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

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

Mr. Byron Lamprecht
Supervisor, Cost Report Appeals
WPS Government Administrators (J-5)
1000 N 90th Street, Suite 302
Omaha, NE 68114-2708

RE: **DETERMINATION RE: TIMELY FILING OF APPEAL**
Stormont Vail Hospital
Provider Number: 17-0086
Appealed Period: FYE 9/30/2020
PRRB Case Number: 24-2616

Dear Messrs. Ravindran and Lamprecht:

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

BACKGROUND:

On September 20, 2024, the above-captioned Provider filed an appeal for its Fiscal Year End ("FYE") 9/30/2020. The final determination, upon which the appeal is based, was dated March 18, 2024. The Confirmation of Correspondence generated by the Office of Hearings Case and Document Management System ("OH CDMS") verifies that the appeal was filed on Friday, September 20, 2024. This filing date was 186 days after the March 18, 2024 date of the final determination.

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 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 receipt of the final determination. Specifically, 42 C.F.R. § 405.1835(a)(3) indicates that, unless the Provider qualifies for a good cause extension, the Board must receive a Provider's hearing request ***no later than 180 days after the date of receipt of the final determination, with a five-day presumption for mailing.***[1]

Board Rule 4.4.3, Due Date Exceptions, provides that if the due date falls on a Saturday, a Sunday, a federal legal holiday, (as enumerated in Rule 6(a) of the Federal Rules of Civil

[1] Emphasis added.

Procedure), or a day on which the Board is unable to conduct business in the usual manner, then the deadline becomes the next day that is not one of the aforementioned days. See 42 C.F.R. § 405.1801(d)(3).

Board Rule 4.5, Date of Receipt by the Board, states that the timeliness of a filing is determined based on the date of receipt by the Board, and the date of receipt is presumed to be the date of filing in OH CDMS as evidenced by the Confirmation of Correspondence generated by the system. See 42 C.F.R. § 405.1801(a)(2)(iii).

BOARD DETERMINATION:

After its review, the Board has determined that Quality Reimbursement Service's appeal request filed on behalf of Stormont Vail Hospital under case number 24-2616 was not timely filed in accordance with the regulations at 42 C.FR. §§ 405.1835(a)(3).

As noted in the facts above, the Medicare Contractor issued the NPR on March 18, 2024. Allowing for the 180-day appeal period and a five-day presumption for mailing, the 185th day fell on Thursday, September 19, 2024. The appeal was received on Friday, September 20, 2024, one day beyond the deadline. Since the appeal was untimely filed, the Board hereby dismisses case number 24-2616 in its entirety 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 105.1877.

BOARD MEMBERS:

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

FOR THE BOARD:

10/4/2024

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

cc: Wilson C. Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Ken Janowski
Strategic Reimbursement Group, LLC
16408 E. Jacklin Dr.
Fountain Hills, AZ 85268

Joseph Bauers
Federal Specialized Services
1701 S. Racine Avenue
Chicago, IL 60608-4058

RE: ***Notice of Dismissal***
Glendale Adventist Medical Centers (Provider Number 05-0239)
FYEs: 12/31/2000 and 12/31/2001
Case Numbers: 04-0141 and 08-1652

Dear Mr. Janowski and Mr. Bauers:

The Provider Reimbursement Review Board ("Board") has reviewed the documentation in Case Nos. 04-0141 and 08-1652. Set forth below is the decision of the Board to dismiss the two remaining issues in the above-referenced appeals, challenging the Medicare Contractor's calculation of the Direct Graduate Medical Education ("DGME or GME") and the Indirect Medical Education ("IME") payments for Medicare Plus Choice ("managed care") enrollees, due to the Provider's failure to respond to the Board's September 19, 2024 Request for Additional Information and failure to appear for the September 30, 2024 Pre-hearing Conference

Procedural History

Glendale Adventist Medical Center, ("Glendale"), Provider No. 05-0239, fiscal years ending ("FYEs") 12/31/00 and 12/31/01, filed timely Individual Appeal Requests on November 7, 2003 (Case No. 04-014) and March 19, 2008 (Case No. 08-1652), from Notice of Program Reimbursements ("NPRs") dated May 30, 2003 (Case No. 04-0141) and September 25, 2007 (Case No. 08-1652), appealing various issues. After issues were transferred or withdrawn the following issues remain in the appeals: the exclusion of managed care days from GME adjustment (Case Nos. 04-0141 and 08-1652), and the exclusion of managed care days from IME adjustment (Case No. 08-1652).

On **August 15, 2016,** the Provider's Representative, Ken Janowski, requested a postponement of the hearing scheduled for September 8, 2016, in Case Nos. 04-0141 and 08-1652 asserting:

> Please accept our apologies for requesting this late postponement to the Hearing scheduled on September 8, 2016. We have made our sincerest efforts to resolve the above appeals with a full resolution by this date but the respective parties have encountered timely documentation concerns to satisfy the Medicare Audit Contractors (MAC) review and potential request for information. We have been in

> constant contact with the MAC during the past several months but we have regretfully determined that we cannot fulfill all commitments for requests during the next few weeks due to information beyond our immediate control. The MAC has endorsed this request as they have been diligently preparing resolution agreements to satisfy all appeal years but have not yet to complete fiscal years 2000 to 2003.[1]

On **September 7, 2016** (Case No. 04-0141), and **September 12, 2016** (Case No. 08-1652), the Board rescheduled the hearing to May 10, 2017, in the above-referenced appeals. On **May 4, 2017**, the Provider Representative requested a ***second*** postponement of the hearing date in the above-referenced appeals asserting:

> Please accept our apologies for requesting this late postponement to the Hearing scheduled on May 10, 2017. We have made our sincerest efforts to resolve the above appeals with a full resolution by this date but we have encountered timely documentation concerns to satisfy two issues for each appeal case.
>
> The two issues refer to the Part C Indirect Medical Education (IME) and Part C Graduate Medical Education (GME) billing reimbursement. These two issues were the only remaining issues for PRRB Case No. 04-0141 for fiscal year December 31, 2000 and issue numbers 1 and 2 from PRRB Case No. 08-1652. These issues refer to submitting documentation on Medicare Part C billing for IME and GME reimbursement that was never completed due to conflicting billing and settlement directions at the time of billing. We have submitted a list of these Part C claims to CMS per the Medicare Audit Contractor (MAC) instructions, and we were contacted by CMS two days ago with a sample request list to audit our listing. As the claims are extremely old and archived, it will take at least one month to retrieve the requested data to satisfy the CMS documentation list. CMS has tentatively granted us at least thirty days from today's date to submit the data.
>
> As we are attempting to abide by CMS's deadline we are requesting at least a six month extension in order to submit the sampled data request and to allow time for CMS to audit the sampled documentation and for the provider to respond to any questions CMS may have from their audit results. We have contacted the MAC on this request and they have verbally agreed to submit our extension request to the Board.[2]

On **May 16, 2017**, the Board rescheduled the hearing in the above-referenced appeals to November 15, 2017. On **October 7, 2017**, via email, the Provider's Representative requested a ***third*** postponement of the hearing date asserting:

> The Provider and MAC have diligently been progressing towards a full resolution

[1] Provider's August 15, 2016 Request for Hearing Postponement at 1.
[2] Provider's May 4, 2017 Request for Hearing Postponement at 1 .

> on the above two cases for the past several years and it appears that there may only be two issues remaining for each case.
>
> In regards to Case Number 04-0141, a partial resolution was agreed to with the MAC on 22 of the 24 issues. The partial resolution was executed on September 6, 2016. The two remaining issues relate to the IME and GME Part C reimbursement.
>
> In regards to Case Number 08-1652, a partial resolution was forwarded to the Provider by the MAC in early August 2017 addressing 20 of the 22 issues. The Provider will review the MAC proposal and most likely accept the partial resolution by Monday, October 9. The two remaining issues again relate to the IME/GME Part C reimbursement
>
> As both cases involved the same issues (IME/GME Part C reimbursement), the provider will address the issues as one disagreement. During 2016 the Provider was instructed to provide detailed log information for all Medicare Part C claims that were not reimbursed. Due to fact that the Part C claims were over 15 years old, the Provider had significant challenges in obtaining all information to satisfy CMS request in completing Part C patient logs. The logs for both Case Number 04-0141 (fiscal year 2000) and Case Number 08-1652 (fiscal year 2001) were finalized with detailed impact on reimbursement and submitted to Ms. Dorothy Braunsar with CMS on April 15, 2017. After reviewing the data it was discovered that the logs contained significant errors in unpaid Part C data and Ms. Braunsar provided us with the opportunity to amend the reports so that the unpaid Part C data would contain no errors. After an exhaustive research of ancient data, the Provider was able to amend the reports and submit the amended Part C log data to CMS at the beginning of September 2017 for Case Number 04-0141 and at the end of September 2017 for Case Number 08- 1652. We are now at the stage of CMS sample selection from our detailed Part C logs and the Provider submission of detailed data to CMS.
>
> *Presuming that the MAC will agree*, the Provider is requesting a postponement of these two cases due to CMS sample selection and Provider submission of required sample data. The Provider anticipates that all audit steps to verification of the data should be completed with the next eight months. Therefore, the Provider is requesting a June 2018 rescheduled hearing data [sic] for both CNs 04-0141 and 08-1652.[3]

On **October 13, 2017**, the Board again rescheduled the hearing in the above-referenced appeals to July 9, 2018. **On June 21, 2018**, via email, the Provider Representative requested a ***fourth*** postponement of the hearing date in the above-referenced appeals asserting:

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[3] Provider's October 7, 2017 email to Rebecca Shirey, Board Advisor, Status Update Response (italics emphasis added).

> Please accept my apologies for not directly communicating with you during the past several weeks concerning our July 9 Hearing dates on the above two appeals but the Provider has reached out to both Cahaba and CMS on the outstanding issues several times and we have progressed to the point where the Provider is waiting for their respective responses. To summarize:
>
> CN 04-0141 -A partial resolution was completed last summer with all issues agreed to except the Part C billing. We had agreed that a complete listing of Part C claims would be forwarded to Dorothy Braunsar of which a sample of the listing would be selected for review. We complied with their request for sample and forwarded the data to CMS/OFM. However, Ms. Braunsar retired this January and our files had to be transferred to a new individual. We recently received notice that they did receive all of our data and, are now in the process of reviewing and compiling the data for allowability. As of last week's communication with CMS we received no timetable as to the finalization. –
>
> CN 08-1652 - Per the attached email on June 7 the Provider agreed to a Partial Resolution on all issues except the Part C Billing. Cahaba has stated that they have forwarded the resolution for final approval to FSS two weeks ago. The Provider has reached out to Cahaba late last week for an update to the Partial Resolution and they were to get back to us. As of today we have not received the formal agreement. However the Provider will immediately sign the Partial Resolution once received which will leave only the Part C billing issue. The Part C billing has been forwarded to CMS simultaneously with the FYE 12-31-00 and we are awaiting their response. See CN 04-0141 for a more descriptive process of events for the Part C issue.
>
> Based on prior resolutions we believe that the Partial Resolution for CN 08-1652 will be processed shortly. However the Part C billing issues for both appeal cases may not be finalized in time for our July 9 Hearing. Therefore the Provider requests that a final extension of time be granted by the Board in order for CMS to finalize the Part C billing issue for both appeals.[4]

On **June 29, 2018**, the Board rescheduled the hearing in the above-referenced appeals to November 23, 2018. **On November 13, 2018**, the hearing was rescheduled by the Board in the above-referenced appeals to November 13, 2019. On **October 29, 2019** (Case No. 04-0141), and **November 4, 2019** (Case No. 08-1652) the hearing was rescheduled by the Board in the above referenced appeals to November 17, 2020.

On **October 29, 2020**, the Provider Representative requested a ***fifth*** postponement of the hearing date in the above-referenced appeals asserting:

[4] Provider's June 21, 2018 email to Board Advisor, Rebecca Shirey, Status Update at 1.

> Let this letter serve as our request for a Hearing Postponement of the above PRRB Appeal Cases. Each of the above cases contain two issues that refer to the reconciliation of Managed Care Part C claims where the documentation of provider data must be submitted to CMS so that beneficiary eligibility can be established for proper recognition of Medicare Part C reimbursement. More directly, the reimbursement of Direct Graduate Medical Education (GME) and Indirect Medical Education (IME) have been affected by this reconciliation of Medicare Part C claims.
>
> At the beginning of this year the Provider was in final negotiations with CMS/OFM on a proposal to resolve the above cases pending the review of all Part C claims. However, the COVID-19 virus affected the continuance of these negotiations. Therefore, in accordance with PRRB Alert 19, the Provider is requesting another Hearing Postponement to finalize this resolution. Both appeals and issues effect only the finalization of Part C claims with CMS/OFM and the MAC has always supported the extension to these appeals.[5]

On **November 4, 2020**, the Board rescheduled the hearing in the above-referenced appeals to May 19, 2021. **On April 7, 2021**, the Provider requested a ***sixth*** postponement of the hearing date in the above-referenced appeals asserting again:

> Let this letter serve as our request for a Hearing Postponement of the above PRRB Appeal Cases. Each of the above cases contain two issues that refer to the reconciliation of Managed Care Part C claims where the documentation of provider data must be submitted to CMS so that beneficiary eligibility can be established for proper recognition of Medicare Part C reimbursement. More directly, the reimbursement of Direct Graduate Medical Education (GME) and Indirect Medical Education (IME) have been affected by this reconciliation of Medicare Part C claims.
>
> At the beginning of last year the Provider was in final negotiations with CMS/OFM on a proposal to resolve the above cases pending the review of all Part C claims. However, the COVID-19 virus affected the continuance of these negotiations. Therefore, in accordance with PRRB Alert 19, the Provider is requesting a Hearing Postponement to finalize this resolution. Both appeals and issues effect only the finalization of Part C claims with CMS/OFM and the MAC has always supported the extension to these appeals.[6]

On **April 8, 2021**, the Board rescheduled the hearing in the above-referenced appeals to November 17, 2021. On **September 29, 2021**, Provider requested a ***seventh*** postponement of the hearing date in the above-referenced appeals making an identical assertion as in its last postponement request:

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[5] Provider's October 29, 2020 Hearing Postponement Request at 1.
[6] Provider's April 7, 2021 Hearing Postponement Request at 1.

> Let this letter serve as our request for a Hearing Postponement of the above PRRB Appeal Cases. Each of the above cases contain two issues that refer to the reconciliation of Managed Care Part C claims where the documentation of provider data must be submitted to CMS so that beneficiary eligibility can be established for proper recognition of Medicare Part C reimbursement. More directly, the reimbursement of Direct Graduate Medical Education (GME) and Indirect Medical Education (IME) have been affected by this reconciliation of Medicare Part C claims.
>
> At the beginning of last year the Provider was in final negotiations with CMS/OFM on a proposal to resolve the above cases pending the review of all Part C claims. However, the COVID-19 virus affected the continuance of these negotiations. Therefore, in accordance with PRRB Alert 19, the Provider is requesting a Hearing Postponement to finalize this resolution. Both appeals and issues effect only the finalization of Part C claims with CMS/OFM and the MAC has always supported the extension to these appeals.[7]

On **October 4, 2021**, the Board rescheduled the hearing in the above-referenced appeals to May 18, 2022. On **April 13, 2022**, the Provider requested an ***eighth*** postponement of the hearing date in the above-referenced appeals making an identical assertion as in its last postponement request. On **April 14, 2022**, the Board rescheduled the hearing in the above-referenced appeals to November 17, 2022.

On **October 13, 2022**, the Provider requested a ***ninth*** postponement of the hearing date in the above-referenced appeals asserting again the exact same thing as in its last postponement request. On **October 18, 2022** (Case No. 04-0141) and **October 20, 2022** (Case No. 08-1652), the Board rescheduled the hearing for in the above-referenced appeals to May 24, 2023. On **April 11, 2023**, the Provider Representative requested a ***tenth*** postponement of the hearing date in the above referenced appeals asserting, again, the exact same thing as in its last postponement request. On **April 14, 2023**, the Board rescheduled to hearing in the above-referenced appeals to March 21, 2024. On **February 9, 2024**, the Provider requested an ***eleventh*** postponement of the hearing date in the above-referenced appeals asserting the exact same thing as in its last several postponement requests. On that same date, the Board rescheduled the hearing in the above-referenced appeals to **October 9, 2024**. On **August 30, 2024**, the Provider Representative requested a ***twelfth*** postponement of the hearing date in the above referenced appeals using the exact same wording as before (except the Provider added that it was requesting a six-month hearing postponement).

On **September 3, 2024**, the Medicare Contractor filed a Response to the Provider's Request for Hearing Extension objecting to the Provider's August 30, 2024 postponement request. The Medicare Contractor contends the Provider has submitted ***identical*** postponement requests on the following dates: • February 8, 2024 • April 11, 2023 • October 13, 2022 • April 12, 2022 •

[7] Provider's September 29, 2021 Hearing Postponement Request at 1.

