment, describe the circumstances why the underlying information was unavailable upon the filing of the cost report.

42 C.F.R. § 405.1853(b)(2)-(3) addresses the content of position papers:

> (b) *Position papers*. . . . (2) The Board has the discretion to extend the deadline for submitting a position paper. **Each position paper must set forth the relevant facts and arguments regarding** the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and **the merits of the provider's Medicare payment claims for each remaining issue.**
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. **Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a**

> **timeframe to be decided by the Board** through a schedule applicable to a specific case or through general instructions.[23]

The regulations require the parties to fully brief the merits of each issue in their position paper (including the relevant facts and legal arguments) and specify that the Board has discretion about setting the time frame for the submission of exhibits supporting the merits of the appeal.

Board Rule 25 (Aug. 2018) requires the Provider to file its complete, *fully* developed preliminary position paper with all available documentation and gives the following instruction on the content of position papers:

> **Rule 25 Preliminary Position Papers**[24]
>
> **COMMENTARY**:
>
> Under the PRRB regulations effective August 21, 2008, all issues will have been identified within 60 days of the end of the appeal filing period. 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 Medicare contractor, and fifteen months for the provider's response. Therefore, preliminary position papers are expected to present fully developed positions of the parties and, therefore, require analysis well in advance of the filing deadline.
>
> **25.1 Content of Position Paper Narrative**
>
> The text of the position papers must include the elements addressed in the following sub-sections.
>
> **25.1.1 The Provider's Position Paper**
>
> A. Identify any issues that were raised in the appeal but are already resolved (whether by administrative resolution, agreement to reopen, transfer, withdrawal, dismissal, etc.) and require no further documentation to be submitted.
> B. For *each* issue that has not been fully resolved, state the material facts that support the provider's claim.
> C. Identify the controlling authority (e.g. statutes, regulations, policy, or case law) supporting the provider's position.
> D. Provide a conclusion applying the material facts to the controlling authorities.

[23] (Bold emphasis added.)
[24] (Underline emphasis added to these excerpts and all other emphasis in original.)

25.2 Position Paper Exhibits

25.2.1 General

With the position papers, the parties must exchange ***all*** available documentation as exhibits to fully support your position. . . . When filing those exhibits in the preliminary position paper, ensure that the documents are redacted in accordance with Rule 1.4. Unredacted versions should be exchanged by the parties separately from the position paper, if necessary.

25.2.2 Unavailable and Omitted Documents

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

25.2.3 List of Exhibits

Parties must attach a list of the exhibits exchanged with the position paper.

25.3 Filing Requirements to the Board

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

> **COMMENTARY**: Note that this is a change in previous Board practice. Failure to file a complete preliminary position paper with the Board will result in dismissal of your appeal or other actions in accordance with 42 C.F.R. § 405.1868. (*See* Rule 23.4.)

The Notice of Case Acknowledgement and Critical Due Dates issued to the Provider on March 5, 2019 included instructions on the content of the Provider's preliminary position paper consistent

with the above Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

Moreover, in connection with Issue 3, Medicare regulations specifically place the burden on hospitals to provide documentation from the State to establish ***each*** *Medicaid eligible day* being claimed. Specifically, when determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(iii) places the burden of production on the provider, stating:

> The hospital has the burden of furnishing data adequate to prove eligibility for ***each*** Medicaid patient *day claimed* under this paragraph, ***and*** of *verifying with the State* that a patient was eligible for Medicaid during each claimed patient hospital day.[25]

Along the same line, 42 C.F.R. § 405.1871(a)(3) makes clear that, in connection with appeals to the Board, "the provider carrie[s the] burden of production of evidence and burden of proof by establishing, by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue."

Additionally, and more generally related to accounting records and reporting requirements for providers, 42 C.F.R. § 413.24(c) describes what cost information is adequate:

> Adequate cost information must be obtained from the provider's records to support payments made for services furnished to beneficiaries. The requirement of adequacy of data implies that the data be accurate and in sufficient detail to accomplish the purposes for which it is intended.

Finally, Board Rule 41.2 permits dismissal or closure of a case on the Board's own motion:

- if it has 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 (see 42 C.F.R. § 405.1868),
- if the Board is unable to contact the provider or representative at the last known address, or
- upon failure to appear for a scheduled hearing.

On October 2, 2019, the Provider filed its preliminary position paper in which it indicated that it the eligibility listing was imminent by promising that the listing was being sent under separate cover.[26] Significantly, the position paper did ***not*** include *the material fact* of how many Medicaid eligible days remained in dispute in this case, but rather continued to reference the

[25] (Emphasis added.)
[26] Provider's Preliminary Position Paper at 12 (Oct. 2, 2019).

"estimated impact" included with its appeal request (i.e., the estimated impact of $77,558 based on an estimated 150 days). The Provider's complete briefing of this issue in its position paper is as follows:

> **Calculation of Medicaid Eligible Days**
>
> Specifically, the Provider disagrees with the MAC's calculation of the computation of the disproportionate patient percentage set forth at 42 C.F.R. § 412.106(b)(4) of the Secretary's regulations.
>
> The Sixth Circuit Court of Appeals, in *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F. 3d 270 (6th Cir. 1994), held that all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage when the DSH adjustment is calculated. Similar decisions were rendered by the Fourth, Eighth, and Ninth Circuits: *Cabell Huntington Hospital, Inc. v. Shalala,* 101 F. 3d 984 (4th Cir. 1996); *Deaconess Health Services Corp. v. Shalala,* 83 F. 3d 1041 (8th Cir. 1996), *aff'g* 912 F. Supp 478 (E.D. Mo. 1995); and *Legacy Emanuel Hospital and Health Center v. Shalala,* 97 F. 3d 1261 (9th Cir. 1996).
>
> The Centers for Medicare and Medicaid Services ("CMS", formerly HCFA) acquiesced in the above decisions and issued HCFA Ruling 97-2, which in pertinent part reads as follows:
>
> > [T]he Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to include all inpatient hospital days of service for patients who were eligible on that day for medical assistance under a state Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for these inpatient hospital services.
>
> Based on the Listing of Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its' 2016 cost report does not reflect an accurate number of Medicaid eligible days, as requested by HCFA Ruling 97-2 and the pertinent Federal Court decisions.

In its Motion to Dismiss, the Medicare Contractor asserts that the Provider has failed to submit a list of additional Medicaid eligible days and neglected to include all supporting documentation,

or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2.

Notably, the Medicare Contractor sent a separate request for the Provider's list of Medicaid Eligible days (and also discussed the lack of the listing in the Medicare Contractor's own position paper filing). The notice was sent to the Provider on January 3, 2023. The Medicare Contractor also informed the Provider in its request for information that the deadline to respond was February 2, 2023. The Provider failed to file any response to this request.

Due to the non-responsiveness of the Provider, on **May 14, 2023**, the Medicare Contractor filed a Motion to Dismiss, requesting dismissal of DSH Medicaid Eligible Days because: (1) the Provider failed to timely furnish documentation (e.g., a listing of days with supporting documentation of Medicaid eligibility) in support of its claim for additional Medicaid eligible days (or explain why such documentation is unavailable); and (2) the Provider failed to furnish the list of additional Medicaid eligible days with its preliminary position paper in violation of Board Rules 25.2.1 and 25.2.2 (or when request by the Medicare Contractor 3 separate times after that). The Medicare Contractor thus asserts that the Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it failed to produce those documents, as required by the regulations and the Board Rules.[27]

Pursuant to Board Rule 44.3, the Provider had 30 days to respond to the Motion for Dismiss. However, the Provider ***failed*** timely respond to that Motion by the June 14, 2023 filing deadline (*i.e.*, 30 days after May 14, 2023).

The Board concurs with the Medicare Contractor that the Provider is required to identify *the material facts* (*i.e.*, the number of days at issue) and provide relevant supporting documentation to identify and prove the specific additional Medicaid Eligible days at issue and for which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3), Board Rule 25, and 42 C.F.R. § 412.106(b)(iii). Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. § 412.106(b)(iii) and 405.1853(b)(2)-(3) and Board Rules 25.2.1 and 25.2.2 related to the submission of documentary evidence required to support its claims or describe why said evidence is unavailable. The Board finds that the Provider also failed to fully develop the merits of the Medicaid eligible days issue because the provider has failed to identify any specific Medicaid eligible days at issue (much less any supporting documentation for those days).

Finally, pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[28] and, pursuant to Board Rule 25, the Provider

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[27] *See also* Board's jurisdictional decision in *Lakeland Regional Health* (Case No. 13-2953, 11/20/2019), in which the Board found a Provider essentially abandoned its appeal by filing a position paper that failed to set forth the merits of its claim, explain why the agency's calculation was wrong, and identifying missing documents to support its claim and to explain why those documents remained unavailable.

[28] (Emphasis added.)

has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. As the Provider failed to identify even a single Medicaid eligible day as being in dispute as part of the position paper filing (much less provider the § 412.106(b)(iii) supporting documentation), notwithstanding its obligations under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25, the Board must find that there are no such days in dispute and that the actual amount in controversy is $0.

Based on the above, the Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(iii) and Board Rules 25.2.1 and 25.2.2 related to identifying the days in dispute (a material fact) and the timely submission of documentary evidence required to support its claims or describe why said evidence is unavailable, which the Provider has failed to do.[29]

C. UCC Distribution Pool

Last, the Board finds that it does not have jurisdiction over the DSH UCC payment issue in the above-referenced appeal because jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2).

1. Bar on Administrative Review

The Board does not generally have jurisdiction over Uncompensated Care DSH payment issues because 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2) preclude administrative and judicial review of certain aspects of the UCC payment calculation. Based on these provisions, judicial and administrative review is precluded under 42 U.S.C. §§ 1395ff and 1395oo for:

> (A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).[30]

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[29] *See also Evangelical Commty Hosp. v. Becerra*, No. 21-cv-01368, 2022 WL 4598546 at *5 (D.D.C. 2022):

> The Board acts reasonably, and not arbitrarily and capriciously, when it applies its "claims-processing rules faithfully to [a provider's] appeal." *Akron*, 414 F. Supp. 3d at 81. The regulations require that a RFH provide "[a]n explanation [ ]for each specific item under appeal." 42 C.F.R. § 405.1835(b)(2). The Board rules further explain that "[s]ome issues may have multiple components," and that "[t]o 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." Board Rules § 8.1. The Board rules also specifically delineate how a provider should address, as here, a challenge to a Disproportionate Share Hospital reimbursement. Board Rule 8.2 explains that an appeal challenging a Disproportionate Share Hospital payment adjustment is a "common example" of an appeal involving issues with "multiple components" that must be appealed as "separate issue[s] and described as narrowly as possible." Board Rules §§ 8.1, 8.2.

[30] Paragraph (2) is a reference to the three factors that make up the uncompensated care payment: (1) 75 percent of estimated DSH payments that would be paid in absence of § 1395ww(r); (2) 1 minus the percentage of individuals under age 65 who are uninsured in 2013 for the FY 2014 calculation; and (3) the hospital specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital with potential

(B) Any period selected by the Secretary for such purposes.

2. Interpretation of Bar on Administrative Review

a. Tampa General v. Sec'y of HHS

In *Florida Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Servs*. ("*Tampa General*"),[31] the U.S. Court of Appeals for the District of Columbia Circuit ("D.C. Circuit") upheld the D.C. District Court's decision[32] that there is no judicial or administrative review of uncompensated care DSH payments. In that case, the provider challenged the calculation of the amount it would receive for uncompensated care for fiscal year 2014. The provider claimed that the Secretary used inappropriate data when she selected the hospital cost data updated in March 2013, instead of data updated in August 2013, when calculating its uncompensated care payments. The provider argued that it was not challenging the estimate of its uncompensated care, but rather the underlying data on which the Secretary relied, judicial review of which is not barred.

The D.C. Circuit found that there was specific language in the statute that precluded administrative or judicial review of the provider's claims because in challenging the use of the March 2013 update data, the hospital was seeking review of an "estimate" used by the Secretary to determine the factors used to calculate additional payments. The D.C. Circuit went on to hold that "the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well."[33] The D.C Circuit also rejected the provider's argument that it could challenge the underlying data, finding that there cannot be judicial review of the underlying data because they are "indispensable" and "integral" to, and "inextricably intertwined" with, the Secretary's estimate of uncompensated care.[34]

The D.C. Circuit went on to address the provider's attempt to reframe its challenge to something other than an estimate of the Secretary. Specifically, it rejected the characterization as a challenge to the "general rules leading to the estimate rather than as a challenge to the estimate itself []" because it was merely an attempt to undo a shielded determination.[35]

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to receive DSH payments, to the amount of uncompensated care for all subsection (d) hospitals that receive payment under 42 U.S.C. § 1395ww(r)(2)(C). 78 Fed. Reg. 50496, 50627, 50631 and 50634.

[31] 830 F.3d 515 (D.C. Cir. 2016).

[32] 89 F. Supp. 3d 121 (D.D.C. 2015).

[33] 830 F.3d 515, 517.

[34] *Id.* at 519.

[35] *Id.* at 521-22. *See also Yale New Haven Hosp. v. Becerra*, 56 F.4th 9 (2nd Cir. 2022) (citing to *Tampa General*"); *Ascension Providence v. Becerra*, No. 21-cv-369, 2023 WL 2042176 (N.D. Ind. 2023) (citing to *Tampa General*").

b. DCH Regional Med. Ctr. v. Azar

The D.C. Circuit Court revisited the judicial and administrative bar on review of uncompensated care DSH payments again in *DCH Regional Med. Ctr. v. Azar* ("*DCH v. Azar*").[36] In *DCH v. Azar*, the provider alleged that it was challenging the methodology adopted and employed by the Secretary to calculate Factor 3 of the DSH payment. Indeed, they stated that the bar on review applied only to the estimates themselves, and not the methodology used to make the estimates. The D.C. Circuit disagreed, stating that "a challenge to the methodology for estimating uncompensated care is unavoidably a challenge to the estimates themselves" and that there is "no way to review the Secretary's method of estimation without reviewing the estimate itself."[37] It continued that allowing an attack on the methodology "would eviscerate the statutory bar, for almost any challenge to an estimate could be recast as a challenge to its underlying methodology." Recalling that it had held in *Tampa General* that the choice of data used to estimate an uncompensated care DSH payment was not reviewable because the data is "inextricably intertwined" with the estimates themselves, the D.C. Circuit found the same relationship existed with regard to the methodology used to generate the estimates.[38]

c. Scranton Quincy Hosp. Co. v. Azar

Recently, in *Scranton Quincy Hosp. Co. v. Azar* ("*Scranton*"),[39] the D.C. District Court considered a similar challenge and held that administrative review was precluded. In *Scranton*, the providers were challenging how the Secretary determined the amount of uncompensated care that would be used in calculating Factor 3 for their FY 2015 DSH adjustments.[40] For 2015 payments, the Secretary announced she would calculate DSH payments based on Medicaid and SSI patient days from 2012 cost reports, unless that cost report was unavailable or was for a period less than twelve months. In that scenario, the Secretary would calculate the FY 2015 DSH payments based on either the 2012 or 2011 cost report that was closest to a full twelve month cost report.[41] Since the providers in *Scranton* changed ownership in FY 2012, each had two cost reports that began in 2012: an initial cost report less than twelve months and a subsequent cost report that was a full twelve months.[42] Nevertheless, the Secretary used each hospital's shorter cost reporting period in calculating the Factor 3 values for their FY 2015 DSH payments.[43]

In *Scranton*, the providers argued that, unlike the providers in *Tampa General* and *DCH v. Azar* who were specifically attacking the methodology and policies adopted by the Secretary, they

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[36] 925 F.3d 503 (D.C. Cir. 2019) ("*DCH v. Azar*").
[37] *Id.* at 506.
[38] *Id.* at 507.
[39] 514 F. Supp. 249 (D.D.C. 2021).
[40] *Id.* at 255-56.
[41] *Id.* (quoting 79 Fed. Reg. 49854, 50018 (Aug. 22, 2014)).
[42] *Id.* One provider had a cost report for the 6-month period from July 1, 2011 to December 31, 2011 and another for the 12-month period from July 1, 2012 to June 30, 2013, while the second had a cost report for the 9-month period from October 1, 2011 to June 30, 2012 and another for the 12-month period from July 1, 2012 to June 30, 2013.
[43] *Id.*

were simply trying to enforce those policies. The D.C. District Court was not persuaded, finding that the complaint was still about the method used and the particular data the Secretary chose to rely upon when estimating the amount of uncompensated care calculated. Just like in *Tampa General* and *DCH v. Azar*, the selection of one cost report for FY 2012 over another was "inextricably intertwined" with the Secretary's estimate in Factor 3 and not subject to administrative review. Similarly, the challenge to the decision to use one cost report over another was also a challenge to a "period selected by the Secretary," which is also barred from review.[44]

Finally, and perhaps most importantly, the D.C. District Court found that any allegations that the Secretary departed from her own policy and/or acted *ultra vires* did not alter its decision. The D.C. District Court found that, in the context of the bar on review of the Secretary's estimates used and periods chosen for calculating the factors in the UCC payment methodology, "saying that the Secretary wrongly departed from his own policies when he chose the data for the estimate or selected the period involved is fundamentally indistinguishable from a claim that he chose the wrong data or selected the wrong period."[45] While there is some case law to support that claims of *ultra vires* acts may be subject to review in narrow circumstances where such review is precluded by statute, the criteria in *Scranton* were not met.[46] For review to be available in these circumstances, the following criteria must satisfied:

> (i) the statutory preclusion of review is implied rather than express; (ii) there is no alternative procedure for review of the statutory claim; and (iii) the agency plainly acts in excess of its delegated powers and contrary to a specific prohibition in the statute that is clear and mandatory.[47]

The D.C. District Court found that the preclusion of review for this issue was express, not implied, which fails to satisfy the first prong of this test. Second, the departure from the period to be used announced in the Secretary's rulemaking does not satisfy the third prong, which requires a violation of a clear statutory command.[48] The D.C. District Court ultimately upheld the Board's decision that it lacked jurisdiction to consider the providers' appeals.

d. Ascension Borgess Hospital v. Becerra

Even more recently, the D.C. Circuit revisited, once again, the judicial and administrative bar on review of uncompensated care DSH payments again in *Ascension Borgess Hospital v. Becerra* ("*Ascension*").[49] In *Ascension*, the providers sought an order declaring the Worksheet S-10 audit protocol was unlawful, vacating the payments based on the Worksheet S-10 audit, requiring the Secretary to recalculate those payments, and setting aside the Board decisions refusing to

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[44] *Id.* at 262-64.
[45] *Id.* at 265.
[46] *Id.* (discussing *Leedom v. Kyne*, 358 U.S. 184, 188 (1958)).
[47] *Id.* at 264 (quoting *DCH v. Azar*, 925 F.3d at 509-510).
[48] *Id.* at 264-6511 (quoting *DCH v. Azar*, 925 F.3d at 509).
[49] Civ. No. 20-139, 2021 WL 3856621 (D.D.C. August 30, 2021).

exercise jurisdiction over their appeals.[50] Ultimately, the D.C. Circuit found that 42 U.S.C. § 1395ww(r)(3) bars administrative and judicial review of the providers claims. In making this finding, the D.C. Circuit pointed to its earlier decisions in *Tampa General* and *DCH v. Azar* where it "repeatedly applied a "functional approach" focused on whether the challenged action was " 'inextricably intertwined' with the unreviewable estimate itself" and eschewing "categorical distinction between inputs and outputs."[51] The D.C. Circuit further dismissed the applicability of the Supreme Court's 2019 decision in *Azar v. Allina Health Servs*.[52] noting that "[t]he scope of the Medicare Act's notice-and-comment requirement would be relevant in evaluating the merits of plaintiffs' claims—i.e., that the Worksheet S-10 audit protocol establishes or changes a substantive legal standard within the meaning of § 1395hh(a)(2)—***but has no bearing on whether these claims are barred by the Preclusion Provision***."[53]

The Board concludes that the same findings are applicable to the Provider's challenge to their FFY 2017 UCC payments. The Provider is challenging their uncompensated care DSH Payment amounts, as well as the general rules governing the methodology used in calculating those amounts, for FFY 2017. The challenge to CMS' notice and comment procedures focuses on a lack of information and underlying data used by the Secretary to determine the UCC payments, but *Tampa General* held that the underlying data cannot be reviewed or challenged. Likewise, the Provider's arguments centering on the *Allina* decision claim that certain data should recalculated or revised. Again, a challenge to the underlying data used in calculating UCC DSH payments is not subject to administrative or judicial review. Likewise, any challenge to the methodology used to determine the payment amounts was rejected in *DSCH v. Azar*, finding that the methodology was just as "inextricably intertwined" with the actual estimates as the underlying data, and barred from review.

* * * * *

Based on the foregoing, the Board has dismissed the three (3) remaining issues in this case – (Issues 1, 3 and 4). As no issues remain, the Board hereby closes Case No. 19-1314 and removes it from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.

For the Board:

1/3/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

[50] *Id*. at *4.
[51] *Id.* at *9.
[52] 139 S. Ct. 1804 (2019).
[53] *Ascension* at *8 (bold italics emphasis added).

cc: Byron Lamprecht, WPS Government Health Administrators (J-5)
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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

RE: ***Notice of Dismissal***
Longview Regional Medical Center, Prov. No. 45-0702, FYE 09/30/2017
Case No. 22-0782

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 22-0782. Set forth below is the decision of the Board to dismiss the 2 remaining issues in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") for SSI Percentage (Provider Specific) and Medicaid Eligible Days payments.

Background

A. *Procedural History for Case No. 22-0782*

On **August 23, 2021,** the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end September 30, 2017. The Provider is commonly owned by Community Health Systems, Inc. ("CHS").

On **February 14, 2022,** CHS filed the Provider's individual appeal request. The initial Individual Appeal Request contained five (5) issues:

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

[1] On September 8, 2022, this issue was transferred to Case No. 20-0997GC.
[2] On September 8, 2022, this issue was transferred to Case No. 19-2620GC.
[3] On September 8, 2022, this issue was transferred to Case No. 20-1383GC.

As the Provider is commonly owned/controlled by CHS, the Provider is subject to the mandatory common issue related party ("CIRP") group regulation at 42 C.F.R. § 405.1837(b)(1). For that reason, on **September 8, 2022,** the Provider transferred Issues 2, 4, and 5 to CHS CIRP groups.

As a result of the case transfers and withdrawn issue, there are two (2) remaining issues in this appeal: Issue 1: DSH Payment/SSI Percentage (Provider Specific) and Issue 3: DSH – Medicaid Eligible Days.

On **February 15, 2022**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

> Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the Provider will use to support its position* and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. See Board Rule 25.[4]

On **October 3, 2022**, the Provider timely filed its preliminary position paper. With respect to Issue 3, the Provider suggested that a list of Medicaid eligible days at issue was imminent by promising that one was being sent under separate cover. However, no such filing was made and no explanation was included explaining why that listing was not included with the position paper filing. Indeed, the filing failed to even provide *the material fact* of how many Medicaid eligible days are at issue.

On **December 5, 2022**, the Medicare Contractor filed its for DSH Package in connection with Issue 3 to formally request that a listing of the Medicaid eligible days at issue plus supporting documentation be provided to the Medicare Contractor within 45 days.

On **January 19, 2023**, the Medicare Contractor timely filed a Jurisdictional Challenge[5] with the Board over Issues 1 and 3 requesting that the Board dismiss these issues. Pursuant to Board Rule

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[4] (Emphasis added.)

[5] Jurisdictional Challenges are not limited to jurisdiction *per se* as exemplified by 42 C.F.R. § 405.1840(a), (b). The Board notes that 42 C.F.R. § 405.1840 is entitled "Board Jurisdiction" but it also addresses certain claims-filing requirements such as timelines or filing deadlines. Whether an appeal request is timely filed with the Board is not a jurisdictional requirement per se, but rather it is a claims-filing requirement as the Supreme Court made clear in *Sebelius v. Auburn Reg. Med. Ctr.*, 568 U.S. 145 (2013) ("*Auburn*"). Unfortunately, following the issuance of *Auburn*, the Secretary has not yet updated § 405.1840 to reflect the clarification made by the Supreme Court in *Auburn* that distinguishes between the claims-filing requirements for a Board hearing request versus jurisdictional requirements for a Board hearing. *See also* Board Rule 4.1 ("The Board will dismiss appeals that fail *to meet the*

44.4.3, the Provider had 30 days in which to file a response to the Jurisdictional Challenge. However, the Provider ***failed*** to file a timely response.

On **January 27, 2023**, the Medicare Contractor timely filed its preliminary position paper. With regard to Issue 3, the Medicare Contractor's position paper noted that: (1) the Provider had failed to include a Medicaid eligible days listing with its position paper notwithstanding its obligation under Board Rules to file a fully developed position paper with all available documentation necessary to support its position; and (2) the Provider had failed to respond to any of the Medicare Contractor's requests for that Medicaid eligible days listing.

On **February 28, 2023**, the Provider changed is designated representative to Mr. Ravindran of Quality Reimbursement Services, Inc. ("QRS").

On **November 13, 2023**, 11 months after the MAC submitted its Request for DSH Package in connection with Issue 3, QRS filed a "Supplement to Position Paper/Redacted Medicaid Eligible Days Listing Submission" and added the *caveat* that the "Listing [is] *pending finalization* upon receipt of State eligibility data."[6] The Listing was 12 pages long with roughly 1700 Medicaid eligible days. QRS' filing did not explain why the listing of so many days (again around 1700 days) was being submitted at this late date or why it was not final (*i.e*., why it was "pending finalization") at this late date, ***more than 7 years after the fiscal year at issue had closed***.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 20-0997GC - CHS CY 2017 HMA DSH SSI Percentage CIRP Group

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

> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> The Provider contends that the SSI percentage issued by CMS 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).[7]

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timely filing requirements ***and/or*** *jurisdictional requirements*."); 42 C.F.R. § 405.1835(b) (addressing certain other claims-filing requirements).

[6] (Emphasis added.)

[7] Issue Statement at 1 (Sept. 11, 2019).

The Group issue Statement in Case No. 20-0997GC, to which the Provider transferred Issue No. 2, reads, in part:

> **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,
> 2. Paid days vs. Eligible days,
> 3. Not in agreement with provider's records,
> 4. Fundamental problems in the SSI percentage calculation,
> 5. Covered days vs. Total days and
> 6. Failure to adhere to required notice and comment rulemaking procedures.[8]

On October 3, 2022, the Board received the Provider's preliminary position paper in Case No. 22-0782. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Provider Specific**
>
> The Provider contends that its' SSI percentage published by the Centers for Medicare and Medicaid Services ("CMS") was incorrectly computed because CMS failed to include all patients

[8] Group Appeal Issue Statement in Case No. 20-0997GC.

> that were entitled to SSI benefits in the Provider's DSH calculation. This is based on certain data from the State of Texas and the Provider that does not support the SSI percentage issued by CMS.
>
> The Provider has worked with the State of Texas and has learned that similar to *Loma Linda Community Hospital v. Dept of Health and Human Services*, No. CV-94-0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records.
>
> 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 amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $63,727.

MAC's Contentions

Issue 1 – DSH Payment/SSI Percentage (Provider Specific)

The MAC argues that the Board lacks jurisdiction over the DSH – SSI Percentage (Provider Specific) issue. Issue 1 has three components: 1) SSI data accuracy; 2) SSI realignment; and 3) individuals who are eligible for SSI but did not receive SSI payment. The MAC contends that the first and third sub-issues should be dismissed because they are duplicative of Issue 2. The portion related to SSI realignment should be dismissed because there was no final determination over SSI realignment and the appeal is premature as the Provider has not exhausted all available remedies.[9]

Issue 3 – DSH – Medicaid Eligible Days

The MAC contends that the Provider failed to properly develop its arguments within its preliminary position paper in accordance with 42 C.F.R. § 405.1853(b)(2) and Board Rule 25.

[9] Medicare Contractor's Jurisdictional Challenge at 2 (Jan. 19, 2023)

The MAC argues the Provider has not submitted a Medicaid eligible days listing and therefore, requests the Board dismiss the issue.

Provider's Jurisdictional Response

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

Decision of the Board

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.

As set forth below, the Board hereby ***dismisses*** the Provider's two (2) remaining issues.

A. DSH Payment/SSI Percentage (Provider Specific)

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

1. *First Aspect of Issue 1*

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH – SSI Percentage (Systemic Errors) issue that was appealed in Case No. 20-0997GC.

The DSH – SSI Percentage (Provider Specific) issue in the present appeal concerns "[w]hether the Medicare Administrative Contractor ("MAC") used the correct Supplemental Security Income ("SSI") percentage in the Disproportionate Share Hospital ("DSH") calculation."[11] Per the appeal request, the Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH

[10] Board Rule 44.4.3, v. 3.1 (Nov. 2021).
[11] Issue Statement at 1.

reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[12] The Provider argues in its issue statement, which was included in the appeal request, that it "disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[13]

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 20-0997GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds that the DSH Payment/SSI Percentage (Provider Specific) issue in Case No. 22-0782 is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 20-0997GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[14], the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

The Board has previously noted that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and the Provider has failed to explain how this argument is ***specific to this provider***. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[15] The Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors are specific to this provider.

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it failed to provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 20-0997GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. For example, it alleges that "SSI entitlement of individuals can be ascertained from State records" but fails to explain how it can, explain how that information is relevant, and whether such a review was done for purposes of the year in question consistent with its obligations under Board Rule 25.2.[16] Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with Board Rule 25 (Nov. 2021) governing the content of position papers. As explained in the Commentary to Rule 23.3 (Nov. 2021), the Board requires position papers "to be ***fully*** developed and include ***all*** *available*

[12] *Id.*
[13] *Id.*
[14] PRRB Rules v. 3.1 (Nov. 2021).
[15] The types of systemic errors documented in *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).
[16] It is also not clear whether this is a systemic issue for CHS providers in the same state subject to the CIRP rules or something that is provider specific because, if it was a common systemic issue, it was required to be transferred to a CIRP group "no later than the filing of the preliminary position paper" in this case per Board Rule 12.11. The Provider fails to comply with its obligation under 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rules to fully brief the merits of its issue.

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" 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 Page 9 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.[17]

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

[17] (Italics and underline emphasis added.)

can obtain certain data used to calculate their DSH SSI ratios directly from the Centers for Medicare and Medicaid Services ("CMS") as explained on the following webpage:

> https://www.cms.gov/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh.[18]

This CMS webpage describes access to DSH data ***from 1998 to 2022*** and instructs providers to send a request via email to access their DSH data."[19]

Indeed, the D.C. Circuit affirmed in *Advocate Christ Med. Ctr. v. Becerra*, 80 F.4th 346 (D.C. Cir. 2023) that "What [MMA] section 951 cannot mean is that HHS must give hospitals data that it never received from SSA in the first place. And SSA does not provide HHS with the specific codes assigned to individual patients. See 75 Fed. Reg. at 50,276." Here, the Provider does not explain what information it needs or is waiting on or claims that it should have access to or why this is not a common issue already covered by the CIRP group under Case No. 20-0997GC.

Accordingly, *based on the record before it*,[20] the Board finds that the SSI Provider Specific issue in Case No. 22-0782 and the group issue from the CHS CIRP group under Case No. 20-0997GC are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

2. *Second Aspect of Issue 1*

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

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

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[18] Last accessed December 3, 2024.
[19] (Emphasis added).
[20] Again, the Board notes that the Provider failed to timely respond to the Jurisdictional Challenge and the Board must make its determination based on the record before it.

B. DSH Payment – Medicaid Eligible Days

The Provider's appeal request did not include a list of the specific additional Medicaid eligible days that are in dispute in this appeal in either the initial appeal or the position papers.

With regard to the filing of an individual appeal, Board Rule 7 (Support for Appealed Final Determination, Issue-Related Information and Claim of Dissatisfaction) (Nov. 2021) states:

> **No Access to Data**
>
> If the provider elects to not claim an item on the cost report because, through no fault of its own, it did not have access to the underlying information to determine whether it was entitled to payment, describe the circumstances why the underlying information was unavailable upon the filing of the cost report.

42 C.F.R. § 405.1853(b)(2)-(3) addresses the content of position papers:

> (b) *Position papers*. . . . (2) The Board has the discretion to extend the deadline for submitting a position paper. **Each position paper must set forth the relevant facts and arguments regarding** the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and **the merits of the provider's Medicare payment claims for each remaining issue.**
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. **Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board** through a schedule applicable to a specific case or through general instructions.[21]

The regulations require the parties to fully brief the merits of each issue in their position paper (including the relevant facts and legal arguments) and specify that the Board has discretion about setting the time frame for the submission of exhibits supporting the merits of the appeal.

Board Rule 25 (Nov. 2021) requires the Provider to file its complete, *fully* developed preliminary position paper with all available documentation and gives the following instruction on the content of position papers:

[21] (Bold emphasis added.)

Rule 25 Preliminary Position Papers[22]

> **COMMENTARY**:
>
> Under the PRRB regulations effective August 21, 2008, all issues will have been identified within 60 days of the end of the appeal filing period. 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 Medicare contractor, and fifteen months for the provider's response. Therefore, preliminary position papers are expected to present fully developed positions of the parties and, therefore, require analysis well in advance of the filing deadline.

25.1 Content of Position Paper Narrative

The text of the position papers must include the elements addressed in the following sub-sections.

25.1.1 The Provider's Position Paper

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

C. Comply with Rule 25.2 addressing Exhibits.

25.2 Position Paper Exhibits

25.2.1 General

With the position papers, the parties must exchange all available documentation as exhibits to fully support your position. The Medicare contractor must also give the provider all evidence the

[22] (Underline emphasis added to these excerpts and all other emphasis in original.)

Medicare contractor considered in making the determination (see 42 C.F.R. § 405.1853(a)(3)) and identify any documentary evidence that the Medicare contractor believes is necessary for resolution but has not been submitted by the provider. When filing those exhibits in the preliminary position paper, ensure that the documents are redacted in accordance with Rule 1.4. Unredacted versions should be exchanged by the parties separately from the position paper, if necessary.

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 Page 9 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.

25.2.3 List of Exhibits

Parties must attach a list of the exhibits exchanged with the position paper.

25.3 Filing Requirements to the Board

The Board requires the parties file a complete preliminary position paper that includes a fully developed narrative (Rule 25.1), all exhibits (Rule 25.2), a listing of exhibits, and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. If the provider fails to brief an appealed issue in its position paper, the Board will consider the unbriefed issue abandoned and effectively withdrawn.

> **COMMENTARY**: Note that the change to require filing of the ***complete*** preliminary position paper was effective on August 29, 2018. Accordingly, failure to file a ***complete*** preliminary position paper with the Board will result in the Board dismissing your appeal or taking other actions in accordance with 42 C.F.R. § 405.1868. (See Rule 23.4.)

The Notice of Case Acknowledgement and Critical Due Dates issued to the Provider on February 15, 2022 included instructions on the content of the Provider's preliminary position paper consistent with the above Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

Moreover, in connection with Issue 3, Medicare regulations specifically place the burden on hospitals to provide documentation from the State to establish ***each*** *Medicaid eligible day* being claimed. Specifically, when determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(iii) places the burden of production on the provider, stating:

> The hospital has the burden of furnishing data adequate to prove eligibility for ***each*** Medicaid patient *day claimed* under this paragraph, ***and*** of *verifying with the State* that a patient was eligible for Medicaid during each claimed patient hospital day.[23]

Along the same line, 42 C.F.R. § 405.1871(a)(3) makes clear that, in connection with appeals to the Board, "the provider carrie[s the] burden of production of evidence and burden of proof by establishing, by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue."

Additionally, and more generally related to accounting records and reporting requirements for providers, 42 C.F.R. § 413.24(c) describes what cost information is adequate:

> Adequate cost information must be obtained from the provider's records to support payments made for services furnished to beneficiaries. The requirement of adequacy of data implies that the data be accurate and in sufficient detail to accomplish the purposes for which it is intended.

Finally, Board Rule 41.2 permits dismissal or closure of a case on the Board's own motion:

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

[23] (Emphasis added.)

procedures (see 42 C.F.R. § 405.1868),
- if the Board is unable to contact the provider or representative at the last known address, or
- upon failure to appear for a scheduled hearing.

On October 3, 2022, the Provider filed its preliminary position paper in which it indicated that it the eligibility listing was imminent by promising that the listing was being sent under separate cover.[24] Significantly, the position paper did ***not*** include *the material fact* of how many Medicaid eligible days remained in dispute in this case. The Provider's complete briefing of this issue in its position paper is as follows:

> **Calculation of Medicaid Eligible Days**
>
> Specifically, the Provider disagrees with the MAC's calculation of the computation of the disproportionate patient percentage set forth at 42 C.F.R. § 412.106(b)(4) of the Secretary's regulations.
>
> The Sixth Circuit Court of Appeals, in *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F. 3d 270 (6th Cir. 1994), held that all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage when the DSH adjustment is calculated. Similar decisions were rendered by the Fourth, Eighth, and Ninth Circuits: *Cabell Huntington Hospital, Inc. v. Shalala,* 101 F. 3d 984 (4th Cir. 1996); *Deaconess Health Services Corp. v. Shalala,* 83 F. 3d 1041 (8th Cir. 1996), *aff'g* 912 F. Supp 478 (E.D. Mo. 1995); and *Legacy Emanuel Hospital and Health Center v. Shalala,* 97 F. 3d 1261 (9th Cir. 1996).
>
> The Centers for Medicare and Medicaid Services ("CMS", formerly HCFA) acquiesced in the above decisions and issued HCFA Ruling 97-2, which in pertinent part reads as follows:
>
> > [T]he Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to include all inpatient hospital days of service for patients who were eligible on that day for medical assistance under a state Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for these inpatient hospital services.

[24] Provider's Preliminary Position Paper at 11 (May 4, 2020).

> Based on the Listing of Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its' 2017 cost report does not reflect an accurate number of Medicaid eligible days, as requested by HCFA Ruling 97-2 and the pertinent Federal Court decisions.

The Medicare Contractor sent a request for the Provider's list of Medicaid Eligible days (and also discussed the lack of the listing in the Medicare Contractor's own position paper filing. The request was filed formally with the Board in OH CMDS on December 5, 2022, *six years after the end of the Provider's cost reporting period*. The Medicare Contractor also informed the Provider in its final request for information that the deadline to respond was January 19, 2023. The Provider failed to file any response to the request.

On November 13, 2023 (10 months after the deadline to respond to the MAC's final request), QRS filed a "Supplement to Position Paper/Redacted Medicaid Eligible Days Listing Submission" and added the caveat that the "Listing [is] pending finalization upon receipt of State eligibility data." The Listing was 12 pages with roughly 1700 Medicaid eligible days. QRS' filing did not explain why the listing of so many days (again around 1700 days) was being submitted at this late date or why it was not final (*i.e.*, why it was "pending finalization") at this late date, ***more than 7 years after the fiscal year at issue had closed***. Regardless, this filing was more than 10 months past the deadline for responding to the MAC's request *and, more importantly,* ***was more than a year past the deadline for including it with its preliminary position paper*** since the position paper deadline was October 12, 2022.

The Board concurs with the Medicare Contractor that the Provider is required to identify *the material facts* (*i.e.*, the number of days at issue) and provide relevant supporting documentation to identify and prove the specific additional Medicaid Eligible days at issue and for which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3), Board Rule 25, and 42 C.F.R. § 412.106(b)(iii). Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. § 412.106(b)(iii) and 405.1853(b)(2)-(3) and Board Rules 25.2.1 and 25.2.2 related to the submission of documentary evidence required to support its claims or describe why said evidence is unavailable. The Board finds that the Provider also failed to fully develop the merits of the Medicaid eligible days issue because the provider has failed to identify any specific Medicaid eligible days at issue (much less any supporting documentation for those days).

The Board rejects the Provider's attempt to label the November 13, 2023 filing as a "Supplement to Position Paper" and does not accept that filing because:

1. The alleged "Supplement" was filed ***more than a year*** *after the deadline* for that exhibit to be included with its preliminary position paper filing consistent with Board Rule 25.2.2 (as authorized by 42 C.F.R. § 405.1853(b)(3)).

2. The alleged "Supplement" fails to explain the following critical information: (a) *why* it was being filed so late (*i.e.*, upon what basis or authority should the Board accept the late

filing); (b) *why* the listing of the roughly 1700 days was not previously available, *in whole or in part* (*i.e.*, it is not clear why the Provider failed to identify a single day at issue until more than a year after this appeal was filed and more than 7 years after the fiscal year at issue had closed); and (c) why the listing still was ***not*** a "*final*" listing at this late date.

3. Neither the Board Rules nor the February 15, 2022 Case Acknowledgment and Critical Due Dates permit the Provider to file a "Supplement" to its preliminary position paper (nor did the Provider allege in the "Supplement" filing that they do).

4. Given the fact that the *material* facts (*e.g.*, the days at issue) and all available exhibits were required to be part of the position paper filing, if the Board were to accept a "Supplement," it would need to be either be a *refinement* of its preliminary position paper or a supplement of documents that were identified in the preliminary position paper as being unavailable consistent with Board Rule 25.2.2. However, neither the preliminary position paper nor the alleged "Supplement" identified any "unavailable" exhibits consistent with Board Rule 25.2.2. Further, the alleged "Supplement" cannot be considered a refinement of the position paper since no specific days or listing were included with the preliminary position paper.[25]

Finally, pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[26] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. As the Provider failed to identify even a single Medicaid eligible day as being in dispute as part of the position paper filing (much less provider the § 412.106(b)(iii) supporting documentation), notwithstanding its obligations under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25, the Board must find that there are no such days in dispute and that the actual amount in controversy is $0.

Based on the above, the Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(iii) and Board Rules 25.2.1 and 25.2.2 related to identifying the days in dispute (a material fact) and the timely submission of documentary evidence required to support its claims or describe why said evidence is unavailable, which the Provider has failed to do.[27]

---

[25] *See, e.g.,* Board Rule 27.3 (Nov. 2021) stating: "Except on written agreement of the parties, revised or supplemental position papers should not present new positions, arguments or evidence."

[26] (Emphasis added.)

[27] *See also Evangelical Commty Hosp. v. Becerra*, No. 21-cv-01368, 2022 WL 4598546 at *5 (D.D.C. 2022):

> The Board acts reasonably, and not arbitrarily and capriciously, when it applies its "claims-processing rules faithfully to [a provider's] appeal." *Akron*, 414 F. Supp. 3d at 81. The regulations require that a RFH provide "[a]n explanation [ ]for each specific item under appeal." 42 C.F.R. § 405.1835(b)(2). The Board rules further explain that "[s]ome issues may have multiple components," and that "[t]o comply with the regulatory requirement to specifically identify the items in dispute, each contested

* * * * *

Based on the foregoing, the Board has dismissed the two (2) remaining issues in this case – (Issues 1 and 3). As no issues remain, the Board hereby closes Case No. 22-0782 and removes it from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.

For the Board:

1/3/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

cc: Byron Lamprecht, WPS Government Health Administrators (J-5)
Wilson Leong, FSS

component must be appealed as a separate issue and described as narrowly as possible." Board Rules § 8.1. The Board rules also specifically delineate how a provider should address, as here, a challenge to a Disproportionate Share Hospital reimbursement. Board Rule 8.2 explains that an appeal challenging a Disproportionate Share Hospital payment adjustment is a "common example" of an appeal involving issues with "multiple components" that must be appealed as "separate issue[s] and described as narrowly as possible." Board Rules §§ 8.1, 8.2.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
7500 Security Boulevard
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410-786-2671

Via Electronic Delivery

Charles Schlauch, Administrator
Glenbrook Rehabilitation & Healthcare Center
801 East 16th Street
Berwick, PA 18603-2314

Re: ***Dismissal for Failure to Meet Minimum Filing Requirements***
Glenbrook Rehabilitation & Healthcare Center (Provider Number 39-5421)
Federal Fiscal Year: 2024
Case Number: 25-0843

Dear Mr. Schlauch:

The Provider Reimbursement Review Board ("Board") has reviewed the above-referenced appeal request. After review of the facts outlined below, the Board has determined that the appeal request is fatally flawed as it was not filed in accordance with the regulations and Board Rules. The Pertinent Facts, the Board's review and determination are set forth below.

Pertinent Facts:

On November 21, 2024, Glenbrook Rehabilitation & Healthcare Center (the "Provider") filed an appeal with the Board to establish Case No. 25-0843. The appeal was filed from a determination entitled "Notice of Quality Reporting Program Noncompliance Decision Upheld" ("Quality Reporting Determination") dated October 4, 2024.

Although the Provider filed a copy of the final determination, a brief statement regarding the 2% reduction for not submitting an Influenza Survey, a copy of the "Seasonal Survey on Influenza Vaccination Programs for Healthcare Personnel" and the "A/R Reconciliation Report," the Provider's appeal request did not include:

- A proper issue statement (Board Rule 7.2);
- a complete Representative letter (Board Rule 5.4) and
- a calculation of the reimbursement impact on the facility (Board Rule 6.4).[1]

On November 22, 2024, the Board issued an Acknowledgement and Critical Due Dates Notice in which it set a briefing schedule for the Parties to file preliminary position papers and requested a Representation Letter, an Issue Statement and Calculation Support. The deadline for the required support documents was set for December 9, 2024.

[1] Board Rules Version 3.2 (Dec 15, 2023)

When the Provider failed to respond to the request for support documents, the Board issued a final request for the Information on December 11, 2024, giving the Provider a new deadline of December 26, 2024 to submit the required documentation. To date, the Provider has not complied with either of the Board's Requests for Information.

Rules/Regulations:

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

42 C.F.R. § 405.1835(b) establishes the required contents for an appeal request.

> The provider's request for a Board hearing under paragraph (a) of this section must be submitted in writing in the manner prescribed by the Board, and the request ***must include the elements described in paragraphs (b)(1) through (4)*** of this section. If the provider submits a hearing request that does not meet the requirements of paragraph (b)(1), (2), or (3) of this section, the ***Board may dismiss*** with prejudice the appeal or take any other remedial action it considers appropriate.
>
> (1) A demonstration that the provider satisfies the requirements for a Board hearing as specified in paragraph (a) of this section, including a specific identification of the final contractor or Secretary determination under appeal.
>
> (2) For each specific item under appeal, ***a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final contractor or Secretary determination under appeal***, including an account of all of the following:
>
> (i) Why the provider believes Medicare payment is incorrect for each disputed item (or, where applicable, why the provider is unable to determine whether Medicare payment is correct because it does not have access to underlying information concerning the calculation of its payment).
>
> (ii) How and why the provider believes Medicare payment must be determined differently for each disputed item.
>
> (iii) If the provider self-disallows a specific item (as specified in § 413.24(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 the final contractor or Secretary determination under appeal and any

> other documentary evidence the provider considers necessary to satisfy the hearing request requirements of paragraphs (b)(1) and (b)(2) of this section.

Board Rules 6 and 7 and 8 further address individual appeal requirements and support for the appealed final determination, availability of issue-related information, and basis for dissatisfaction. Board Rule 6.1.1 advises that the Board "will dismiss appeal requests that do not meet the *minimum* filing requirements as identified in 42 C.F.R. § 405.1835(b) . . . ."[2]

Further, Board Rule 5.2 makes it clear that the Provider's representative is responsible for being familiar with Board Rules and Regulations, meeting the Board's deadlines and responding to correspondence or requests from the Board.

Board Determination:

The Board has determined that the Provider's appeal request is fatally flawed as it was not filed in accordance with the regulations at 42 C.F.R. §§ 405.1837 and 405.1835(b) and with the Board Rules.

First, the Board finds that the document labeled by the Provider as an "Issue Statement" is a three-sentence statement in which the Provider indicates the Influenza Survey was submitted and that the facility has proof establishing it was submitted in May 2024.[3] The Board finds, however, that this document does not constitute an issue statement consistent with the appeal content requirements in Board Rule 7.2 and 42 C.F.R. § 405.1835(b). Board Rule 7.2 requires, among other things, that an issue statement include adjustment numbers, why the adjustment is incorrect, and a calculation or other support. The document uploaded by the Provider is merely a statement acknowledging the 2% reduction and claiming that the Provider has proof the data was submitted. Thus, it does not constitute a proper issue statement as required in Board Rule 7.2 and 42 C.F.R. § 405.1835(b)(1).

Secondly, the Provider's appeal request failed to include calculation support as required under 42 C.F.R. § 405.1835(a)(2) and Board Rule 6.4. In lieu of calculation support, the provider submitted a copy of the "A/R Reconciliation Report" which lists resident names, receipts and balances. It does not explain how the reimbursement impact, which the Provider estimated to be $57,087, was calculated.

Finally, the Provider did not file a Representative letter in accordance with Board Rule 5.4. A representative letter is required for all appeals. It must reference the ". . . provider's name, number and fiscal year under appeal." It must also contain the following contact information for the case representative: name, organization, address, telephone number and email address. In this case, the same document was uploaded as both the Representative letter and the issue

[2] Board Rules v. 3.2.
[3] This statement was also uploaded as the Representative Letter.

statement, but this document fails to meet the requirements as it is missing information like the Provider No., facility address, and the cost year under appeal.[4]

The Board finds that the Provider was afforded two separate opportunities to cure the noted deficiencies. The Provider has failed to respond to the Board's November 22, 2024 and December 11, 2024 Requests. Accordingly, the Board hereby dismisses Case No. 25-0843 since the appeal request is fatally flawed and does not meet the *minimum* filing requirements as outlined above.

Based on the final determination date specified in the appeal request, the Provider may still be within its appeal period.[5] Therefore, if the Provider elects, it may request the Board reconsider its determination and reinstate the appeal. A request for reinstatement must be filed by the appeal filing deadline (see Board Rule 4.4.1) and must include the missing documentation as noted herein. Please see Board Rule 47 regarding reinstatement requirements, as well as 42 C.F.R. § 405.1835 and Board Rules 6 and 7, which discuss *individual provider appeal rights* ***and*** *requirements*.

Based on the above, the Board closes this case and removes it from its docket. Review of this determination may be available under the provisions of 42 U.S.C. §1395oo(f) and 42 C.F.R. §§ 405.1875 and 105.1877.

Board Members:
Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.

For the Board:

1/7/2025

X Kevin D. Smith, CPA

Kevin D. Smith, CPA
Chair
Signed by: Kevin D. Smith -A

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services
Byron Lamprecht, WPS Government Health Administrators (J-5)

[4] The Representative letter was submitted on letterhead, and indirectly includes some of the required information (i.e., name of facility, email and phone no. and contact name). If there were no other deficiencies in the appeal, the Board may have considered the Representative letter to be sufficient as submitted.
[5] The final determination is dated October 1, 2024. Based on that date, the appeal period expires on April 4, 2025.

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

RE: ***Board Jurisdictional Determination***

DCH Health CY 2009 Part C Days Retroactive Final Rule CIRP Group
PRRB Case No. 25-0732GC

Specifically, as a participant:
DCH Regional Medical Center (Prov. No. 01-0092)

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (the "Board") has reviewed the above-captioned common issue related party ("CIRP") group and finds an impediment over the initiating participant in the group. The pertinent facts regarding the deficient provider and the Board's determination are set forth below.

Background:

On **November 12, 2024**, Quality Reimbursement Services, Inc. ("QRS") filed a group on behalf of DCH Health System for the Part C Days Retroactive Final Rule issue for calendar year ("CY") 2009. The group was established in the Office of Hearings Case and Document Management System ("OH CDMS") with one provider:

- DCH Regional Medical Center ("DCH - RMC"/Prov. No. 01-0092).

DCH RMC filed from a revised Notice of Program Reimbursement ("RNPR") that was dated May 16, 2024. However, instead of QRS uploading a copy of the RNPR, it uploaded a copy of the HCRIS Report as final determination support for the provider.

Board Determination:

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

Further, 42 C.F.R. § 405.1835(b), indicates that a Provider's appeal may be dismissed if it does not include . . . "A copy of the final contractor or Secretary determination under appeal and any other documentary evidence the provider considers necessary to satisfy the hearing request requirements . . . ". Including the actual determination with the appeal request is critical for a myriad of reasons, including to determine whether the Provider meets the claim filing requirements specified in 42 C.F.R. § 405.1835.

In the case of DCH - RMC as a participant in the CIRP group, the HCRIS DSH Report is NOT considered a final determination and, therefore, the Direct Add of this Provider is technically deficient. In addition, the Board notes that QRS has previously been put on notice that additions of deficient Providers (i.e., participants that do not include the proper final determinations) will be dismissed for failure to meet the requirements of 42 C.F.R. § 405.1835. Because the Representative failed to submit the required copy of the final determinations under appeal in Case No. 25-0732GC (i.e., RNPR), the Board finds that DCH -RMC does not meet the regulatory requirements for filing an appeal (in this case directly adding to the group). Accordingly, the Board finds dismissal is appropriate under § 405.1835(b) and Board Rules and hereby dismisses DCH - RMC. As there are no other participants in Case No. 25-00732GC, the Board hereby dismisses the group.

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:
Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.

For the Board:

1/8/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

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

RE: ***Board Dismissal – Remaining Issues #1 – DSH – Medicaid Fraction/Dual Eligible Days and #3 – DSH – SSI Fraction/Dual Eligible Days Abandoned***
St. Vincent's Medical Center, Provider No. 07-0028, FYE 9/30/2014
PRRB Case No. 19-0358

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (the "Board") has reviewed the record in the above-captioned appeal in advance of the hearing scheduled for **February 3, 2025**. The pertinent facts and the Board's determination are set forth below.

Pertinent Facts

The Provider submitted a request for hearing on **October 31, 2018**, from a Notice of Program Reimbursement ("NPR") **April 30, 2018**. The Appeal contained six (6) issues:

1. DSH – Medicaid Fraction/Dual Eligible Days
2. DSH – Medicaid Eligible Days
3. DSH – SSI Fraction/Dual Eligible Days
4. DSH – Medicaid Eligible Patient Days – Connecticut State Administered General Assistance Days
5. Uncompensated Care Distribution Pool
6. 2 Midnight Census IPPS Payment Reduction

On **June 26, 2019**, the Provider submitted a Preliminary Position Paper briefing Issue Nos. 4, 5, and 6. The Provider noted that all other issues were being transferred to relevant Ascension Health group appeals. [1]

On **October 23, 2019**, the Medicare Contractor filed its Preliminary Position Paper briefing Issue Nos. 4, 5, and 6. The Medicare Contractor noted that it had not received any transfer documents from the Provider for Issue Nos. 1, 2, and 3. As the issues were not addressed in the

[1] In its Preliminary Position Paper transmittal letter dated June 18, 2019, the Provider stated the following: "All issues other than the General Assistance Days, UCC Distribution Pool and 2 Midnight Census issues that have been addressed in this position paper are being transferred to relevant Ascension Health group appeals."

Provider's Preliminary Position Paper, the Medicare Contractor considered the issues to be abandoned and did not address them in its own Preliminary Position Paper.[2]

The Provider did not submit a Final Position Paper.[3] On **March 7, 2024**, the Medicare Contractor submitted its Final Position Paper.

On **April 15, 2024**, the Medicare Contractor submitted a jurisdictional challenge over Issue Nos, 4, 5, and 6. The Provider did not file a response.

On **April 17, 2024**, Quality Reimbursement Services, Inc was designated as the new Provider Representative in the appeal.

On **December 23, 2024**, the Provider **withdrew Issue Nos. 2, 4, 5, and 6** from the appeal leaving Issue Nos. 1 and 3 as the sole remaining issues. As a result, the Medicare Contractor's **April 15, 2024** jurisdictional challenge is now moot.

Pertinent Regulations

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.[4]

Board Rule 25 (Aug. 2018) addresses Preliminary Position Papers. In this regard, it states the following, in pertinent part:

---

[2] With respect to each of these issues, the Medicare Contractor stated the following in its Preliminary Position Paper: "The Provider stated in its preliminary position paper dated June 18, 2019, that this issue is being transferred to a relevant Ascension Health group appeal. The MAC has not received transfer documents for this issue. As this issue was not addressed in the Provider's preliminary position paper, the MAC considers the issue to be abandoned and has not addressed the issue in this preliminary position paper."