September 29, 2021, and • April 7, 2021. The Medicare Contractor maintains it has been informed by CMS that there are no ongoing negotiations with the Provider to resolve the remaining issues relating to the exclusion of the managed care days from the IME and GME reimbursement. Thus, it objects to the Provider's rationale for the Postponement Request.[8]

On **September 19, 2024**, the Board sent the parties in the above-referenced appeals a Request for Additional Information letter ordering the Provider to file its response to the following requests no later than Wednesday, September 25, 2024:

> 1. In your August 30, 2024 letter you advise that CMS and the Provider are in final negotiations with full resolution. However, in the Medicare Contractor's September 3, 2024 Response to your Request for Postponement, the Medicare Contractor asserts it has been informed by CMS that there are no ongoing negotiations with the Provider to resolve the remaining issues. Please provide the status of the alleged final negotiations with CMS.
>
> 2. If final negotiations are ongoing, please provide the details of the ongoing negotiations including the date you last communicated with CMS regarding the GME/IME managed care issues in the above-referenced cases, with whom at CMS you communicated, the details and outcome of the communication, and any documentary proof of the communication (if available).
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> 3. If you are not in final negotiations with CMS, please advise if you intend to continue pursuing the above-referenced appeals.
>
> 4. If you intend on pursuing the above-referenced appeals, please consider a) whether a hearing on the record pursuant to Board Rule 32.4 may be appropriate, and, if so, b) whether the parties have discussed entering into stipulations to narrow the case.
>
> 5. If one or both parties wishes to have a video hearing, please advise whether this can be accomplished in one day.

The Board advised the Provider in the Additional Information letter that "failure to timely respond (without a Board-approved extension) may result in remedial action (e.g., dismissal for failure to comply with Board filing deadlines)."

On **September 23, 2024**, Randall Gienko of SRG, filed an Extension Request to the Board's September 19, 2024 Request for Additional Information. Mr. Gienko asserted "the provider representative is currently out of the country with no access to any of the information requested and will not return until October 7th, 2024. As such, we respectfully request the due date of September 25th, 2024, be extended to October 30th, 2024."

[8] Medicare Contractor September 3, 2024 Response to Provider Request for Hearing Extension at 1.

On **September 24, 2024**, the Board Denied the Provider's Extension Request stating:

> [t]he hearing in these cases, which were filed in 2004 and 2008, respectively, has been postponed numerous times. The Provider has had ample time to prepare for the hearing since 2004/2008, and FSS, the opposing party has responded in opposition to the postponement request on the grounds that the Provider has requested numerous postponements in the past, using the same grounds.
>
> The Board has requested information on whether the cases are appropriate for a record hearing. If the case proceeds to live hearing on the scheduled date of October 9, 2024, a pre-hearing will be scheduled for September 30, 2024, whether or not the Provider's Representative is in the country. The October 9th Hearing will be held, via video, with no witnesses, as the parties have not indicated any witnesses will be presented. The hearing will be limited to oral arguments, in which each party will have 30 minutes to make their oral argument. A separate Notice of Video Hearing will be issued as appropriate, if the appeals proceed to the scheduled live hearing.[9]

The Provider did not submit the Additional Information requested by the Board by the **September 25, 2024** deadline. On **September 26, 2024**, A Notice of Video Hearing was sent to the parties in the above-referenced appeals advising the parties that the Board had determined to conduct the October 9, 2024 hearing at 9:00AM EDT as a video hearing using CMS' Zoom platform (rather than as an in-person hearing). The Notice also advised that the Board would hold a Video Pre-Hearing Conference on **September 30, 2024**. Each party's representative was required to attend by video and the notification listed several filing deadlines for required filings for the video hearing.

On **September 29, 2024**, the Medicare Contractor submitted its list of Video Hearing attendees. On **September 30, 2024**, the Medicare Contractor submitted its updated Exhibit list and a Motion Consenting to Remote Video Hearing. The Medicare Contractor asserted in its Motion Consenting to Remote Video Hearing that on September 27, 2024, it sent an email to the Provider's Representative of record requesting review, approval and submission of a draft Joint Motion consenting to the Board's remote video hearing procedures and other items requested by the Board in its September 26, 2024 Notice of Video Hearing. As of 5:00 PM EDT, it had not received a response from the Provider's Representative of record. Therefore, the Motion consenting to the PRRB's remote video hearing procedures was executed only by FSS.

The scheduled Video Pre-Hearing Conference was held on **September 30, 2024,** however, only the PRRB members and staff, and the FSS Representative were in attendance. The Provider had no attendees present.

[9] Board Denial of Extension Request at 1 (Sept. 24, 2024).

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

42 U.S.C § 405.1868(a)(b) Board actions in response to failure to follow Board rules provides:

(a) The Board has full power and authority to make rules and establish procedures, not inconsistent with the law, regulations, and CMS Rulings, that are necessary or appropriate to carry out the provisions of section 1878 of the Act and of the regulations in this subpart. The Board's powers include the authority to take appropriate actions in response to the failure of a party to a Board appeal to comply with Board rules and orders or for inappropriate conduct during proceedings in the appeal.

(b) If a provider fails to meet a filing deadline or other requirement established by the Board in a rule or order, the Board may—

(1) Dismiss the appeal with prejudice;

(2) Issue an order requiring the provider to show cause why the Board should not dismiss the appeal; or

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

PRRB Rule 41.2 Own Motion Dismissal or Closure (effective 12/15/23) provides:

The Board may dismiss a case or an issue on its 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.

PRRB Rule 30.3 Submitting a Motion to Postpone the Hearing,

30.3.2 Request Content (effective 12/15/23) provides:

A motion for postponement must be filed in compliance with Rule 2 and contain the following:

• The reason the party[ies] are not ready for hearing.

• An explanation (including dates and events) of how the parties have worked together to settle or narrow the issues.

• A list of the actions needed to be ready for hearing.

• Whether both parties concur in the Motion.

• A proposed month and year in which to reschedule the case.

NOTE: A motion for postponement pending before the Board that has not yet been completed or ruled upon will not suspend either the hearing date or any pre-hearing filing deadlines (e.g., position papers, witness lists). If a motion for postponement is not complete or has not been ruled on, the parties must proceed as if it will not occur (or will not be granted) and comply with the hearing date and all filing deadlines.

PRRB Rule 30.3.4 Opposing a Postponement Request

If a motion to postpone is filed and a party opposes the motion, then the opposing party must file its response within the applicable time frame:

• If the request for postponement is filed no less than twenty (20) days prior to the hearing date, then the opposing party's response is due within two (2) business days.

• If the request for postponement is filed less than twenty (20) days prior to the hearing, then the opposing party's response is due as soon as possible because the Board will not wait a specified period of time before ruling on the postponement request.

In the instant appeals, on August 30, 2024, the Provider's Representative filed a Request for a Postponement in the above-referenced appeals. On September 3, 2024, the Medicare Contractor filed an Objection to the Provider's Postponement Request.

On September 19, 2024, the Board issued a Request for Additional Information letter to the parties ordering the Provider to submit additional information by September 25, 2024.

On September 23, 2024, Randall Gienko, of SRG, filed a request for an extension to respond to the Board's Request for Additional Information. Mr. Gienko requested until October 30, 2024, to

respond to the Board's request because its Provider Representative for the above-referenced appeals was out of the country and would not return until October 7, 2024. While Mr. Gienko is not listed as the representative of this case, he is known by the Board to be a long time employee of SRG with hundreds of PRRB appeals assigned to him.

Due to the numerous postponements that have been granted by the Board in the above-referenced appeals (14 total), and because the provider had ample time to prepare for the hearing, the Board denied the Provider's Extension Request. The Provider's Representative did not submit the required additional information requested by the Board by the September 25, 2024 deadline. 42 U.S.C § 405.1868(b) provides that if a provider fails to meet a filing deadline or other requirement established by the Board in a rule or order, the Board may dismiss the appeal with prejudice. Further, Board Rule 41.2 provides the Board may dismiss a case or an issue on its own motion upon failure of the provider to comply with Board procedures or filing deadlines. Per Board Rule 30.3.2, A motion for postponement pending before the Board that has not yet been ruled upon does not suspend either the hearing date or any pre-hearing filing deadlines.

In these cases, the Board ordered the Provider's Representative to submit the requested additional information by September 25, 2024; the Provider requested an extension of the September 25th deadline. The Board denied the Provider's request for an extension. Thus, per the Board's order the Provider was required to submit the additional information requested by September 25, 2024. The Provider did not do so. As such, in accordance with 42 U.S.C § 405.1868(b), the Board dismisses the above-referenced appeals, Case Nos. 04-0141 and 08-1652, with prejudice for failing to meet the filing deadline.

The Board notes the Provider also failed to appear for the Pre-Hearing Conference on September 30, 2024. The Board advised in its Notice of Video Hearing that each party's representative was required to appear by video for the Pre-Hearing Conference. The Provider failed to do so and failed to meet a Board requirement. This is another ground for dismissal.

Based on the foregoing, the Board dismisses the two (2) remaining issues in the above-referenced appeals, challenging the Medicare Contractor's calculation of the Direct Graduate Medical Education ("DGME or GME") and the Indirect Medical Education ("IME") payments for Medicare Plus Choice ("managed care") enrollees. As no issues remain in the appeals, the Board hereby closes Case Nos. 04-0141 and 08-1652 and removes the cases 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:

10/8/2024

X Kevin D. Smith, CPA

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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

RE: ***Board Determination on Transfers of SSI Issues to QRS Optional DSH SSI Unduly Narrow Definition of SSI Entitlement Group, Case Number 23-1650G***

Specifically:
Antelope Valley Hospital (Provider Number 05-0056)
- from Case Number 16-1545

Blue Mountain Hospital – Gnaden Huetten Campus (Provider Number 39-0194)
- from Case Number 23-1503

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the subject fully formed optional group appeal filed by Quality Reimbursement Services, Inc. ("QRS"/ "Representative.") The pertinent facts with regard to the group appeal and the transfer of providers from their respective individual appeals, as well as the Board's Determination, are set forth below.

Pertinent Facts with regard to Optional Group – Case No. 23-1650G:

On **September 6, 2023**, QRS filed the optional group for the calendar year ("CY") 2012 DSH SSI Unduly Narrow Definition of SSI Entitlement issue under Case No. 23-1650G.

Characterization of DSH SSI Unduly Narrow Definition of SSI Entitlement Group Issue

The group issue statement describes the issue under appeal as:

> The Provider(s) protest(s) CMS's policy of excluding unpaid SSI days from the numerator of the Medicare fraction. Despite CMS's seemingly contrary policy of treating unpaid Part A days as days entitled to benefits under Part A, CMS requires that a beneficiary be paid SSI benefits (or "covered" by SSI) during the period of his or her hospital stay in order for such days to be considered "entitled to supplemental security income benefits" and included in the numerator of the SSI fraction.
>
> CMS does not include days in the numerator of the SSI fraction when individuals were eligible for SSI but did not receive a SSI payment during their hospitalization for such reasons as failure of the beneficiary to have a valid address, representative payee problems, Medicaid paying for more than 50 percent of the cost of care in a medical

facility, or the period of hospitalization is during the first month of eligibility before a cash payment is made. None of these reasons affect the patient's indigency.

CMS's policy of applying different interpretations to the same term, "entitled," used in the same sentence of the statute is the epitome of arbitrary and capricious agency action and must be reversed. *See Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1, 20 n.1 (D.C. Cir. 2011) (Kavanaugh, J., concurring) ("HHS thus interprets the word 'entitled' differently within the same sentence of the statute. The only thing that unifies the Government's inconsistent definitions of this term is its apparent policy of paying out as little money as possible. I appreciate the desire for frugality, but not in derogation of law."); see also *Walter O. Boswell Mem'l Hosp. v. Heckler*, 749 F.2d 788, 799 (D.C. Cir. 1984) ("It would be arbitrary and capricious for [the Secretary] to bring varying interpretations of the statute to bear, depending upon whether the result helps or hurts Medicare's balance sheets….").

In rulemaking, commenters specifically requested that CMS include other payment codes that identified "entitled" individuals, but the Secretary nonetheless adopted a policy of including only codes that identify people receiving actual SSI cash payment. Id. For example, commenters requested that codes S06 (suspended payment because recipients' whereabouts are unknown based on "undeliverable checks, mail, reports of change or a change of address") and S07 ("checks returned for reasons that are unclear or for reasons other than address or a representative payee problem") be included. CMS refused the suggestion.

Because CMS's treatment of unpaid Part A days as "days entitled to benefits under part A" was upheld by the Supreme Court in *Becerra v. Empire Health Found., for Valley Hosp. Med. Ctr.*, 597 S.Ct. June 24, 2022 WL 227680 (2022), CMS must apply the same interpretation of the word "entitled" in the context of "entitled to supplemental security income benefits." By doing so, CMS will necessarily have to widen the number of SSI status codes it treats as being "entitled to SSI benefits" to encompass not just the three codes CMS currently includes, but all codes that reflect eligibility for SSI benefits.

On **September 6, 2023**, the date the group was formed, QRS transferred two providers into Case No.. 23-1650G:

- Antelope Valley Hospital ("Antelope Valley") from Case No. 16-1545; and
- Blue Mountain Hospital – Gnaden Huetten Campus ("Blue Mountain") from Case No. 23-1503.

On **September 6, 2024**, Case No. 23-1650G was automatically deemed to be fully formed, one year after the group was established.

Pertinent Facts: Antelope Valley -Case No. 16-1545

On **May 4, 2016**, Gong Nashed Pascoe, Inc. filed the individual appeal on behalf of Antelope Valley for FYE 06/30/2012 under Case No. 16-1545.[1] The individual appeal included six issues, one of which was described as "DSH SSI Ratio: Accuracy of Underlying Data" ("SSI Accuracy"/Issue #4).

The Provider withdrew the DSH – SSI Ratio: MMA Section 951 Days and Understatement of Outlier issues; the Board issued remands for two of the issues related to Part C Days; and on September 6, 2023, QRS transferred the remaining two issues:

- SSI Ratio: Medicare Part A Exhausted Days issue (#2) to the "QRS CY 2012 Improper Rulemaking Related-DSH SSI & MCD Fractions DE Days Group," Case No. 23-1651G[2]
- SSI Accuracy issue (#4) to, the "QRS CY 2012 DSH SSI Unduly Narrow Definition of SSI Entitlement Group," Case No. 23-1650G.[3]

Characterization of SSI Accuracy Issue (#6) In Case No. 16-1545

The issue statement uploaded for the SSI Accuracy issue was titled **"DSH Reimbursement – SSI Ratio: Accuracy of Underlying Data".** In this issue, the Provider questioned whether the DSH Calculation was understated due to the matching process.

The issue statement was as follows:

> The Provider contends that the SSI Ratio may be understated due to the matching process used to develop the fraction's underlying data.
>
> As a result of the *Baystate Medical Center v. Leavitt* case, the process CMS uses to match MedPAR data to SSA data was revised to produce a more accurate ratio; however, no data is available to the provider community to prove the level of accuracy.
>
> The IPPS FY 2011 Final Rule mentions that as part of CMS' revised process they would produce "summary statistics" of the matching process (see 75 Fed. Reg. No. 157 Page 50278-50279, August 16, 2010). These statistics should be made public so providers can see the number of errors generated in the matching process.[4]

Pertinent Facts: Blue Mountain -Case No. 23-1503

On **July 11, 2023**, the Board disbanded four fully formed, common issue related party ("CIRP") groups that included Blue Mountain as the sole participant. In disbanding the groups, the Board noted that Blue Mountain's original individual appeal from which the issues were transferred, Case No. 15-1138, had been closed more than three years prior. Therefore, the Board elected to establish a

[1] On June 29, 2023, QRS became the authorized representative for Case No. 16-1545.
[2] The Parties will receive correspondence regarding the transfer of Issue #2 to Case No. 23-1651G under separate cover.
[3] Although it appeared no issues remained in Case No. 16-1545 after the withdrawals, remands and transfers, the case remained open while the Issue Transfers were under review.
[4] Issue Statement at 5 (Case No. 16-1545) (May 4, 2016).

new individual appeal under Case No. 23-1503 to allow pursuit of the disbanded group issues to include:

- DSH SSI Percentage
- Outlier Payments – Fixed Loss Threshold[5]
- DSH SSI Fraction Dual Eligible Days
- DSH Medicaid Fraction Dual Eligible Days

On **September 6, 2023**, QRS requested the transfer of the SSI Percentage (#1) issue to the optional "QRS CY 2012 DSH SSI Unduly Narrow Definition of SSI Entitlement Group," Case No. 23-1650G *and* the DSH *SSI Fraction* Dual Eligible Days (#3) to the "QRS CY 2012 Improper Rulemaking Related-DSH SSI & MCD Fractions DE Days Group," Case No. 23-1651G.[6]

On **November 13, 2023**, QRS requested the transfer of the DSH *Medicaid Fraction* Dual Eligible Days (#3) to the "QRS CY 2012 Improper Rulemaking Related-DSH SSI & MCD Fractions DE Days Group," Case No. 23-1651G.[7]

Characterization of SSI Systemic Issue (#4) In Case No. 23-1503

The issue statement uploaded for this issue is titled **"Disproportionate Share Hospital (DSH)/Supplemental Security Income (SSI) (Systemic Errors)"** and includes the following excerpts**:**

> Whether the Secretary properly calculated the Providers' Disproportionate Share Hospital ("DSH")/Supplemental Security Income ("SSI") percentage.
>
> The Provider(s) contend(s) 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)(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 Lead MAC to settle their Cost Report does not address all the deficiencies as described in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37, 44 (D.D.C. 2008) and incorporates a new methodology inconsistent with the Medicare statute.
>
> The Providers challenge their SSI percentages based on the following reasons:
>
> 1. Availability of MEDPAR and SSA records,
> 2. Paid days vs. Eligible days,
> 3. Not in agreement with provider's records,
> 4. Fundamental problems in the SSI percentage calculation,
> 5. Covered days vs. Total days and
> 6. Failure to adhere to required notice and comment rulemaking procedures.[8]

[5] The Outlier Payments issue (#2) was withdrawn on October 31, 2023.
[6] The Parties will receive correspondence regarding the transfer of Issue #3 to Case No. 23-1651G under separate cover.
[7] Although it appeared no issues remained in Case No. 23-1503 after the withdrawal and transfers, the case remained open while the Issue Transfers were under review.
[8] Issue Statement at 1 (Case. No. 23-1503).

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 contractor 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.

Regarding group appeals, the regulation at 42 C.F.R. § 405.1837(a) states:

> (a) Right to Board hearing as part of a group appeal: Criteria. A provider (but no other individual, entity, or party) has a right to a Board hearing, as part of a group appeal with other providers, with respect to a final contractor or Secretary determination for the provider's cost reporting period, only if—
>
> (1) The provider satisfies individually the requirements for a Board hearing under §405.1835(a) or §405.1835(c), except for the $10,000 amount in controversy requirement in §405.1835(a)(2) or §405.1835(c)(3).
>
> (2) The matter at issue in the group appeal involves a single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group; and
>
> (3) The amount in controversy is, in the aggregate, $50,000 or more, as determined in accordance with §405.1839 of this subpart.

The Board is bound by the statutes and regulations, including those governing group cases. Specifically, 42 C.F.R. § 405.1837(b)(2) requires that an optional group must be comprised of two or more providers appealing a common issue. Board Rule 12.2 also references the fact that, "[t]he matter at issue in the group appeal must involve a ***single*** question of fact or interpretation of law, regulation, or CMS Rulings that is common to each provider in the group."[9] Additionally, Board Rule 12.6.2 discusses the minimum number of providers required in an optional group, and indicates that there must be ". . . a minimum number of two different providers, both at inception and at full formation of the group."[10]

Accordingly, for purposes of the two group participants in the appeal of the CY 2012 optional group characterized as "DSH SSI Unduly Narrow Definition of SSI Entitlement" in Case No. 23-1650G the Board finds that the two Providers' appealed distinctly different issues in the individual appeals from which they transferred. Therefore, **the transfers of the SSI Percentage (Accuracy/Systemic) issues for Antelope Valley from Case No. 16-1545 and Blue Mountain from Case No. 23-1503 must be denied**, and the issues returned to the respective individual appeals.[11]

---

[9] Board Rules v 3.1 issued Nov. 1, 2021.
[10] *Id.*
[11] As noted, both cases remained open in OH CDMS even though there were no "active" issues.

The Board finds that the group issue under appeal in Case No. 23-1650G relates to the exclusion of unpaid SSI days from the Medicare Fraction numerator. It further discusses the definition/interpretation of the word "entitled," and cites to the Empire case. The issue statements for both Antelope Valley in Case No. 16-1545 and Blue Mountain in Case No. 23-1503 are NOT consistent with the Unduly Narrow Definition of SSI Entitlement issue under appeal in the group. In both instances, Antelope Valley and Blue Mountain are appealing the "Baystate" aspect of the SSI Accuracy issue in that both involve SSI data matching and the potential errors in that process.[12]

Again, the Board finds that the SSI Accuracy/Systemic ("Baystate") issue is not the same issue as described in the group under Case No. 23-1650G, which relates to the Supreme Court's *Empire* decision (regarding entitlement to paid and unpaid Part A days).[13] Consequently, the SSI Accuracy issue transfers from Case Nos. 16-1545 and 23-1503 are hereby denied. The issues are being returned to the respective individual appeals. The Board notes that the SSI Percentage issue was addressed in the final position paper filed in Case No. 16-1545, but was transferred out of Case No. 23-1503 prior to the submission of any position papers. Therefore, under separate cover in Case No. 23-1503, the Board will issue a Request for Information for the submission of preliminary position papers to allow the Parties an opportunity to brief the SSI Accuracy issue.

As there are no remaining participants in Case No. 23-1650G, the optional group is hereby closed and removed from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

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

FOR THE BOARD:

10/8/2024

X Kevin D. Smith, CPA

Kevin D. Smith, CPA
Acting 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-L)- MAC for 23-1503
Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba (J-E) -MAC for 16-1545 & 23-1650G

[12] *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008)
[13] *Becerra v. Empire Health Found.*, 142 S. Ct. 2354 (2022).

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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

RE: ***Board Determination on Transfers of Issues to Optional QRS CY 2012 Improper Rulemaking Related -DSH SSI & MCD Fractions DE Group, Case Number 23-1651G***

Specifically:
Antelope Valley Hospital (Provider Number 05-0056)
- from Case Number 16-1545

Blue Mountain Hospital – Gnaden Huetten Campus (Provider Number 39-0194)
- from Case Number 23-1503

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the subject fully formed optional group appeal filed by Quality Reimbursement Services, Inc. ("QRS"/ "Representative"). The pertinent facts with regard to the group appeal and the transfers of providers from their respective individual appeals, as well as the Board's Determination, are set forth below.

Pertinent Facts with regard to Optional Group – Case No. 23-1651G:

On **September 6, 2023**, QRS filed the optional group for the calendar year ("CY") 2012 DSH Improper Rulemaking Related-DSH SSI & MCD Fractions DE Days issue under Case No. 23-1651G.

Characterization of Improper Rulemaking Related-DSH SSI & MCD Fractions DE Days Group Issue

The group issue statement includes the following excerpts:

> Whether patient days associated with patients entitled to Medicare Part A for whom no Medicare Part A payment is made and who are eligible for Title XIX should be **excluded from the Medicare fraction and included in the numerator of the Medicaid fraction of the Medicare Disproportionate Share Hospital ("DSH") calculation**?
>
> * * *
>
> In the August 11, 2004 final rule, effective with respect to patient discharges on or after October 1, 2004, the Secretary deleted the word "covered" where it previously appeared in the definition of the Medicare fraction in 42 C.F.R. §

> 412.106(b)(2)(i). Thus, both exhausted benefit and Medicare secondary payment days associated with patient discharges occurring on or after Oct 1, 2004 are included inthe Medicare fraction. Consistent with this regulation, inpatient days not covered remain in the DSH Medicare Fraction, even for patients entitled to Medicaid.
>
> * * *
>
> The 2004 regulation was improperly promulgated and should therefore be vacated because it was not promulgated with notice requirements of the Administrative Procedure Act ("APA"), 5 U.S.C. § 553(b)- (c). . . . The Secretary failed to consider all of the reasonably available alternatives, including the alternative represented by her prior policy, i.e., exclusion of exhausted benefit days from both fractions. Finally, the 2004 regulation is invalid because it departs from prior policy on which the Provider detrimentally relied.[1]

On **September 6, 2023**, the date the group was formed, QRS transferred the **DSH - SSI Ratio: Medicare Part A Exhausted Days** issue for Antelope Valley Hospital ("Antelope Valley") from Case No. 16-1545; and the **DSH SSI Fraction Dual Eligible Days** issue for Blue Mountain Hospital – Gnaden Huetten Campus ("Blue Mountain") from Case No. 23-1503 to the group.

On **November 13, 2023**, QRS transferred Blue Mountain's **DSH Medicaid Fraction Dual Eligible Days** issue from Case No. 23-1503 to the group.

On **September 6, 2024**, Case No. 23-1651G was automatically deemed to be fully formed, one year after the group was established.

Pertinent Facts: Antelope Valley -Case No. 16-1545

On **May 4, 2016**, Gong Nashed Pascoe, Inc. filed the individual appeal on behalf of Antelope Valley for FYE 06/30/2012 under Case No. 16-1545.[2] The individual appeal included six issues, one of which was described as "DSH Reimbursement - **SSI Ratio**: Medicare Part A Exhausted Days" (Issue #2).

The Provider withdrew the DSH – SSI Ratio: MMA Section 951 Days and Understatement of Outlier issues; the Board issued remands for two of the issues related to Part C Days; and on September 6, 2023, QRS transferred the remaining two issues:

- **SSI Ratio**: Medicare Part A Exhausted Days issue (#2) to the "QRS CY 2012 Improper Rulemaking Related-DSH SSI & MCD Fractions DE Days Group," Case No. 23-1651G.[3]
- SSI Accuracy issue (#4) to, the "QRS CY 2012 DSH SSI Unduly Narrow Definition of SSI Entitlement Group," Case No. 23-1650G.[4]

[1] Issue Statement at 1 (Group Case No. 23-1651G) (Sept. 6, 2023).
[2] On June 29, 2023, QRS became the authorized representative for Case No. 16-1545.
[3] Although it appeared no issues remained in Case No. 16-1545 after the withdrawals, remands and transfers, the case remained open while the Issue Transfers were under review.
[4] The Parties will receive correspondence regarding the transfer of Issue #4 to Case No. 23-1650G under separate cover.

Characterization of SSI Ratio: Medicare Part A Exhausted Days Issue (#2) In Case No. 16-1545

The issue statement uploaded for this issue included the following description:

> The Provider contends that days related to Medicare Part A Exhausted Days should be excluded from the **SSI Fraction**.[5]
>
> Under current CMS methodology (as outlined in CMS Ruling 1498-R), the SSI ratios are calculated to include "the inpatient days of a person entitled to Medicare Part A in the numerator of the hospital's SSI fraction (provided that the patient was also entitled to SSI) and in that fraction's denominator, even if the inpatient stay was not covered under Part A or the patient's Part A hospital benefits were exhausted." CMS' view is that a beneficiary remains entitled to Medicare Part A even if their Part A benefits are exhausted.
>
> The Provider's view is that once their Part A benefits are exhausted, the beneficiary is no longer "entitled" to Part A. The plain language of the Medicare statute defines entitlement to benefits under Part A as the right to have payment made on the patient's behalf for covered services.
>
> Various U.S. courts have found that the term "entitlement" denotes a right to have payment made under Part A of Title XVIII. Since Medicare Part A benefits have been exhausted, the patients whose days are at issue were clearly not entitled to have payment made on their behalf for those days, therefore, the days should be excluded from the SSI Fraction.[6]

Pertinent Facts: Blue Mountain -Case No. 23-1503

On **July 11, 2023**, the Board disbanded four fully formed, common issue related party ("CIRP") groups that included Blue Mountain as the sole participant. In disbanding the groups, the Board noted that Blue Mountain's original individual appeal from which the issues were transferred, Case No. 15-1138, had been closed more than three years prior. Therefore, the Board elected to establish a new individual appeal under Case No. 23-1503 to allow pursuit of the disbanded group issues to include:

- DSH SSI Percentage
- Outlier Payments – Fixed Loss Threshold[7]
- DSH **SSI Fraction** Dual Eligible Days
- DSH **Medicaid Fraction** Dual Eligible Days

On **September 6, 2023**, QRS requested the transfer of the SSI Percentage (#1) issue to the optional "QRS CY 2012 DSH SSI Unduly Narrow Definition of SSI Entitlement Group," Case No. 23-1650G

[5] Bold emphasis added.
[6] Issue Statement (#2) (Case No. 16-1545).
[7] The Outlier Payments issue (#2) was withdrawn on October 31, 2023.

and the DSH **SSI Fraction** Dual Eligible Days (#3) to the "QRS CY 2012 Improper Rulemaking Related-DSH **SSI & MCD Fractions** DE Days Group," Case No. 23-1651G.[8]

On **November 13, 2023**, QRS requested the transfer of the DSH **Medicaid Fraction** Dual Eligible Days (#4) to the "QRS CY 2012 Improper Rulemaking Related-**DSH SSI & MCD** Fractions DE Days Group," Case No. 23-1651G.[9]

Characterization of SSI Fraction Dual Eligible Days Issue (#3) In Case No. 23-1503

The issue statement uploaded for this issue includes the following excerpts**:**

> Whether patient days associated with Medicare Part A and Title XIX eligible patients should be **excluded from the SSI or Medicare fraction** of the Medicare Disproportionate Share Hospital ("DSH") calculation. Further, whether the MAC should have excluded from the SSI or Medicare fraction of the DSH calculation patient days applicable to patients who were eligible for both Medicare and Medicaid where Medicare Part A did not make a payment.
>
> * * *
>
> While CMS has stated that the SSI fraction would only include patient days paid by Medicare Part A, intermediaries have refused to recognize these dual eligible patient days, which lack Medicare Part A payments, in the Medicaid percentage of the Medicare DSH payment calculation. Since CMS has stated that only "paid" days will be used in the SSI percentage, the Provider contends that the terms paid and entitled must be consistent with one another due to the usage of the two terms in 42 C.F.R. § 412.106(b) and CMS testimony. The numerator of the SSI percentage requires SSI payments to have been made, thus the denominator should also require Part A payment.
>
> It is the Provider's contention that these days must [*be*] **excluded from both the numerator and the denominator of the SSI percentage** factor in the Medicare DSH formula.[10]

Characterization of Medicaid Fraction Dual Eligible Days Issue (#4) In Case No. 23-1503

The issue statement uploaded for this issue includes the following excerpts**:**

> Whether patient days associated with Medicare Part A and Title XIX eligible patients should be **included in the Medicaid percentage** of the Medicare Disproportionate Share Hospital ("DSH") calculation. Further, whether the Lead MAC should have included in the Medicaid fraction of the DSH calculation

[8] The Parties will receive correspondence regarding the transfer of Issue #1 to Case No. 23-1650G under separate cover.
[9] Although it appeared no issues remained in Case No. 23-1503 after the withdrawal and transfers, the case remained open while the Issue Transfers were under review.
[10] Issue Statement (#3) (Case No. 23-1503) (Bold Emphasis added).

> patient days applicable to patients who were eligible for both Medicare and Medicaid where Medicare Part A did not make a payment.
>
> * * *
>
> While CMS has stated that the SSI fraction would only include patient days paid by Medicare Part A, intermediaries have refused to recognize these dual eligible patient days, which lack Medicare Part A payments, in the Medicaid percentage of the Medicare DSH payment calculation. Since CMS has stated that only "paid" days will be used in the SSI percentage, the Provider contends that the terms paid and entitled must be consistent with one another due to the usage of the two terms in 42 C.F.R. § 412.106(b) and CMS testimony. The numerator of the SSI percentage requires SSI payments to have been made, thus the denominator should also require Part A payment.
>
> It is the Provider's contention that these days must be **included in the Medicaid percentage**.[11]

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 contractor 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.

Regarding group appeals, the regulation at 42 C.F.R. § 405.1837(a) states:

> (a) Right to Board hearing as part of a group appeal: Criteria. A provider (but no other individual, entity, or party) has a right to a Board hearing, as part of a group appeal with other providers, with respect to a final contractor or Secretary determination for the provider's cost reporting period, only if—
>
> (1) The provider satisfies individually the requirements for a Board hearing under §405.1835(a) or §405.1835(c), except for the $10,000 amount in controversy requirement in §405.1835(a)(2) or §405.1835(c)(3).
>
> (2) The matter at issue in the group appeal involves a single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group; and
>
> (3) The amount in controversy is, in the aggregate, $50,000 or more, as determined in accordance with §405.1839 of this subpart.

The Board is bound by the statutes and regulations, including those governing group cases. Specifically, 42 C.F.R. § 405.1837(b)(2) requires that an optional group must be comprised of two or

[11] Issue Statement (#4) (Case No. 23-1503) (Bold Emphasis added).

more providers appealing a common issue. Board Rule 12.2 also references the fact that, "[t]he matter at issue in the group appeal must involve a *single* question of fact or *interpretation* of law, regulation, or CMS Rulings that is common to each provider in the group."[12] Additionally, Board Rule 12.6.2 discusses the minimum number of providers required in an optional group, and indicates that there must be ". . . a minimum number of two different providers, both at inception and at full formation of the group."[13]

Accordingly, for purposes of the three group *participants* in the appeal of the CY 2012 optional group characterized as "Improper Rulemaking Related-DSH **SSI & MCD Fractions** DE Days" in Case No. 23-1651G the Board finds that one of the two Providers, Antelope Valley, appealed only the "DSH - **SSI Ratio**: Medicare Part A Exhausted Days" issue in its individual appeal from which it transferred. Because the group issue under appeal in Case No. 23-1651G *currently* includes both **the SSI and Medicaid Fraction** Dual Eligible Days issues, the Board is **denying** the transfer of the **DSH - SSI Ratio: Medicare Part A Exhausted Days** issue for Antelope Valley from Case No. 16-1545.