[3] This appeal was filed on October 31, 2018. Under the Board Rules effective August 29, 2018, the filing of a final position paper was optional.

[4] Emphasis added.

> **Rule 25 Preliminary Position Papers**
>
> 25.1 Content of Position Paper Narrative
>
> The text of the position papers must contain the elements addressed in the following subsections.
>
> 25.1.1 Provider's Position Paper
>
> A. Identify any issues that were raised in the appeal but are already resolved (whether by administrative resolution, agreement to reopen, transfer, withdrawal, dismissal, etc.) and require no further documentation to be submitted.
>
> B. ***For each issue that has not been fully resolved***, state the material facts that support the provider's claim.
>
> C. Identify the controlling authority, (e.g. statutes, regulations, policy or, case law) supporting the provider's position.
>
> D. Provide a conclusion applying the material facts to the controlling authorities.[5]

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.

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

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

[5] Emphasis added.

(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 Determination

The Board finds that the Provider failed to brief Issue #1 - DSH - Medicaid Fraction/Dual Eligible Days and Issue #3 - DSH – SSI Fraction/Dual Eligible Days in its Preliminary Position Paper. The Provider stated that these issues were transferred to group appeals, but no transfers were ever effectuated.

The regulation at 42 C.F.R. § 405.1853 as well as Board Rule 25 makes it clear that Preliminary Position Papers must address **each** remaining issue in the appeal. The Board finds that the Provider abandoned Issue #1 - DSH - Medicaid Fraction/Dual Eligible Days and Issue #3 - DSH – SSI Fraction/Dual Eligible Days when it failed to brief the issues in its Preliminary Position Paper. As a result, the Board dismisses the issues from the appeal. As no issues remain in the appeal, the Board closes Case No. 19-0358 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:
Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.

For the Board:

1/13/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Mail Stop: B1-01-31
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410-786-2671

Via Electronic Delivery

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

RE: ***Notice of Issue Dismissal***
Highlands Regional Medical Center, Prov. No. 10-0049, FYE 09/30/2016
Case No. 19-1708

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 19-1708. Set forth below is the decision of the Board to dismiss the Disproportionate Share Hospital ("DSH") Medicaid Eligible Days issue.

Background

A. *Procedural History for Case No. 19-1708*

On **September 5, 2018**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end September 30, 2016.

On **March 6, 2019**, the Provider filed an individual appeal request. The initial Individual Appeal Request contained nine (9) issues:

1. DSH Payment/SSI Percentage (Provider Specific)[1]
2. DSH/SSI Percentage[2]
3. DSH SSI Fraction/Medicare Managed Care Part C Days[3]
4. DSH SSI Fraction/Dual Eligible Days[4]
5. DSH Payment – Medicaid Eligible Days
6. DSH Medicaid Fraction/Medicare Managed Care Part C Days[5]
7. DSH Medicaid Fraction/Dual Eligible Days[6]
8. Uncompensated Care Distribution Pool[7]

[1] On January 3, 2025, the Provider withdrew this issue.
[2] On October 22, 2019, the Provider transferred this issue to PRRB Case No. 19-0173GC.
[3] On October 22, 2019, the Provider transferred this issue to PRRB Case No. 19-0175GC.
[4] On October 22, 2019, the Provider transferred this issue to PRRB Case No. 19-0198GC.
[5] On October 22, 2019, the Provider transferred this issue to PRRB Case No. 19-0159GC.
[6] On October 22, 2019, the Provider transferred this issue to PRRB Case No. 19-0197GC.
[7] On October 22, 2019, the Provider transferred this issue to PRRB Case No. 19-0177GC.

9. 2 Midnight Census IPPS Payment Reduction[8]

On **April 16, 2019**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

> Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the Provider will use to support its position* and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. See Board Rule 25.[9]

On **June 11, 2019**, the Medicare Contractor filed a Jurisdictional Challenge over issues: 1, 8, and 9. The Provider did not file a Jurisdictional Response.

On **October 29, 2019**, the Provider filed its Preliminary Position Paper. With respect to Issue 5, the Provider suggested that a list of Medicaid eligible days at issue was imminent by promising that one was being sent under separate cover. However, no such filing was made and no explanation was included explaining why that listing was not included with the position paper filing. Indeed, the filing failed to even provide *the material fact* of how many Medicaid eligible days are at issue and instead asserted that "[b]ased on the Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its' 2016 cost report does not reflect an accurate number of Medicaid eligible days.". The Medicare filed its Preliminary Position Paper on **February 27, 2020**.

On **July 26, 2021**, the Medicare Contractor, WPS Government Health Administrators filed a Request for Documentation and Withdrawal of Duplicate Issue.

On **January 12, 2023**, the Medicare Contractor, WPS Government Health Administrators filed a Request for Days Documentation.

On **June 3, 2024**, the Board issued the Notice of Hearing and Critical Due Dates, providing among other things, the filing deadlines for the parties' final position papers. This Notice also gave the following instructions to the Provider regarding the content of its final position paper:

> Provider's Final Position Paper – *For each remaining issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes,

[8] On October 22, 2019, the Provider transferred this issue to PRRB Case No. 19-0185GC.
[9] (Emphasis added.)

> regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *also include* ***any exhibits*** *the Provider will use to support to support its position*. *See* Board Rule 27 for more specific content requirements. If the Provider misses its due date, the Board will dismiss the cases.[10]

On **July 1, 2024**, the Medicare Contractor filed a Jurisdictional Challenge over issue 5. Pursuant to Board Rule 44.4.3, the Provider had 30 days in which to file a response to the Jurisdictional Challenge. However, the Provider's response was filed over four months late, on **December 7, 2024**.

On **October 25, 2024**, the Provider filed a Final Position Paper, and the Medicare Contractor filed its Final Position Paper on **November 8, 2024**.

On **December 2, 2024**, the Provider filed a Change of Representative request, and the Board acknowledged the request on the same day.

On **December 3, 2024**, the Provider filed a "Redacted Medicaid Eligible Days Listing Submission". The Listing was 4 pages with no explanation about the new number of days or why the listing was being submitted at this late date.

As a result of the case transfers and a withdrawal, there is one remaining issue in this appeal: Issue 5 (the DSH – Medicaid Eligible Days).

B. Description of Issue 5 in the Appeal Request

According to its Appeal Request, the Provider asserts that all Medicaid eligible days were not included in the calculations of the DSH calculations. The Provider describes Issue 5 as:

> **Statement of Issue**
>
> Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.
>
> **Statement of the Legal Basis**
>
> The Provider contends that the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.

[10] (Emphasis added.)

> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.
>
> Audit Adjustment Number(s): 5, 11, 13,S-D
>
> Estimated Reimbursement Amount: $98,000[11]

Regarding the Medicaid eligible days issue, the Provider argues in its Preliminary Position Paper that pursuant to the Jewish Hospital case[12] and HCFA Ruling 97-2, "all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage" of the DSH payment adjustment.[13]

MAC's Contentions

Issue 5 – DSH Payment – Medicaid Eligible Days

The MAC contends that the Provider failed to properly develop its arguments within its preliminary position paper in accordance with 42 C.F.R. § 405.1853(b)(2) and Board Rule 25. The MAC argues the Provider has not submitted a Medicaid eligible days listing and therefore, requests the Board dismiss the issue. The MAC maintains that it has been over four years since the Provider's fiscal year has ended and essentially abandoned the issue.

Provider's Jurisdictional Response

The Board Rules require that Provider Responses to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[14] The Provider filed a response to the Jurisdictional Challenge, but the time for doing so had elapsed. Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. A provider's failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

The Provider's response to the Jurisdictional Challenge was due within 30 days but the Provider failed to timely file a response. In this regard, Board Rule 44.3 specifies with respect to motions that "[u]nless the Board imposes a different deadline, an opposing party may send a response, with

[11] Appeal Request at Issue 5.
[12] *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F.3d 270 (6th Cir. 1994).
[13] Provider's Preliminary Position Paper at 7.
[14] Board Rule 44.4.3, v. 2.0 (Aug. 2018).

relevant supporting documentation, within 30 days from the date that the motion was sent to the Board and opposing party

Decision of the Board

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

A. DSH Payment- Medicaid Eligible Days

The Provider's appeal request did not include a list of the specific additional Medicaid eligible days that are in dispute in this appeal in either the initial appeal or the position papers.

With regard to the filing of an individual appeal, Board Rule 7 (Support for Appealed Final Determination, Issue-Related Information and Claim of Dissatisfaction) (Aug. 2018) states:

> **No Access to Data**
>
> If the provider elects to not claim an item on the cost report because, through no fault of its own, it did not have access to the underlying information to determine whether it was entitled to payment, describe the circumstances why the underlying information was unavailable upon the filing of the cost report.

42 C.F.R. § 405.1853(b)(2)-(3) addresses the content of position papers:

> (b) *Position papers*. . . . (2) The Board has the discretion to extend the deadline for submitting a position paper. **Each position paper must set forth the relevant facts and arguments regarding** the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and **the merits of the provider's Medicare payment claims for each remaining issue.**
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. **Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board** through a schedule applicable to a specific case or through general instructions.[15]

[15] (Bold emphasis added.)

The regulations require the parties to fully brief the merits of each issue in their position paper (including the relevant facts and legal arguments) and specify that the Board has discretion about setting the time frame for the submission of exhibits supporting the merits of the appeal.

Board Rule 25 (Aug. 2018) requires the Provider to file its complete, *fully* developed preliminary position paper with all available documentation and gives the following instruction on the content of position papers:

> **Rule 25 Preliminary Position Papers**[16]
>
> **COMMENTARY**:
>
> Under the PRRB regulations effective August 21, 2008, all issues will have been identified within 60 days of the end of the appeal filing period. 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 Medicare contractor, and fifteen months for the provider's response. Therefore, preliminary position papers are expected to present fully developed positions of the parties and, therefore, require analysis well in advance of the filing deadline.
>
> **25.1 Content of Position Paper Narrative**
>
> The text of the position papers must include the elements addressed in the following sub-sections.
>
> **25.1.1 The Provider's Position Paper**
>
> A. Identify any issues that were raised in the appeal but are already resolved (whether by administrative resolution, agreement to reopen, transfer, withdrawal, dismissal, etc.) and require no further documentation to be submitted.
> B. For *each* issue that has not been fully resolved, state the material facts that support the provider's claim.
> C. Identify the controlling authority (e.g. statutes, regulations, policy, or case law) supporting the provider's position.
> D. Provide a conclusion applying the material facts to the controlling authorities.
>
> **25.2 Position Paper Exhibits**
>
> **25.2.1 General**

[16] (Underline emphasis added to these excerpts and all other emphasis in original.)

> With the position papers, the parties must exchange ***all*** available documentation as exhibits to fully support your position. . . . When filing those exhibits in the preliminary position paper, ensure that the documents are redacted in accordance with Rule 1.4.
>
> Unredacted versions should be exchanged by the parties separately from the position paper, if necessary.
>
> **25.2.2 Unavailable and Omitted Documents**
>
> If documents necessary to support your position are still unavailable, identify the missing documents, explain why the documents remain unavailable, state the efforts made to obtain the documents, and explain when the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.
>
> **25.2.3 List of Exhibits**
>
> Parties must attach a list of the exhibits exchanged with the position paper.
>
> **25.3 Filing Requirements to the Board**
>
> Parties should file with the Board a *complete* preliminary position paper with a fully developed narrative (Rule 23.1), all exhibits (Rule 23.2), a listing of exhibits, and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. Any issue appealed, but not briefed by the Provider in its position paper will be considered withdrawn.
>
> **COMMENTARY**: Note that this is a change in previous Board practice. Failure to file a complete preliminary position paper with the Board will result in dismissal of your appeal or other actions in accordance with 42 C.F.R. § 405.1868. (*See* Rule 23.4.)

The Notice of Case Acknowledgement and Critical Due Dates issued to the Provider on April 16, 2019, included instructions on the content of the Provider's preliminary position paper consistent with the above Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

Moreover, in connection with Issue 5, Medicare regulations specifically place the burden on hospitals to provide documentation from the State to establish ***each*** *Medicaid eligible day* being claimed. Specifically, when determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(iii) places the burden of production on the provider, stating:

> The hospital has the burden of furnishing data adequate to prove eligibility for ***each*** Medicaid patient *day claimed* under this paragraph, ***and*** of *verifying with the State* that a patient was eligible for Medicaid during each claimed patient hospital day.[17]

Along the same line, 42 C.F.R. § 405.1871(a)(3) makes clear that, in connection with appeals to the Board, "the provider carrie[s the] burden of production of evidence and burden of proof by establishing, by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue."

Additionally, and more generally related to accounting records and reporting requirements for providers, 42 C.F.R. § 413.24(c) describes what cost information is adequate:

> Adequate cost information must be obtained from the provider's records to support payments made for services furnished to beneficiaries. The requirement of adequacy of data implies that the data be accurate and in sufficient detail to accomplish the purposes for which it is intended.

Finally, Board Rule 41.2 permits dismissal or closure of a case on the Board's own motion:

- if it has 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 (see 42 C.F.R. § 405.1868),
- if the Board is unable to contact the provider or representative at the last known address, or
- upon failure to appear for a scheduled hearing.

On October 29, 2019, the Provider filed its preliminary position paper in which it indicated that it the eligibility listing was imminent by promising that the listing was being sent under separate cover.[18] Significantly, the position paper did ***not*** include *the material fact* of how many Medicaid eligible days remained in dispute in this case, but rather continued to reference the "estimated impact" included with its appeal request (i.e., the estimated impact of $98,000). The Provider's complete briefing of this issue in its position paper is as follows:

---

[17] (Emphasis added.)
[18] Provider's Preliminary Position Paper at 8.

Calculation of Medicaid Eligible Days

Specifically, the Provider disagrees with the MAC's calculation of the computation of the disproportionate patient percentage set forth at 42 C.F.R. § 412.106(b)(4) of the Secretary's regulations.

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

The Centers for Medicare and Medicaid Services ("CMS", formerly HCFA) acquiesced in the above decisions and issued HCFA Ruling 97-2, which in pertinent part reads as follows:

> [T]he Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to include all inpatient hospital days of service for patients who were eligible on that day for medical assistance under a state Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for these inpatient hospital services.

Based on the Listing of Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its' 2016 cost report does not reflect an accurate number of Medicaid eligible days, as requested by HCFA Ruling 97-2 and the pertinent Federal Court decisions.

In its Jurisdictional Challenge, the Medicare Contractor asserts that the Provider has failed to submit a list of additional Medicaid eligible days and neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2. Pursuant to Board Rule 44.3, the Provider had 30 days to respond to the Jurisdictional Challenge. However, the Provider ***failed*** timely respond to that Motion by the August 1, 2024, filing deadline (*i.e*., 30 days after July 1, 2024).

However, on December 3, 2024, (4 months after the deadline to respond to the Jurisdictional Challenge), QRS filed a "Redacted Medicaid Eligible Days Listing Submission". QRS' filing did not explain why the listing of so many days was being submitted at this late date ***more than 8 years after the fiscal year at issue had closed***. Regardless, this filing was nearly 4 months past the deadline for responding to the Jurisdictional Challenge *and, more importantly,* ***was roughly 4 years past the deadline for including it with its preliminary position paper*** since the position paper deadline was October 29, 2019.

The Board concurs with the Medicare Contractor that the Provider is required to identify *the material facts* (*i.e*., the number of days at issue) and provide relevant supporting documentation to identify and prove the specific additional Medicaid Eligible days at issue and for which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3), Board Rule 25, and 42 C.F.R. § 412.106(b)(iii). Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. § 412.106(b)(iii) and 405.1853(b)(2)-(3) and Board Rules 25.2.1 and 25.2.2 related to the submission of documentary evidence required to support its claims or describe why said evidence is unavailable. The Board finds that the Provider also failed to fully develop the merits of the Medicaid eligible days issue because the provider has failed to identify any specific Medicaid eligible days at issue (much less any supporting documentation for those days).

The change in the designated representative to QRS does not excuse the Provider for its failure to include the information with its preliminary position paper or its failure to timely respond to the Jurisdictional Challenge. Board Rule 5.2 makes clear that "the recent appointment of a new representative will also not be considered cause for delay of any deadlines or proceedings."

Moreover, the Board rejects the December 7, 2024, filing because:

1. The listing was filed ***more than 4 years*** *after the deadline* for that exhibit to be included with its preliminary position paper filing consistent with Board Rule 25.2.2 (as authorized by 42 C.F.R. § 405.1853(b)(3)). Indeed, the Provider failed to timely reply to the Medicare Contractor's Jurisdictional Challenge Issue 5 and the listing was filed ***4 months*** *after the deadline* for filing a response to the Jurisdictional Challenge.

2. The listing fails to explain the following critical information: (a) *why* it was being filed so late (*i.e*., upon what basis or authority should the Board accept the late filing); (b) *why* the listing was not previously available, *in whole or in part* (*i.e*., it is not clear why the Provider failed to identify a single day at issue until more than 4 years after this appeal was filed and more than 8 years after the fiscal year at issue had closed).
3. Neither the Board Rules nor the April 16, 2019, Case Acknowledgment and Critical Due Dates permit the Provider to file a supplement to its preliminary position paper (nor did the Provider allege in the listing filing that they do).

4. Given the fact that the *material* facts (*e.g*., the days at issue) and all available exhibits were required to be part of the position paper filing, if the Board were to accept a supplemental listing, it would need to be either be a *refinement* of its preliminary position paper or a supplement of documents that were identified in the preliminary position paper

> as being unavailable consistent with Board Rule 25.2.2. However, neither the preliminary position paper nor the listing filed identified any "unavailable" exhibits consistent with Board Rule 25.2.2. Further, the listing cannot be considered a refinement of the position paper since no specific days or listing were included with the preliminary position paper (indeed the 799 days listed is, without explanation, *exponentially* larger than the original estimated 100 days included with the appeal request).[19]

Finally, pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[20] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. As the Provider failed to identify even a single Medicaid eligible day as being in dispute as part of the position paper filing (much less provider the § 412.106(b)(iii) supporting documentation), notwithstanding its obligations under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25, the Board finds that there are no such days in dispute and that the actual amount in controversy is $0.

Based on the above, the Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(iii) and Board Rules 25.2.1 and 25.2.2 related to identifying the days in dispute (a material fact) and the timely submission of documentary evidence required to support its claims or describe why said evidence is unavailable, which the Provider has failed to do.[21]

* * * *

Based on the foregoing, the Board dismisses the DSH- Medicaid Eligible Days Issue. As no issues remain, the Board hereby closes Case No. 19-1708 and removes it from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

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[19] *See, e.g.,* Board Rule 27.3 (Aug. 2018) stating: "Except on written agreement of the parties, revised or supplemental position papers should not present new positions, arguments or evidence."

[20] (Emphasis added.)

[21] *See also Evangelical Commty Hosp. v. Becerra*, No. 21-cv-01368, 2022 WL 4598546 at *5 (D.D.C. 2022):

> The Board acts reasonably, and not arbitrarily and capriciously, when it applies its "claims-processing rules faithfully to [a provider's] appeal." *Akron*, 414 F. Supp. 3d at 81. The regulations require that a RFH provide "[a]n explanation [ ]for each specific item under appeal." 42 C.F.R. § 405.1835(b)(2). The Board rules further explain that "[s]ome issues may have multiple components," and that "[t]o 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." Board Rules § 8.1. The Board rules also specifically delineate how a provider should address, as here, a challenge to a Disproportionate Share Hospital reimbursement. Board Rule 8.2 explains that an appeal challenging a Disproportionate Share Hospital payment adjustment is a "common example" of an appeal involving issues with "multiple components" that must be appealed as "separate issue[s] and described as narrowly as possible." Board Rules §§ 8.1, 8.2.

Board Members Participating:

Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.

For the Board:

1/13/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

cc: Bryon Lamprechet, WPS Government Health Administrators
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Nathan Summar
Vice President, Revenue Management
Community Health Systems, Inc.
4000 Meridian Boulevard
Franklin, TN 37067

RE: ***Notice of Dismissal***
AllianceHealth Durant (Prov. No. 37-0014)
FYE: 09/20/2016
Case No. 21-0051

Dear Mr. Summar:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 21-0051. Set forth below is the decision of the Board's dismissal of the remaining issue in the appeal that challenges the Provider's Medicaid Eligible Days payment.

Background

A. *Procedural History for Case No. 21-0051*

On **October 30, 2019,** the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end September 20, 2016. The Provider is commonly owned by Community Health Systems, Inc. ("CHS").

On **April 14, 2020**, CHS filed the Provider's individual appeal request. The initial Individual Appeal Request contained nine (9) issues:

1. Disproportionate Share Hospital (DSH) Payment/Supplemental Security Income (SSI) Percentage (Provider Specific)[1]
2. DSH SSI Percentage[2]
3. DSH Medicare Part C Days – SSI Fraction[3]
4. DSH Dual Eligible Days – SSI Fraction[4]
5. DSH Payment – Medicaid Eligible Days

[1] This issue was dismissed by the Board in a letter dated August 9, 2024.
[2] The Provider transferred this issue to Group Case No. 19-0173GC on January 26, 2021.
[3] The Provider transferred this issue to Group Case No. 19-0175GC on January 26, 2021.
[4] The Provider transferred this issue to Group Case No. 19-0198GC on January 26, 2021.

6. DSH Medicare Part C Days – Medicaid Fraction[5]
7. DSH Dual Eligible Days – Medicaid Fraction[6]
8. DSH – Uncompensated Care ("UCC") Distribution Pool[7]
9. 2 Midnight Census IPPS Payment Reduction[8]

As the Provider is commonly owned/controlled by CHS, the Provider is subject to the mandatory common issue related party ("CIRP") group regulation at 42 C.F.R. § 405.1837(b)(1). For that reason, on **January 26, 2021**, the Provider transferred Issues 2, 3, 4, 6 and 7 to CHS CIRP groups.

On **October 6, 2020**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

> Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the Provider will use to support its position* and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. See Board Rule 25.[9]

On **January 14, 2021,** the Provider withdrew Issue 8 – DSH – Uncompensated Care ("UCC") Distribution Pool and Issue 9 - 2 Midnight Census IPPS Payment Reduction from the appeal.

On **January 28, 2021**, the Provider timely filed its preliminary position paper. With respect to Issue 5, the Provider stated "[b]ased on the Medicaid Eligible days *being sent under separate cover*, the Provider contends that the total number of days reflected in its' 2016 cost report does not reflect an accurate number of Medicaid eligible days." Additionally, the Provider attached as Exhibit 1, a placed holder for the eligibility listing for FYE 2016. Attached as Exhibit 2 was an "estimated impact" calculation of $94,618 based on an *estimated* 150 eligible days.

On **March 22, 2021,** the Medicare Contractor filed a Jurisdictional Challenge[10] requesting that the Board dismiss the Issue 1. Pursuant to Board Rule 44.4.3, the Provider had 30 days in which to file a response to the Jurisdictional Challenge. However, the Provider ***failed*** to file any response.

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[5] The Provider transferred this issue to Group Case No. 19-0159GC on January 26, 2021.
[6] The Provider transferred this issue to Group Case No. 19-0197GC on January 26, 2021.
[7] The Provider withdrew this issue on January 14, 2021.
[8] The Provider withdrew this issue on January 14, 2021.
[9] (Emphasis added.)
[10] Jurisdictional Challenges are not limited to jurisdiction *per se* as exemplified by 42 C.F.R. § 405.1840(a), (b). The Board notes that 42 C.F.R. § 405.1840 is entitled "Board Jurisdiction" but it also addresses certain claims-filing requirements such as timelines or filing deadlines. Whether an appeal request is timely filed with the Board is not a jurisdictional requirement per se, but rather it is a claims-filing requirement as the Supreme Court made clear in

On **May 28, 2021,** the Medicare Contractor timely filed its preliminary position paper. With regard to Issue 5, the Medicare Contractor stated that on February 1, 2021, the MAC requested an eligibility listing from the Provider and that the listing had not been provided at that time. Additionally, the MAC argued that notwithstanding its obligation under Board Rules, the Provider failed to file a fully developed position paper with all available documentation necessary to support its position and also failed to provide an explanation as to the unavailability of such documentation or its efforts to obtain it.

On **August 9, 2024,** the Board dismissed Issue 1 - DSH Payment/SSI Percentage (Provider Specific) from the appeal.

On **September 30, 2024,** the Medicare Contractor filed a second Jurisdictional Challenge, requesting dismissal of Issue 5: DSH Payment – Medicaid Eligible Days. Pursuant to Board Rule 44.3, the Provider had 30 days to respond to the Jurisdictional Challenge. However, the Provider ***failed*** to timely respond to the Jurisdictional Challenge.

As a result of the case transfers, withdrawn issues, and dismissal of Issue 1, there is only one (1) remaining issue in this appeal: Issue 5: DSH – Medicaid Eligible Days.

B. Description of Issue 5 in the Appeal Request

According to its appeal request, the Provider asserts that all Medicaid eligible days were not included in the calculations of the DSH calculation. The Provider states Issue 5 as:

> **Statement of Issue**
>
> Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.
>
> **Statement of the Legal Basis**
>
> The Provider contends that the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory [sic] instructions at 42 U.5.C. $ l395ww(d)(5)(F)(i). Specifically, the Provider disagrees [] with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.

Sebelius v. Auburn Reg. Med. Ctr., 568 U.S. 145 (2013) ("*Auburn*"). Unfortunately, following the issuance of *Auburn*, the Secretary has not yet updated § 405.1840 to reflect the clarification made by the Supreme Court in *Auburn* that distinguishes between the claims-filing requirements for a Board hearing request versus jurisdictional requirements for a Board hearing. *See also* Board Rule 4.1 ("The Board will dismiss appeals that fail *to meet the timely filing requirements* ***and/or*** *jurisdictional requirements*."); 42 C.F.R. § 405.1835(b) (addressing certain other claims-filing requirements).

> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State [sic] eligible days in the Medicaid Percentage of the Medicare DSH calculation.
>
> Audit Adjustment Number(s): 9,8,19,S-D *See* Tab. 4
> Estimated Reimbursement Amount: $94,000 *See* Tab. 5[11]

MAC's Contentions

The MAC contends that the Provider failed to properly develop its arguments within its preliminary position paper in accordance with 42 C.F.R. § 405.1853(b)(2) and Board Rule 25. The MAC argues the Provider has not submitted a Medicaid eligible days listing and therefore, requests the Board dismiss the issue.[12]

Provider's Jurisdictional Response

The Board Rules require that Provider Responses to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[13] The Provider has not filed a response to the Jurisdictional Challenge and the time for doing so has elapsed. Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. A provider's failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

Board Analysis and Decision

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

However, as set forth below, the Board hereby dismisses the Provider's Issue No. 5, the sole remaining issue in the appeal.

When determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days that affect the percentage), 42 C.F.R. § 412.106(b)(4)(iii), which places the burden of production on the provider states in pertinent part:

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[11] Appeal Request at Issue 5.
[12] Jurisdictional Challenge at 1.
[13] Board Rule 44.4.3, v. 3.2 (Dec. 2023).

> The hospital has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.

Additionally, and more generally related to accounting records and reporting requirements for providers, 42 C.F.R. § 413.24(c) describes what cost information is adequate:

> Adequate cost information must be obtained from the provider's records to support payments made for services furnished to beneficiaries. The requirement of adequacy of data implies that the data be accurate and in sufficient detail to accomplish the purposes for which it is intended.

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

> The provider must support the determination being appealed and the basis for its dissatisfaction for each issue under appeal. *See* subsections below and Rule 8 for special instructions regarding multi-component disputes.
>
> If the provider, through no fault of its own, does not have access to the underlying information to determine whether the adjustment is correct, describe why the underlying information is unavailable.