With the denial of Antelope Valley's issue transfer to Case No. 23-1651G, only *two participants* remain in the group – however, those *two participants involve the same Provider*, Blue Mountain *(i.e.*, one participant appealing the SSI Fraction DE issue and one appealing the Medicaid Fraction DE issue). Therefore, the Board finds that Case No. 23-1651G no longer meets the regulatory requirements for the minimum number of providers in a group. The Board disbands the group and returns the three issues to the respective individual appeals as follows:

- DSH - **SSI Ratio**: Medicare Part A Exhausted Days for Antelope Valley to Case No. 16-1545;
- DSH *SSI Fraction* Dual Eligible Days for Blue Mountain to Case No. 23-1503; and
- DSH *Medicaid Fraction* Dual Eligible Days for Blue Mountain to Case No. 23-1503.[14]

The Board notes that the DSH - **SSI Ratio**: Medicare Part A Exhausted Days issue was previously addressed in the final position paper filed in Case No. 16-1545, but the SSI and Medicaid Fraction Dual Eligible Days issues were transferred out of Case No. 23-1503 prior to the submission of any position papers. Consequently, under separate cover in Case No. 23-1503, the Board will issue a Request for Information for the submission of preliminary position papers to allow the Parties an opportunity to brief both the SSI and Medicaid Fraction Dual Eligible Days issues.

As there are no remaining participants in Case No. 23-1651G, the optional group is hereby closed and removed from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Finally, as QRS is aware, the Board has recently determined the Improper Rulemaking Related DSH SSI Fraction and Medicaid Fraction Dual Eligible Days to be distinct issues that must be separately appealed. The Board's position has been that the exclusion of days associated with no-pay Part A situations, where the underlying patient is dually eligible, does not automatically mean such days must be counted in the Medicaid fraction. To that end, QRS may file separate

[12] Board Rules v 3.1 issued Nov. 1, 2021.
[13] *Id*.
[14] As noted, both cases remained open in OH CDMS even though there were no "active" issues.

CY 2012 optional groups for the Improper Rulemaking Related-DSH **SSI Fraction** DE Days and the Improper Rulemaking Related-DSH **Medicaid Fraction** DE Days, provided that, once established, at least two providers immediately transfer to each group to fulfill the regulatory requirement for the minimum number of providers in accordance with Board Rule 12.6.

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

FOR THE BOARD:

10/8/2024

X Kevin D. Smith, CPA

Kevin D. Smith, CPA
Acting 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-L)- MAC for 23-1503
Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba (J-E) -MAC for 16-1545 & 23-1650G

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Nicholas Putnam
Strategic Reimbursement Group, LLC.
360 W Butterfield Rd., Suite 310
Elmhurst, Illinois 60126

Pamela VanArsdale
National Government Services, Inc.
P.O. Box 6474
Indianapolis, IN 46206

RE: ***Board Decision***
SRG Aurora 2012 Unmatched Medicaid Days CIRP Group
FYE: 2012
Case No.: 16-2016GC

Dear Mr. Putnam and Ms. VanArsdale:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Medicare Administrative Contractor's ("MAC") Motion to Dismiss the above identified appeal. The Board's analysis and determination to dismiss the appeal in total is set forth below.

Background

On **July 7, 2016**, the Board received the Group Appeal Request from the Providers' Representative, Strategic Reimbursement Group, LLC. The Group Appeal contained four (4) providers:

Aurora Sheboygan Memorial Medical Center (52-0035), FYE 12/31/2012
Aurora Lakeland Medical Center (52-0102), FYE 12/31/2012
Aurora BayCare Medical Center (52-0193), FYE 12/31/2012
Aurora Medical Center (52-0198), FYE 12/31/2012

The Providers' Group Issue Statement reads:

Medicaid Eligible Medicare Unmatched Days: -

> The provider contends that the Medicaid fraction of its Operating Disproportionate Share Hospital and Capital Disproportionate Share Hospital adjustment calculations (collectively Calculations') has not been calculated in accordance with Medicare regulations and manual provisions as described in 42 CFR 412.106.
>
> The provider requests that patient days pertaining to additional patient stays that were not paid by Medicaid, but related to patients

> with Medicaid coverage during the stay be included in the Medicaid fraction of the Calculations[1]

On **March 20, 2017**, Aurora West Allis Medical Center (52-0139) was transferred to the group appeal. The Group was fully formed on **May 24, 2023**.

On **May 26, 2023**, the Board issued a CIRP Group Fully Formed and Critical Due Dates Notice ("Critical Due Dates Notice"). Significantly, the Critical Due Dates notice set the deadline for the Provider's preliminary position paper as July 25, 2023, and included the following instruction on that filing:

> "Group's Preliminary Position Paper – 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 Group 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."

On **July 25, 2023**, the Provider filed its Preliminary Position Paper, and the Medicare Contractor filed its Preliminary Position Paper on **November 20, 2023**.

On **August 1, 2024**, the Provider filed its Final Position Paper, and the Medicare Contractor filed its Final Position Paper on **August 26, 2024**.

On **August 21, 2024**, the Medicare Contractor filed a Motion to Dismiss. The Providers did not file a Response to the MAC's Motion to Dismiss. The Provider had until September 20, 2024 to file a timely response.

Medicare Contractor's Contentions

The Medicare Contractor maintains the Providers have effectively abandoned its claim for additional Medicaid Eligible Days. The Medicare Contractors argues the group has failed to furnish documentation in support of its claim for additional Medicaid Eligible Days or describe why the documentation is unavailable which violates PRRB Rules 7, 27.2, 25.2.1 and 25.2.2.

The Medicare Contractor requests the Board to dismiss the issue with prejudice for failure to comply with Board procedures or filing deadlines under PRRB Rule 41.2 (Nov.2021) and 42 C.F.R. § 405.1868(b).

[1] Group Issue Statement (July 7, 2016)

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.[2] 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. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record." Similarly, 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."

Board Analysis and Decision:

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

The Providers' 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 appeal, Board Rule 7.1 (Support for Appealed Final Determination, Issue-Related Information and Claim of Dissatisfaction) (2015) 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.

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

> (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.[3]

So essentially, 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 (v 3.1) gives the following instruction on the content of position papers:

> **Rule 25 Preliminary Position Papers**
>
> **25.1 Content of Position Paper Narrative**
>
> The text of the position papers must include the elements addressed in the applicable subsection.
>
> **25.1.1 Provider's Position Paper**
>
> The provider's preliminary position paper must:
>
> 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.
>
> **Rule 25.2 Position Paper Exhibits**

[3] (Bold emphasis added.)

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 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.

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,

- 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.

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.

As the Provider failed to timely include a list of additional Medicaid eligible days with its preliminary position paper, or final position paper or submit such list under separate cover as instructed. 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.[4]

The Medicare Contractor contends that the Provider is required to identify and provide documentation to prove what additional Medicaid Eligible days are at issue and to which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rule 25.

The Board finds that the Providers have failed to satisfy the requirements of 42 C.F.R. § 412.106(b)(4)(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 Providers 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).

Decision

The Board dismisses each of the Providers in this DSH Medicaid Eligible Days issue because the Providers failed to ***timely*** furnish Medicaid eligible days listings and failed to meet the obligations under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25. To date, the Group failed has failed to submit the listings of eligible days to the MAC for review. As no issues remain pending, the Board hereby closes Case No. 16-2016GC 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: For the Board:

[4] *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.

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

10/9/2024

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

cc: Wilson Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
7500 Security Boulevard
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Via Electronic Delivery

Nicholas Putnam
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Elmhurst, Illinois 60126

Pamela VanArsdale
National Government Services, Inc.
P.O. Box 6474
Indianapolis, IN 46206

RE: ***Board Decision***
SRG Presence 2012 Unmatched Medicaid Days CIRP Group
FYE: Various
Case No.: 16-1876GC

Dear Mr. Putnam and Ms. VanArsdale:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Medicare Administrative Contractor's ("MAC") Motion to Dismiss. The Board's analysis and determination is set forth below.

Background

On **June 9, 2016**, the Provider Group Representative, Strategic Reimbursement Group LLC filed a request for hearing. The Initial Appeal contained three (3) Providers: Provena United Samaritans Medical Center (14-0093), Provena Covenant Medical Center (14-0113), and Provena St. Mary S. Hospital (14-0155). The Providers' Group Issue Statement reads:

Medicaid Eligible Medicare Unmatched Days: -

> The provider contends that the Medicaid fraction of its Operating Disproportionate Share Hospital and Capital Disproportionate Share Hospital adjustment calculations (collectively Calculations') has not been calculated in accordance with Medicare regulations and manual provisions as described in 42 CFR 412.106.
>
> The provider requests that patient days pertaining to additional patient stays that were not paid by Medicaid, but related to patients with Medicaid coverage during the stay be included in the Medicaid fraction of the Calculations[1]

On **July 1, 2016**, Provena Mercy Center (14-0174) was added to the group appeal.

[1] Group Issue Statement (June 9, 2016)

On **April 17, 2014**, Saint Francis Hospital (14-0080) was added to the group appeal. The Group was fully formed **on June 27, 2023**.

On **June 27, 2023**, the Board issued a CIRP Group Fully Formed and Critical Due Dates Notice ("Critical Due Dates Notice"). Significantly, the Critical Due Dates notice set the deadline for the Provider's preliminary position paper as August 26, 2023, and included the following instruction on that filing:

> "Group's Preliminary Position Paper – 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 Group 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."

On **August 7, 2023**, the Provider filed its Preliminary Position Paper, and the Medicare Contractor filed its Preliminary Position Paper on **November 27, 2023**.

On **July 31, 2024**, the Provider filed its Final Position Paper, and the Medicare Contractor filed its Final Position Paper on **August 26, 2024**.

On **August 6, 2024**, the Medicare Contractor filed a Motion to Dismiss. The Providers did not file a Response to the MAC's Motion to Dismiss. The Provider had until September 6, 2024, to file a timely response.

Medicare Contractor's Contentions

The Medicare Contractor maintains the Providers have effectively abandoned its claim for additional Medicaid Eligible Days and requests the Board to dismiss the issue.

The Medicare Contractors argues the group has failed to furnish documentation in support of its claim for additional Medicaid Eligible Days or describe why the documentation is unavailable which violates PRRB Rules 7, 27.2, 25.2.1 and 25.2.2.

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.[2] 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. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record." Similarly, Board Rule 44.3 specifies

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

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."

Board Analysis and Decision:

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

The Providers' 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 appeal, Board Rule 7.1 (2015) 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.[3]

So essentially, 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

[3] (Bold emphasis added.)

discretion about setting the time frame for the submission of exhibits supporting the merits of the appeal.

Board Rule 25 (v 3.1) gives the following instruction on the content of position papers:

> **Rule 25 Preliminary Position Papers**
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> The text of the position papers must include the elements addressed in the applicable subsection.
>
> **25.1.1 Provider's Position Paper**
>
> The provider's preliminary position paper must:
>
> 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.
>
> **Rule 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 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.

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,
> - 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.

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 documented (8) eights requests for the Providers' list of Medicaid Eligible days: 1/16/2020, 8/16/2023, 3/1/2024, 4/5/2024, 5/20/2024, 6/5/2024, 6/17/2024, and 7/31/2024[4].

[4] Medicare Contractor's Motion to Dismiss at 2.

As the Provider failed to timely include a list of additional Medicaid eligible days with its preliminary position paper, or submit such list under separate cover as instructed, or when requested from the Medicare Contractor. 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.[5]

The Medicare Contractor contends that the Provider is required to identify and provide documentation to prove what additional Medicaid Eligible days are at issue and to which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rule 25.

The Board finds that the Providers have failed to satisfy the requirements of 42 C.F.R. § 412.106(b)(4)(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 Providers also failed to fully develop the merits of its Medicaid Eligible Medicare Unmatched Days because the provider has failed to identify any specific Medicaid eligible days at issue (much less any supporting documentation for those days).

Decision

The Board dismisses the Provider' appeal of the DSH Medicaid Eligible Days issue because the Provider failed to ***timely*** furnish a Medicaid eligible days listing and failed to meet its obligations under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25. To date, the Group failed has failed to submit a listing of eligible days to MAC for review. As no issues remain pending, the Board hereby closes Case No. 16-1876GC 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:

For the Board:

[5] *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.

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

10/10/2024

X Ratina Kelly

Ratina Kelly, CPA
Chair
Signed by: PIV

cc: Wilson Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Corinna Goron, President
Healthcare Reimbursement Services, Inc.
3900 American Drive, Suite 202
Plano, TX 75075

RE: ***Board Determination on Request for Reconsideration of Board Determination – Jurisdiction in Part***

Prime Healthcare CY 2020 Low Wage Index Quartile Adjustment CIRP Group
Case Number: 24-2406GC

Riverview Regional Medical Center (Provider Number 01-0046), FYE 12/31/2020
Case Number: 24-2127

Specifically, dismissal as a group participant & reinstatement of individual appeal

Dear Ms. Goron:

The Provider Reimbursement Review Board (the "Board") has reviewed the October 3, 2024 reconsideration/reinstatement request from Healthcare Reimbursement Services ("HRS") with regard to the Board's earlier determination dismissing Riverview Regional Medical Center ("Riverview" or "Provider") from the above-captioned common issue related party ("CIRP") group. The pertinent facts considered by the Board and the Board's determination are set forth below.

Background:

On **July 16, 2024**, HRS timely filed an individual appeal for Riverview's FYE 12/31/2020 based on a January 26, 2024 Notice of Program Reimbursement ("NPR"). The sole issue in the appeal, which was assigned Case No. 24-2127, was DSH Medicaid Eligible Days.

On **August 30, 2024**, HRS established the "Prime Healthcare CY 2020 Low Wage Index Quartile Adjustment CIRP Group" under Case No. 24-2406GC. The group was formed with the Lehigh Regional Medical Center (Prov. No. 10-0107). A few days later, HRS directly added several more participants to the group.[1]

[1] The term "Direct Add" refers to the addition of a provider to a group using the "Add Participant" case action in OH CDMS.

For one of those participants, the Direct Add was filed on **September 4, 2024**, at 2:38 p.m., when HRS added Riverview to Case No. 24-2406GC.

On **September 4, 2024**, at 2:43 p.m., a few minutes after having filed the Direct Add for Riverview in the group, HRS withdrew the DSH Medicaid Eligible Days issue from Riverview's individual appeal, Case No. 24-2127, resulting in closure of the case.

On **October 2, 2024**, the Board issued a "Board Determination – Jurisdiction in Part" in Case No. 24-2406GC, in which it dismissed Riverview from the group. Because Riverview's Direct Add was filed 222 days after the issuance of its January 26, 2024 NPR, the Board found the Direct Add did not meet regulatory filing requirements in that it was not filed timely.

On **October 3, 2024**, HRS filed a request for reconsideration of the Board's "Jurisdiction in Part" determination ("Reconsideration Request") in Case No. 24-2406GC. HRS argued that it inadvertently utilized a "Direct Add" to group, rather than an "Add New Issue to Individual Case." HRS indicated that this was an administrative error in that, had it used the correct case action and, instead, added the Low Wage Index Quartile Adjustment issue to Case 24-2127, the add issue request would have been considered timely since it was filed within 245 days of the Provider's NPR.[2] Seemingly, the Low Wage Index Quartile Adjustment issue could then have been transferred to Case No. 24-2406GC and the timeliness of Riverview as a participant in the group would not have been in dispute. HRS concluded by saying that this error was a matter of it inadvertently "checking the wrong box." Therefore, HRS requested the Board grant the Provider's "good cause" ***reinstatement of the individual appeal***.

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.

Board Rule 47.1 governs motions for reinstatement of an issue or case:

> **47.1 Motion for Reinstatement**
>
> A provider may request reinstatement of an issue(s) or case within three years from the date of the Board's decision to dismiss the issue(s)/case or, if no dismissal was issued, within three years of the Board's receipt of the provider's withdrawal of the issue(s) (see 42 C.F.R. § 405.1885 addressing reopening of Board decisions). The request for reinstatement is a motion and must be in writing setting out

[2] See, 42 C.F.R. § 405.1835(e) and Board Rule 6.2.1 which indicates the Provider may add an issue to an individual appeal if the request is filed ". . . no later than 60 days after the expiration of the applicable 180 day period for filing the initial hearing request, and the request meets the minimum filing requirements as identified in 42 C.F.R. § 4005.1835(e)."

> the reasons for reinstatement (see Rule 44 governing motions). **The Board will not reinstate an issue(s)/case if the provider was at fault. . . .**
> . . . .
>
> **47.3 Dismissals for Failure to Comply with Board Procedures**
>
> **Upon written motion demonstrating good cause**, the Board may reinstate a case dismissed for failure to comply with Board procedures. Generally, **administrative oversight**, settlement negotiations or a change in representative **will not be considered good cause to reinstate**. . . .[3]

Board Rule 47.1 makes clear that the Board will not reinstate a case or issue **if the provider was at fault.** Additionally, the Board refers HRS to Board Rule 47.3, which is specific to dismissals due to failure to comply with Board procedures. Although Riverview's dismissal from the group was due to its failure to meet a regulatory requirement as opposed to its failure to comply with a Board procedure, the Rule is pertinent because it details what the Board **does not consider to be good cause**, specifically, *administrative oversight*.

First, although the Board's dismissal of Riverview was issued in Case No. 24-2406GC, and Case No. 24-2406GC is the case in which HRS filed the Reconsideration Request, HRS is actually requesting the reinstatement of the Provider's individual appeal, Case No. 24-2127.[4] According to HRS' Reconsideration Request, Case No. 24-2127 was withdrawn just over a month ago, on September 4, 2024, based on the Medicare Contractor's proposal to administratively resolve the sole issue under appeal, Medicaid eligible days. HRS' Reconsideration Request does not argue that the Medicare Contractor failed to reopen or revise the cost report for the Medicaid eligible days issue. Thus, the Board finds that there is no basis for good cause to justify reinstatement of Riverview's individual appeal. Instead, it appears HRS is requesting reinstatement of the individual appeal in order to have a case to which it could add the Low Wage Index Quartile Adjustment issue (*from which it could then transfer to the group*). Nonetheless, had the Board found there was good cause to reinstate Case No. 24-2127, the deadline to add issues to the individual appeal expired on Friday, September 27, 2024.[5]

Second, the Board denies the October 2, 2024 Reconsideration Request in Case No. 24-2406GC. In denying the request, the Board directs the Parties to 42 C.F.R. § 405.1835(a)(3) which specifies that, unless the Provider qualifies for a good cause extension, the Board must receive a Provider's hearing request no later than 180 days after the date of receipt of the final determination, with a five-day presumption for mailing. In the case of Riverview, the Medicare Contractor issued the NPR on January 26, 2024. The 185th day fell on Monday, July 29, 2024. Although the Provider filed a timely individual appeal, the Direct Add of Riverview to Case No.

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[3] (Bold emphasis added with the exception of the titles, which had bold emphasis in original.)
[4] The Reconsideration Request was filed **only** in the group, Case No. 24-2406GC, although HRS has specifically requested that "the Board grant the Provider a 'good cause' reinstatement of the Individual appeal, given this administrative error."
[5] The deadline to add issues to Case No. 24-2127 expired a week before HRS filed the request for reconsideration in Case No. 24-2406GC.

24-2406GC was not filed until Wednesday, September 4, 2024, which was 222 days after the issuance of the final determination.[6]

HRS summed up its request for reconsideration/reinstatement with the argument that this was simply a matter of having "checked the wrong box." The Board has considered this line of reasoning but finds that the "Add Participant" and "Add Issue" case actions are completely separate in that they must be effectuated in different cases (*i.e.,* one in a group case and the other in an individual appeal as discussed in sections 3.3.2 and 3.3.3.2 of the External User Manual.)[7] Additionally, the "add issue" case action would have had to take place in a different appeal, the induvial appeal, not the group case to which it added the provider. A group case, by regulation can only have one issue[8], therefore they could not have performed an "add issue" to the group appeal. Therefore, the Board rejects this explanation as a justification for good cause to reinstate the individual appeal.

In short, the Representative has admitted fault for filing its request to pursue the Low Wage Index Quartile Adjustment issue in the wrong appeal, by filing a late Direct Add into the group case instead of having timely added the issue to the Provider's individual case. Having reconsidered its October 2, 2024 determination, the Board finds that:

1. HRS has failed to establish good cause under Board Rules 47.1 and 47.3; and
2. The Board properly exercised its authority under 42 C.F.R. § 405.1868(b) to dismiss Riverview from the group, Case No. 24-2406GC.

Consequently, the Board declines its discretion to reinstate the Provider's related individual appeal, Case No. 24-2127. Accordingly, Case No. 24-2127 remains closed and off the Board's docket and Riverview remains dismissed from Case No. 24-2406GC.

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

For the Board:

10/16/2024

X Kevin D. Smith, CPA

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

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services
Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Admin (J-E)
Byron Lamprecht, WPS Government Health Admin. (J-5)

[6] There was no allegation of good cause filed with Riverview's Direct Add filing.
[7] https://www.cms.gov/regulations-and-guidance/review-boards/prrbreview/downloads/oh-cdms-prrb-external-user-manual-v-10.pdf
[8] 42 C.F.R. §405.1837(a)(2).

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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410-786-2671

Via Electronic Delivery

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

Michael Redmond
Novitas Solutions
501 Grant St., Suite 600
Pittsburgh, PA 15219

RE: ***Board Decision*** **– SSI Percentage (Provider Specific) Issue**
Regional Hospital of Scranton (Provider No. 39-0237)
FYE 06/30/2015
Case No. 19-1034

Dear Mr. Summar and Mr. Redmond,

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. 19-1034***

On **July 26, 2018**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end June 30, 2015.

On **January 14, 2019**, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained five (5) issues:

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

As the Provider is owned by Community Health Systems, Inc. (hereinafter "CHS") and, thereby, subject to the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1), the Provider transferred Issues 2, 4, and 5 to CHS groups on August 23, 2019. The remaining issues in this appeal are Issues 1 and 3.

[1] On August 23, 2019, the Provider transferred this issue to PRRB Case No. 18-0552GC.
[2] On August 23, 2019, the Provider transferred this issue to PRRB Case No. 18-0555GC
[3] On August 23, 2019, the Provider transferred this issue to PRRB Case No. 18-0554GC

On **May 13, 2019**, the MAC filed a Jurisdictional Challenge over Issue 1: DSH SSI Percentage (Provider Specific), Issue 4: Uncompensated Care Distribution Pool and Issue 5: 2 Midnight Census IPPS Payment Reduction.[4] The Provider filed a response on June 7, 2019.

On **September 6, 2019**, the Provider filed its Preliminary Position Paper, and the Medicare Contractor filed its Preliminary Position Paper on **January 7, 2020.**

On **September 10, 2024**, the Provider filed its Final Position Paper, and the Medicare Contractor filed its Final Position Paper on **October 8, 2024**.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 18-0552GC – QRS CHS 2015 DSH SSI Percentage CIRP Group

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.
>
> . . .
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[5]

The group issue statement in Case No. 18-0552GC, to which the Provider transferred Issue 2 reads, in part:

> **Statement of the Issue:**
>
> Whether the Medicare/SSI fraction used in the Medicare Disproportionate Share Hospital and LIP payment calculations accurately and correctly counted the correct number of patient days to be included in the numerator and denominator of the Medicare/SSI fraction calculation per the Medicare Statute at 42 U.S.C. §1395ww(d)(5)(F)(vi)?.
>
> **Statement of the Legal Basis**

[4] As issues number 4 and 5 were transferred, the Board will only review the challenge for issue #1.
[5] Issue Statement at 1 (Jan. 14, 2019).

> The Provider(s) contend(s) that the Lead MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww (d)(5)(F)(vi). The Provider(s) contend(s) that the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") and used by the Lead MAC to settle their Cost Report were incorrectly computed.
>
> The Provider(s) also contend(s) 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 551 but did not receive an SSI payment.
>
> The Provider(s) further contend(s) 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 0. Leavitt, 545 F. Supp. 2d 20, as amended, 587 F. Supp. 2d 37, 44 (D.D.C. 2008) and incorporate a new methodology inconsistent with the Medicare Statute.
>
> Providers in this case are also seeking resolution of the following additional aspects of the Medicare fraction that were not addressed in the Baystate case:
>
> 1. Availability of MEDPAR and SSA records,
> 2. Failure to adhere to required notice and comment rulemaking procedures,
> 3. Fundamental problems in the SSI percentage calculation,
> 4. Not in agreement with provider's records,
> 5. Paid days vs. Eligible days, and
> 6. Covered days vs. Total days.[6]

On September 6, 2019, the Provider filed its preliminary position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

[6] Group Appeal Issue Statement in Case No. 18-0552GC.

Issue #1: Provider Specific

The Provider contends that its' SSI percentage published by the Centers for Medicare and Medicaid Services ("CMS") was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation based on the Provider's Fiscal Year End (June 30).

The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.

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

MAC's Contentions

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 portion of Issue one 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.[8]

Provider's Jurisdictional Response

[7] Provider's Preliminary Position Paper at 8-9 (Sept. 6, 2019).
[8] Medicare Contractor's Jurisdictional Challenge. (May 13, 2019)

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

The Provider contends each SSI issues are separate and distinct issues and represent different components of the SSI issue. The Provider has "specifically identified patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS, due to errors that are or may be specific to the Provider, but in any case, are not the systemic errors that have been previously identified in the *Baystate* litigation."[9]

The Provider argues "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 2015, as a result of its understated SSI percentage due to errors of omission and commission"[10] The Provider request the Board find jurisdiction over the DSH/SSI provider specific issue.

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.

A. DSH Payment/SSI Percentage (Provider Specific)

The jurisdictional analysis for Issue 1 has several relevant aspects to consider: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period; and 3) the Provider incorporating the arguments from *Advocate Christ*[11] into its appeal. As set forth below, the Board should dismiss all aspects of Issue 1.

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. 18-0552GC.

The DSH – SSI Percentage (Provider Specific) issue in the present appeal concerns "[w]hether the Medicare Administrative Contractor ("MAC") used the correct Supplemental Security

[9] Provider's Jurisdictional Response at 2 (June 7, 2019)
[10] *Id*.
[11] The Provider has included the Appellants' Reply Brief in *Advocate Christ Med. Ctr. v. Becerra*, No. 22-5214 (D.C. Cir.), which is on appeal from the decision in *Advocate Christ Med. Ctr. V. Azar*, 17-cv-1519 (TSC), 2022 WL 2064830, (D.D.C. June 8, 2022).

Income ("SSI") percentage in the Disproportionate Share Hospital ("DSH") calculation."[12] 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)."[13] 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."[14]

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 18-0552GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds the DSH Payment/SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 18-0552GC. 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 Payment/SSI Percentage (Provider Specific) issue.

In making this finding, the Board further notes that CMS regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, is pursuing that issue as part of the group under Case No. 18-0552GC, which is required since it is subject to the CIRP group regulations under 42 C.F.R. § 405.1837(b)(1). Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[16] Provider is misplaced in referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 18-0552GC.

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. 18-0552GC, 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*

[12] Issue Statement at 1.
[13] *Id.*
[14] *Id.*
[15] PRRB Rules v. 3.1 (Nov. 2021).
[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).

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.[17]

The Board further notes that the Provider only cites to the 2000 Federal Register but additional issuances and developments on the availability of data underlying the SSI fraction, such MEDPAR data, have occurred. For example, as noted in the FY 2006 IPPS Final Rule,

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

Further highlighting the perfunctory nature of the briefing is the fact that providers *can* obtain certain data used to calculate their DSH SSI ratios directly from CMS, as explained on the following webpage:

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[17] (Emphasis added).

> 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]

Accordingly, the Board finds that the remaining issue in the instant appeal and the group issue from Group Case 18-0552GC are the same issue.[20] 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 Final Position Paper, the Provider stated, "The [Provider] hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra (Appellants' reply brief included as Exhibit P-3)." The Board finds that this purported argument does not comply with the regulations and Board rules to *fully* develop the Provider's position in the Final Position Paper, because the Provider merely lists a case name and does not explain further what the arguments are that it would like to incorporate into its appeal.

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

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.[21]

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

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.

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[18] Last accessed July 16, 2024.
[19] Emphasis added.
[20] 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).
[21] (Emphasis added).

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

****

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. 18-0552GC and there is no final determination from which the Provider can appeal the SSI realignment portion of the issue.

The case remains open as the Medicaid Eligible Days Issue is still pending.

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

Board Members Participating:

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

For the Board:

10/17/2024

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Nathan Summar
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4000 Meridian Blvd.
Franklin, TN 37067

RE: ***Board Decision– SSI Percentage (Provider Specific)***
Merit Health Rankin (Provider Number 25-0096)
FYE 12/31/2015
Case Number: 19-0735

Dear Mr. Summar:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 19-0735. 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).

Background

A. *Procedural History for Case No. 19-0735*

On **July 11, 2018**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end December 31, 2015.

On **December 19, 2018**, the Board received 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[1]
3. DSH SSI Fraction / Medicare Managed Care Part C Days[2]
4. DSH SSI Fraction / Dual Eligible Days[3]
5. DSH Medicaid Eligible Days[4]
6. DSH Medicaid Fraction / Medicare Managed Care Part C Days[5]
7. DSH Medicaid Fraction / Dual Eligible Days[6]

[1] On July 18, 2019, the Provider transferred this issue to PRRB Case No. 18-0588GC.
[2] On July 18, 2019, the Provider transferred this issue to PRRB Case No. 18-0589GC.
[3] On July 18, 2019, the Provider transferred this issue to PRRB Case No. 18-0584GC.
[4] The Provider withdrew this issue on September 13, 2024.
[5] On July 18, 2019, the Provider transferred this issue to PRRB Case No. 18-0591GC.
[6] On July 18, 2019, the Provider transferred this issue to PRRB Case No. 18-0585GC.

8. Uncompensated Care Distribution Pool[7]
9. 2 Midnight Census IPPS Payment Reduction[8]

As a result of the withdrawl and case transfers, the remaining issue in this appeal is Issue 1 (the DSH – SSI Percentage Provider Specific issue).

On **April 5, 2019**, the Medicare Contractor filed a Jurisdictional Challenge over Issues 1, 3, 6, 8, and 9. The Provider filed a response on **May 1, 2019**.

On **August 7, 2019**, the Provider filed its Preliminary Position Paper. The Medicare Contractor filed its Preliminary Position on **December 9, 2019**.

On **August 2, 2024**, the Provider filed its Final Position Paper. The Medicare Contractor filed its Final Position Paper on **August 27, 2024**.

On **August 15, 2024**, the Medicare Contractor filed a Motion to Dismiss over Issue 5: Medicaid Eligible Days. The Provider withdrew the issue on **September 13, 2024.**

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 18-0588GC – QRS HMA 2015 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).[9]

The Group issue Statement in Case No. 18-0588GC, to which the Provider transferred Issue No. 2, reads, in part:

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[7] On July 18, 2019, the Provider transferred this issue to PRRB Case No. 18-0587GC.
[8] On July 18, 2019, the Provider transferred this issue to PRRB Case No. 18-0592GC.
[9] Issue Statement at 1 (Dec. 19, 2018).

Statement of the Issue:

Whether the Medicare/SSI fraction used in the Medicare Disproportionate Share Hospital and LIP payment calculations accurately and correctly counted the correct number of patient days to be included in the numerator and denominator of the Medicare/SSI fraction calculation per the Medicare Statute at 42 U.S.C. §1395ww(d)(5)(F)(vi)?

Statement of the Legal Basis

The Provider(s) also contend(s) that the Lead MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww(d)(5)(F)(vj). The Provider contends that the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CM8" and used by the Lead MAC to settle their Cost Report were incorrectly computed.

The Provider(s) also contend(s) 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(s) further contend(s) 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 incorporate a new methodology inconsistent with the Medicare Statute.

Providers in this case are also seeking resolution of the following additional aspects of the Medicare fraction that were not addressed in the Baystate case:

The Providers challenge their SSI percentages based on the following reasons:

1. Availability of MEDPAR and SSA records,
2. Paid days vs. Eligible days,
3. Not in agreement with provider's records,
4. Fundamental problems in the SSI percentage calculation,
5. Covered days vs. Total days and
6. Failure to adhere to required notice and comment rulemaking procedures.[10]

On August 7, 2019, the Board received the Provider's preliminary position paper in 19-0735. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Calculation of the SSI Percentage**
>
> **Provider Specific**
>
> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation based on the Provider's Fiscal Year End (December 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).[11]

[10] Group Appeal Issue Statement in Case No. 18-0588GC.
[11] Provider's Preliminary Position Paper at 8-9 (August 7, 2019).

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $14,000.

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, stating,

> Issue 1 has three components: 1) SSI data accuracy; 2) 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.[12]

Provider's Jurisdictional Response

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

The Provider argues that it is entitled to appeal an item with which it is dissatisfied, stating:

> [T]he Provider has specifically identified patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS, due to errors that are or may be specific to the Provider, but in any case, are not the systemic errors that have been previously identified in the Baystate litigation. Once these patients are identified, the Provider contends that it will be entitled to a correction of these errors of omission to its SSI percentage.[13]

The Provider maintains it is not addressing the errors which result from CMS' improper data matching process but is addressing the various errors of omission and commission that do not fit into the "systematic errors" category. The Provider cites Board Rule 8.1 which allows issues with multiple components such as Issue 1 and Issue 2, that represents different components of the SSI issue. [14]

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[12] Medicare Contractor's Jurisdictional Challenge (April 5, 2019)
[13] Provider's Jurisdictional Response at 2 (May 9, 2019)
[14] *Id.*

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 remaining 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 issue that was appealed in Case No. 18-0588GC.

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]

The Provider's DSH/SSI Percentage issue in group Case No. 18-0588GC 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. 19-0735 is duplicative of the DSH/SSI Percentage issue in Case No. 18-0588GC. Because the issue is duplicative, and duplicative issues

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

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 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. 18-0588GC, 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.[20] 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.

[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).
[20] It is also not clear whether this is a systemic issue for HMA 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.[21]

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

> https://www.cms.gov/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh.[22]

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."[23]

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. 18-0588GC.

Accordingly, the Board finds that the SSI Provider Specific issue in Case No. 19-0735 and the group issue from the CIRP group under Case No. 18-0588GC 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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[21] (Italics and underline emphasis added.)
[22] Last accessed Oct. 15, 2024.
[23] (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.