Furthermore, 42 C.F.R. § 405.1853(b) addresses the content of position papers and states in pertinent part:

> (b) *Position papers*. . . . (2) The Board has the discretion to extend the deadline for submitting a position paper. **Each position paper must set forth the relevant facts and arguments regarding** the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and **the merits of the provider's Medicare payment claims for each remaining issue.**
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. **Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a**

> **timeframe to be decided by the Board** through a schedule applicable to a specific case or through general instructions.[14]

Similarly, with regard to position papers,[15] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[16] This requirement is consistent with 42 C.F.R. § 405.1853(b)(3). Also consistent with that regulation, Board Rule 25.2.2 provides the following instruction on the content of position papers as it relates to unavailable documentation/exhibits:

> *If documents necessary to support your position are still unavailable,* then provide the following information in the position papers:
>
> 1. Identify the missing documents;
> 2. Explain why the documents remain unavailable;
> 3. State the efforts made to obtain the documents; and
> 4. Explain when the documents will be available.
>
> Once the documents become available, ***promptly*** forward them to the Board and the opposing party.[17]

Further, Board Rule 25.3 and its commentary provides:

> The Board requires the parties file a ***complete*** preliminary position paper that includes a fully developed narrative (Rule 25.1), all exhibits (Rule 25.2), a listing of exhibits, and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. If the provider fails to brief an appealed issue in its position paper, the Board will consider the unbriefed issue abandoned and effectively withdrawn.
>
> **COMMENTARY**: Note that the change to require filing of the ***complete*** preliminary position paper was effective on August 29, 2018. Accordingly, failure to file a ***complete*** preliminary position paper with the Board will result in the Board dismissing your appeal or taking other actions in accordance with 42 C.F.R. § 405.1868. (See Rule 23.4.)[18]

Finally, Board Rule 41.2 permits dismissal or closure of a case on the Board's own motion:

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[14] (Bold emphasis added.)
[15] The minimum requirements for Final Position Paper narratives and exhibits are the same as those for Preliminary Position Papers. *See* Board Rule 27.2.
[16] (Emphasis added).
[17] (Emphasis added).
[18] Original emphasis.

- 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 (*see* 42 C.F.R. § 405.1868);
- if the Board is unable to contact the provider or representative at the last known address; or
- upon failure to appear for a scheduled hearing.

Relative to a Medicaid Eligible Days determination, it is well-established that adequate data to prove eligibility for each Medicaid patient day claimed is a complete and accurate (i.e., auditable) Medicaid eligible days listing, which upon timely submission by a provider, a MAC can examine to make applicable adjustments.

This appeal was initiated on April 14, 2020 (nearly 5 years ago), and at that time, the Provider did not include a list of additional Medicaid eligible days they expect to be included in their Medicaid percentage and DSH computations with their appeal request. Subsequently, the Provider's preliminary position paper indicated that it would be sending the eligibility listing under separate cover.[19] ***To-date, no listing has been provided***. Accordingly, the Provider has abandoned the issue by failing to properly develop its arguments and provide supporting documents, and by failing to explain why it cannot produce those documents, as required by the regulations and the Board Rules.[20]

Specifically, the Board finds that the Provider has failed to satisfy the requirements of Board Rules 25.2.1, 25.2.2, 25.3, as well as the requirements of 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3)—related to identifying the days in dispute and the submission of documentary evidence required to support its claims or describe why said evidence is unavailable. The Board takes administrative notice that it has issued similar dismissals in other cases involving CHS providers.[21]

****

In summary, the Board dismisses the DSH Payment - Medicaid Eligible Days issue as the Provider failed to meet the Board requirements for submitting fully developed and complete position papers in compliance with 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25. As

[19] Provider's Preliminary Position Paper at 9.
[20] *See also* Board's jurisdictional decision in *Lakeland Regional Health* (Case No. 13-2953, 11/20/2019), in which the Board found a Provider essentially abandoned its appeal by filing a position paper that failed to set forth the merits of its claim, explain why the agency's calculation was wrong, and identifying missing documents to support its claim and to explain why those documents remained unavailable.
[21] An example of a CHS individual provider case in which the Board dismissed for failure of the Provider to provide a listing of Medicaid eligible days include, but are not limited to: Case No. 22-0676 (dismissed by Board letter dated December 7, 2022 based on a MAC July 13, 2022 request for dismissal of the Medicaid eligible days issue for failure to file Medicaid eligible days listing with the preliminary position paper).

no issues remain pending, the Board hereby closes Case No. 21-0051 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:

Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.

For the Board:

1/14/2025

X Shakeba DuBose

Shakeba DuBose, Esq.
Board Member
Signed by: PIV

cc: Byron Lamprecht, WPS Government Health Administrators (J-5)
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

James Ravindran, President
Quality Reimbursement Services, Inc.
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Arcadia, CA 91006

RE: ***Board Determination on Optional Group Formed with Single Provider***

QRS CY 2007 Part C Days Retroactive Final Rule Group
Case Number: 25-0972G

Specifically: Skagit Valley Hospital (Provider Number 50-0003) ***as a participant***
FYE 12/31/2007

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("the Board") has reviewed the subject optional group appeal and notes an impediment in the group. The pertinent facts and the Board's determination are set forth below.

Pertinent Facts:

On **December 3, 2024**, Quality Reimbursement Services, Inc. ("QRS") filed the referenced optional group for the calendar year ("CY") 2007. The group appeal was formed with one participant, Skagit Valley Hospital (Prov. No. 50-0003) which was directly added to the group from receipt of its June 11, 2024 revised Notice of Program Reimbursement ("RNPR"). The Provider identified the reimbursement impact for the Part C Days Retroactive Final Rule issue as $468,248.

Board Determination:

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

Pursuant to 42 C.F.R. § 405.1837(b):

> (2) Optional group appeals. (i) Two or more providers not under common ownership or control may bring a group appeal before the

> Board under this section, if the providers wish to appeal to the Board a specific matter at issue that involves a question of fact or interpretation of law, regulations, or CMS Rulings that is common to the providers. Alternatively, any provider may appeal to the Board any issues in a single provider appeal brought under §405.1835 of this subpart.

With regard to the establishment of groups in the Office of Hearings Case & Document Management System ("OH CDMS"), the commentary under Board Rule 12.1 indicates

> . . . if a group is to be formed solely through transfers, it may initially be established in OH CDMS with no participating providers. In such cases, the providers must be transferred i***mmediately*** following the establishment of the group case in order to fulfill the regulatory requirement for the minimum number of providers per Rule 12.6. The Board will close all group cases that do not meet the minimum participant requirements.[1]

Board Rule 12.6.2, goes on to state that "[o]ptional group appeals must have a minimum of two different providers, both at inception and at full formation of the group."

The Board finds that the subject group appeal, under Case No. 25-0972G, is an optional group that was formed with only a single provider and is, therefore, not in compliance with Board Rules or the regulations.

Accordingly, the Board hereby:

1. Disbands the optional group, Case No. 25-0972G;
2. Creates a new individual appeal for Skagit Valley Hospital for FYE 2007[2] (The Parties will receive an Acknowledgement and Critical Due Dates notification for the new case under separate cover);
3. Transfers the Part C Days Retroactive Final Rule issue from the group case to the new individual appeal; and
4. Closes Case No. 25-0972G as no participants remain.[3]

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

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[1] Board Rules v. 3.2 (Dec. 15, 2023).
[2] There was a previous individual appeal for Skagit Valley for CY 2007 under Case No. 24-0424. That appeal was filed from the Federal Register and was dismissed on by the Board on March 7, 2024. Although closed less than three years ago, the Board is electing to establish a new individual appeal based on the final determination under appeal.
[3] Should QRS identify additional participants appealing this issue for CY 2007, it may form a new optional group and effectuate a transfer of Skagit Valley Hospital from the individual appeal.

Finally, the Board notes that QRS has filed many group appeals over the years. The improper formation of this optional group appears to be an attempt to cut corners by circumventing the need for QRS to *first*, create an individual appeal for the originating provider until a second eligible participant is identified, and ***then*** form an optional group by effectuating the necessary transfers. As noted, this "*shortcut*" violates the Board's rules and creates an unnecessary burden on the Board staff (***i.e.***, having to disband the group and create the individual appeal for the sole provider). As QRS is not new to the regulations governing appeals, nor is it new to the Board's Rules and procedures, the Board admonishes QRS for again failing to follow the Board Rules governing the formation of an optional group.

Board Members:
Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.

For the Board:

1/15/2025

X Kevin D. Smith, CPA

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

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services
Dean Wolfe, Noridian Healthcare Solutions (J-F)

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

RE: ***Determination on Transfer of Provider from Single Participant CIRP Groups***

From: BS&W Health CY 2008 DSH SSI Fraction Dual Eligible Days CIRP Group
Case Number: 20-1971GC and

BS&W Health CY 2008 DSH Medicaid Fraction Dual Eligible Days CIRP Group
Case Number: 20-1973GC

To: Baylor Scott & White Medical Center Lake Pointe (Provider Number 45-0742)
FYE: 05/31/2008
Case Number: 20-0593

Dear Mr. Ravindran:

On December 18, 2024, in a Rule 18 Request for Information ("RFI"), the Provider Reimbursement Review Board (the "Board") proposed the expansion of two calendar year ("CY") 2017 common issue related party ("CIRP") groups for the SSI & Medicaid Fraction DE days issues. The Board explained that the expansion of the later year CIRP groups, under Case Nos. 20-1344GC & 20-1346GC, would allow the consolidation of the sole provider, Baylor Scott & White Medical Center Lake Pointe ("Lake Pointe"), from the referenced fully formed CY 2008 CIRP groups under Case Nos. 20-1971GC & 20-1973GC.

In response to the Board's RFI, on January 2, 2025, QRS requested that the Board postpone its decision to expand/consolidate the CY 2017 and CY 2008 groups pending the issuance of the Supreme Court decision in the *Advocate Christ Medical Center et.al. v. Xavier Becerra* case. QRS reasoned that the Supreme Court decision may impact the two years (CYs 2008 and 2017) under appeal differently.

The Board's determination is set forth below.

Board Determination:

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

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

42 C.F.R. § 405.1837(b), provides that two or more providers under common ownership may appeal a common issue as a group. However, Board Rule 12.6.1 stipulates that although a **"CIRP group may be initiated by a single provider under common ownership or control, . . . at least two different providers must be in the group upon full formation**."[1]

The Board finds that the fully formed BS&W CY 2008 SSI and Medicaid Fraction Dual Eligible Days CIRP Groups under Case Nos. 20-1971GC and 20-1973GC do not meet the minimum participant jurisdictional requirement. Since QRS does not agree with the Board's previously proposed expansion of the later year CIRP groups to consolidate the single participant CIRPs, the Board finds that the respective group issues must be pursued in the sole provider's pending individual appeal. Consequently, the Board hereby:

1. Transfers the SSI Fraction Dual Eligible Days issue from Case No. 20-1971GC and the Medicaid Fraction Dual Eligible Days issue from Case No. 20-1973GC to Lake Pointe's individual appeal under Case No. 20-0593; and
2. closes Case Nos. 20-1971GC and 20-1973GC and removes them from the docket since there are no remaining participants in either group.

The Board notes that the Parties have already filed preliminary position papers in the individual appeal, but at the time they were filed, the SSI and Medicaid Fraction Dual Eligible Days issues had already been transferred to groups. Therefore, these issues were not briefed in the preliminary position papers. The Parties will receive a request for supplemental preliminary position papers briefing the SSI and Medicaid Fraction Dual Eligible Days issues in Case No. 20-0593 under separate cover.

Board Members:
Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.

For the Board:

1/17/2025

X Kevin D. Smith, CPA

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

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services
Michael Redmond, Novitas Solutions, Inc. c/o GuideWell Source (J-H)

[1] Board Rules v. 3.1 (November 1, 2021) (emphasis added).

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Mark Polston
King & Spalding, LLP
1700 Pennsylvania Avenue NW
Washington, D.C. 20006

RE: ***EJR Determination and Notice of Dismissal***
Univ. of KS Health Sys FFY Reasonable Cost-to-IPPS BNA CIRP Group
Case Number: 25-1141GC

Dear Mr. Polston:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request and Petition for Expedited Judicial Review ("EJR") filed by the Providers in the above-referenced Common Issue Related Party ("CIRP") group case. The issue in this case relates to the standardized amounts used in federal rates for the inpatient prospective payment system ("IPPS") during federal fiscal year ("FFY") 1986 as it allegedly impacts their FFY 2025 IPPS rates. As set forth below, the Board Majority has determined that, consistent with 42 U.S.C. §§ 1395ww(d)(7) and 1395oo(g)(2) and 42 C.F.R. § 405.1840(b), it lacks substantive jurisdiction over the appealed issue and, therefore, is dismissing the group case in its entirety. Challenges to the standardized amounts are not new to the Board, and this determination is consistent with the Board's prior dismissal determinations in other cases involving the similar issues where the Board found no *substantive* jurisdiction.[1] While the specific issue under appeal in this case differs slightly from the issue in those decisions, the Board finds that the challenged federal rates for FFY 1986 and subsequent FFYs still use the FFY 1985 budget-neutrality-adjusted federal rates.

In summary, the Board Majority finds that it lacks substantive jurisdiction over the issue raised in this group appeal because the standardized amount used for IPPS rates for FFY 1986 is based on the rates from FFY 1985, which included the budget neutrality adjustment ("BNA"). The Board also finds that the *final* FFY 1985 standardized amount (on which the FFY 1986 standardized amount was based) is *inextricably intertwined* with the FFY 1985 BNA.[2] The Board Majority has

[1] Prior Board dismissal determinations of issues related to standardized amounts and/or the budget neutrality adjustments include but are not limited to: Board dec. dated Apr. 6, 2023 (lead Case No. 19-0233GC); Board dec. dated Dec. 14, 2023 (lead Case No. 23-0695GC); Board dec. dated Jan. 23, 2024 (lead Case No. 19-1094GC); Board dec. dated Jan. 24, 2024 (lead Case No. 23-1522GC); and Board dec. dated Jan. 31, 2024 (lead Case No. 19-0847GC). These jurisdictional decisions are posted on the Board's website, by the relevant year and month, at https://www.cms.gov/medicare/regulations-guidance/provider-reimbursement-review-board/list-prrb-jurisdictional-decisions.

[2] *See infra* note 53 (citing to decisions that discuss similar circumstances involving Medicare provisions found to be inextricably tied to certain other provisions for which Congress precluded administrative and judicial review).

also included at **Appendix A** examples of other adjustments to the standardized amounts that have occurred outside of the FFY 1985 BNA. These intervening adjustments for FFYs 1986 and 2018 include both mandatory and discretionary revisions ***to the standardized amounts*** (as well as Congress' decisions to revise or not revise the "applicable percentage increases" for FFYs 1986 and forward as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i)) and highlight the complexity of the issue before the Board, particularly where such adjustments were made in a budget neutral manner or were based on factoring in certain other estimated impacts.

Because the FFY 1985 budget-neutrality-adjusted rate was used/flowed forward for determining FFY 1986 rates and the rates for subsequent FFYs and because 42 U.S.C. § 1395ww(d)(7) prohibits administrative or judicial review of the FFY 1985 BNA, the Board Majority finds that it may not review the standardized amount used for the FFY appealed as it relates to the common issue in this appeal. In this regard, the Board Majority again notes that the rates for FFY 1986 and subsequent years are based on the FFY 1985 budget-neutrality-adjusted rates. Accordingly, the Providers' assertion that the initial FFY 1985 standardized amount continues to serve as the base for all future calculations is incorrect as the causal link is broken.[3]

PROCEDURAL BACKGROUND:

A. Group Issue – Limited to Alleged Improper Carry-forward of FFY 1985 Adjustments

1. Initial Appeal and Issue Statement

The Board received a request, filed by the Providers' designated representative, King & Spalding, LLP ("Providers' Representative"), to create this CIRP group on December 20, 2024. The appeal involves the Federal Register published on August 28, 2024.

The Providers' appeal challenges their FY 2025 IPPS payments, arguing that CMS unlawfully applied a pair of budget neutrality adjustments that could only apply to IPPS rates ***for FY 1985***.[4] They note that 42 U.S.C. § 1395ww(d)(3)(C) directed CMS' predecessor, the Health Care Financing Administration ("HCFA"), to adjust the average standardized amounts as may be required under § 1395ww(e)(1)(B). Section § 1395ww(e)(1)(B) requires, for discharges occurring in FY 1984 or 1985, equal proportional adjustments in each of the average standardized amounts as may be necessary to assure that:

> (i) The aggregate payment amounts provided under [IPPS] for that fiscal year for operating costs of inpatient services of hospitals,
>
> Are not greater or less than –

[3] *See also* **Appendix A** outlining additional intervening adjustments that could be adversely impacted by the relief being sought by the Providers, thereby raising other similar IPPS integrity concerns.
[4] Issue Statement at 1.

> (ii) . . . the payment amounts which would have been payable for such services for those same hospitals for that fiscal year under this section under the law as in effect before April 20, 1983.

Pursuant to his authority at 42 U.S.C. §§ 1395ww(d)(3)(C) and (e)(1)(B), the Secretary implemented two adjustments that resulted in a reduction of IPPS payments by 5.59% in FY 1985.[5] The Providers argue that these budget neutrality adjustments were not to be applied in future years, and that the statute includes instructions for calculating the standardized amount for FY 1986 and all years thereafter. For FY 1986, the amount was to start with the "average standardized amount computed for the previous fiscal year under [§ 1395ww(d)(3)(A)]." The Providers interpret the statute to require the standardized amount computed under this section be the amount *after* it was adjusted for inflation but before it was adjusted under §§ 1395(d)(3)(B) (for outliers), 1395(d)(3)(C) and (e)(1)(B) (for budget neutrality).[6]

The Providers continue by explaining that "for FY 1986, HCFA decided that the 'budget-neutrality adjusted rates for FY 1985 are…to be used as the basis for the determination of rates for later years.'"[7] They argue that calculating FY 1986 rates by preserving these ***FY 1985*** budget neutrality adjustments is unlawful and has been carried forward every year since, resulting in a present day IPPS payment understatement of 0.9441, "which could be corrected by an adjustment of 5.92% . . . ."[8] They "challenge the continued application of these budget neutrality adjustment because that statute says that they should have sunset at the end of FY 1985."[9]

2. Request for EJR

On December 20, 2024, the same day the group appeal was filed, the Providers' Representative filed a certification that the group was complete with five (5) providers, as well as a Petition for EJR. The Petition for EJR makes the same arguments found in the Providers' Issue Statement, with some elaboration. They discuss how the FY 1984 standardized amount was set using FY 1981 data. They also note that this amount was later adjusted pursuant to 42 U.S.C. § 1395ww(d)(2)(E) to account for outliers, and again pursuant to § 1395ww(d)(2)(F) to adjust the standardized amount "as may be required under subsection (e)(1)(B)." This BNA adjusted the FY 1984 standardized amount by a factor of 0.97, which translated to a 3 percent decrease.[10] The Petition for EJR claims (***for the first time***) that "[t]he current group appeal involves the second adjustment which required the Secretary to ensure that aggregate payments for FY 1984 did not exceed aggregate payments for services under the reasonable cost payment system."[11]

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[5] *Id.* (citing 49 Fed. Reg. 34728, 34771 34796, (Aug. 31, 1984)).
[6] *Id.*
[7] *Id.* at 2 (citing 50 Fed. Reg. 35646, 35695 (Sept. 3, 1985)).
[8] *Id.*
[9] *Id.*
[10] Petition for Expedited Judicial Review at 3 (Dec. 20, 2024) (citing 49 Fed. Reg. 234, 334 (Jan 1. 1984)).
[11] *Id.* at 3.

The Providers then repeat the same arguments found in their Issue Statement with regard to the FY 1985 rate setting being unlawfully carried forward into FY 1986 and beyond.[12] While the Issue Statement claimed the 1985 adjustment persisted creating a present day IPPS payment understatement of 0.9441, 'which could be corrected by an adjustment of 5.92% . . . ,"[13] the Petition for EJR now claims that "the FY 2025 rates continue to include the 0.954 adjustment to the standardized amount and the 1.05 percent adjustment to the DRG weights from FY 1985."[14]

The Providers request the Board grant EJR in this case, first noting the Board has jurisdiction over the appeal. They claim that each Provider is dissatisfied with the Secretary's final payment determination in the FY 2025 IPPS final rule – specifically the Secretary's refusal to correct the rates to remove the budget neutrality adjustment he adopted in FY 1985.[15] They also argue that the challenge is not precluded from administrative and judicial review (specifically 42 U.S.C. § 1395ww(d)(7)(A)), because they are not challenging the "determination" of the FY 1985 budget neutrality adjustments, but rather the application of that adjustment to today's standardized amount, which it argues is not authorized pursuant to 42 U.S.C. § 1395ww(e)(1).[16] They conclude that 42 U.S.C. § 1395ww(d)(7)(A) was intended to "preclude review of the Secretary's application of the budget neutrality adjustments in FYs 1984 and 1985 and nothing more."[17] Finally, they argue that since the Board is bound to comply with all provisions of Title XVIII of the Social Security Act and regulations issued thereunder,[18] the Board is bound by the rates published in the FY 2025 IPPS final rule and cannot declare them unlawful; thus, the Board does not have authority to resolve this dispute and EJR is appropriate.[19]

The Medicare Contractor has not filed any Jurisdictional or Substantive Claim Challenges and the time for doing so has elapsed.[20]

3. Board Finding on Scope of Appealed Issue

42 C.F.R. § 405.1837(c)(3) specifies that a group appeal request must include "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." Further, the group appeal request must explain "[w]hy the provider[s] believe[] Medicare payment is incorrect for each disputed item" and "[h]ow and why the provider[s] believe[] Medicare payment must be determined differently for each disputed item." Consistent with these regulatory provisions, 42 C.F.R. § 405.1837(f)(1) specifies that, after a group appeal request is filed, "a provider *may*

[12] *Id.* at 3-7.
[13] Issue Statement at 2.
[14] Petition for Expedited Judicial Review at 7.
[15] *Id.* at 12.
[16] *Id.* at 13-14.
[17] *Id.* at 15.
[18] 42 U.S.C. § 405.1867.
[19] Petition for Expedited Judicial Review at 15-16.
[20] Board Rule 44.6. The Request for EJR was received by the Board on Friday, December 20, 2024. The Medicare Contractor (or its representative) was required to file any Jurisdictional or Substantive Claim Challenges (or a certification that either such challenge would be forthcoming) within five business days (*i.e.*, no later than close of business December 31, 2024, since December 24 and 25, 2024 were both federal holidays – *see* Board Rule 4.4.3).

not *add* other questions of fact or law to the appeal, *regardless of whether the question is common to other members of the appeal*."

The Board notes that the appealed issue differs from the issues raised in the Petition for EJR. The Petition for EJR claims (***for the first time***) that "Congress directed [the Secretary] to calculate ***two adjustments to the FY 1984 standardized amount*** . . . .The current group appeal involves the second adjustment which required the Secretary to ensure that aggregate payments for FY 1984 did not exceed aggregate payments for services under the reasonable cost payment system."[21] It also claims that "the FY 2025 rates continue to include the 0.954 adjustment to the standardized amount and the 1.05 percent adjustment to the DRG weights from FY 1985."[22] The group Issue Statement, however, alleges there is a present day IPPS payment understatement of 0.9441, "which could be corrected by an adjustment of 5.92% . . . ."[23] The group Issue Statement does **not** discuss or implicate any adjustments from FY 1984 or their impact on their FFY 2025 IPPS rates, and explicitly states that "[t]he Providers challenge the continued application of [the 1985] budget neutrality adjustments because [] they should have sunset at the end of FY 1985."[24] This is more limited than the arguments presented in the petition for EJR.

Accordingly, the Board ***dismisses*** the Providers' new issue related to the second adjustment to the FY 1984 standardized amount, pursuant to 42 C.F.R. §§ 405.1837(a)(2), (c), and (f)(1).[25]

The Board, therefore, pursuant to 42 C.F.R. §§ 405.1837(c) and (f)(1),[26] finds that the scope of this appeal is limited to the use of the BNA-adjusted rate from FY 1985 and does not include any

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[21] Petition for Expedited Judicial Review at 2-3. (Bold and italics emphasis added.)
[22] *Id.* at 7.
[23] Issue Statement at 2.
[24] *Id.*
[25] *See also* Board Rule 8. Consistent with these regulations, Board Rule 8.1 (July 2015) specifies: "Some issues may have multiple components. To comply with the regulatory requirement to ***specifically*** *identify* the items in dispute, ***each*** contested component must be appealed as a ***separate*** *issue* ***and*** *described as* ***narrowly*** *as possible* using the applicable format outlined in Rule 7." (Emphasis added.) *See also Evangelical Comty. Hosp. v. Becerra*, No. 21-cv-01368, 2022 WL 4598546 at *5 (D.D.C. 2022):

> The Board acts reasonably, and not arbitrarily and capriciously, when it applies its "claims-processing rules faithfully to [a provider's] appeal." *Akron*, 414 F. Supp. 3d at 81. The regulations require that a RFH provide "[a]n explanation [ ]for each specific item under appeal." 42 C.F.R. § 405.1835(b)(2). The Board rules further explain that "[s]ome issues may have multiple components," and that "[t]o 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." Board Rules § 8.1. The Board rules also specifically delineate how a provider should address, as here, a challenge to a Disproportionate Share Hospital reimbursement. Board Rule 8.2 explains that an appeal challenging a Disproportionate Share Hospital payment adjustment is a "common example" of an appeal involving issues with "multiple components" that must be appealed as "separate issue[s] and described as narrowly as possible." Board Rules §§ 8.1, 8.2.

[26] *See also* Board Rule 8. Consistent with these regulations, Board Rule 8.1 (July 2015) specifies: "Some issues may have multiple components. To comply with the regulatory requirement to ***specifically*** *identify* the items in dispute, ***each*** contested component must be appealed as a ***separate*** *issue* ***and*** *described as* ***narrowly*** *as possible* using the applicable format outlined in Rule 7." (Emphasis added.) *See also Evangelical Comty. Hosp. v. Becerra*, No. 21-cv-01368, 2022 WL 4598546 at *5 (D.D.C. 2022):

challenge to any adjustments made from FY 1984 (or any other FY) or any alleged continuing impact on their FFY 2025 IPPS rates resulting from any FY apart from FY 1985. The Board hereby denies any request for relief in the Petition for EJR related to these other adjustments as it is beyond the scope of this CIRP group appeal. Additionally, though it need not resolve the source of the discrepancy, the Board does note that the alleged IPPS payment understatement presented in the Petition for EJR differs from the alleged understatement presented in the original appeal request. Finally, while the Board Majority's previous decisions on the standardized amounts[27] discussed the relationship between both the FFY 1984 and 1985 BNAs, based on the issue in this case, the Board will generally limit its discussion to the relationship between the FY 1985 BNA and its impact on future IPPS rates and standardized amounts.

BOARD DECISION:

As described more fully below, the Board Majority finds that it lacks substantive jurisdiction over this group because: (1) the FFY 1985 budget neutrality-adjusted rates were used to determine the rates for FFY 1986 and, thus, became embedded into the rates determined for subsequent FFYs;[28] and (2) 42 U.S.C. § 1395ww(d)(7) prohibits administrative or judicial review of the FFY 1984 and 1985 BNAs.

A. Statutory Background on IPPS and the Standardized Amount Used in IPPS Rates

Part A of the Medicare program covers "inpatient hospital services." Since October 1, 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the IPPS.[29] Under IPPS, Medicare pays a prospectively-determined rate per eligible discharge, subject to certain payment adjustments.[30]

In order to implement IPPS, "the statute require[d] that the Secretary determine national and regional adjusted DRG prospective payment rates for each DRG to cover the operating costs of

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The Board acts reasonably, and not arbitrarily and capriciously, when it applies its "claims-processing rules faithfully to [a provider's] appeal." *Akron*, 414 F. Supp. 3d at 81. The regulations require that a RFH provide "[a]n explanation [ ]for each specific item under appeal." 42 C.F.R. § 405.1835(b)(2). The Board rules further explain that "[s]ome issues may have multiple components," and that "[t]o 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." Board Rules § 8.1. The Board rules also specifically delineate how a provider should address, as here, a challenge to a Disproportionate Share Hospital reimbursement. Board Rule 8.2 explains that an appeal challenging a Disproportionate Share Hospital payment adjustment is a "common example" of an appeal involving issues with "multiple components" that must be appealed as "separate issue[s] and described as narrowly as possible." Board Rules §§ 8.1, 8.2.

[27] *See supra* note 1.

[28] *But see* **Appendix A**. The Board has not traced the standardized amount after FFY 1986 all the way up to the each of the years in question. **Appendix A** highlights how, in addition to the use of the FFY 1985 budget-neutrality-adjusted rates for FFY 1986 and forward, there could be other intervening statutory or regulatory events (whether discretionary or mandatory) that could break the Providers' alleged causal link between the alleged error in the initial FFY 1984 rates and the standardize amounts used in the years at issue.

[29] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.

[30] *Id.*

inpatient hospital services."[31] The methodology for arriving at the appropriate rate structure is located at 42 U.S.C. § 1395ww(d)(2) and "requires that certain base period cost data be developed and modified in several specified ways (*i.e.*, inflated, standardized, grouped, and adjusted) resulting in 20 average standard amounts per discharge according to urban/rural designation in each of the nine census divisions and the nation."[32] Section 1395ww(d)(2)(A) requires that the Secretary determine a "base period" operating cost per discharge using the most recent cost reporting period for which data are available:

> (II) DETERMINING ALLOWABLE INDIVIDUAL HOSPITAL COSTS FOR BASE PERIOD.—The Secretary shall determine the allowable operating costs per discharge of inpatient hospital services for the hospital for the most recent cost reporting period for which data are available.

Consistent with these statutory provisions, the Secretary used Medicare hospital cost reports for reporting periods ending in 1981 and set the 1981 "base period" operating cost per discharge amount using the 1981 operating costs per discharge amount and then *updated* by an inflationary factor to bring it forward to FFY 1984.[33] The Secretary then "standardized" the FFY 1984 base period operating cost per discharge using the process prescribed at 42 U.S.C. § 1395ww(d)(2)(c). The standardization process removed the effects of certain variable costs from the cost data, including (but not limited to) excluding costs associated with indirect medical education costs, adjusting for variations in average hospital wage levels, and adjusting for variations in case mix among hospitals.

The initial standardized amounts have been annually adjusted and/or updated. However, contrary to the characterization in the D.C. Circuit's 2011 decision in *Saint Francis Med. Ctr. v. Azar* ("*Saint Francis*"), the standardized amount is not adjusted each year simply for inflation.[34] Significantly, some of these annual adjustments were required to be *budget neutral* and are not subject to administrative review and others are discretionary (*see also* **Appendix A**). In particular, 42 U.S.C. § 1395ww(e)(1)(B) provides the BNA for "the applicable percentage increases" to the standardized amounts for 1984 and 1985 and states, in pertinent part:

> **(e) Proportional adjustments in *applicable percentage increases***
>
> (1) . . . .
>
> (B) For discharges occurring in fiscal year 1984 or fiscal year 1985, the Secretary shall provide under subsections (d)(2)(F) and (d)(3)(C) for such equal proportional adjustment *in each of the*

[31] 48 Fed. Reg. 39752, 39763 (Sept. 1, 1983).
[32] *Id.* (emphasis added).
[33] *Id*. at 39763-64.
[34] 894 F.3d 290, 291 (D.C. Cir. 2011). *Saint Francis* did not analyze how the standardized amount is updated annually nor did it make specific legal holdings regarding the standardized amount.

> *average standardized amounts* otherwise computed for that fiscal year as may be necessary to assure that—
>
> > (i) the aggregate payment amounts otherwise provided under subsection (d)(1)(A)(i)(II) and (d)(5) for that fiscal year for operating costs of inpatient hospital services of hospitals (excluding payments made under section 1395cc(a)(1)(F) of this title),
>
> *are not greater or less than*—
>
> > (ii) the DRG percentage (as defined in subsection (d)(1)(C)) of *the payment amounts which would have been payable for such services* for those same hospitals for that fiscal year under this section *under the law as in effect before April 20, 1983* (excluding payments made under section 1395cc(a)(1)(F) of this title).[35]

The Secretary implemented the above budget neutrality provisions at 42 C.F.R. §§ 412.62(i) and 412.63(v) for the 1984 and 1985 rate years, respectively. Specifically, § 412.62(i) provides the following instruction for maintaining budget neutrality for the 1984 Federal IPPS rates:

> (i) *Maintaining budget neutrality.* (1) CMS adjusts each of the **reduced standardized amounts** determined under paragraphs (c) through (h) of this section as required for fiscal year 1984 so that the estimated amount of aggregate payments made, excluding the hospital-specific portion (that is, the total of the Federal portion of transition payments, plus any adjustments and special treatment of certain classes of hospitals for Federal fiscal year 1984) **is not greater or less than** 25 percent of **the payment amounts that would have been payable** for the inpatient operating costs for those same hospitals for fiscal year 1984 **under the Social Security Act as in effect on April 19, 1983**.
>
> (2) The aggregate payments considered under this paragraph exclude payments for per case review by a utilization and quality control quality improvement organization, as allowed under section 1866(a)(1)(F) of the Act.[36]

Similarly, the regulation at 42 C.F.R. § 412.63(v) provides the following instruction for maintaining budget neutrality for the 1985 Federal rates for IPPS:

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[35] (Bold emphasis in original and italics and underline emphasis added.) The BNA at 42 U.S.C. § 1395ww(e)(1)(B) is cross-referenced for 1984 at 1395ww(d)(2)(F) and for 1985 at § 1395ww(d)(3)(C).
[36] (Italics emphasis in original and bold and underline emphasis added.)

> (v) *Maintaining budget neutrality for fiscal year 1985.* (1) For fiscal year 1985, CMS will adjust each of the reduced standardized amounts determined under paragraph (c) of this section as required for fiscal year 1985 to ensure that the estimated amount of aggregate payments made, excluding the hospital-specific portion (that is, the total of the Federal portion of transition payments, plus any adjustments and special treatment of certain classes of hospitals for fiscal year 1985) is **not greater or less** than 50 percent of the **payment amounts that would have been payable** for the inpatient operating costs for those same hospitals for fiscal year 1985 **under the law as in effect on April 19, 1983**.
>
> (2) The aggregate payments considered under this paragraph exclude payments for per case review by a utilization and quality control quality improvement organization, as allowed under section 1866(a)(1)(F) of the Act.[37]

Essentially, Congress mandated that the Secretary/CMS adjust the standardized amounts for both 1984 and 1985 to ensure that the estimated amount of aggregate payments made under IPPS was not *greater than* ***or*** *less than* what would have been payable for inpatient operating costs for the same hospitals under the prior reimbursement system (*i.e.*, reasonable costs subject to TEFRA limits). In other words, pursuant to budget neutrality, the size of the pie, expressed as average payment per case, is prescribed by law to be *no more* ***and*** *no less* than what would have been paid had IPPS not been implemented. Significantly, the reference points for maintaining budget neutrality for 1984 and 1985 are ***external*** to IPPS and, thus, ***fixed*** (no greater *and* no less) based on the best data available.[38] Since these points are ***fixed,*** it also means that it is capped (*i.e.*, cannot be increased subsequently outside of the BNA).

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

[38] 48 Fed. Reg. 39752, 39887 (Sept. 1, 1983) provides the following discussion supporting the Board Majority's pie concept:

> Section 1886(e)(1) of the Act requires that, for Federal fiscal years 1984 and 1985, prospective payments be adjusted so that aggregate payments for the operating costs of inpatient hospital services are neither more nor less than we estimate would have been paid under prior legislation for the costs of the same services. To implement this provision, we are making actuarially determined adjustments to the average standardized amounts used to determine Federal national and regional payment rates and to the updating factors used to determine the hospital-specific per case amounts incorporated in the blended transition payment rates for fiscal years 1984 and 1985. Section 1886(d)(6) of the Act requires that the annual published notice of the methodology, data and rates include an explanation of any budget neutrality adjustments. This section is intended to fulfill that requirement.
>
> Although, for methodological reasons, the budget neutrality adjustment is calculated on a per discharge basis, it should be emphasized that the ultimate comparison is between the aggregate payments to be made under the prospective payment system and the aggregate payments that would have been incurred under the prior legislation. Therefore, changes in hospital behavior from that which would have occurred in the absence of the prospective payment system are required to be taken into account in determining the budget neutrality adjustment if they affect

This conclusion is supported by the fact that the normal annual inflation adjustments to the standardized amount provided for in IPPS apply only for FY 1986 forward, as set forth in 42 U.S.C. § 1395ww(b)(3)(B)(3)(i) and cross referenced in § 1395ww(d)(3)(A). Specifically, 42 U.S.C. § 1395ww(b)(3)(B)(i) (2018) defines the term "applicable percentage increase" starting with fiscal year 1986 (as opposed to 1984):

> (B)(i) For purposes of subsection (d) and subsection (j) for discharges occurring during a fiscal year, the "applicable percentage increase" shall be—
>
> (I) ***for fiscal year 1986***, 1/2 percent,
>
> (II) for fiscal year ***1987***, 1.15 percent,
>
> (III) for fiscal year ***1988***, 3.0 percent for hospitals located in a rural area, 1.5 percent for hospitals located in a large urban area (as defined in subsection (d)(2)(D)), and 1.0 percent for hospitals located in other urban areas,
>
> (IV) for fiscal year ***1989***, the market basket percentage increase minus 1.5 percentage points for hospitals located in a rural area, the market basket percentage increase minus 2.0 percentage points for hospitals located in a large urban area, and the market basket percentage increase minus 2.5 percentage points for hospitals located in other urban areas,
>
> (V) for fiscal year ***1990***, the market basket percentage increase plus 4.22 percentage points for hospitals located in a rural area, the market basket percentage increase plus 0.12 percentage points for hospitals located in a large urban area, and the market basket percentage increase minus 0.53 percentage points for hospitals located in other urban areas,
>
> (VI) for fiscal year ***1991***, the market basket percentage increase minus 2.0 percentage points for hospitals in a large urban or other urban area, and the market basket percentage increase minus 0.7 percentage point for hospitals located in a rural area,
>
> (VII) for fiscal year ***1992***, the market basket percentage increase minus 1.6 percentage points for hospitals in a large urban or other urban area, and the market basket percentage increase minus 0.6 percentage point for hospitals located in a rural area,

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aggregate payment. For example, any expectation of increased admissions beyond the level that would have occurred under prior law would have to be considered in the adjustment. To assist in making the budget neutrality adjustment for, and take account of, fiscal year 1985, HCFA will monitor for changes in hospital behavior attributable to the new system.

> (VIII) for fiscal year ***1993***, the market basket percentage increase minus 1.55 percentage point for hospitals in a large urban or other urban area, and the market basket percentage increase minus 0.55 percentage point for hospitals located in a rural area,
>
> (IX) for fiscal year ***1994***, the market basket percentage increase minus 2.5 percentage points for hospitals located in a large urban or other urban area, and the market basket percentage increase minus 1.0 percentage point for hospitals located in a rural area,
>
> (X) for fiscal year ***1995***, the market basket percentage increase minus 2.5 percentage points for hospitals located in a large urban or other urban area, and such percentage increase for hospitals located in a rural area as will provide for the average standardized amount determined under subsection (d)(3)(A) for hospitals located in a rural area being equal to such average standardized amount for hospitals located in an urban area (other than a large urban area),
>
> (XI) for fiscal year ***1996***, the market basket percentage increase minus 2.0 percentage points for hospitals in all areas,
>
> (XII) for fiscal year ***1997***, the market basket percentage increase minus 0.5 percentage point for hospitals in all areas,
>
> (XIII) for fiscal year ***1998***, 0 percent,
>
> (XIV) for fiscal year ***1999***, the market basket percentage increase minus 1.9 percentage points for hospitals in all areas,
>
> (XV) for fiscal year ***2000***, the market basket percentage increase minus 1.8 percentage points for hospitals in all areas,
>
> (XVI) for fiscal year ***2001***, the market basket percentage increase for hospitals in all areas,
>
> (XVII) for fiscal year ***2002***, the market basket percentage increase minus 0.55 percentage points for hospitals in all areas,
>
> (XVIII) for fiscal year ***2003***, the market basket percentage increase minus 0.55 percentage points for hospitals in all areas,
>
> (XIX) for each of fiscal years ***2004*** through ***2006***, subject to clause (vii), the market basket percentage increase for hospitals in all areas; and
>
> (XX) ***for each subsequent fiscal year***, subject to clauses (viii), (ix), (xi), and (xii), the market basket percentage increase for hospitals in all areas.[39]

[39] (Emphasis added.)

The "applicable percentage increase" as defined in § 1395ww(b)(3)(A) is incorporated into § 1395ww(d)(3)(A), as it relates to updating of the standardized amount:

> (A)(i) For discharges occurring in a fiscal year beginning ***before*** October 1, 1987, the Secretary shall compute an average standardized amount for hospitals located in an urban area and for hospitals located in a rural area within the United States and for hospitals located in an urban area and for hospitals located in a rural area within each region, ***equal to*** *the respective average standardized amount computed for the previous fiscal year under paragraph (2)(D) or under this subparagraph*, ***increased for the fiscal year involved by the applicable percentage increase under subsection (b)(3)(B)***. With respect to discharges occurring on or after October 1, 1987, the Secretary shall compute urban and rural averages on the basis of discharge weighting rather than hospital weighting, making appropriate adjustments to ensure that computation on such basis does not result in total payments under this section that are greater or less than the total payments that would have been made under this section but for this sentence, and making appropriate changes in the manner of determining the reductions under subparagraph (C)(ii).
>
> (ii) For discharges occurring in a fiscal year beginning on or after October 1, 1987, and ending on or before September 30, 1994, the Secretary shall compute an average standardized amount for hospitals located in a large urban area, for hospitals located in a rural area, and for hospitals located in other urban areas, within the United States and within each region, equal to the respective average standardized amount computed for the previous fiscal year under this subparagraph increased by the applicable percentage increase under subsection (b)(3)(B)(i) with respect to hospitals located in the respective areas for the fiscal year involved.
>
> (iii) For discharges occurring in the fiscal year beginning on October 1, 1994, the average standardized amount for hospitals located in a rural area shall be equal to the average standardized amount for hospitals located in an urban area. For discharges occurring on or after October 1, 1994, the Secretary shall adjust the ratio of the labor portion to non-labor portion of each average standardized amount to equal such ratio for the national average of all standardized amounts.
>
> (iv)(I) Subject to subclause (II), for discharges occurring in a fiscal year beginning on or after October 1, 1995, the Secretary shall compute an average standardized amount for hospitals located in a

> large urban area and for hospitals located in other areas within the United States and within each region equal to the respective average standardized amount computed for the previous fiscal year under this subparagraph increased by the applicable percentage increase under subsection (b)(3)(B)(i) with respect to hospitals located in the respective areas for the fiscal year involved.
>
> (II) For discharges occurring in a fiscal year (beginning with fiscal year 2004), the Secretary shall compute a standardized amount for hospitals located in any area within the United States and within each region equal to the standardized amount computed for the previous fiscal year under this subparagraph for hospitals located in a large urban area (or, beginning with fiscal year 2005, for all hospitals in the previous fiscal year) increased by the applicable percentage increase under subsection (b)(3)(B)(i) for the fiscal year involved.

Thus, while 42 U.S.C. § 1395ww(d)(2) provides the methodology for calculating the standardized amount to be used for each year, and that the amount is subject to the "applicable percentage increase" under subsection (b)(3)(B) for years after 1984, it remains that it is not always a simple inflationary or market basket adjustment. In particular, the FFY 1984 and 1985 BNAs (as referenced in § 1395ww(d)(2)(F) and in § 1395ww(d)(3)(C)) were the applicable percentage increases for FFYs 1984 and 1985 and, as described below, those adjustments are not administratively reviewable. Further, as discussed *infra*, **it is clear that the Secretary has interpreted 42 U.S.C. § 1395ww(d)(3)(A)(i) to require the FFY 1985 budget neutrality-adjusted rates be used in determining the rates for FFY 1986 and subsequent FFYs**. This is reflected in the following excerpt from 42 C.F.R. § 405.473(c) as initially adopted in the September 3, 1983 final rule:

> (c) *Federal rates for fiscal years after Federal fiscal year 1984.*
>
> ****
>
> (2) *Updating previous standardized amounts.*
>
> (i) *For fiscal year 1985*. HCFA will compute an average standardized amount for each group of hospitals described in paragraph (b)(5) of this section . . . equal to the respective adjusted average standardized amount computed for fiscal year 1984 under paragraph (b)(7) of this section—
>
> (A) Increased for fiscal year 1985 by the applicable percentage increase under § 405.463(c);
>
> (B) Adjusted by the estimated amount of Medicare payment for nonphysician services furnished to hospital inpatients that would have been paid under Part B were it not for the fact that such

> services must be furnished either directly by hospitals or under arrangements;
>
> (C) Reduced by a proportion equal to the proportion (estimated by HCFA) of the total amount of prospective payments which are additional payment amounts attributable to outlier cases under § 405.475; and
>
> (D) **Adjusted for budget neutrality under paragraph (c)(4) of this section**.
>
> (ii) **For fiscal year 1986** and thereafter, **HCFA will compute an average standardized amount** for each group of hospitals described in paragraph (b)(5) of this section, **equal to the respective adjusted average standardized amounts computed for the previous fiscal year**—
>
> (A) Increased by the applicable percentage increase determined under paragraph (c)(3) of this section; and
>
> (B) Adjusted by the estimated amount of Medicare payment for nonphysician services furnished to hospital inpatients that would have been paid under Part B were it not for the fact that such services must be furnished either directly by hospitals or under arrangements.
>
> (C) Reduced by a proportion equal to the proportion (estimated by HCFA) of the amount of payments based on the total amount of prospective payments which are additional payment amounts attributable to outlier cases under § 405.475.
>
> (3) *Determining applicable percentage changes for fiscal year 1986 and following*. The Secretary will determine for each fiscal year (beginning with fiscal year 1986) the applicable percentage change which will apply for purposes of paragraph (c)(2)(ii) of this section as the applicable percentage increase for discharges in that fiscal year, and which will take into account amounts the Secretary believes necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality. In making this determination, the Secretary will consider the recommendations of the Prospective Payment Assessment Commission.[40]

[40] 48 Fed. Reg. at 39823 (italics emphasis in original and bold and underline emphasis added). This provision was later moved to 42 C.F.R. § 412.63(c)(2022) which states in pertinent part:

B. Jurisdictional Findings -- 42 U.S.C. § 1395ww(d)(7)(A) Precludes Administrative Review of the Base Year Standardized Amounts

While the Providers in this case claim they are not specifically challenging the FY 1984 and 1985 standardized amounts, these amounts and their associated BNAs are implicated in their appealed issue and the preclusion on their review discussed below is still relevant.

The published standardized amount for the FFY in this appeal reflects the prior year's standardized amount plus "the applicable percentage increase" as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i) (as referenced in 42 U.S.C. § 1395ww(d)(3)(A)) *as well as other potential adjustments*. Significantly, the "applicable percentage increase[s]" for 1984 forward are ***not*** always simply a cost inflation adjustment or other similar percentage adjustment. To this point, for the first two (2) years of IPPS, Congress mandated that the BNAs for FFYs 1984 and 1985 serve as the "applicable percentage increase" for those years. As a result, the IPPS rates that the Secretary used for the very first year of IPPS and then the second year of IPPS were adjusted for budget neutrality. For FFYs 1986 and forward, Congress provided for an "applicable percentage increase" in 42 U.S.C. § 1395ww(b)(3)(B)(i) as referenced in 42 U.S.C. § 1395ww(d)(3)(A). In addition, there are other *permanent* adjustments (*i.e.*, adjustments not for that year only but that also apply on a going-forward basis) to the standardized amount that have occurred in other

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(c) *Updating previous standardized amounts*.

****

(2) Each of those amounts is equal to the respective adjusted average standardized amount computed for fiscal year 1984 under §412.62(g)—
(i) Increased for fiscal year 1985 by the applicable percentage increase in the hospital market basket;
(ii) Adjusted by the estimated amount of Medicare payment for nonphysician services furnished to hospital inpatients that would have been paid under Part B were it not for the fact that such services must be furnished either directly by hospitals or under arrangements;
(iii) Reduced by a proportion equal to the proportion (estimated by CMS) of the total amount of prospective payments that are additional payment amounts attributable to outlier cases under subpart F of this part; and
(iv) **Adjusted for budget neutrality under paragraph (h) of this section**.
(3) ***For fiscal year 1986*** *and thereafter*. CMS computes, for urban and rural hospitals in the United States and for urban and rural hospitals in each region, average standardized amount equal to the respective **adjusted average standardized amounts computed for the previous fiscal year**—
(i) Increased by the applicable percentage increase determined under paragraphs (d) through (g) of this section;
(ii) Adjusted by the estimated amount of Medicare payment for nonphysician services furnished to hospital inpatients that would have been paid under Part B were it not for the fact that such services must be furnished either directly by hospitals or under arrangements; and
(iii) For discharges occurring on or after October 1, 1985 and before October 1, 1986, reduced by a proportion (estimated by HCFA) of the amount of payments based on the total amount of prospective payments that are additional payment amounts attributable to outlier cases under subpart F of this part, and for discharges occurring on or after October 1, 1986, reduced by a proportion (estimated by HCFA) of the amount of payments that, based on the total amount of prospective payments for urban hospitals and the total amount of prospective payments for rural hospitals, are additional payments attributable to outlier cases in such hospitals under subpart F of this part.

years outside of the "applicable percentage increase."[41] Thus, the standardized amount for a particular year is an amalgamation that builds upon the prior year's standardized amount and then adds additional adjustments for the current year. As noted *supra* and discussed more *infra*, **the Secretary has used the FFY 1985 budget neutrality-adjusted rates for determining the FFY 1986 rates and those for subsequent FFYs**.

The Providers are, essentially, seeking to peel back the amalgamated standardized amount for each applicable FFY *and, thus, reach back* ***roughly 20 to 35 years*** to increase the FFY 1985 budget-neutrality adjusted rate to exclude the BNA and then use that increased rate to calculate the 1986 standardized amount. They would then simply carry or flow that *increase forward by the relevant 20 to 35 years*. However, in order to peel the amalgamated standardized amounts for the FFY at issue *as used in the IPPS rates for each FFY* back to the standardized amount***s*** (plural) used in FFY 1986, and then carry/flow any change forward *to the FFY at issue*, when necessarily implicates the FFY 1985 budget neutrality adjustment, as the providers are requiring that adjustment be excluded in the calculation of the 1986 rate.

However, they cannot do so because this BNA had the effect of ***fixing*** the pie for FFY 1985 to (*i.e.*, no more ***and*** no less than) the aggregate amounts that would have been paid had IPPS not been implemented.[42] More specifically, the amalgamated standardized payment amount for each FFY at issue reflects the *fixed* FFY 1985 BNA and the IPPS rates paid for FFY 1985 are based on standardized amounts that were adjusted downwards as a result of the budget neutrality adjustment for FFY 1985.[43]

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[41] *See* **Appendix A.**

[42] *See, e.g.,* 48 Fed. Reg. 39752, 39805 (Sept. 1, 1983) (stating: "Hospital Impact—During its first two years, aggregate payments under the prospective payment system will be adjusted, in accordance with Section 1886(e)(1) of the Act, to be "budget neutral"; that is, so that aggregate payments under the prospective payment system, including outlier payments, exceptions, and adjustments, will be neither more nor less than the estimated payment amounts to affected hospitals that would have resulted under the Social Security Act as in effect before April 20,1983.").

[43] Indeed, the FY 1986 IPPS Final Rule included an example where the Secretary recognized an adjustment to the BNAs would be impacted by the removal of nurse anesthetists costs and confirmed that the adjustments to the standardized amounts had already taken this removal into account:

> c. Nonphysician anesthetist costs. In the August 31, 1984 final rule, we implemented section 2312 of Pub. L. 98-369, which provided that hospital costs for the services of nonphysician anesthetists will be paid in full as a reasonable cost pass-through for cost reporting periods beginning before October 1, 1987.
>
> We did not directly reduce the FY 1985 Federal rates to exclude the estimated costs of these services, *because any required adjustment would be incorporated in the budget neutrality adjustment factors applied to the national and regional standardized amounts*. (See 49 FR 34794; August 31, 1984). ***Since the FY 1986 standardized amounts are derived from an update of the FY 1985 amounts, which were adjusted for budget neutrality, the rates will automatically include the appropriate adjustment***. We are not making further adjustments to the Federal rates for this factor for either FY 1986 or FY 1987.

50 Fed. Reg. at 35708 (emphasis added). *See also* 52 Fed. Reg. 33034, 33064 (Sept. 1, 1987) (stating: "In the September 3, 1985 final rule, we noted that to the extent an adjustment was warranted to reflect the removal of these costs from the prospective payment rates for FY 1985, *it was incorporated in the overall* ***budget neutrality adjustment*** (50 FR 35708). Therefore, because this adjustment has already been built into the FY 1985 base from which the FY 1986, FY 1987, and proposed FY 1988 rates are derived, we did not propose to make further adjustments to the average standardized amounts for FY 1988.").

Accordingly, the Board Majority finds that the Providers' challenge to the standardized amounts at issue are *inextricably* tied to the BNA made for FFY 1985.[44][45]

Furthermore, Congress has precluded Board (and judicial) review of the FFY 1985 BNA. Specifically, 42 U.S.C. § 1395ww(d)(7)(A) precludes administrative and judicial review of the neutrality adjustment at § 1395ww(e)(1):

> (7) There shall be no administrative or judicial review under section 1395oo of this title or otherwise of—
>
> (A) the determination of the requirement, or the proportional amount, of any adjustment effected pursuant to subsection (e)(1) or the determination of the applicable percentage increase under paragraph (12)(A)(ii), . . .[46]

Similarly, the statute governing Board appeals is located at 42 U.S.C. § 1395oo and states in subsection (g)(2):

> The determinations and other decisions described in section 1395ww(d)(7) of this title shall not be reviewed by the Board or by

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[44] The Board Majority notes that the D.C. Circuit's decision in *Saint Francis* is not applicable to the 1984 and 1985 BNAs given the statutory provision precluding administrative and judicial review of those adjustments. Further, *Saint Francis* did not analyze how the standardized amount is updated annually nor did it make specific legal holdings regarding the standardized amount.

[45] The Board majority also recognizes the recent D.C. District Court decision in *St. Mary's Reg'l Med. Ctr. v. Becerra*, 1:23-cv-1594-RCL, 2024 WL 5186641 (D.D.C. Dec. 20, 2024) ("*St. Mary's*") and the Providers' position that, while that case involves a different substantive issue - whether the Secretary miscalculated the standardized amount in FY 1984 by including transfer cases in the denominator –that it "held that section 1395ww(d)(7)(A) does not bar review of the Secretary's decision to apply the 1985 budget neutrality adjustment to the present-day rates." *See* Notice of Supplemental Authority (Dec. 31, 2024). The Board Majority notes that this District Court decision is not binding on the Board and, given its recent issuance, is still subject to appeal. Based on the foregoing, the Board declines to follow the holdings in *St. Mary's*.

[46] With regard to implementing this statutory provision, 48 Fed. Reg. 39752, 39785 (Sept. 1, 1983) states:

> Section 1886(d)(7) of the Act precludes administrative and judicial review of the following:
> —A determination of the requirement, or the proportional amount, of any "budget neutrality" adjustment effected under section 1886(e)(1) of the Act; or
> —The establishment of DRGs, of the methodology for the classification of hospital discharges within DRGs, or of the appropriate weighting factors of DRGs under section 1886(d)(4) of the cost. It was the clear intent of Congress that a hospital would not be permitted to argue that the level of the payment that it receives under the prospective payment system is inadequate to cover its costs. Thus, as discussed above, neither the definition of the different DRGs, their weight in relation to each other, nor the method used to assign discharges to one of the groups is to be reviewable. However, if there is an error in the coding of an individual patient's case, review would be permitted. (See the Report of the Committee on Ways and Means on H.R. 1900, H. Report No. 98-25, (98th Cong., 1st Sess.) 143 (1982).) As noted below, we believe the appropriate review concerning coding errors should be conducted by the entity (i.e., the PSRO/PRO or fiscal intermediary) which made the initial determination.