* * * *

Based on the foregoing, the Board has dismissed the remaining issue in this case – (Issue 1). As no issues remain, the Board hereby closes Case No. 19-0735 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:

10/17/2024

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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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410-786-2671

Via Electronic Delivery

James Ravindran
Quality Reimbursement Services, Inc.
150 N. Santa Anita Avenue, Suite 570A
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RE: ***Board Decision***
Tennova Healthcare Regional Jackson (Prov. No. 44-0189)
FYE: 09/30/2016
Case No.: 19-2369

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the documentation in the above referenced appeal. 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. 19-2369*

On **February 27, 2019**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end September 30, 2016.

On **August 6, 2019**, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained five (5) issues:

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

As the Provider is owned by Community Health Systems, Inc. (hereinafter "Community Health") and, thereby, subject to the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1), the

[1] On March 20, 2020, the Provider transferred the issue to PRRB Case No. 19-1409GC.
[2] On March 20, 2020, the Provider transferred the issue to PRRB Case No. 19-1410GC.

Provider transferred Issues #2 (DSH SSI Percentage) and #5 (2 Midnight Census IPPS Payment Reduction) to Community Health groups on March 20, 2020.

On **January 2, 2020**, the Medicare Contractor timely filed a Jurisdictional Challenge[3] with the Board over Issues 1, 4, and 5 requesting that the Board dismiss these issues. 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.

On **March 27, 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."

On **July 31, 2020**, the Medicare Contractor filed its preliminary position paper.

On **November 14, 2022**, the Medicare Contractor filed its second Jurisdictional Challenge for issue 3 Medicaid Eligible days. The Provider filed a response on **December 14, 2022**.

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

On **December 28, 2022**, the Medicare Contractor filed a Request for Dismissal, restating its request for the Board to dismiss the DSH Medicaid Eligible Days issue from the appeal for the Provider's failure to meet the Board requirements for position papers. The Provider failed to file a response.

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:

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[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).

> 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).[4]

The Group issue Statement in Case No. 19-1409C, 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] Issue Statement (August 6, 2019).

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.[5]

On March 27, 2020, the Board received the Provider's preliminary position paper in 19-2369. 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. This is based on certain data from the State of Tennessee and the Provider that does not support the SSI percentage issued by CMS.
>
> The Provider has worked with the State of Tennessee 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 ("MEDP AR") database, HHS/HCF NOIS, 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.[6]

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $36,000.

MAC's Contentions

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

[5] Group Appeal Issue Statement in Case No. 19-1409C.
[6] Provider's Preliminary Position Paper at 8-9.

The MAC argues that the Board lacks jurisdiction over the DSH – SSI Percentage (Provider Specific) Issue 1 has three components: SSI data accuracy; realignment; and individuals who are eligible for SSI but did not receive SSI payment. The MAC contends that the portions of Issue 1 concerning SSI data accuracy and individuals who are eligible for SSI but did not receive SSI payment should be consolidated into Issue 2.

The MAC contends that the Board lacks jurisdiction over the SSI realignment portion of Issue 1.2 There was no final determination over SSI realignment and the appeal is premature as the Provider has not exhausted all available remedies.[7]

Issue 3 – DSH – Medicaid Eligible Days

The MAC argues that the Board lacks jurisdiction over the DSH – Medicaid Eligible Days issue because the issue has been abandoned "when they failed to properly develop their arguments within their preliminary position paper in accordance with Board Rule 25.3. Additionally, the Providers have failed to provide a list of additional Medicaid eligible days or any other supporting documents expanding why they cannot produce those documents."[8]

Issue 4 – 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)."[9]

The MAC also contends that this issue is a duplicate of PRRB Case No. 16-0769GC and should therefore be dismissed.[10]

Provider's Jurisdictional Response

On December 14, 2022, the Provider filed a Jurisdictional Response for the issue of Medicaid Eligible days only (no response was received for issues 1 or 4). The Provider contends that they have not abandoned the Medicaid Eligible days issue and has complied with the preliminary position paper rules. The Provider argues that the MAC overlooks that CMS recognizes that "practical impediments" frequently impede a provider's ability to obtain the necessary support when claiming additional Medicaid eligible days. The Provider cites to several Board cases in which the Board has applied the practical impediment standard. Additionally, the Provider notes that it "faced, and continue to face, the challenge of providing lifesaving health services to patients suffering from COVID (and, more recently, children suffering from life-threatening respiratory disease)."[11]

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[7] Medicare Contractor's Jurisdictional Challenge at 2-3. (Jan. 2, 2020)
[8] Medicare Contractor's Jurisdictional Challenge at 1 (Nov. 14, 2022).
[9] Medicare Jurisdictional Challenge at 8 (Jan. 2, 2020)
[10] *Id*.
[11] Provider Jurisdictional Response at 1

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."[12] 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)."[13] 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."[14]

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. 19-2369 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

[12] Issue Statement at 1.
[13] *Id.*
[14] *Id.*

PRRB Rule 4.6[15], 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.[16] The Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors 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.[17] 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.

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

> https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH.[19]
> This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows: "DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[20]

Accordingly, *based on the record before it*,[21] the Board finds that the SSI Provider Specific issue in Case No. 19-2369 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*

[18] (Italics and underline emphasis added.)
[19] Last accessed February 24, 2023.
[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.

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 nor was this information filed in the preliminary position paper.

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.[22]

So, essentially, 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**[23]
>
> **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

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

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 August 8, 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.[24]

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 March 27, 2020, the Provider filed its preliminary position paper in which it indicated that it would be sending the eligibility listing under separate cover.[25] The position paper did not identify how many Medicaid eligible days remained in dispute in this case. Significantly, the position paper

[24] (Emphasis added.)
[25] Provider's Preliminary Position Paper at 8 (March 27, 2020).

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.

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 November 14, 2022, 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.

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"[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]

---

[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 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.

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).[28]
>
> (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*"),[29] the U.S. Court of Appeals for the District of Columbia Circuit ("D.C. Circuit") upheld the D.C. District Court's decision[30] 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

---

[28] 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 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.
[29] 830 F.3d 515 (D.C. Cir. 2016).
[30] 89 F. Supp. 3d 121 (D.D.C. 2015).

review of the Secretary's estimates precludes review of the underlying data as well."[31] 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.[32]

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.[33]

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*").[34] 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."[35] 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.[36]

c. Scranton Quincy Hosp. Co. v. Azar

Recently, in *Scranton Quincy Hosp. Co. v. Azar* ("*Scranton*"),[37] 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.[38] 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

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[31] 830 F.3d 515, 517.
[32] *Id.* at 519.
[33] *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*").
[34] 925 F.3d 503 (D.C. Cir. 2019) ("*DCH v. Azar*").
[35] *Id.* at 506.
[36] *Id.* at 507.
[37] 514 F. Supp. 249 (D.D.C. 2021).
[38] *Id.* at 255-56.

payments based on either the 2012 or 2011 cost report that was closest to a full twelve month cost report.[39] 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.[40] Nevertheless, the Secretary used each hospital's shorter cost reporting period in calculating the Factor 3 values for their FY 2015 DSH payments.[41]

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 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.[42]

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."[43] 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.[44] 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.[45]

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

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[39] *Id.* (quoting 79 Fed. Reg. 49854, 50018 (Aug. 22, 2014)).
[40] *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.
[41] *Id.*
[42] *Id.* at 262-64.
[43] *Id.* at 265.
[44] *Id.* (discussing *Leedom v. Kyne*, 358 U.S. 184, 188 (1958)).
[45] *Id.* at 264 (quoting *DCH v. Azar*, 925 F.3d at 509-510).

requires a violation of a clear statutory command.[46] 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*").[47] 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 exercise jurisdiction over their appeals.[48] 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."[49] The D.C. Circuit further dismissed the applicability of the Supreme Court's 2019 decision in *Azar v. Allina Health Servs*.[50] 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***."[51]

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. 19-2369 and removes

[46] *Id.* at 264-6511 (quoting *DCH v. Azar*, 925 F.3d at 509).
[47] Civ. No. 20-139, 2021 WL 3856621 (D.D.C. August 30, 2021).
[48] *Id*. at *4.
[49] *Id.* at *9.
[50] 139 S. Ct. 1804 (2019).
[51] *Ascension* at *8 (bold italics emphasis added).

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 Musgrave, Esq.
Shakeba DuBose, Esq.

For the Board:

10/17/2024

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

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RE: ***Board Decision* – SSI Percentage (Provider Specific)**
Merit Health Natchez (Provider No. 25-0084)
FYE 09/30/2015
Case No. 19-0784

Dear Mr. Ravindran and Mr. Redmond,

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. 19-0784

On **July 9, 2018**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end September 30, 2015.

On **December 19, 2018**, 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[1]
3. DSH Medicaid Eligible Days[2]
4. Uncompensated Care Distribution Pool[3]
5. 2 Midnight Census IPPS Payment Reduction[4]

As a result of the withdrawal and case transfers, the remaining issue in this appeal is Issue 1 (the DSH – SSI Percentage Provider Specific issue).

[1] On July 17, 2019, the Provider transferred this issue to PRRB Case No. 18-0552GC.
[2] On October 10, 2024, the Provider withdrew this issue.
[3] On July 17, 2019, the Provider transferred this issue to PRRB Case No. 18-0555GC.
[4] On July 17, 2019, the Provider transferred this issue to PRRB Case No. 18-0554GC.

On **August 6, 2019**, the MAC filed a Jurisdictional Challenge over Issue 1: DSH SSI Percentage (Provider Specific). The Provider did not file a response.

On **August 7, 2019**, the Provider filed its Preliminary Position Paper, and the Medicare Contractor filed its Preliminary Position Paper on **December 5, 2019.**
On **August 12, 2024**, the Provider filed its Final Position Paper, and the Medicare Contractor filed its Final Position Paper on **September 9, 2024**.

On **September 5, 2024**, the MAC filed a second Jurisdictional Challenge over issues 1 and 3. The Provider did not file a response but withdrew Issue 3 on **October 10, 2024**.

On **September 9, 2024**, the Provider filed a Change or Representative request.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 18-0552GC – QRS CHS 2015 DSH SSI Percentage CIRP Group

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.
>
> . . .
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[5]

The group issue statement in Case No. 18-0552GC, to which the Provider transferred Issue 2 reads, in part:

> **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

[5] Issue Statement at 1 (Dec. 19, 2018).

Medicare/SSI fraction calculation per the Medicare Statute at 42 U.S.C. §1395ww(d)(5)(F)(vi)?.

Statement of the Legal Basis

The Provider(s) contend(s) that the Lead MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww (d)(5)(F)(vi). The Provider(s) contend(s) that the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") and used by the Lead MAC to settle their Cost Report were incorrectly computed.

The Provider(s) also contend(s) 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(s) further contend(s) 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 0. Leavitt, 545 F. Supp. 2d 20, as amended, 587 F. Supp. 2d 37, 44 (D.D.C. 2008) and incorporate a new methodology inconsistent with the Medicare Statute.

Providers in this case are also seeking resolution of the following additional aspects of the Medicare fraction that were not addressed in the Baystate case:

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

[6] Group Appeal Issue Statement in Case No. 18-0552GC.

On August 7, 2019, the Provider filed its preliminary position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Issue #1: 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. This is based on certain data from the State of Mississippi and the Provider that does not support the SSI percentage issued by CMS.
>
> The Provider has worked with the State of Mississippi 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, HHSIHCFAIOIS, 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. Leavit*t, 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction.[7]

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.[8]

[7] Provider's Preliminary Position Paper at 8-9 (Aug. 7, 2019).
[8] Medicare Contractor's Jurisdictional Challenge at 2 (Dec. 8, 2023)

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.[9] 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. 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.

A. DSH Payment/SSI Percentage (Provider Specific)

The jurisdictional analysis for Issue 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. As set forth below, the Board dismisses all aspects of Issue 1.

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. 18-0552GC.

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."[10] 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)."[11] The Provider argues in its issue statement, which was included in the

[9] Board Rule 44.4.3, v. 2.0 (Aug. 2018).
[10] Issue Statement at 1.
[11] *Id.*

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."[12] The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 18-0552GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds the DSH Payment/SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 18-0552GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6,[13] the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

In making this finding, the Board further notes that CMS regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, is pursuing that issue as part of the group under Case No. 18-0552GC, which is required since it is subject to the CIRP group regulations under 42 C.F.R. § 405.1837(b)(1). 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.[14] Provider is misplaced in referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 18-0552GC.

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. 18-0552GC, 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:

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[12] *Id.*

[13] PRRB Rules v. 3.1 (Nov. 2021).

[14] 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).

> **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.[15]

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

> https://www.cms.gov/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh.[16]

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."[17]

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

[15] (Emphasis added).
[16] Last accessed Oct. 15, 2024.
[17] (Emphasis added).

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. 18-0552GC. Accordingly, the Board finds that the SSI Provider Specific issue in Case No. 19-0784 and the group issue from the CIRP group under Case No. 18-0552GC 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.

****

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. 18-0552GC and there is no final determination from which the Provider can appeal the SSI realignment portion of the issue. As no issues remain, Case No. 19-0784 is closed and removed from the Board's docket.

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

Board Members Participating:

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

For the Board:

10/18/2024

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Board Decision*** **– SSI Percentage (Provider Specific) & Medicaid Eligible Days Issues**
Steward Melbourne Hospital (Provider No. 10-0291)
FYE 09/30/2016
Case No. 19-1322

Dear Mr. Ravindran and Mr. Pike,

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 19-1322. 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 issues.

Background:

A. ***Procedural History for Case No. 19-1322***

On **August 10, 2018**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end September 30, 2016.

On **February 5, 2019**, the Board received 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[1]
3. DSH Payment – SSI Fraction/Medicare Managed Care Part C Days[2]
4. DSH Payment – SSI Fraction/Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)[3]
5. DSH Payment – Medicaid Eligible Days
6. DSH Payment – Medicaid Fraction/Medicare Managed Care Part C Days[4]

[1] On September 23, 2019, this issue was transferred to PRRB Case No. 19-0173GC.
[2] On September 23, 2019, this issue was transferred to PRRB Case No. 19-0175GC.
[3] On September 23, 2019, this issue was transferred to PRRB Case No. 19-0198GC.
[4] On September 23, 2019, this issue was transferred to PRRB Case No. 19-0159GC.

7. DSH Payment – Medicaid Fraction/Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)[5]
8. Uncompensated Care ("UCC") Distribution Pool[6]
9. 2 Midnight Census IPPS Payment Reduction[7]

As the Provider is commonly owned/controlled by Community Health Systems ("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, 3, 4, 6, 7, 8 and 9 to CHS CIRP groups. As a result of the case transfers, there are two (2) remaining issues in this appeal: Issue 1 (DSH – SSI Percentage Provider Specific) and Issue 5 (DSH – Medicaid Eligible Days).

On March 11, 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.[8]

On **October 2, 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.[9] 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 $60,617 based on an estimated 100 days.

On **December 23, 2019**, the Medicare Contractor timely filed a Jurisdictional Challenge[10] with the Board over Issue 1 requesting that the Board dismiss this issue. Pursuant to Board

[5] On September 23, 2019, this issue was transferred to PRRB Case No. 19-0197GC.
[6] On September 23, 2019, this issue was transferred to PRRB Case No. 19-0177GC.
[7] On September 23, 2019, this issue was transferred to PRRB Case No. 19-0185GC.
[8] (Emphasis added.)
[9] Provider's Preliminary Position Paper ("Provider's PPP") at 8 (October 2, 2019).
[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

Rule 44.4.3, the Provider had 30 days in which to file a response to the Jurisdictional Challenge. The Provider filed a response on January 15, 2020.

On **January 10, 2020**, the Medicare Contractor filed its preliminary position paper. With regard to Issue 5, the Medicare Contractor's position paper noted that 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.[11]

On **August 6, 2024**, the Provider filed its final position paper. On **August 20, 2024**, the Medicare Contractor filed its final position paper.

On **August 26, 2024**, the Medicare Contractor filed a second jurisdictional challenge, requesting the dismissal of Issue No. 5 - Medicaid Eligible Days.

On **August 27, 2024**, 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. 19-0173GC

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

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

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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).

[11] Medicare Contractor's Preliminary Position Paper ("Contractor's PPP") at 10 (Jan. 10, 2020).

> 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.[12]

The Group Issue Statement in Case No. 19-0173GC, to which the Provider transferred Issue No. 2 reads:

> **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 at 42 U.S.C. § 1395ww(d)(5)(vi)(I). The Provider(s) further contend(s) that the SSI percentages calculated by the [CMS] and used by the MAC to settle their Cost Reports incorporates a new methodology inconsistent with the Medicare statute.

[12] Issue Statement at 1 (Feb. 5, 2019).

> 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.[13]

On October 2, 2019, the Provider filed its preliminary position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Issue #1: Provider Specific**
>
> The Provider contends that its SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation. This is based on certain data from the State of Florida and the Provider 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 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

[13] Group Issue Statement, Case No. 19-0173GC. (Oct. 31, 2018)

> that did not account for all patient days in the Medicare fraction.[14]

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $22,000.