> any court pursuant to an action brought under subsection (f) or otherwise.

Since the FFY 1985 BNA is based on an ***external, fixed*** reference point (*i.e.*, no greater and no less than the reference point) and is not reviewable, the Board Majority finds that the FFY 1985 BNA effectively fixed the standardized amounts from that point forward for use in the IPPS system.[47]

1. *The Secretary has applied the FFY 1985 budget neutrality-adjusted rates to FFY 1986 and subsequent years.*

For FFY 1986, the Secretary confirmed that she used the FFY 1985 budget-neutrality-adjusted federal rates as the basis for determining the FFY 1986 federal rates:

> [T]he FY 1985 adjusted average standardized amounts (Federal rates) were required by law to be adjusted to achieve budget neutrality; that is, to ensure that aggregate payments for the operating costs of inpatient hospital services would be ***neither more nor less than*** *we estimated would have been paid under prior legislation for the costs of the same services*. (The technical explanation of how this adjustment was made was published in the August 31, 1984 final rule (49 FR 34791).) ***These budget neutrality-adjusted rates for FY 1985 are then to be used as the basis for the determination of rates for later years***.
>
> Our FY 1985 budget neutrality adjustment factors were based on data and assumptions that resulted in standardized amounts that were higher than necessary to achieve budget neutrality. Therefore, we have updated the FY 1985 standardized amounts using a factor that takes into account the overstatement of the FY 1985 amounts ***to ensure that accuracy of the FY 1986 standardized amounts***. To this end, we have identified several factors, discussed in section III.A.3.c., below, that contributed to the *overstatement* of the FY 1985 standardized amounts. We have determined an appropriate percent value for each of them, and have combined them into a proposed composite ***correction*** factor for FY 1986 that equals —7.5 percent.[48]

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[47] *See, e.g.,* 48 Fed. Reg. 39752, 39765 (Sept. 1, 1983) (stating "We point out that aside from being technically desirable, the effect of standardizing nonlabor hospital costs in Alaska and Hawaii is to decrease the reduction for budget neutrality stemming from the requirements in section 1886(e)(1)(B) of the Act.").

[48] 50 Fed. Reg. 35646, 35695 (Sept. 3 1985) (emphasis added). *See also* 49 Fed. Reg. at 34767 (stating "We believe the explicit language of section 2310 of Pub. L. 98-369 and section 1886(d)(3)(A) of the Act requires a reduction in the standardized amounts used to compute the Federal rates before adjusting for budget neutrality. . .. Thus, while

Significantly, in the above excerpt, the Secretary further confirmed that "[t]hese budget neutrality-adjusted rates for FY 1985 are then to be used *as the basis for the determination of rates* ***for later years***."[49] While it is true that the implementation of these rates for FFY 1986 were delayed by Congressional action extending the FFY 1985 rates through April 30, 1986 (as discussed further in **Appendix A**), the Secretary confirmed that it used the rates published in the FFY 1986 IPPS Final Rule plus a 1.0 percent modification ***specified by Congress***:

> Section 9101(a) of Pub. L. 99-272 amends section 5(c) of Pub. L. 99-107 to extend the FY 1985 inpatient hospital prospective payment rates through April 30,1986. Therefore, the DRG classification changes and recalibrated DRG weights that were set forth in the September 3,1985 final rule (50 FR 35722) are effective for discharges occurring on or after May 1, 1986.
>
> ****
>
> In accordance with the provisions of section 9101(b) and (e) of Pub. L. 99-272, the adjusted standardized amounts that were published in the September 3,1985 final rule (which reflected a zero percent update) are updated by one-half of one percent effective for discharges on or after May 1,1986. The revised standardized amounts are set forth in Table 1, below.[50]

The Board Majority has set forth in **Appendix B** excerpts from the preambles of other final rules to provide additional contexts in which the Secretary confirmed that the FFY 1985 budget neutrality-adjusted rates applied to later years. Thus, *regardless of how the Providers contend the Medicare statute should be interpreted relative to the 1985 BNA*, it is clear that:

- The Secretary herself interpreted those provisions as requiring the application of the FFY 1985 budget neutrality-adjusted rates to later years; and
- The FFY 1985 budget neutrality-adjusted rates are the basis for the rates used in FFY 1986 forward through to the years at issue.
- Congress was both aware and involved in the final rates used in FFY 1986, and therefore, aware that those rates were based upon the FFY 1985 budget-neutrality adjusted rates.

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the Federal rates. . .. have been reduced in this final rule to reflect the inflation factor prescribed by section 2310 of Pub. L. 98-369, we point out that the offset for budget neutrality has also been adjusted. The reduction in the regional and national standardized rates . . . attributable to section 2310 of Pub. L. 98-369 is entirely due to the revised budget neutrality adjustments for 1984 and 1985.").

[49] *Id.* (emphasis added).

[50] 87 Fed. Reg. 16772, 16773 (May 6, 1986).

Given the incorporation of the FFY 1985 budget-neutrality-adjusted rates into subsequent years, the Board Majority finds that the Providers' issue is inextricably tied, at a minimum, to the FFY 1985 BNA.

* * * * *

The Board Majority finds that it lacks substantive jurisdiction over the issue raised in this appeal because the ***prospectively-set*** standardized amount used for IPPS rates for FFY 1985 is based on the BNA made for that FFY.[51] Therefore, the *final* FFY 1984 and 1985 standardized amounts are *inextricably tied* with those applicable BNAs.[52] Because 42 U.S.C. 1395ww(d)(7) prohibits administrative or judicial review of the FFY 1985 BNA and the resulting *final* standardized amounts for FFY 1985 was carried/flowed forward in the determination of the rates for FFY 1986 and succeeding FFYs, the Board Majority finds that it may not review the standardized amount

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[51] The Board Majority has included at **Appendix A** examples of other adjustments to the standardized amounts that have occurred outside of the FFY 1985 BNA. These intervening adjustments for FFYs 1986 and 2018 include both mandatory and discretionary revisions ***to the standardized amounts*** (as well as the Congress' decisions to revise or not revise the "applicable percentage increases" for FFYs 1986 and forward as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i)) and highlight the complexity of the issue before the Board, particularly where such adjustments were made in a budget neutral manner or were based on factoring in certain other estimated impacts.

[52] *See DCH Reg'l Med. Ctr. v. Azar*, 925 F.3d 503, 507 (D.C. Cir. 2019) ("We cannot review the Secretary's method of estimation without also reviewing the estimate. And because the two are inextricably intertwined, section 1395ww(r)(3)(A) precludes review of both."); *Mercy Hosp., Inc. v. Azar*, 891 F.3d 1062, 1067 (D.C. Cir. 2018) ("As both a textual and a practical matter, the LIP adjustment is inextricably intertwined with the step-two rate, and so the shield that protects the step-two rate from review protects the LIP adjustment as well."); *Yale New Haven Hosp. v. Becerra*, 56 F.4th 9, 18 (2nd Cir. 2022) ("Thus, we join the D.C. Circuit in "reject[ing] the argument that 'an "estimate" is not the same thing as the "data" on which it is based.'" *DCH Reg'l Med. Ctr. v. Azar* . . . . We also adopt the D.C. Circuit's holding that "[i]n this statutory scheme, a challenge to the [Secretary's choice of what data to include and exclude] for estimating uncompensated care is ... a challenge to the estimates themselves. The statute draws no distinction between the two." *Id*. at 506. Indeed, the statutory text of section 1395ww(r)(2)(C)(i) explicitly and affirmatively defines the statutory term "estimate[ ]" to encompass "the Secretary['s] determin[ation]" of what data is the "be[st] proxy for the costs of [qualifying] hospitals for treating the uninsured" and, ultimately, of what data to "use" or not "use." 42 U.S.C. § 1395ww(r)(2)(C)(i)." (citations partially omitted)). Similarly, the Board Majority notes that the Board erred in finding that it had jurisdiction in *Columbia/HCA 1984-1986 PPS Federal Rate/Malpractice Group v. Blue Cross & Blue Shield Ass'n*, PRRB Dec. 2000-D74 (Aug. 18, 2000). In that decision, the Board found that "the issue in this case, whether the federal portion of the PPS rates should be adjusted because it was based on 1981 hospital cost report data which incorporated an invalid 1979 Malpractice Rule, does not fall into either [of the] limitations on Board jurisdiction [at 42 U.S.C. §§ 1395ww(d)(7) or 1395oo(g)(2)]. The Board finds that it can determine whether the existing statute and regulations concerning the establishment of the federal portion of the PPS rate require or permit retroactive adjustments." *Id.* at 16. The Board further found that "the retroactive adjustment proposed by the Provider would increase the federal portion of the PPS rates ***and therefore require some adjustment to be made to maintain budget neutrality***. 42 U.S.C. § 1395ww(e) and 42 C.F.R. § 412.63(j)" but that "[b]ecause the Board has determined that the adjustments are not required, how those adjustments would be made are moot, and in any event would not be subject to review by the Board. 42 C.F.R. § 405.1804(a)." *Id.* at 18 (Emphasis added.) While the Board's 2000 decision got it right that the FFY 1984 budget neutrality provision is implicated and precluded from administrative review, the above case law demonstrates that the Board erred in finding it could review the FY 1984 standardized amounts. Rather, the case law (as well as the Board Majority's discussion herein) demonstrates that any adjustment to the FFY 1984 standardized amounts (and, as discussed *supra*, any future FFY standardized amounts, since the incorporation of the FFY 1985 budget-neutrality-adjusted rates into subsequent years leaves them inextricably tied, at a minimum, to the FFY 1985 BNA) would be *inextricably* tied to the ensuing BNAs made for FFYs 1984 and 1985.

used for the FFY being appealed as it relates to the common issue in these appeals.[53] In this regard, the Board Majority again notes that the rates for FFY 1986 and subsequent years are based on the FFY 1985 budget-neutrality-adjusted rates and the Providers may not simply pass through, or over, the BNA for FFY 1985, *for purposes of future FFYs*, because those adjustments are tied to an absolute *external* event (the Secretary's estimate, based on the best available data, of what would have been paid for those years if there were no IPPS) ***and*** were ***fixed*** (no greater *and* no less than what would have been paid had there been no IPPS). To do otherwise, would impact the very integrity of IPPS.

Further, a review of the Providers' calculations of the Amounts in Controversy filed with the original appeal on December 20, 2024, shows that these calculations are single-page summaries which identify IPPS payments and simply inflate them by 5.92%.[54] There is no evidence that the numerous adjustments made in the intervening years, some of which were required to be budget neutral, and some of which were discretionary, have been properly accounted for. As addressed above, the causal link between the 1986 rates and the 2025 rates is not clearly delineated, and cannot be verified.

Accordingly, the Board Majority finds that: (1) the appealed issue is *inextricably* tied with the FFY 1985 BNA to the standardized amounts *for purposes of future FFYs* under the operation of 42 U.S.C. §§ 1395ww(b)(3)(B), 1395ww(d)(3)(A), and both 1395ww(d)(2)(F) and 1395ww(d)(3)(C) which reference 1395ww(e)(1)(B), as demonstrated by the fact that the FFY 1985 budget-neutrality adjusted rates were used as the basis for the determination of rates for FFY 1986 and later years; and (2) 42 U.S.C. §§ 1395oo(g)(2) and 1395ww(d)(7) (and related implementing regulations[55]) prohibit administrative and judicial review of those BNAs. Based on these findings, the Board Majority concludes that it does not have substantive jurisdiction over the issue this group case, denies the Petition for EJR, and hereby closes the case and removes it from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq. (concurring in part, dissenting in part)

For the Board:

1/17/2025

X Kevin D. Smith, CPA

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

[53] *But see supra* note 28.
[54] *e.g.* Appeal Request, Impact Calculation for Hays Medical Center (Prov. No. 17-0013) at 1.
[55] *See, e.g.*, 42 C.F.R. §§ 405.1804, 405.1840(b)(2).

Appendices A – Examples of other adjustments to the standardized amount that may potentially break the causal link from FFY 1984 to the fiscal years at issue
B – Additional Excerpts from FFY 1985 IPPS Final Rule Affirming Application of FFY 1985 budget-neutrality-adjusted rates to FFY 1986 and subsequent years.
C – Pending cases involving standardized amounts vis-à-vis and FFY 1985 budget-neutrality-adjusted rates to FFY 1986 and subsequent years.

cc: Byron Lamprecht, WPS Government Health Administrators (J-5)
Wilson Leong, FSS
Jacqueline Vaughn, CMS OAA

Concurring in part, dissenting in part

Before the courts are numerous challenges to the present-day IPPS rates stemming from perceived errors in the 1981 discharge data, 1984 and 1985 standardized amounts and adjustments, and 1986 standardized amounts.[56] When first presented, it seems odd that providers are still arguing about the 1980s and one might ask why this issue is being raised 40 years later. The answer is, the court held in *Kaiser Foundation Hospitals v. Sebelius*, 708 F.3d 226, 232-33 (D.C. Cir. 2013) that, "the reopening regulation allows for modification of predicate facts in closed years provided the change will only impact the total reimbursement determination in open years."[57] The D.C. Circuit later decided that subsequent revisions to the reopening regulation at 42 C.F.R. § 405.1885 to bar predicate fact challenges were inapplicable to appeals to the PRRB.[58] As a result, the 1981 discharge data, 1984 and 1985 standardized amounts and adjustments, and 1986 standardized amounts are predicate facts that providers, since *Kaiser*, have the opportunity to challenge insofar as they have impacted the FFY 2025 IPPS rates at issue in this appeal (and the years prior).

The first challenges in this standardized amount genre were based on the theory that, "when calculating 'allowable operating costs per discharge' in the first step of the IPPS process outlined in 42 U.S.C. § 1395ww(d)(2), the Secretary erroneously counted inter-hospital transfers as 'discharges.'"[59] That indistinction between transfers and discharges in 1981, according to the providers, "has perpetuated chronic underpayment up to the present day."[60] The Board has consistently dismissed such cases based on "lack of subject matter jurisdiction, on the grounds that the standardized amounts at issue in the appeal are 'inextricably intertwined' with the Secretary's budget neutrality adjustments [in 1985], which are in turn exempt from administrative and judicial review under the statutes and regulations barring review of the Secretary's budget neutrality adjustments, i.e., 42 U.S.C. §§ 1395oo(g)(2) and 1395ww(d)(7), and 42 C.F.R. § 405.1804 (the "Preclusion Provisions")."[61]

Of those cases dismissed by the Board, a few raised the issue that the FFY 1986 (and subsequent years) standardized amount rates were improperly based on the FFY 1985 budget-neutrality adjusted rates ("the 1986 issue").[62] The providers in those cases argue that,

> [T]he baseline for FY 1986 should have been the FY 1985 standardized amount before it was adjusted for outliers under (3)(B), budget neutrality under (3)(C) and (e)(1)(B), the weighting factors under (3)(D) or area wages under (3)(E). Moreover,

[56] *See* **Appendix C**.
[57] *Kaiser Found. Hosp. v. Sebelius*, 708 F.3d 226, 232-33 (D.C. Cir. 2013), referring to the "reopening regulation" at 42 C.F.R. § 405.1885(a).
[58] *See St. Francis Med. Ctr. v. Azar*, 894 F. 3d 290, 297 (D.C. Cir. 2018).
[59] *St. Mary's* at 7, *citing* . Pls.' Mot. for Summ. J. 5–6, ECF No. 20-1.
[60] *St. Mary's* at 8, *citing* . Pls.' Mot. for Summ. J. 8-9.
[61] *St. Mary's* at 10, *citing* . Pls.' Mot. for Summ. J. 15.
[62] *See, e.g.*, Ex. 4 to Complaint at 30, *Armstrong County Mem'l Hosp. et al v. Becerra* (D.D.C. 1:24-cv-03359) filed Nov. 27, 2024, appeal from Board dec. dated Sept. 30, 2024 (lead Case No. 24-1601GC).

> neither section 1395ww(d)(3)(B)(C)(i) nor (e)(1)(B) required calculating a new budget neutrality adjustment for FY 1986.[63]

The Board dismissed that issue as it was beyond the scope of the Issue Statement submitted with those appeals.[64] Now, in yet another attempt to displace the foundation of the IPPS, Providers in the instant case have brought the 1986 issue to the forefront, and similarly contend that the plain text of the statute does not allow the budget neutrality adjustments to apply to fiscal years *after* 1985, consequently, the FY 2025 IPPS rate is understated.[65]

The Board Majority first limits the scope of this appeal such that it does not include any challenge to any adjustments made from FY 1984 (or any other FY) or any alleged continuing impact on their FFY 2025 IPPS rates resulting from any FY apart from FY 1985.[66] Although Provider's references to FY 1984 may have been presented simply as background,[67] I ***concur*** with the Majority in that the scope of this appeal should be limited to whether the FY 2025 IPPS payment rates "are lower than required by a faithful reading of the statute because since FY 1986, CMS and its precursor the Health Care Financing Administration (HCFA) have unlawfully applied a pair of budget neutrality adjustments that by statute could only apply to the IPPS rates for FY 1985."[68]

The Board Majority then finds that it lacks substantive jurisdiction over the issue raised in this group appeal because the standardized amount used for IPPS rates for FFY 1986 is based on the rates from FFY 1985, which was based on the budget neutrality adjustment made for that FFY. The Board Majority also finds that the final FFY 1985 standardized amount (on which the FFY 1986 standardized amount was based) is inextricably intertwined with the FFY 1985 budget neutrality adjustment. In the Board Majority's opinion, the budget neutrality application leaves the issue inextricably intertwined with those applicable budget neutrality adjustments for which administrative and judicial review is prohibited by the Preclusion Provisions. Here, I respectfully ***dissent*** from the Majority opinion, and instead agree with Provider's conclusion that 42 U.S.C. § 1395ww(d)(7)(A) was intended to "preclude review of the Secretary's application of the budget neutrality adjustments in FYs 1984 and 1985 and nothing more."[69]

While the recent District Court decision in *St. Mary's* is not binding on the Board, the Court's methodology in determining whether one agency decision is inextricably intertwined with another is instructive.[70] Approaching the 1986 issue the same way, I find that FFY 1986 IPPS Rates are

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[63] Ex. 2 to Complaint at 4, *Armstrong County Mem'l Hosp.*.
[64] *See* Board dec. dated Sept. 30, 2024 (lead Case No. 24-1601GC).
[65] Petition for Expedited Judicial Review at 1 (Dec. 20, 2024).
[66] *See supra*, "Board Finding on Scope of Appealed Issue."
[67] *See* Issue Statement at 1, *citing* 42 U.S.C. 1395ww(e)(1)(B).
[68] Issue Statement at 1.
[69] Petition for Expedited Judicial Review at 15.
[70] "First, one agency decision is inextricably intertwined with another if the former is entirely subsumed within or practically indistinguishable from the latter, i.e. because the former constitutes the entire factual or methodological basis for the latter. Second, textual clues, such as whether the two agency processes appear in the same or different subsections of the controlling statute and the presence or absence of internal cross-references, may suggest whether the processes are inextricably intertwined. Third, agency actions are not inextricably intertwined if the means of

not inextricably intertwined with the 1985 budget neutrality adjustment. First, the 1985 budget neutrality adjustment does not constitute the entire methodological basis for the FFY 1986 IPPS Rates. While, as highlighted by the Majority, the Secretary confirmed that the FFY 1985 budget-neutrality-adjusted federal rates would be the basis for determining the FFY 1986 federal rates,[71] it is also true that the Secretary "will take into account amounts the Secretary believes necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality"[72] and "the Secretary will consider the recommendations of the Prospective Payment Assessment Commission."[73] Continuing the analysis, the agency actions occur at different times (1985 versus 1986) and entail distinct rulemaking processes (each FFY has its own IPPS Final Rule). A challenge to one does not necessarily constitute a challenge to the other.

Finding that the issues are not inextricably intertwined (i.e., review is not precluded), I find that Providers have met the requirements of 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 establishing a right to a Board hearing.[74] However, I find that the question regarding the lawfulness of the FFY 2025 IPPS Final Rule properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and would subsequently grant EJR.[75]

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implementing them are very different in practice, such as if they entail distinct rulemaking processes, impose different obligations on private parties, or occur at different times. Fourth, lest a plaintiff circumvent Congress's intent to preclude review through artful pleading, agency decisions are inextricably intertwined if a challenge to one necessarily constitutes a challenge to the other." *St. Mary's* at 33.

[71] *See* 50 Fed. Reg. 35646 at 35697 (Sept. 3, 1985), which Provider cites in Petition for Expedited Judicial Review at 6 to illustrate that the Secretary ignored the limits imposed by the statute.

[72] 42 C.F.R. § 405.473(c)(3) (1983).

[73] *Id*.

[74] Specifically, (1) Providers have appealed from a valid final determination (i.e., the Federal Register publication setting forth the FFY 2025 IPPS rates). *See* Issue Statement at 1. The amount in controversy is over the $50,000 threshold for a group. *See* individual Calculation Support Documents filed by Providers. The request for a hearing was filed within 180 days of the date of receipt of the final determination (the Federal Register publication setting forth the FFY 2025 IPPS rates was published on August 28, 2024 and this appeal was filed December 20, 2024, or 114 days later). *See* appeal filing.

The Board notes that 42 C.F.R. § 405.1840 is entitled "Board Jurisdiction" but it also addresses certain claims-filing requirements such as timelines or filing deadlines. Whether an appeal request is timely filed with the Board is not a jurisdictional requirement per se, but rather it is a claims-filing requirement as the Supreme Court made clear in *Sebelius v. Auburn Reg. Med. Ctr.*, 568 U.S. 145 (2013) ("*Auburn*"). Unfortunately, following the issuance of *Auburn*, the Secretary has not yet updated § 405.1840 to reflect the clarification made by the Supreme Court in *Auburn* that distinguishes between the claims-filing requirements for a Board hearing request versus jurisdictional requirements for a Board hearing. *See also* Board Rule 4.1 ("The Board will dismiss appeals that fail to meet the timely filing requirements and/or jurisdictional requirements."); 42 C.F.R. § 405.1835(b) (addressing certain other claims-filing requirements).

[75] 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 expedited judicial review ("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. *See* 42 C.F.R. §§ 405.1842, 405.1867.

1/17/2025

X Nicole E. Musgrave

Nicole E. Musgrave, Esq.
Board Member
Signed by: Nicole Musgrave-burdette -A

APPENDIX A
Examples of other adjustments to the standardized amount that may potentially break the causal link from FFY 1985 to the fiscal years at issue

Set forth below are examples of other adjustments to the standardized amounts that have occurred outside of the FFY 1984 and 1985 budget neutrality adjustments ("BNAs") and the "applicable percentage increases" for FFYs 1986 and forward as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i). These other examples raise questions about the causal link between the standardized amount rates at issue and the standardized amounts set for FFY 1985.

a. "Restandardization of base year costs per case used in [the] calculation of Federal rates" for both the labor and non-labor portions to reflect the survey-based wage index as discussed in the FY 1986 IPP Final Rule. 50 Fed. Reg. 35646, 35692 (Sept. 3, 1985).

b. Recalibration of DRG weights done in a budget neutral manner pursuant to 42 U.S.C. § 1395ww(d)(4)(C) at least every 4 years beginning with 1986.[76] An example of recalibration can be found in the FY 1986 IPPS Final Rule wherein the Secretary changed its methodology for calculating the DRG relative weights.[77]

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[76] The Secretary confirmed that, beginning in 1991, these adjustments are to be made in a budget neutral manner:

> Section 1886(d)(4)(C)(iii) of the Act requires that beginning with FY 1991, reclassification and recalibration changes be made in a manner that assures that the aggregate payments are neither greater than nor less than the aggregate payments that would have been made without the changes. Although normalization is intended to achieve this effect, equating the average case weight after recalibration to the average case weight before recalibration does not necessarily achieve budget neutrality with respect to aggregate payments to hospitals because payment to hospitals is affected by factors other than average case weight. Therefore, as discussed in section II.A.4.b. of the Addendum to this final rule, we are making a budget neutrality adjustment to implement the requirement of section 1886(d)(4)(C)(iii) of the Act.

59 Fed. Reg. 45330, 45348 (Sept. 1, 1994).

[77] 50 Fed. Reg. 35646, 35652 (Sept. 3, 1985). As part of this recalibration process, the Secretary responded to a comment on the use of transfers in the recalibration process as follows:

> *Comment:* A commenter was concerned that, by including transfer cases in the calculation of the relative weights, we might be inappropriately reducing the relative weights of DRGs in which there are significant proportions of transfer cases.
> *Response:* This commenter assumes that the charges for transfer cases are lower than charges for the average case in a DRG. Our data show that this assumption is not correct for many DRGs. To test the effect of including transfers in the calculation of the relative weights, we computed mean charges for each DRG, both with and without the transfer cases. We then conducted statistical tests to determine whether these two means differed significantly at the .05 confidence level (that is, there is only a .05 probability that the observed difference in the means would occur if the two sets of cases came from the same underlying population). The results indicate that transfers have a statistically significant effect on the mean charges of only 16 DRGs. For 13 of the 16 DRGs, inclusion of transfer cases tends to ***increase*** the mean charges. However, for three DRGs, the mean charges are reduced by the inclusion of the transfer cases.
> Since the inclusion of transfer cases raises the mean charges for some DRGs and lowers them for others, and because these effects are limited to such a small number of DRGs, we decided not to revise the method we used to recalibrate the relative weights. During FY 1986, we will be

c. BNAs made to the standardized amount designated for urban hospitals and the one designated for rural hospitals when certain urban hospitals were deemed to be urban effective with discharges occurring on or after October 1, 1988. 53 Fed. Reg. 38476, 38499-500, 38539 (Sept. 30, 1988) (implementing OBRA 87, Pub. L. 100-203, § 4005).[78]

d. Effective for FFY 1995, eliminating the initial two standardized amounts (one for urban hospital and another for rural hospitals)[79] and replacing them with one single standardized amount as specified at 42 C.F.R. § 1395ww(d)(3)(C)(iii).[80]

e. Budget neutrality provision at 42 U.S.C. § 1395ww(d)(3)(A)(vi) that allows Secretary to adjust standardized amount to eliminate the effect of "changes in coding or classification of discharges that do not reflect real changes in case mix."[81]

> studying the entire issue of transfers and the appropriate payment for these cases. This study may reveal other ways of handling transfer cases in future recalibrations.

Id. at 35655-56.

[78] *See also* 56 Fed. Reg. 43358, 43373 (Aug. 30, 1991) (stating "Consistent with the prospective payment system for operating costs, the September 1, 1987 capital final rule provided for separate standardized amounts for hospitals located in urban and rural areas. Subsequently, the Omnibus Budget Reconciliation Act of 1987 (Pub. L. 100-203) provided for a higher update factor for hospitals located in large urban areas than in other urban areas and thereby established three standardized amounts under the prospective payment system for operating costs. Large urban areas are defined as those metropolitan statistical areas (MSAs) with a population of more than 1 million (or New England County metropolitan statistical areas (NECMAs) with a population of more than 970,000). Beginning with discharges on or after April 1,1988 and continuing to FY 1995, the Congress has also established higher update factors for rural hospitals than for urban hospitals. The differential updates have had the effect of substantially reducing the differential between the rural and other urban standardized amounts. Section 4002(c) of Public Law 101-508 provides for the elimination of the separate standardized amounts for rural and other urban hospitals in FY 1995 by equating the rural standardized amount to the other urban standardized amount. The separate standardized amount for large urban hospitals would continue. Currently, the large urban standardized amount under the prospective payment system for operating costs is 1.6 percent higher than the standardized amount for hospitals located in other urban areas.").

[79] *See* 42 U.S.C. §§ 1395ww(d)(2)(D), 1395ww(d)(3)(A).

[80] Omnibus Reconciliation Act of 1990, Pub. L. 101-508, § 4002(c), 104 Stat. 1388, 1388-33 – 1388-35 (1990).