MAC's Contentions

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

The MAC argues that the Board should dismiss the DSH – SSI Percentage (Provider Specific) issue for two reasons. First, the MAC argues that the appeal is duplicative:

> In Issue 1, the Provider contends that "…its' (sic) SSI percentage published by the Centers for Medicare and Medicaid Services ('CMS') was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation." In Issue 2, the Provider asserts "…that the SSI percentages calculated by the Centers for Medicare and Medicaid Services ('CMS') and used by the Lead MAC to settle their Cost Report were incorrectly computed." In both Issue 1 and Issue 2, the Provider is disputing whether the correct SSI percentage was used in computing its DSH payments. The accuracy of the SSI data is a common issue in both the DSH – SSI (Provider Specific) issue and the DSH – SSI issue.
>
> …
>
> Issue 2 has been transferred to group case 19-0173GC. Thus, the Provider has ventured an attempt to appeal the same issue in more than one appeal at the same time.
>
> The PRRB's rules are clear on this matter: No duplicate filings. Rule 4.6 states:
>
> A provider may not appeal an issue from a single final determination in more than one appeal.
>
> The fact pattern in this case is not new to the Board. The Board has dealt with it in other cases – and there are many such cases.

[14] Provider's Preliminary Position Paper at 8-9 (Oct. 2, 2019).

> Moreover, the Board has consistently ruled that these issues are considered the same issue. The MAC maintains that a similar decision should be reached in this case.[15]

The MAC also argues that the appeal is premature because the Provider has not requested realignment in accordance with 42 C.F.R. § 412.106(b)(3):

> 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 (see Exhibit C-3). PRRB Rule 25.3 addresses issues that are not briefed in a provider's position paper. In relevant part, this rule states:
> Any issue appealed, but not briefed by the Provider in its position paper will be considered withdrawn. Even if the Board finds that the issue of SSI realignment is still active it should still be dismissed. The Board has consistently ruled that a provider's appeal of the SSI issue to preserve its right to a recalculation is not a valid issue. 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.[16]

Issue 5 – DSH – Medicaid Eligible Days

The MAC argues that the Board should dismiss the DSH – Medicaid Eligible Days issue because the Provider has effectively abandoned the issue:

[15] Jurisdictional Challenge at 3-4 (Dec. 23, 2019).
[16] Id. at 5-6

> The MAC contends 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 cannot produce those documents, as required by the regulations and the Board Rules. Therefore, the MAC respectfully requests that the Board dismiss the DSH – Medicaid Eligible Days issue.[17]

The Medicare Contractor also argues that the Provider attempts to improperly and untimely add the Section 1115 waiver days issue to the appeal in the narrative of its final position paper. The Medicare Contractor contends:

> Added issues must be added within 60 days of the expiration of the appeal filing deadline. In this case, that would be 240 days from the date of the original Notice of Program Reimbursement (NPR). The inclusion of any added issues in the Provider's position paper would have occurred after the deadline to add issues (i.e., 240 days after the NPR date).
>
> A provider's inclusion of this sub-issue in its final position paper does not qualify as adding an issue.
>
> …
>
> Moreover, pursuant to Board Rule 8.1, "each contested component must be appealed as a separate issue and described as narrowly as possible…"
>
> …
>
> According to Board Rule 6.2.1, an issue may be added if the provider "timely files a request with the Board to add issues to an open appeal no later than 60 days after the expiration of the applicable 180-day period for filing the initial hearing request". The original NPR was issued on August 10, 2018, thereby setting the period to add issues to close on April 7, 2019. The Provider did not raise the issue of Section 1115 Waiver Days in its appeal request or in its preliminary position paper. Rather, the Provider first introduced the issue of Section 1115 Waiver Days in its final position paper which was filed on August 6, 2024, over five years after the deadline to add new issues.
>
> Specifically, the Provider modified Issue 5 in its final position paper as follows:

[17] Medicare Contractor's Jurisdictional Challenge at 7 (Aug. 26, 2024).

> The issue is whether the Medicare Administrative Contractor (MAC) included in the Provider's Medicaid Fraction of the disproportionate patient percentage all Medicaid eligible days (including section 1115 waiver days).
>
> Again, the issue the Provider is now trying to address was not timely added, and even if it had been timely as part of the position paper, this does not constitute adding an issue. Moreover, the Provider did not formally add the disputed issue to the appeal request via a Model Form C. Therefore, the Section 1115 Waiver Days issue should be dismissed.[18]

Provider's Jurisdictional Response

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

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."[19] 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."[20]

Finally, the Provider contends the Provider Specific issue is appealable "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, resulting from its understated SSI percentage due to errors of omission and commission."[21]

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.

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[18] *Id.* at 8-9.
[19] Jurisdictional Response at 1 (Jan. 15, 2020).
[20] *Id*. at 2.
[21] *Id*.

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. 19-0173GC.

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."[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, filed as part of the original 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. 19-0173GC 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). Both the issue statement in Case No. 19-1322 and the issue statement in CIRP Group Case No. 19-0173GC use the exact same paragraph discussing the definition of "entitled," as well. Thus, the Board finds that the DSH Payment/SSI Percentage (Provider Specific) issue in Case No. 19-1322 is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 19-0173GC. 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

[22] Issue Statement at 1.
[23] *Id*.
[24] *Id.*
[25] PRRB Rules v. 2.0 (Aug. 2018).

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. 19-0173GC, 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"[27] but fails to explain how it can be done, 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.[28] 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. Once the documents become available, promptly forward them to the Board and the opposing party.[29]

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[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] Provider's PPP at 9.

[28] 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.

[29] (Italics and underline emphasis added.)

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.[30]

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.[31]

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. 19-0173GC.

Accordingly, based on the record before it, the Board finds that the SSI Provider Specific issue in Case No. 19-1322 and the group issue from the CHS CIRP group under Case No. 19-0173GC are the same issue. Because the issue is duplicative, and duplicative issues appealed

[30] Last accessed September 23, 2024.
[31] Emphasis added.

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. Further, the Board notes that the Provider's fiscal year ends on 9/30, which is congruent with the Federal Fiscal Year. In such a case, realignment of the SSI percentage would have no effect on DSH reimbursement for such a provider, as the periods are the same. Therefore, the Board dismisses this aspect of the appeal.

B. DSH Payment – Medicaid Eligible Days

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

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

7.3.2 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.[32]

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.

As cited above, Board Rule 25 requires the Provider to file its complete, *fully* developed preliminary position paper with all available documentation.

Rule 25 Preliminary Position Papers

> **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,

[32] (Bold emphasis added.)

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.)

Further, the Notice of Case Acknowledgement and Critical Due Dates issued to the Provider on March 11, 2019, included instructions on the content of the Provider's preliminary position paper consistent with the above-referenced 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.[33]

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:

[33] (Emphasis added.)

- 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 would be sending the eligibility listing under separate cover.[34] The position paper did not identify how many Medicaid eligible days remained in dispute in this case.

The Provider's complete briefing of this issue in its final position paper, filed on August 6, 2024, 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.

[34] Provider's Preliminary Position Paper at 10.

…

Based on the Listing of Medicaid Eligible days being sent under separate cover directly to the MAC, including Section 1115 waiver days (a redacted copy is attached), 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 required by HCFA Ruling 97-2 and the pertinent Federal Court decisions.[35]

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.

The Provider failed to timely include a list of additional Medicaid eligible days with its preliminary position paper, or submit such list under separate cover as instructed. 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.[36]

The Board thereby finds the issue abandoned due to the Provider's failure to file a listing. The Medicare Contractor contends that the Provider is required to identify and provide documentation to prove what additional Medicaid Eligible days are at issue and to which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rule 25.

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).

Further, 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"[37] and, pursuant to Board

[35] Provider's Final Position Paper at 9-10 (August 20, 2024).
[36] *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.
[37] (Emphasis added.)

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 filings, 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 dismisses this issue from the appeal.

Section 1115 Waiver Days

The Board finds that the § 1115 Waiver Days issue is *not* properly part of this appeal because it was not properly included in the original appeal request, and it was not properly or timely added to the appeal. While the Provider appealed Medicaid eligible days, this issue is separate and distinct from the § 1115 Waiver Days as recognized by multiple Board, Administrator and Court decisions[38] (many of which were issued prior to the Provider's April 12, 2019 deadline for adding issues to this appeal).[39]

The appeal was filed with the Board in February 2 of 2019 and 42 C.F.R. § 405.1835(b) gives the following "contents" requirements for an initial appeal request for a Board hearing:

> (b) *Contents of request for a Board hearing on final contractor determination.* The provider's request for a Board hearing under paragraph (a) of this section must be submitted in writing to the Board, and the request **must include** the elements described in paragraphs (b)(1) through (b)(4) of this section. **If the provider submits a hearing request that does not meet the requirements of paragraph (b)(1), (b)(2), or**

[38] *See, e.g.*, *QRS 1993-2007 DSH/Iowa Indigent Patient /Charity Care (GA) Group v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (Jan. 15, 2013), *affirming* PRRB Dec. No. 2013-D02 (Nov. 21, 2012)*; St. Dominic-Jackson Mem'l Hosp. v. Sebelius*, No. 3:12-cv-832, 2014 WL 8515280 (S.D. Miss. 2014); *Singing River Health Sys. v. Novitas Solutions, Inc.*, PRRB Dec. 2016-D19 (Sept. 20, 2016), *rev'd* CMS Adm'r Dec. (Nov. 18, 2016); *CCT&B 2005- 2006 Hurricane Katrina § 1115 Waiver UCP Days Grp. v. Novitas Solutions, Inc*., PRRB Dec. 2016-D18 (Sep. 16, 2016), *rev'd* CMS Adm'r Dec. (Nov. 18, 2016), *aff'd sub nom. Forrest Gen. Hosp. v. Hargan*, No. 2:17-CV-8, 2018 WL 11434575 (S.D. Miss. Feb. 22, 2018), *rev'd & remanded Forrest Gen. Hosp. v. Azar*, 926 F.3d 221 (5th Cir.
2019); *Southwest Consulting UMass Mem'l Health Care & Steward Health 2009 DSH CCHIP Section 1115 Waiver Days Grps. v. Nat'l Gov't Servs., Inc*., PRRB Dec. 2017-D04 (Jan. 27, 2017), *rev'd* CMS Adm'r Dec. (Mar. 21, 2017), *vacated & remanded sub nom*. *HealthAlliance Hosps., Inc. v. Azar*, 346 F. Supp. 3d 43 (D.D.C. Oct. 26, 2018); *Florida Section 1115 LIP Rehab DSH Waiver Days Grps. v. First Coast Serv. Options*, PRRB Decs. 2018- D21, 2018-D22 (Feb. 8, 2018), *vacated by* Adm'r Dec. (Mar. 30, 2018), *rev'd by Bethesda Health Inc. v. Azar*, 389
F. Supp. 3d 32 (DDC 2019), *aff'd by* 980 F.3d 121 (D.C. Cir. 2020).

[39] Here, the NPR at issue was issued on Aug 10, 2018 and the Provider had until Monday, Feb. 11, 2019 to file the appeal (where receipt is presumed to be 5 days later and the Provider had 180 from that date to file an appeal request). Accordingly, the deadline to add issues is 60 days beyond that date, *i.e.*, Monday, April 12, 2019.

> **(b)(3) of this section, the Board <u>may dismiss</u>** 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 **<u>each</u>** 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.[40]

Board Rule 7 (Aug. 29, 2018) elaborated on these regulatory "contents" requirements instructing providers:

> **7 - Support for Final Determination, Issue-Related Information and Claim of Dissatisfaction**
>
> The Provider must support the determination being appealed and the basis for its dissatisfaction for <u>each</u> 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.

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

Board Rules 7.2 and 7.3 provider further information regarding issue pleading and specificity:

7.2 - Issue Related Information

7.2.1 General Information

The following information and supporting documentation 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.

- A copy of the applicable audit adjustment report page(s) or a statement addressing why an adjustment report is not applicable or available.
- A calculation or other support for the reimbursement effect noted in the issue statement.
- Support for protested items or claim of dissatisfaction as noted in Rules 7.3 and 7.4.

7.2.2. Additional Information

Providers must submit additional information not specifically addressed above in order to support jurisdiction or appropriate claim for the appealed issue(s). Example: Revised NPR workpapers and applicable cost report worksheets to document that the issue under appeal was specifically adjusted.

7.3 Self Disallowed Items (Applies to Cost Reporting Periods Ending On or Before 12/31/15)

7.3.1 Authority Requires Disallowance

If the Provider claims that the item being appealed was not claimed on the cost report because a regulation, manual, ruling, or some other legal authority predetermined that the item would not be allowed, the following information must be submitted:

- a concise issue statement describing the self-disallowed item,
- the reimbursement or payment sought for the item, and
- the authority that predetermined that the claim would be disallowed.

7.3.2 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.

7.3.3 Protest

Effective for cost reporting periods ending on or after December 31, 2008, items claimed under protest on the cost report must follow the applicable procedures as contained in CMS Pub. 15-2, Section 115. See 42 C.F.R.§ 405.1835(a)(1)(ii). [*March 2013*][41]

For the appeal, you must:

• identify the amount that was protested for the specific item being appealed,
• attach a copy of the protested items worksheet submitted with your as-filed cost report, and
• the as-filed Worksheet E or audit adjustment report to demonstrate the total protested claim.
Note: CMS Ruling 1727-R governs for cost reporting periods ending on or after 12/31/08 and beginning before 1/1/16.

Board Rule 8 (Aug. 29, 2018) provides "*special instructions*" for issue statements *involving* ***multi-component disputes***. In particular, 8.1 explains that, when framing issues for adjustments *involving multiple components*, that providers must "***specifically*** identify" each cost item in dispute, and "…each contested component must be appealed as a *separate* issue and described as ***narrowly as possible***…".[42] Board Rule 8.1 (Aug. 29, 2018) gives common *examples* of different components of the Disproportionate Share Hospital payment calculation that may be in dispute. Specifically, Board Rule 8 states:

Rule 8 – Framing Issues for Adjustments Involving Multiple Components

8.1 – General
Some issues may have multiple components. To comply with the regulatory requirement to specifically identify the items in dispute, each contested component must be appealed as a separate issue and described as narrowly as possible using the

[41] (Underline emphasis in initial paragraph for Rule 7 added.)
[42] (Emphasis added.)

applicable format outlined in Rule 7. Several examples are identified below, ***but these are not exhaustive lists of categories or issues.***[43]

A. Disproportionate Share Hospital Payments
Common examples include: dual eligible Medicare Part A/Medicaid, dual eligible Medicare Part C/Medicaid, SSI data matching, state/program specific general assistance days, Section 1115 waiver days (program/waiver specific), and observation bed days.

B. Bad Debts
Common examples include: crossover bad debts, collection effort, use of collection agency, 120-day presumption, and indigence determination.

C. Graduate Medical Education/Indirect Medical Education
Common examples include: managed care days, new programs, current year resident count, prior year count, penultimate year count, intern to bed ratio, and rotations to non-hospital settings.

D. Wage Index
Common examples include: wage data corrections, occupational mix, wage vs. wage-related costs, pension, rural floor, and data corrections.[44]

Pursuant to the May 23, 2008 final rule, new Board regulations went into effect on August 21, 2008 *that limited the* ***addition*** *of issues to appeals*.[45] As a result of this final rule, 42 C.F.R. § 405.1835(e) (Sept. 2016) provides in relevant part:

> (b) *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 –
>
> ****
>
> 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 establish that the Provider timely and properly added the § 1115 Waiver Days to the case. In this regard, the first discussion of § 1115 waiver days in this case

[43] (Emphasis added.)
[44] Board Rules are available https://www.cms.gov/medicare/regulations-guidance/provider-reimbursement-review-board/prrb-rules-and-board-orders (last visited September 23, 2024).
[45] *See* 73 Fed. Reg. 30190 (May 23, 2008).

occurred in the Provider's August 6, 2024 final position paper, well after the deadline for adding issues had passed.

In this regard, the Board notes that § 1115 Waiver days are *not* traditional Medicaid eligible days. Indeed, it was only effective January 20, 2000 that the Secretary incorporated, ***at her discretion*** *by regulation*, only ***certain*** types of § 1115 waiver days into the DSH calculation (*i.e.,* the Secretary maintains that no statute requires that days associated with § 1115 waiver/expansion programs be included in the DSH calculation and that she exercised her discretion to include only certain such days).[46] Rather, § 1115 waiver days 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 § 1115 waiver days. 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 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**

[46] 65 Fed. Reg. 47054, 47087 (Aug. 1, 2000). *See also* 68 Fed. Reg. 45346, 45420 (Aug. 1, 2003) (stating: "On January 20, 2000, we issued an interim final rule with comment period (65 FR 3136), followed by a final rule issued on August 1, 2000 (65 FR 47086 through 47087), to allow hospitals to include the patient days of all populations that receive benefits under a section 1115 demonstration project in calculating the Medicare DSH adjustment.
Previously, hospitals were to include only those days for populations under the section 1115 demonstration project who were, or could have been made, eligible under a State plan. Patient days of those expansion waiver groups who could not be made eligible for medical assistance under the State plan were not to be included for determining Medicaid patient days in calculating the Medicare DSH patient percentage. Under the January 20, 2000 interim final rule with comment period (65 FR 3137), hospitals could include in the numerator of the Medicaid fraction those patient days for individuals who receive benefits under a section 1115 expansion waiver demonstration project (effective with discharges occurring on or after January 20, 2000).").