[81] For example, the Secretary included the following discussion in the preamble to the FFY 1986 IPPS Final Rule:

> As stated above, we have already built case-mix increases into the cost-per-case assumptions used in deriving budget neutral prospective payment rates for FY 1984 and FY 1985.
> Now that there is no further requirement for budget neutrality, we agree that real case-mix increases should be explicitly recognized. In fact, to the extent that case mix continues to increase, hospitals realize the benefit of such increase in increased payments for the current year. This is because we do not recoup payments already made, but only adjust the rates to avoid compounding such overpayments in the future. Thus, FY 1986 prospective payment rates were based on FY 1985 rates, corrected to eliminate all increases in case mix through FY 1985 (since FY 1985 was a budget neutral year). However, we now have data that indicate that case mix has increased an additional 2.6 percent. Hospitals have been realizing the benefit of that increase through increased payments. Our update factor will be adjusted so as to not pass through in the FY 1987 rates 2.0 percentage points of the increase in case mix. However, the 0.6 percentage points that we estimate to reflect a real increase in case mix will be added to the update factor for FY 1987.

51 Fed. Reg. 31505-06.

f. The discretion of the Secretary in 42 U.S.C. § 1395ww(d)(3)(I)(i) to "provide by regulation for such other exceptions and adjustments to such payments amounts under this subsection as the Secretary deems appropriate."

g. The subsequent amendments that Congress made in 1994[82] and 1997[83] to add subparagraphs (I) and (J) to 42 U.S.C. § 1395ww(d)(5) to recognize and incorporate the concept of transfers into IPPS *in a budget neutral manner*. The Secretary made adjustments to the standardized amounts in order to implement the permanent incorporation of transfers into IPPS.[84]

To illustrate the complex nature of these issues, the Board Majority points to the Secretary's exercise of her discretion under 42 U.S.C. § 1395ww(d)(3)(I)(i) on making recommendations to Congress on whether to make adjustments to the "applicable percentage increases" or update factor for FFY 1986 as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i). In the September 1985 Final Rule,[85] the Secretary asserted that the FFY 1985 Federal rates were "overstated" and cited to the GAO's 1985 report entitled "Report to the Congress of the United States: Use of Unaudited Hospital Cost Data Resulted in Overstatement of Medicare Prospective Payment System Rates" and, pursuant to 42 U.S.C. § 1395ww(e)(4), made a recommendation to Congress that it not provide any increase to FFY 1985 standardized amounts but rather freeze the FFY 1986 amounts at the FFY 1985 levels (*i.e.*, recommended an update factor of 0 percent for FFY 1986).[86] The following excerpts from that rulemaking describe how the Secretary determined that the FFY 1985 standardized amounts were overstated when reviewing whether to recommend that Congress adjust the update factor for the FFY 1986 standardized amounts:

> Since the standardized amounts for FY 1985 are used as the basis for the determination of rates for later years, the level of the FY 1985 standardized amounts must be corrected for any experience that developed since they were published. *We believe that it is necessary, **each year**, to review the appropriateness of the level of the previous year's prospective payment rates for providing reasonable payment*

[82] Social Security Act Amendments of 1994, § 109, Pub. L. 103-432, 108 Stat. 4398, 4408 (1994) placed the then-existing language of 42 U.S.C. § 1395ww(d)(5)(I) into clause (i) and added the following clause (ii): "(ii) In making adjustments under clause (i) for transfer cases (as defined by the Secretary) in a fiscal year, the Secretary may make adjustments to each of the average standardized amounts determined under paragraph (3) to assure that the aggregate payments made under this subsection for such fiscal year are not greater than or lesser than those that would have otherwise been made in such fiscal year."
[83] Balanced Budget Act of 1997, Pub. L. 105-33, § 4407, 111 Stat. 251, 401 (1997), further revised 42 U.S.C. § 1395ww(d)(5)(I) and added § 1395ww(d)(5)(J).
[84] *See* 60 Fed. Reg. 45778, 45854 (Sept. 1, 1995) ("[W]e are revising our payment methodology for transfer cases, so that we will pay double the per diem amount for the first day of a transfer case, and the per diem amount for each day after the first, up to the full DRG amount. For the data that we analyzed, this would result in additional payments for transfer cases of $159 million. *To implement this change in a budget neutral manner*, we adjusted the standardized amounts by applying a budget neutrality adjustment of 0.997583 in the proposed rule.").
[85] 50 Fed. Reg. 35646, 35704 (Sept. 3, 1985).
[86] U.S. Gov't Accountability Office, GAO/HRD-85-74, Use of Unaudited Hospital Cost Data Resulted in Overstatement of Medicare's Prospective Payment System Rates (1985).

for inpatient hospital services furnished to beneficiaries. Further, we think this review must include assessment of whether the previous year's prospective payment rates have established adequate incentives for the efficient and effective delivery of needed care.

In addition to this general consideration, *the FY 1985 adjusted average standardized amounts* (***Federal rates***) *were required by law* ***to be adjusted to achieve budget neutrality***; that is, to ensure that aggregate payments for the operating costs of inpatient hospital services would be *neither more* ***nor*** *less than* we estimated would have been paid under prior legislation for the costs of the same services. (The technical explanation of how this adjustment was made was published in the August 31, 1984 final rule (49 FR 34791).) *These budget neutrality-adjusted rates for FY 1985 are then to be used as the basis for the determination of rates for later years*.

Our FY 1985 budget neutrality adjustment factors were based on data and assumptions that resulted in standardized amounts that were ***higher*** *than necessary to achieve budget neutrality*. Therefore, *we have updated the FY 1985 standardized amounts using a factor that takes into account the* ***overstatement*** *of the FY 1985 amounts to ensure that accuracy of the FY 1986 standardized amounts*. To this end, we have identified several factors, ***discussed in section II.A.3.c.***, below, that contributed to the overstatement of the FY 1985 standardized amounts. *We have determined an appropriate percent value for each of them, and have combined them into* ***a proposed composite correction factor*** *for FY 1986 that equals –7.5 percent*.

In addition, we have developed factors representing productivity, technological advances, and the elimination of ineffective practice patterns, which are necessary to ensure the cost-effective delivery of care. Each of these factors interacts with the others, to some extent, and has an impact on the quality of care. Making conservative assumptions, we have determined an appropriate percent value for each of these factors, taking into consideration their potential effect on quality. **We have combined these values into a composite policy target adjustment factor**, **as discussed in section III.3.e., below**. For FY 1986, this factor equals —1.5 percent.

The Secretary is required under section 1886(e)(4) of the Act to make those adjustments in establishing the update factor that are ". . . necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality." *Establishing FY 1986 prospective payment rates based on FY 1985 rates* ***that have been demonstrated to be overstated****, clearly would not comport*

with the statutory requirement that the rates represent payment for efficiently delivered care.

Since the forecasted hospital market basket increase for FY 1986 is +4.27 percent, and the adjustment for Part B costs and FICA taxes is +.31 percent, it is clear that there is a potential justification of a –4.42 percent decrease in the FY 1986 standardized amounts as compared to those for FY 1985 as described below:

	Percent
Forecasted market basket increase..	+4.27
Part B costs and FICA taxes.....	+.31
Composite correction factor.....	–7.5
Composite policy target adjustment factor.....	–1.5

However, for the reasons discussed in section II.A.3.f., below, we have decided that such a decrease is undesirable. Therefore, we are maintaining the FY 1986 standardized amounts at the same average level as FY 1985, in effect applying a zero percent update factor.[87]

****

(3) *Additional causes for the overstatement of FY 1985 Federal rates*. In addition to the factors above, which we believe we must correct, **other considerations also contributed significantly to the overstatement of the FY 1985 standardized amounts**.

When we set the standardized amounts for FY 1985, we made assumptions on hospital cost per case increases in order to estimate, for purposes of budget neutrality, the payments that would have been made had prior payment rules continued in effect. These assumed rates of increase in cost per case were 10.9 percent for 1983, 9.8 percent for 1984, and 9.8 percent for 1985. These assumptions were significantly higher than the actuarial estimates. The actuarially estimated rates of increase in cost per case (which ignore any effects of the prospective payment system such as shorter lengths of stay) are 9.8 percent for 1983, 8.1 percent for 1984, and 8.5 percent for 1985. After application of the revised market basket, discussed previously, use of these actuarial estimates would reduce the standardized amounts by an additional 1.2 percent.

[87] 50 Fed. Reg. at 35695 (bold, italics, and underline emphasis added).

For FY 1985, we also used 1981 unaudited, as-submitted cost reports (to get recent data as quickly as possible) to set the Federal rates. The hospital specific rates were set using later (1982 or 1983) cost reports that were fully audited. The audits adjusted the total cost for these reports downward by $2.2 billion, of which Medicare realized about $900 million in inpatient recoveries. **Since the cost data used to set the Federal rates do not reflect audit recoveries, it is likely that they are overstated by a similar amount**. We do not know precisely what proportion of this amount applies to capital-related costs and other costs that would not affect the Federal rates. However, approximately 90 percent of hospitals" total inpatient costs are operating costs, and if only 40 percent of the $900 million in audit recoveries is related to Federal payments for inpatient operating costs, there would have been, conservatively estimated, at least a one percent overstatement of allowable costs incorporated into the cost data to determine the FY 1985 standardized amounts.

In addition, the General Accounting Office (GAO) recently conducted a study to evaluate the adequacy of the Standardized amounts. In its report to Congress dated July 18, 1985 (GAO/HRD-85-74), **GAO reported findings that the standardized amounts, as originally calculated, are overstated by as much as 4.3 percent because they were based on unaudited cost data and include elements of capital costs.** GAO recommended that the rates be adjusted accordingly.

We believe that these causes for the overstatement of the standardized amounts are related to our own procedures and decisions. Thus, they are unlike both the market basket index, which is a technical measure of input prices, and the increases in case-mix, which would not have been passed through beyond the extent to which they affected the estimates of cost per case. Further, as discussed below, even without making these corrections, we could justify a negative update factor for FY 1986, although we are not establishing one. **Since we have decided to set FY 1986 standardized amounts at the same level as those for FY 1985, making corrections now to reflect the cost per case assumptions and the audit data would have no practical effect. Therefore, we have decided <u>at this time not</u> to correct the standardized amounts for these factors.**

We received no comments on this issue.

> (4) ***Composite Correction Factor.*** We are adjusting the standardized amounts as follows to take into consideration the overstatement of the prior years, amounts:
>
> | | *Percent* |
> |---|---|
> | Case mix..... ..... | –6.3 |
> | Market basket..... | –1.2 |
> | Composite correction factor..... | –7.5[88] |

Congress did immediately act on the Secretary's September 3, 1985 recommendation because, shortly thereafter on September 30, 1985, it enacted § 5(a) of the Emergency Extension Act of 1985 ("EEA-85") to maintain existing IPPS payment rates for FFY 1986 at the FFY 1985 Rates (*i.e.*, provide a 0 percent update factor) until November 14, 1985 as specified in EEA-85 § 5(c).[89] Congress subsequently modified this freeze on several different occasions as explained in the interim final rule published on May 6, 1986:

> - Pub. L. 99-155, enacted December 14, 1985, extended the [EEA-85] delay through December 14, 1985.
>
> - Pub. L. 99-181, enacted December 13, 1985, extended the [EEA-85] delay through December 18, 1985.
>
> - Pub. L. 99-189, enacted December 18, 1985, extended the [EEA-85] delay through December 19, 1985.
>
> - Pub. L. 99-201 enacted December 23, 1985, extended the [EEA-85] delay through March 14, 1986.[90]

Second, on April 7, 1986, Congress further revised EEA-85 § 5(c) by extending the 0 percent update factor through April 30, 1986 and then specified that, for discharges on or after May 1, 1986, the update factor would be ½ of a percentage point.[91] As previously discussed above in the decision at Section B.3, in the final rule published on May 6, 1986, the Secretary confirmed that "*the adjusted standardized amounts that were published in the September 3,1985 final rule* (which reflected a zero percent update) are updated by one-half of one percent effective for discharges on or after May 1,1986"[92] and these FFY 1986 adjusted standardized rates are based on the FFY 1985 budget neutrality-adjusted rates.

---

[88] *Id.* at 35703-04 (bold and underline emphasis added).
[89] Pub. L. 99-107, § 5(a), 99 Stat. 479, 479 (1985). In July 1984, Congress had *already* reduced the 1 percent update factor planned for FFY 1986 to ¼ of a percentage point. Deficit Reduction Act of 1984, Pub. L. 98-369, § 2310(a), 98 Stat. 494, 1075 (1984). As part of the Emergency Extension Act of 1985, Congress further reduced the update factor for FFY 1986, presumably in response to the Secretary's recommendation.
[90] 51 Fed. Reg. 16772, 16772 (May 6, 1986).
[91] *See id.* at 16773. *See also* Medicare and Medicaid Budget Reconciliation Amendments of 1985, Pub. L. 99-272, § 9101(a), 100 Stat. 151, 153 (1986).
[92] 51 Fed. Reg. at 16773.

The examples highlight concerns about how certain future actions and decisions by the Secretary and Congress build upon prior decisions.

APPENDIX B
Additional Excerpts from FFY 1985 IPPS Final Rule
Affirming Application of FFY 1985 budget-neutrality-adjusted rates to
FFY 1986 and subsequent years.

In its decision, the Board Majority has noted that the Secretary confirmed in the preamble of the FFY 1986 IPPS Final Rule that the FFY budget neutrality-adjusted rates were used in determining the rates for FFY 1986 and would similarly be part of subsequent FFYs rates. The following excerpts from the preambles to various IPPS final rules provide additional contexts in which the Secretary confirmed that the FFY 1985 budget neutrality-adjusted rates were part of the rate for later FFYs and illustrate how embedded the FFY 1985 budget neutrality-adjusted rates are in the rates used for FFY 1986 and subsequent years. Thus, *regardless of how the Providers contend the Medicare statute should be interpreted relative to the 1985 BNA*, it is clear that the Secretary herself interpreted those provisions as requiring the application of the FFY 1985 budget neutrality-adjusted rates to later years; and that the FFY 1985 budget neutrality-adjusted rates are the basis for the rates used in FFY 1986 forward through to the years at issue. Further, it is clear from the fact that the comments and responses quoted below from the various final rules directly address the use of the budget-neutrality-adjusted FFY 1985 rates in the development of future rates and that proper notice-and-comment rulemaking was followed in the development of these rates. The Providers were aware of the Secretary's handling, with no ambiguity, as early as 1986.

1. In the preamble to the FFY 1986 IPPS Final Rule, the Secretary recognizes that the FFY 1985 BNA accounted for the removal of nonphysician anesthetist costs from the base rates and no further adjustments were needed relative to those costs since the FFY 1985 budget neutrality-adjusted rates were used in determining the FY 1986 rates and would similarly be used for the 1987 rates:

> c. *Nonphysician anesthetist costs*. In the August 31, 1984 final rule, we implemented section 2312 of Pub. L. 98-369, which provided that hospital costs for the services of nonphysician anesthetists will be paid in full as a reasonable cost pass-through for cost reporting periods beginning before October 1, 1987. We did not directly reduce the FY 1985 Federal rates to exclude the estimated costs of these services, **because any required adjustment would be incorporated in the budget neutrality adjustment factors applied to the national and regional standardized amounts.** (See 49 FR 34794; August 31, 1984). **Since the FY 1986 standardized amounts are derived from an update of the FY 1985 amounts, which were adjusted for budget neutrality, the rates will automatically include the**

> **appropriate adjustment**. We are not making further adjustments to the Federal rates for this factor for either FY 1986 or FY 1987.[93]

2. In the preamble to the FFY 1986 IPPS Final Rule, the Secretary addresses the issue of using the pre-BNA or post-BNA FFY 1985 rate for the development of the FFY 1986 rate:

> We have also considered the commenter's position that FY 1984 and FY 1985 standardized rates be recalculated to remove the entire effect of budget neutrality prior to developing the FY 1986 payment rates. We do not agree that the prior years' standardized rates before budget neutrality should serve as the basis for updating the FY 1986 rates. Since the budget-neutralized standardized amounts represent the actual payment rates used to pay hospitals in FY 1985, we believe the 'percentage change' for FY 1986 should be applied to these amounts. In addition, section 1886(d)(3)(A) and (C) of the Act does not explicitly require that the update factor apply to the FY 1985 payment rates prior to the adjustments for budget neutrality in FY 1985.[94]

3. In the preamble to the FFY 1987 IPPS Final Rule, the Secretary explains how her BNAs for FFYs 1984 and 1985 had "already built case-mix increases into the cost-per case assumptions used in deriving the budget neutral prospective rates for FY 1984 and FY 1985" and confirms that "FY 1986 prospective payment rates were based on FY 1985 rates, corrected to eliminate all increases in case mix through FY 1985 (since FY 1985 was a budget neutral year)":

> *Comment*: Several commenters stated that we did not consider real case mix increases in the 1983 to 1984 period, and that we finally are considering real case mix increases for the first time.
>
> *Response*: FY 1984 and FY 1985 were years subject to the requirements for budget neutrality. As required under section 1886(e)(1) of the Act, payments under the prospective payment

---

[93] 50 Fed. Reg. at 35708 (Italics emphasis in original and bold and underline emphasis added). The Board Majority notes that the FFY 1985 IPPS Final Rule explained how the FFY 1985 BNA accounted for Anesthetists services:

> *Anesthetists' Services*. Under section 2312 of Pub. L. 98-369, the costs to the hospital of the services of nonphysician anesthetists will be reimbursed in full by Medicare on a reasonable cost basis. In order to ensure that these services will be paid for only once, we must remove their costs from the prospective payment rates.
> For cost reporting periods beginning in FY 1985, we have reduced the adjusted standardized amounts to reflect the removal of these costs **by means of the budget neutrality adjustment methodology**. Our method for doing this is explained in section V.D. of this Addendum. We estimate that FY 1985 payments for anesthetists' services will be about $160 million, or 0.5 percent of Medicare operating costs for hospital accounting years beginning in FY 1985.

[94] 50 Fed. Reg. at 35697.

> system were to be equal to what would have been paid under rate-of-increase and peer group limits on reasonable costs under prior law (section 1886(b) of the Act) as if the prospective payment system had never been implemented. Under the rate-of-increase limits and peer group limits, as long as a hospital's cost was lower than that hospital's limits, we paid that cost, regardless of whether real case mix increased or decreased, and regardless of the effect of actual case mix on the cost level for that hospital. . . . Increases in real case mix were built into the cost per case increase assumptions we used to model the rate-of-increase limits. These assumptions took into account estimates of the impact of the rate-of-increase limits and the peer group limits. **Consequently, we considered increases in real case mix in FYs 1984 and 1985.** Moreover, even these assumed increases in cost per case proved to be overstated as we received more recent data against which to evaluate our estimates. To have passed through updated prospective payment case-mix increases for FY 1984 and FY 1985 would have been improper because they would increase program payments over the level that would have been paid under the section 1886(b) limits. **As stated above, we have already built case-mix increases into the cost-per-case assumptions used in deriving budget neutral prospective payment rates for FY 1984 and FY 1985.**
>
> Now that there is no further requirement for budget neutrality, we agree that real case-mix increases should be explicitly recognized. In fact, to the extent that case mix continues to increase, hospitals realize the benefit of such increase in increased payments for the current year. This is because we do not recoup payments already made, but only adjust the rates to avoid compounding such overpayments in the future. **Thus, FY 1986 prospective payment rates were based on FY 1985 rates, corrected to eliminate all increases in case mix through FY 1985 (since FY 1985 was a budget neutral year).**[95]

4. In the preamble to the FFY 1988 IPPS Final Rule, the Secretary again recognizes the prior FFY 1985 BNA to the standardized amounts had already taken into account the removal of nonphysician anesthetist costs and the *FFY 1985 budget neutrality-adjusted rates* ***were reflected in the FFY 1986, 1987, and 1988 rates.***

> c. *Nonphysician Anesthetist Costs*. Section 1886(d)(5)(E) of the Act provides that hospital costs for the services of nonphysician anesthetists are paid in full as a reasonable cost pass-through.

[95] 51 Fed. Reg. at 31505-31506.

> Under section 2312(c) of Pub. L. 98-369, this pass-through was made effective for cost reporting periods beginning on or after October 1,1984, and before October 1,1987. Section 9320(a) of Pub. L. 99-509 extended the period of applicability of this pass-through so that services will continue to be paid under reasonable cost for any cost reporting periods (or parts of cost reporting periods) ending before January 1,1989 and struck subsection (E) effective on that date.
>
> In the September 3, 1985 final rule, we noted that to the extent an adjustment was warranted to reflect the removal of these costs from the prospective payment rates for FY 1985, it was incorporated in the overall **budget neutrality** adjustment (50 FR 35708). Therefore, **because this adjustment has already been built into the FY 1985 base from which the FY 1986, FY 1987, and proposed FY 1988 rates are derived**, we did not propose to make further adjustments to the average standardized amounts for FY 1988.[96]

[96] 52 Fed. Reg. 33034, 33064 (Sept. 1, 1987) (emphasis added).

Appendix C

Pending cases involving standardized amounts vis-à-vis and FFY 1985 budget-neutrality-adjusted rates to FFY 1986 and subsequent years.

In its dissent, the Board Minority has noted that numerous challenges to the present-day IPPS rates stemming from perceived errors in the 1981 discharge data, 1984 and 1985 standardized amounts and adjustments, and 1986 standardized amounts are before the courts. At present, only one case (*St. Mary's)* has received a decision, and that decision is still within the time period where it may be appealed. Many of the others are stayed pending its resolution. Below is a sampling, where "*" designates a case in which the Board dismissed the 1986 issue.

St. Mary's Reg'l Med. Ctr. v. Becerra, 1:23-cv-1594-RCL, 2024 WL 5186641 (D.D.C. Dec. 20, 2024), *appealed from* Board dec. dated Apr. 6, 2023 (lead Case No. 19-1723GC);

Nea Baptist Mem'l Hosp. et al v. Becerra, 1:24-cv-00419 (D.D.C. filed Feb. 12, 2024) *stayed pending resolution of St. Mary's*, *appealed from* Board dec. dated Dec. 14, 2023 (lead Case No. 19-0520GC);

Baystate Franklin Med. Ctr. et al v. Becerra, 1:24-cv-00822 (D.D.C. filed Mar. 22, 2024) *stayed pending resolution of St. Mary's*, *appealed from* Board dec. dated Jan. 23, 2024 (lead Case No. 19-1094GC);

Acadia Gen. Hosp., Inc. et al v. Becerra, 1:24-cv-00936 (D.D.C. filed Apr. 1, 2024) *stayed pending resolution of St. Mary's*, *appealed from* Board dec. dated Jan. 31, 2024 (lead Case No. 19-0847GC);

Catholic Med. Ctr. et al v. Becerra, 1:24-cv-01231 (D.D.C. filed Apr. 26, 2024) *stayed pending resolution of St. Mary's*, *appealed from* Board dec. dated Feb. 28, 2024 (lead Case No. 19-0696GC);

Capital Health Med. Ctr. Hopewell et al v. Becerra, 1:24-cv-01240 (D.D.C. filed Apr. 26, 2024) *stayed pending resolution of St. Mary's*, *appealed from* Board dec. dated Feb. 28, 2024 (lead Case No. 19-0695GC);

Alameda Health Sys. et al v. Becerra, 1:24-cv-01259 (D.D.C. filed Apr. 29, 2024) *stayed pending resolution of St. Mary's*, *appealed from* Board dec. dated Feb. 28, 2024 (lead Case No. 19-0355GC);

Washington Hosp. Ctr. Corp. et al v. Becerra, 1:24-cv-01243 (D.D.C. filed Apr. 26, 2024) *stayed pending resolution of St. Mary's*, *appealed from* Board dec. dated Feb. 29, 2024 (lead Case No. 19-0456GC);

Albany Med. Ctr. et al v. Becerra, 1:24-cv-01258 (D.D.C. filed Apr. 29, 2024) *stayed pending resolution of St. Mary's*, *appealed from* Board dec. dated Feb. 29, 2024 (lead Case No. 19-0212G);

New York City Health and Hosp. Corp. et al v. Becerra, 1:24-cv-01302 (D.D.C. filed May 3, 2024) *stayed pending resolution of St. Mary's*, *appealed from* Board dec. dated Mar. 4, 2024 (lead Case No. 19-1643GC);

Northwestern Mem'l Hosp. et al v. Becerra, 1:24-cv-01309 (D.D.C. filed May 3, 2024) *stayed pending resolution of St. Mary's*, *appealed from* Board dec. dated Mar. 4, 2024 (lead Case No. 19-0295);

**Adena Reg'l Med. Ctr. et al v. Becerra*, 1:24-cv-03336 (D.D.C. filed Nov. 26, 2024) *appealed from* Board dec. dated Sept. 27, 2024 (lead Case No. 18-1646G);

**Christus St. Frances Cabrini Hosp. et al v. Becerra*, 1:24-cv-03355 (D.D.C. filed Nov. 27, 2024) *related St. Mary's*, *appealed from* Board dec. dated Sept. 30, 2024 (lead Case No. 20-2104GC);

**Armstrong County Mem'l Hosp. et al v. Becerra*, 1:24-cv-03359 (D.D.C. filed Nov. 27, 2024) *related St. Mary's*, *appealed from* Board dec. dated Sept. 30, 2024 (lead Case No. 24-1601G);

**Alameda Health Sys. et al v. Becerra*, 1:24-cv-03357 (D.D.C. filed Nov. 27, 2024) *related St. Mary's*, *appealed from* Board dec. dated Sept. 30, 2024 (lead Case No. 19-0354GC); and

St. Barnabas Med. Ctr. et al v. Becerra, 1:24-cv-03363 (D.D.C. filed Nov. 29, 2024) *related St. Mary's*, *appealed from* Board dec. dated Sept. 30, 2024 (lead Case No. 19-1143GC).

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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

RE: ***Board Determination on Pending CIRP Group Without Participants***

CHS CY 2015 Part C Days Retroactive Final Rule CIRP Group
Case Number: 25-1011GC

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("the Board") has reviewed the subject common issue related party ("CIRP") group appeal and notes that it was not properly filed. The pertinent facts and the Board's determination are set forth below.

Pertinent Facts:

On **December 9, 2024**, Quality Reimbursement Services, Inc. ("QRS") filed a CIRP group on behalf of Community Health Services ("CHS") for the calendar year ("CY") 2015 Part C Days Retroactive Final Rule issue under Case No. 25-1011GC. The group appeal was formed in the Office of Hearings Case & Document Management System ("OH CDMS") without any participants.

On **January 9, 2025**, the Medicare Contractor filed its Rule 15.2 Review letter in which it requested dismissal of the group. The Medicare Contractor advised that there have been no providers added or transferred into the group and, therefore, it was not properly initiated in accordance with 42 C.F.R. § 405.1837(b)(2) and Board Rule 12.6.1.

Board Determination:

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

42 C.F.R. § 405.1837(b)(1) discusses the use of Mandatory groups and states:

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

42 C.F.R. § 405.1837(b)(3) provides the details for initiating a group appeal and indicates:

> With respect to group appeals brought under paragraph (b)(1) of this section, one or more commonly owned or operated providers must make a written request for a Board hearing as a group appeal in accordance with paragraph (c) of this section. Any group appeal filed by a single provider must be joined by related providers on common issues in accordance with paragraphs (b)(1) and (e) of this section….

Regarding the establishment of groups in OH CDMS, the commentary under Board Rule 12.1 indicates:

> . . . if a group is to be formed solely through transfers, it **may initially** be established in OH CDMS **with no participating providers. In such cases, the providers must be transferred i*mmediately* following the establishment of the group case** in order to fulfill the regulatory requirement for the minimum number of providers per Rule 12.6. **The Board will close all group cases that do not meet the minimum participant requirements**.[1,2]

Board Rule 12.6.1, goes on to state that "[a] CIRP group **may be initiated by a single provider under common ownership or control**, but at least two different providers must be in the group upon full formation. (*See* Rule 19.)"[3]

The Board finds that the subject group appeal, under Case No. 25-1011GC, is a CIRP group that was formed without any providers. Further, there have been no additions or transfers to the group in the more than forty days since its formation. Because the CIRP group was not filed in compliance with Board Rules or the regulations, the Board hereby dismisses the CIRP group, Case No. 25-1011GC.[4] 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.

Finally, the Board notes that QRS has filed many group appeals, both CIRP and optional, over the years. It is also noted that QRS is not new to using OH CDMS, which became mandatory

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[1] Board Rules v, 3.2 (Dec. 15, 2023)
[2] Bold emphasis added.
[3] Bold emphasis added.
[4] Should QRS identify any CHS participants appealing this issue for CY 2015, it may form a new CIRP group by either effectuating a transfer or by including a CIRP provider when the group is formed (i.e., Direct Add from receipt of the NPR/RNPR).

for all filings after November 2021. The improper formation of this "provider-less" CIRP group appears to be an attempt by QRS to create a "holding spot" for the future addition or transfer of related providers pursuing the Part C Days Retroactive Final Rule issue. Although the Commentary at Board Rule 12.1 does permit a "shell" to be formed in OH CDMS, it is only on a limited basis - for the sole purpose of allowing the ***transfer*** of issues from pending individual appeals. QRS' formation of this CIRP group, where there have been no transfers effectuated in over forty days, violates the intent of the Board's rules and creates an unnecessary administrative burden on the Board and its staff (***i.e.***, having to formally dismiss the CIRP group.) The Board admonishes QRS for again failing to follow Board Rules governing the formation of a group.[5] The Representative is on notice that if this type of filing violation continues, the Board may prohibit the Representative from re-filing a perfected CIRP group for the same issue/CY in future cases.

Board Members:
Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.

For the Board:

1/22/2025

X Kevin D. Smith, CPA

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

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services
Byron Lamprecht, WPS Government Health Administrators (J-5)

[5] The Board has recently dismissed QRS optional groups formed with only a single provider. See January 15, 2025 determination issued in Case No. 25-0972G, and January 17, 2025 determination issued in Case Nos. 20-1971GC and 20-1973GC.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Expedited Judicial Review Determinations***
New York Presbyterian Hospital (Provider Number 33-0101)
FYE: 12/31/2005
Case Number: 25-0819

New York Presbyterian Hospital (Provider Number 33-0101)
FYE: 12/31/2006
Case Number: 25-0820

Dear Ms. Webster and Ms. Decker:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' two Petitions for Expedited Judicial Review ("EJR") filed on November 25, 2024, in the two (2) above-referenced group appeals. Additionally, the Board has reviewed the Jurisdictional Challenges filed on December 2 and 3, 2024 respectively, and the Provider's responses. The Board's decision ***denying*** the Jurisdictional Challenge and ***granting*** EJR for the two (2) above-referenced individual appeals is set forth below.

Issue:

Each of these appeals is from a Revised Notice of Program Reimbursement ("RNPR") and contains substantively identical filings.

On **November 19, 2024**, the Board received the Provider's individual appeal requests. The Individual Appeal Requests both contain one (1) issue:

1. Post-*Allina II* DSH Part C Days

In both cases the provider challenges the DSH calculation of days for patients who were enrolled in Medicare Advantage plans ("Part C Days") in the aftermath of the *Allina II* litigation and contends that Part C days must be excluded in their entirety from the SSI fraction and included in the numerator of the Medicaid fraction for patients eligible for Medicaid.

Background:

A. RNPR Appeals

The Code of Federal Regulations provides for an opportunity for a reopening and issuance of a RNPR at 42 C.F.R. § 405.1885 (2023), 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)) 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 (2023)[1] explains the issue specific nature of a cost report revision on appeal:

> (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.

As outlined above, when a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[2]

B. Medicare DSH Payment

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the

[1] *See also Flint v. Azar,* 464 F. Supp. 3d. 1 (D.D.C. 2020)*; Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F. Supp. 3d 348 (D.D.C. 2014); *HCA Health Services of OK v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994).
[2] 42 C.F.R. § 405.1889(b)(1).

prospective payment system ("PPS").[3] Under PPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[4]

The PPS statute contains several provisions that adjust reimbursement based on hospital-specific factors.[5] This case involves the hospital-specific DSH adjustment, which requires the Secretary to provide increased PPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[6]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[7] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and the amount of the DSH payment to be paid to a qualifying hospital.[8] The DPP is defined as the sum of two fractions expressed as percentages.[9] Those two fractions are referred to as the "Medicare/SSI fraction" and the "Medicaid fraction." Both fractions consider whether a patient was "entitled to benefits under part A."

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

> the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were ***entitled to benefits under part A*** of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were ***entitled to benefits under part A*** of this subchapter . . . .[10]

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.[11]

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

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

> 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.[12]

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.[13]

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

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

In the September 4, 1990, Federal Register, the Secretary[14] stated that:

> Based on the language of section 1886(d)(5)(F)(vi) of the Act [42 U.S.C. § 1395ww(d)(5)(F)(vi)], which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A," we believe it is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs, and therefore, were unable to fold this number into the calculation [of the DSH adjustment]. However, as of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[15]

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[16]

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[12] (Emphasis added.)
[13] 42 C.F.R. § 412.106(b)(4).
[14] of Health and Human Services.
[15] 55 Fed. Reg. 35990, 35994 (Sept. 4, 1990).
[16] *Id.*

With the creation of Medicare Part C in 1997,[17] Medicare beneficiaries who are entitled to Medicare Part A benefits may elect to receive managed care coverage under Medicare Part C and, following that election, the beneficiary's benefits are no longer administered under Medicare Part A.[18] As part of the federal fiscal year ("FFY") 2004 IPPS proposed rule, the Secretary noted she had received "questions whether patients enrolled in an M+C Plan should be counted in the Medicare fraction or the Medicaid fraction of the DSH patient percentage calculation." In response to those questions, the Secretary proposed:

> . . . to clarify that *once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage. These patient days should be included in the count of total patient days in the Medicaid fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction . . . .*[19]

The Secretary did not finalize that policy in the FFY 2004 IPPS final rule because the Secretary had not yet completed review of the large number of comments received.[20]

In the FFY 2005 IPPS proposed rule, the Secretary referenced the Part C proposal in the FFY 2004 IPPS proposed rule and stated her intention to address the comments received on that proposal in the FY 2005 IPPS final rule.[21] In the FFY 2005 IPPS final rule, the Secretary purportedly changed her position by noting she was "revising our regulations at [42 C.F.R.] § 412.106(b)(2)(i) to include the days associated with [Part C] beneficiaries in the Medicare fraction of the DSH calculation."[22] In response to a comment regarding this change, the Secretary explained that:

> . . . *We do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A. We agree with the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days*

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[17] The Medicare Part C program did not begin operating until January 1, 1999. *See* P.L. 105-33, 1997 HR 2015*, codified as* 42 U.S.C. § 1394w-21 Note (c) "Enrollment Transition Rule.- An individual who is enrolled [in Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered to be enrolled with that organization on January 1, 1999, under part C of Title XVIII . . . if that organization as a contract under that part for providing services on January 1, 1999 . . . ." This was also known as Medicare+Choice. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub.L. 108-173), enacted on December 8, 2003, replaced the Medicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.
[18] 68 Fed. Reg. 27154, 27208 (May 19, 2003).
[19] *Id.* (italics emphasis added).
[20] 68 Fed. Reg. 45346, 45422 (Aug. 1, 2003).
[21] 69 Fed. Reg. 28196, 28286 (May 18, 2004).
[22] 69 Fed. Reg. at 48916, 49099 (Aug. 11, 2004).

> *associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.*[23]

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

Although the change in DSH policy regarding 42 C.F.R. § 412.106(b)(2)(i) was included in the August 11, 2004, Federal Register, it was not codified into the Code of Federal Regulations. The Secretary did not codify the policy change until August 22, 2007, when the FFY 2008 IPPS final rule was issued.[24] In that publication the Secretary noted that no regulatory change had in fact occurred and announced that she had made "technical corrections" to the regulatory language consistent with the change adopted in the FFY 2005 IPPS final rule. These "technical corrections" are reflected at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).[25] As a result of these rulemakings, Part C days were required to be included in the Medicare fraction as of October 1, 2004 (the "Part C DSH policy"). Subsequently, as part of the FFY 2011 IPPS final rule published on August 15, 2010, the Secretary made a minor revision to §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) "to clarify" the Part C DSH policy by replacing the word "or" with "including" in reference to Medicare Advantage (Part C).[26]

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

First, in 2011, the D.C. Circuit held that the Secretary's Part C policy in the FY 2005 IPPS Final Rule could not be applied retroactively for fiscal years 1999 through 2002, but did not address whether it could be applied to later years or whether the interpretation was reasonable.[27] In 2014, the D.C. Circuit in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[28] vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005

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[23] *Id.* (emphasis added).
[24] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[25] *Id*. at 47411.
[26] 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: "We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word 'or' with the word 'including' in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B)."); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff'd in part and rev'd in part*, 746 F. 3d 1102 (D.C. Cir. 2014).
[27] *Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1, 17 (D.C. Cir. 2011).
[28] 746 F. 3d 1102 (D.C. Cir. 2014).

IPPS rule.[29] In vacating the final rule, it reasoned that this deprived the public of adequate opportunity for notice and comment before the final rule was promulgated in 2004.[30] However, the Secretary has not acquiesced to that decision.

In 2013, the Secretary promulgated a new rule that would include Part C days in the Medicare fraction for fiscal years 2014 and beyond.[31] However, at that point, no new rule had been adopted for FFYs 2004-2013 following the D.C. Circuit's decision in *Allina I* to vacate the Part C policy adopted in the FFY 2005 IPPS final rule. In 2014 the Secretary published Medicare fractions for fiscal year 2012 which included Part C days.[32] A number of hospitals appealed this action.[33] In *Azar v. Allina Health Services* ("*Allina II*"),[34] the Supreme Court held that the Secretary did not undertake appropriate notice-and-comment rulemaking when it applied its policy to fiscal year 2012, despite having no formal rule in place.[35] There was no rule to vacate in this instance, and the Supreme Court merely affirmed the D.C. Circuit's decision to remand the case "for proceedings consistent with [its] opinion."[36] The Supreme Court did not reach the question of whether the policy to count Part C days in the Medicare fraction was impermissible or unreasonable.[37]

On August 6, 2020, the Secretary published a notice of proposed rulemaking to adopt a policy to include Part C days in the Medicare fraction for fiscal years prior to 2013.[38] On August 17, 2020, CMS issued CMS Ruling 1739-R stating that, as "CMS has announced its intention to conduct the rulemaking required by the Supreme Court's decision in *Allina [II*]":

> This Ruling provides notice that the Provider Reimbursement Review Board (PRRB) and other Medicare administrative appeals tribunals lack jurisdiction over certain provider appeals regarding

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[29] *Id*. at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").
[30] *Id.* at 2011.
[31] 78 Fed. Reg. 50496, 50614 (Aug. 19, 2013).
[32] *See Allina Health Services v. Price*, 863 F.3d 937, 939-940 (D.C. Cir. 2017).
[33] The Board takes administrative notice that, in the Complaint filed to establish the Allina II litigation, none of the 9 Plaintiff hospitals based their right to appeal on the publication of the SSI fractions pursuant to 42 U.S.C. § 1395oo(a)(1)(A)(ii). Rather, the Complaint makes clear that each of the 9 Plaintiff hospitals based their right to appeal on the failure of the Medicare Contractor to timely issue an NPR as set forth in 42 U.S.C. § 1395oo(a)(1)(B) as implemented at 42 C.F.R. 405.1835(c) (2014). Allina Health Servs. v. Burwell, No. 14-01415, Complaint at ¶¶ 38-39 (D.D.C. Aug. 19, 2014) (stating: 38. . . . None of the [9] plaintiff Hospitals has received an NPR reflecting final Medicare DSH payment determinations for their cost reporting periods beginning in federal fiscal years 2012. 39. As a result, the [9] plaintiff Hospitals timely filed appeals to the Board, pursuant to 42 U.S.C. §§ 1395oo(a)(1)(B), to challenge the agency's treatment of Medicare part C days as Medicare part A days for purposes of the part A/SSI fraction and the Medicaid fraction of the Medicare DSH calculation for their 2012 cost years." (footnote omitted and emphasis added)).
[34] 139 S. Ct. 1804 (2019).
[35] *Id.* at 1817.
[36] *Id.*; *Allina Health Services v. Price*, 863 F.3d at 945.
[37] 139 S. Ct. at 1814.
[38] 85 Fed. Reg. 47723 (Aug. 6, 2020).

> the treatment of patient days associated with patients enrolled in Medicare Advantage plans in the Medicare and Medicaid fractions of the disproportionate patient percentage; this ruling applies only to appeals regarding patient days with discharge dates before October 1, 2013 that arise from Notices of Program Reimbursement (NPRs) that are issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013 or that arise from an appeal based on an untimely NPR under 42 U.S.C. 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for that fiscal year pre-dates the new final rule.[39]

The Secretary did not change the proposed rule and issued it in final on June 9, 2023.[40] Relevant to the instant EJR Request, the June 2023 Final Rule provides the following guidance on the extent to which it is to be applied *retroactively*:

> [T]he Secretary has determined that it is in the public interest for CMS to adopt a retroactive policy for the treatment of MA patient days in the Medicare and Medicaid fractions through notice and comment rulemaking for discharges before October 1, 2013 (the effective date of the FY 2014 IPPS final rule). CMS must calculate DSH payments for periods that include discharges occurring before the effective date of the prospective FY 2014 IPPS final rule for hundreds of hospitals whose DSH payments ***for those periods are still open or have not yet been finally settled***, encompassing thousands of cost reports.[41]

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

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

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

> the Supreme Court's decision in *Allina II*, he could not defend such appeals of fractions issued in the absence of a valid regulation.[42]

Finally, the following excerpts from the June 9, 2023, Final Rule discussing a hospital's right to challenge the Part C days policy adopted therein make clear that the Secretary did not consider the final rule or subsequent publication of SSI ratios to be an appealable "final determination":

1. "Additionally, the Secretary has determined that it is in the public interest for CMS to adopt a retroactive policy for the treatment of MA patient days in the Medicare and Medicaid fractions through notice and comment rulemaking for discharges before October 1, 2013 (the effective date of the FY 2014 IPPS final rule). *CMS must calculate DSH payments for periods that include discharges occurring before the effective date of the prospective FY 2014 IPPS final rule for hundreds of hospitals* ***whose DSH payments for those periods are still open or have not yet been finally settled, encompassing thousands of cost reports***. *In order to calculate these payments, CMS* ***must*** *establish Medicare fractions for* ***each*** *applicable cost reporting period* during the time period for which there is currently no regulation in place that expressly addresses the treatment of Part C days."[43]

2. "We do not agree that it is arbitrary or capricious to treat hospitals' Part C days differently on the basis of the timing of their appeals vis-à-vis Supreme Court and lower court decisions. The instructions to contractors that issued after the *Northeast* decision cannot control over the holding of the Supreme Court in *Allina II.* It is also not unusual for cost reports to be finalized differently from one another with respect to a legal issue depending on the outcome of litigation raising that issue and the status of a hospital's appeal at the time of a final non-appealable decision. Providers will also be able to request to have their Medicare fraction realigned to be based on their individual cost reporting periods rather than the Federal fiscal year, in accordance with the normal rules. **Providers who remain dissatisfied after receiving NPRs and revised NPRs that reflect the interpretation adopted in this final action retain appeals rights and can challenge the reasonableness of the Secretary's interpretation set forth in this final action**."[44]

3. "Providers who have pending appeals reflecting fractions calculated in the absence of a valid rule will receive NPRs or revised NPRs reflecting DSH fractions calculated pursuant to this new final action and *will have appeal rights with respect to the treatment of Part C days in the calculation of the DSH fractions* ***contained in the NPRs or revised NPRs***. Providers whose appeals of the Part C days issue have been remanded to the Secretary *will likewise receive NPRs or revised NPRs* reflecting fractions calculated pursuant to this new final action, *with attendant appeal rights*. Because NPRs and revised NPRs will reflect the application of a new DSH Part C days rule, CMS will have taken action under the new action, and *the new or revised* ***NPRs*** *will provide hospitals with a* ***vehicle to appeal*** *the new final action* even if the Medicare fraction or DSH payment does not change numerically."[45]

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[42] 88 Fed. Reg. at 37788 (emphasis in original).
[43] 88 Fed. Reg. at 37774-75 (emphasis added).
[44] *Id.* at 37787 (underline and bold emphasis added and italics emphasis in original).
[45] *Id.* at 37788 (emphasis added).

4. "*When the Secretary's treatment of Part C days in this final action is reflected* ***in NPRs and revised NPRs****, providers*, including providers whose appeals were remanded under the [CMS] Ruling [1739-R], *will be able to challenge the agency's interpretation* ***by appealing those NPRs and revised NPRs***. While some providers have already received reopening notices and had their NPRs held open for resolution of the Part C days issue, the issuance of new NPRs and revised NPRs pursuant to remands under the Ruling are not reopenings."[46]

The above discussion in the preamble to the June 9, 2023, Final Rule makes clear that hospitals covered by that Final Rule would have appeal rights maturing with the yet-to-be-issued NPRs (original or revised) that would apply the finalized policy.

Provider's Appeal Requests:

The statement of issue in both cases states that the issue concerns the proper treatment in the Medicare DSH calculation of days for Medicare Part C patients in the aftermath of the *Allina* litigation. The Provider contends that the Part C days must be included in the numerator of the Medicaid fraction and excluded from the numerator and denominator of the SSI fraction.[47]

The Provider characterized the relevant background facts as follows:

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

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

3. In *Allina II*, the Supreme Court affirmed a D.C. Circuit decision that "the Secretary's continued application of the same [Part C days] standard from the 2004 rule in the 2012 SSI fractions published in 2014 was procedurally invalid because 42 U.S.C. § 1395hh(a)(2) required the Secretary to engage in notice-and-comment rulemaking to adopt the 2004 standard . . . . The Supreme Court's decision did not address the D.C. Circuit's alternate ruling that the readopted policy was also invalid under 42 U.S.C. § 1395hh(a)(4) because the Secretary failed to engage in notice-and-comment rulemaking and the policy could not 'take effect' under the terms of the statute until after proper notice-and-comment rulemaking."[48]

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

Based on the above, the Provider maintains that the retroactive re-adoption of the Part C days policy in the June 2023 Final Rule "is substantively and procedurally invalid and must be set aside because it was taken without observance of procedure required by law, exceeds the

[46] *Id.* (emphasis added).
[47] Appeal Request (Case No. 25-0819), Statement of Issue at 1 (Nov. 19, 2024).
[48] *Id.* (citing to 139 S. Ct. at 1816).

agency's statutory authority, and it is otherwise contrary to law, arbitrary and capricious, an abuse of discretion, and unsupported by substantial evidence."[49]

The Provider also claims that the vacatur of the 2004 rule in *Allina I* effectively restored the pre-2004 DSH Part C standard embodied in the 1986 regulation. Since that policy was established through notice-and-comment rulemaking, the Provider argues that the Secretary is incorrect in alleging it needed to engage in further notice-and-comment rulemaking to establish such a standard.[50] The Provider further argues that the retroactive nature of the new Part C regulation violates 42 U.S.C. § 1395hh(e) "because neither of the narrow exceptions for retroactive rulemaking applies here . . ." First, the "DSH statute does not require any specific treatment of Part C days" and second, the new regulation "cannot be said to be in the public interest." It also notes there is a well-established presumption in law against retroactivity.[51] The Provider claims that the new Part C regulation violates *Allina II* and is procedurally invalid and arbitrary and capricious based on the lack of explanation for changing from the pre-2004 standard and the lack of consideration or recognition of the severe impact it will have on hospitals.[52]

Provider's Request for EJR:

The Provider's requests for Expedited Judicial Review ("EJR") reiterates the same arguments in the Statements of Issue included with the RNPRs. It notes that after the issuance of the original NPR, the Provider challenged the 2004 final DSH part C days rule. In both cases, the Provider requested and was granted EJR. Ultimately, the RNPRs were issued and the Provider claims the impact for these appeals are as follows:

- $2,431,507, from PRRB Case No. 25-0819, FYE 12/31/2005;
- $5,803,817, from PRRB Case No. 25-0820, FYE 12/31/2006;

reflecting the increase to the Provider's DSH payment if Medicare part C days were properly excluded from the SSI fraction and included in the Medicaid fraction numerator for the cost year at issue.[53]

The Medicare Contractor filed responses to the Requests for EJR on December 2, 2024. The entirety of the response is as follows:

> Federal Specialized Services ("FSS"), as representative for the Medicare Administrative Contractors ("MAC"), writes to advise that a jurisdictional

[49] *Id.* at 2 (citing 4 U.S.C. § 706(2)).
[50] *Id.* (citing 88 Fed. Reg. at 37776).
[51] *Id.* (citing *Bowen v. Georgetown Univ. Hospital*, 488 U.S. 204, 208 (1988); *Landgraf v. USI Film Prods.*, 511 U.S. 244, 245 (1994)).
[52] *Id.*
[53] *See e.g.,* PRRB Case No. 25-0820, Provider's Petition for Expedited Judicial Review – Post-*Allina II* DSH Part C Days Issue at 10 (Nov. 25, 2024).

challenge will be filed challenging the Board's jurisdiction for lack of a final determination.[54]

Jurisdictional Challenge:

The Medicare Contractor's Jurisdictional Challenge requested the Board to dismiss the issue because the Provider is appealing from an RNPR that does not include a final determination regarding the specific item at issue,[55] and points to Audit Adjustments Nos. 1 and 2, which revised Medicaid Eligible days and revised the DSH percentage in accordance with the audited DSH calculation, respectively.[56]

The Provider responded that CMS has stated in the June 2023 final Part C days rule and in federal court that "[p]roviders have a right to appeal where they are dissatisfied with a revised NPR issued by the contractor, applying the policy adopted retroactively in the June 2023 rule, regardless of whether any changes are made to the DSH payment or underlying calculation."[57] Further, the Provider contends the MAC's own workpapers show that the revised NPRs clearly applied that rule.[58]

Decision of the Board:

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

A. Jurisdiction

An individual Provider generally has a right to a hearing before the Board with respect to specific items claimed on timely filed cost reports if:

- It is dissatisfied with final determinations of the Medicare Contractor;
- The request for a hearing is filed within 180 days of the date of receipt of the final determinations. Providers must appeal from a "final determination" related to their cost

[54] *See e.g.,* PRRB Case No. 25-0820, Response to Provider's Request for Expedited Judicial Review (Dec. 2, 2024).
[55] *See e.g.,* PRRB Case No. 25-0820, Medicare Contractor's Jurisdictional Challenge at 2 (Dec. 3, 2024).
[56] *Id*.
[57] Provider's Response to MAC's Jurisdiction Challenges at 14 (Jan. 2, 2025).
[58] *Id*. *See also* Ex. P-5.

report or payment, which includes an NPR, a Revised NPR, or failure to timely issue a final determination; [59] and

- The amount in controversy is $10,000 or more.[60]

As set forth below, the Board ***denies*** the Medicare Contractor's jurisdictional challenges filed in each appeal and finds that it does have jurisdiction over the Post-*Allina II* DSH Part C Days issue in each appeal.

Although the audit adjustment reports for the appeals at issue do not indicate that there was an adjustment to the SSI Percentage or the Part C days issue, the Provider's representative included the following email correspondence between the Provider and the MAC:

> From Provider to MAC:
>
> New York-Presbyterian (33-0101) recently received revised NPRs dated July 2, 2024, for its cost years ending December 31, 2005 and December 31, 2006. Based upon our review, these RNPRs appear to address the Medicaid eligible days issue only and do not appear to implement or address CMS's June 2023 final action and/or CMS Transmittal 12513 (Change Request 13294) relating to Part C days in the DSH calculation. We would appreciate your confirmation that our understanding is correct.
>
> If we do not hear from you, we will assume that our understanding is correct and that NGS intends to separately address the Part C days issue in a different NPR applying the Part C Rule for these years in the near future.
>
> MAC Response:
>
> The RNPRs dated 7/2/2024 for 33-0101 12/31/2005 R-A and 12/31/2006 R-A did include a review of CR-13294. I have attached the workpapers for you. Neither of the SSIs changed, therefore, revisions were not necessary.[61]

The Provider's representative also supplied workpapers which indicate in the "Purpose" statement that the review was, "[t]o ensure the SSI is accurately reported on the cost report for the implementation of the June 9, 2023 Final Rule (88 FR 37772) regarding the Treatment of

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[59] 42 U.S.C. § 1395oo(a)(1)(A)(i); *see also Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 144-145 (D.C. Cir. 1986).
[60] 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835 – 1840.
[61] Provider's Jurisdictional Challenge Response, Ex. 4 (Jan. 2, 2025).

Medicare Part C Days in the Calculation of a Hospital's Medicare Disproportionate Share Patient Percentage."[62]

42 C.F.R. § 405.1889 governs the scope of appeals once a contractor determination is "reopened as provided in § 405.1885." In this circumstance, Providers have *limited* appeal rights and are only able to appeal issues or matters that were "specifically revised" in the RNPR. In the June 9, 2023, Final Rule, however, the Secretary made clear that the Part C Days rule could be appealed following the issuance of a new NPR or RNPR "***even if the Medicare fraction or DSH payment does not change numerically.***"[63] Thus, the new rule could be appealed even if the treatment of Part C Days was not "specifically revised."

Following the issuance of a RNPR, the Secretary stated that Providers "***will have appeal rights with respect to the treatment of Part C days in the calculation of the DSH fractions contained in the NPRs or revised NPRs***[,]" "**will be able to challenge the agency's interpretation** [of the treatment of Part C days in this final action] by appealing those NPRs and revised NPRs[,]" and further stated that they "**can challenge the reasonableness of the Secretary's interpretation set forth in this final action**."[64] Therefore, as the Providers are appealing from RNPRs that were issued as a result of the June 9, 2023, Final Rule, the Board finds that it has jurisdiction and ***denies*** the MAC's Jurisdictional Challenge.

Further, the provider appealed within 180 days of the issuance of its RNPRs and the amount in controversy exceeds $10,000 in both appeals.

Therefore, the Board finds that the Provider in Cases 25-0819 and 25-0820 filed timely appeals from their RNPRs concerning the same common issue related to the June 9, 2023, Final Rule which set forth a retroactive policy regarding the treatment of Part C Days. The same Final Rule made clear that the Part C Days policy could be appealed from these RNPRs, even if there was no change in payment. The Board also finds that the amount in controversy in each case exceeds $10,000 as required by 42 C.F.R. § 405.1835(a)(2). The Board, however, is without the authority to grant the relief requested: to declare the Part C Days policy set forth in the June 9, 2023, Final Rule invalid.

B. Board's Decision Regarding the EJR Requests

The Board finds that:

1) It has jurisdiction over the Part C Days policy issue, as set forth in the June 9, 2023, Final Rule, for the subject years in these cases and that the Provider in Case Nos. 25-0819 and 25-0829 is entitled to a hearing before the Board;

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[62] *Id.* at Ex. 5 at 1.
[63] 88 Fed. Reg. at 37788 (emphasis added).
[64] *Id.* at 37787-88 (emphasis added).

2) Based upon the Providers' assertions regarding the Post-*Allina II* DSH Part C Days Issue, as set forth in the June 9, 2023, Final Rule, there are no findings of fact for resolution by the Board;

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

4) It is without the authority to decide the legal question of whether the Post-*Allina II* DSH Part C Days Issue, as set forth in the June 9, 2023, Final Rule, is substantively or procedurally valid.

Accordingly, the Board finds that the question of the validity of the DSH Part C Days policy issue, as set forth in the June 9, 2023, Final Rule, properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Provider's requests for EJR for the issue and the subject years in Case Nos. 25-0819 and 25-0820.

The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in these individual appeals, the Board hereby closes these cases.

Board Members Participating:

Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.

FOR THE BOARD:

1/31/2025

X Kevin D. Smith, CPA

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

cc: Wilson Leong, Federal Specialized Services