> **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.[47]

Significantly, ***§ 1115 waiver programs can pertain*** *to not just Medicaid (Title XIX),* *but also* ***to other programs under Titles I, X, XIV, XIV or part A or D of Title IV of the Social Security Act***.[48] Hence, an important limitation is that the § 1115 waiver program receive Title XIX matching payments. Moreover, not every state Medicaid program has a qualifying § 1115 expansion program receiving Title XIX matching payments[49] and not every inpatient day associated with a beneficiary enrolled in such a § 1115 waiver program qualifies to be included in the numerator of the DSH Medicaid fraction.[50] In contrast, every state has a Medicaid state

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[47] (Bold emphasis added.)

[48] Section 1115 of the Social Security Act (42 U.S.C. § 1315] pertains to "experimental, pilot, or demonstration project[s] which, in the judgment of the Secretary, is likely to assist in promoting the objectives of ***title I, X, XIV, XVI, or XIX, or part A or D of title IV***, in a State or States." 1115(a) of the Social Security Act (emphasis added). As such, § 1115 waiver programs are not just limited to Title XIX Medicaid programs but may also relate to programs under Titles I, X, XIV, XVI, or part A or D of Title IV.

[49] Further, a specific approved state § 1115 waiver day program is not necessarily static and may vary from one year to the next.

[50] Unlike traditional Medicaid eligible days under a State Plan, the following discussion from the FY 2004 IPPS Final Rule, 68 Fed. Reg.at 45420-21 highlights that not all § 1115 waiver days can be included in the numerator of the Medicaid fraction and that factual determinations must be made regarding any § 1115 waiver day program to determine if 42 C.F.R. § 412.106(b)(4) is applicable to that program:

> Since that revision, we have become aware that there are certain section 1115 demonstration projects that serve expansion populations with benefit packages so limited that the benefits are not similar to the medical assistance available under a Medicaid State plan. These section 1115 demonstration projects extend coverage only for specific services and do not include inpatient care in the hospital. Because of the limited nature of the coverage offered, the population involved may have a significantly higher income than traditional Medicaid beneficiaries.
> In allowing hospitals to include patient days related to section 1115 expansion waiver populations, our intention was to include patient days of section 1115 expansion waiver populations who receive benefits under the demonstration project that are similar to those available to traditional Medicaid beneficiaries, including inpatient benefits. Because of the differences between expansion populations in these limited benefit demonstrations and traditional Medicaid beneficiaries, in the May 19, 2003 proposed rule, we proposed that the Medicare DSH calculation should exclude from treatment as Medicaid patient days those patient days attributable to limited benefit section 1115 expansion waiver populations (proposed § 412.106(b)(4)(i)).
> For example, a State may extend a family planning benefit to an individual for 2 years after she has received the 60- day postpartum benefit under Medicaid, or a State may choose to provide a family planning benefit to all individuals below a certain income level, regardless of having

plan; every state Medicaid plan includes inpatient hospital benefits; and by statute at 42 U.S.C.§ 1395ww(d)(5)(F)(vi)(II), the numerator of the DSH Medicaid fraction must include inpatient days of patients "who . . . were eligible for medical assistance ***under a State plan*** approved under subchapter XIX" but who were not entitled to Medicare Part A.[51]

In this regard, documentation needed to verify eligibility for a § 1115 waiver day is materially different than that for a traditional Medicaid eligible day[52] and, similarly, it is not a given that *all*
§ 1115 waiver days (even those under a program receiving Title XIX matching payments) necessarily would qualify under § 412.106(b)(4) as demonstrated by Board decisions and case law.[53] Here, 42 C.F.R. § 405.1835(b) and Board Rules 7 and 8

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previously received the Medicaid postpartum benefit. This is a limited, temporary benefit that is generally administered in a clinic setting (see section 1905(a)(4)(C) of the Act). Also, a number of States are developing demonstrations that are limited to providing beneficiaries an outpatient prescription drug benefit.
Generally, these limited benefits under a demonstration project do not include inpatient benefits. If a hospital were to include the days attributable to patients receiving benefits under such a
limited benefit, the hospital would be able to receive higher DSH payments, perhaps substantially, for patients who may otherwise be insured for inpatient care. For example, these limited demonstrations provide benefits that may be needed to supplement private insurance coverage for individuals who do not have incomes low enough to qualify for Medicaid under the State plan. We do not believe such patients should be counted in the DSH patient percentage as eligible for title XIX.

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Therefore, we proposed to revise § 412.106(b)(4)(i) to clarify that patients must be eligible for medical assistance inpatient hospital benefits under an approved State Medicaid plan (or similar benefits, including inpatient hospital benefits, under a section 1115 demonstration project) in order for their hospital inpatient days to be counted as Medicaid days in the calculation of a hospital's DSH patient percentage. Under the proposed clarification, hospital inpatient days attributed to patients who do not receive coverage for inpatient hospital benefits either under the approved State plan or through a section 1115 demonstration would not be counted in the calculation of Medicaid days for purposes of determining a hospital's DSH patient percentage.
Under this reading, in the examples given above, the days associated with a hospital inpatient who receives coverage of prescription drugs or family planning services on an outpatient basis, but no inpatient hospital coverage, through either a Medicaid State plan or a section 1115 demonstration, would not be counted as Medicaid days for purposes of determining the DSH patient percentage.

[51] (Emphasis added.)
[52] In addition to providing proof that the patient at issue was eligible for the § 1115 waiver program for each day claimed, the Provider must also establish that the particular § 1115 waiver program at issue relates to Title XIX and qualified under 42 C.F.R. § 412.106(b)(4) as demonstrated by the preamble discussion in *supra* note 50 and litigation in *supra* note 38.
[53] *See* litigation in *supra* note 38.

required each separate issue to be identified in the appeal request. Here, the Provider failed to do so, notwithstanding including a ***detailed*** description of "The Process That the Provider Used To Identify And Accumulate The Actual Medicaid Paid And Unpaid Days That Were Reported And Filed On The Medicare Cost Report At Issue" to support its assertion that the Medicaid eligible days at issue in the appeal were ones that could not have been identified through that process.[54]
Regardless, of whether the Provider *properly* included the § 1115 waiver days issue in its appeal request (which it did not), the Provider failed to properly develop the merits of § 1115 waiver day issue in any of the Provider's position papers. Specifically, neither the Provider's preliminary position paper nor the final position paper mention, much less identify, the **specific state** § 1115 waiver program(s) at issue[55] or how any days under such program(s) would qualify under 42 C.F.R.§ 412.106(b) to be included in the numerator of the DSH Medicaid fraction, notwithstanding its obligation to do so consistent with the position paper content requirements at 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rules 25 and 27.[56] This is an independent basis for dismissal of the § 1115 waiver day issue. Specifically, the material facts and legal arguments needed to establish the merits of the Provider's claims regarding the § 1115 waiver days issue along with the relevant supporting documentation were not properly briefed and included in the position paper filings.

Finally, even if the Board were to find that Issue 5 encompassed § 1115 waiver days, **there is no indication that any of the § 1115 waiver days, not included in any listing, were included with the as-filed cost report and, if true,** this would make them an *unclaimed* cost and provide an independent basis for dismissal (*see* Board Alert 10). In raising this issue, the Board notes that it has found that when a class of days (*e.g.*, § 1115 waiver days) is excluded due to choice, error, and/or inadvertence

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[54] The Board recognizes that the appeal request states that "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." However, the "including but not limited to" phrase only pertained to traditional Medicaid eligible days and reasons why they may not have been included in the fraction. It did not expand to include other classes of days such as general assistance, State-only days or § 1115 waiver days. A generic catchall phrase cannot be used to essentially shoehorn in the later addition of an issue on an ***untimely*** basis in contravention of Board Rules and regulations. Indeed, neither the appeal request or the preliminary position paper include any description (much less identification of) § 1115 waiver days as being an issue, notwithstanding the obligation to do so under the requirements for the content of position papers at 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rules 25 and 27.

[55] In failing to identify the specific state § waiver program(s) at issue, the Provider fails to address whether such § 1115 waiver program(s) are under Titles I, X, XIV, XVI, XIX, or IV and whether such § 1115 waiver program(s) received Title XIX matching funds and would otherwise qualify under 42 C.F.R. § 412.106(b) to be counted in the numerator of the DSH Medicaid fraction.

[56] 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rule 25 (Aug. 2018) required a fully-developed preliminary position paper that includes the legal merits and material facts of the Provider's position as well as all available supporting documents as required Board Rule 25.2 (Aug. 2018).

from the as-filed cost report,[57] then that class of days is an unclaimed cost for which the Board would lack jurisdiction under 42 U.S.C. § 1395oo(a) and 42 C.F.R. § 405.1835(a)(1)(i)-(ii) (2012) as clarified by CMS Ruling 1727-R.[58] The Provider's briefings generally address this jurisdictional issue by generically asserting that its process did not identify certain Medicaid eligible days. However, this discussion did not identify or discuss the class of days involving § 1115 waiver days and whether that class of days were included on the cost report. In this regard, if the Provider purposefully excluded § 1115 waiver days from the as-filed cost report, then CMS Ruling 1727-R confirms that the Provider only had a right to appeal those days if it "***had a good faith belief*** *that claiming reimbursement for [the § 1115 waiver days at issue] in the cost report would be futile because [the § 1115 waiver days at issue] was subject to a regulation or other payment policy* ***that bound the Medicare contractor and left the contractor with no authority or discretion to make payment in the manner sought by the provider***."[59] Here the Provider has failed to specifically address or discuss the Board's jurisdiction over this unique class of days. This is an independent basis for the Board to dismiss the § 1115 waiver days issue (*i.e.*, in addition to and independent from dismissal for failure to properly include the issue in its appeal request or properly brief and develop the issue).

In summary, as the DSH Medicaid Eligible Days issue as stated in the original appeal request did not include the § 1115 waiver days and the issue was not timely added to the appeal, the Board is dismissing it from this appeal. Because the Provider did not raise the § 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 Medicaid Eligible Days issue as stated in the original appeal request cannot be construed to include Section 1115 Waiver Days. Indeed, even if the Provider had properly included the issue as part of its appeal request, there are multiple independent bases upon which the Board would dismiss the issue, namely the failure to establish

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[57] CMS Transmittal 11912 (Mar. 16, 2023) makes clear that hospitals must maintain records on § 1115 waiver days:

> Each provider with an approved [§] 1115 waiver program ***has a method for identifying the days*** that are applicable to such waiver for reimbursement from the Medicaid program. As such, ***the provider is responsible for maintaining the appropriate supporting documentation*** *for the accrual of the days associated with [§] 1115 waiver reimbursements. Providers typically keep this information in the form of a listing of specific patient accounts for each individual acute hospital stay ([§] 1115 log) that is subject to [§] 1115 reimbursement. This [§] 1115 log is similar to a provider's DSH Medicaid eligible days listing. (Emphasis added.)*

[58] *See, e.g.,* PRRB Jurisdictional Decision, Case Nos. 06-1851, 06-1852 (Nov. 17, 2017) (dismissing the class of adolescent psychiatric days because no days were claimed with the as-filed cost report due to choice, error and/or inadvertence and, as such, the practical impediment standard or futility concept in the *Norwalk* and *Danbury* decisions under PRRB Dec. Nos. 2012-D14 and 2014-D03 is not applicable (available at: https://www.cms.gov/regulations-and-guidance/review-boards/prrbreview/downloads/jd-2017-11.pdf (last accessed September 19, 2024)).

[59] CMS Ruling 1727-R (emphasis added).

the Board's jurisdiction over the issue and the failure to properly develop the merits of the issue in its position paper filings.

* * * * *

Based on the foregoing, the Board dismisses the final two (2) remaining issues in this case – (Issue 1- DSH Payment/SSI Percentage and Issue 5- DSH Payment - Medicaid Eligible Days). As no issues remain, the Board hereby closes Case No. 19-1322 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:

10/21/2024

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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

RE: ***Notice of Dismissal***
Dupont Hospital LLC, (Prov. No. 15-0150)
FYE 03/31/2016
Case No. 19-0861

Dear Mr. Summar:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 19-0861. 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 Uncompensated Care ("UCC") payments.

Background

A. Procedural History for Case No. 19-0861

On **July 3, 2018**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end March 31, 2016. The Provider is commonly owned by Community Health Systems, Inc. ("CHS").

On **December 19, 2018**, 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 July 22, 2019, this issue was transferred to Case No. 19-1409GC.
[2] On September 13, 2024, the Provider withdrew this issue from the appeal.
[3] On July 22, 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 **July 22, 2019**, the Provider transferred Issues 2 and 5 to CHS CIRP groups.

On **April 8, 2019**, the Medicare Contractor timely filed a Jurisdictional Challenge[4] with the Board over Issues 1, 4 and 5 requesting that the Board dismiss these issues. 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.

On **August 7, 2019**, the Provider timely filed its preliminary position paper.

On **November 7, 2019**, the Medicare Contractor filed its preliminary position paper.

On **August 15, 2024**, 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.

On **September 13, 2024**, the Provider withdrew Issue 3 from the appeal.

As a result of the case transfers and withdrawn issue, there are only two (2) remaining issues in this appeal: Issue 1 (DSH – SSI Percentage Provider Specific), Issue 4 (UCC Distribution Pool).

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[.]

[4] 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).

> 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).[5]

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

[5] Provider's Individual Appeal at Submission at 9 (Dec. 19, 2018).

6. Failure to adhere to required notice and comment rulemaking procedures.[6]

On August 7, 2019, the Board received the Provider's preliminary position paper in 19-0861. 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 based on the Provider's Fiscal Year End (March 31).
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.
>
> Similar to *Loma Linda Community Hospital v. Dept. of Health and Human Services,* No. 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 (March 31) when it determined the Provider's SSI. *See Baystate Medical Center v. Leavitt,* 545 F. Supp. 2d 20 (D.D.C. 2008).[7]

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $12,000.

MAC's Contentions

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

The MAC argues that the Board should dismiss the DSH – SSI Percentage (Provider Specific) issue for two reasons. First, the MAC argues that the appeal is duplicative:

[6] Group Appeal Issue Statement in Case No. 19-1409GC.
[7] Provider's Preliminary Position Paper at 8-9 (Aug. 7, 2019).

> In Issue 1 the Provider asserts that "… its' (sic) SSI percentage published by the Centers for Medicare and Medicaid Services ("CMS") was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation." In Issue 2 the Provider asserts that "…the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") and used by the Lead MAC to settle their Cost Report were incorrectly computed." In both Issue 1 and Issue 2 the Provider is disputing whether the correct SSI percentage was used in computing its DSH payments. The accuracy of the SSI data is the underlying issue in both the DSH – SSI Percentage Provider Specific issue and the DSH – SSI Percentage issue.[8]

The MAC also argues that the appeal is premature because the Provider has not requested realignment in accordance with 42 C.F.R. § 412.106(b)(3):

> The decision to realign a hospital's SSI percentage with its fiscal year end is a provider 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 the 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); therefore, 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.[9]

Issue 4 – 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)."[10] The MAC also contends that this issue is a duplicate of PRRB Case Nos. 15-1134GC and 16-0769GC and should therefore be dismissed.[11]

Provider's Jurisdictional Response

[8] Jurisdictional Challenge at 5-6 (Apr. 8, 2019).
[9] *Id.* at 6.
[10] *Id.* at 9-10.
[11] *Id*. at 11.

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.[12] 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 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.

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."[13] 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)."[14] 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."[15]

[12] Board Rule 44.4.3, v. 2.0 (Aug. 2018).
[13] Issue Statement at 1.
[14] *Id.*
[15] *Id.*

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. 19-0861 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[16], 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.[17] 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.[18] 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)

[16] PRRB Rules v. 2.0 (Aug. 2018).
[17] 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).
[18] 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.

> 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.[19]

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.[20]

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."[21]

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.

[19] (Italics and underline emphasis added.)
[20] Last accessed October 21, 2024.
[21] Emphasis added.

Accordingly, *based on the record before it*,[22] the Board finds that the SSI Provider Specific issue in Case No. 19-0861 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. 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).[23]
>
> (B) Any period selected by the Secretary for such purposes.

[22] 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.

[23] 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 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.

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*"),[24] the U.S. Court of Appeals for the District of Columbia Circuit ("D.C. Circuit") upheld the D.C. District Court's decision[25] 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."[26] 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.[27]

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.[28]

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*").[29] 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

[24] 830 F.3d 515 (D.C. Cir. 2016).
[25] 89 F. Supp. 3d 121 (D.D.C. 2015).
[26] 830 F.3d 515, 517.
[27] *Id.* at 519.
[28] *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*").
[29] 925 F.3d 503 (D.C. Cir. 2019) ("*DCH v. Azar*").

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."[30] 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.[31]

c. Scranton Quincy Hosp. Co. v. Azar

Recently, in *Scranton Quincy Hosp. Co. v. Azar* ("*Scranton*"),[32] 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.[33] 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.[34] 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.[35] Nevertheless, the Secretary used each hospital's shorter cost reporting period in calculating the Factor 3 values for their FY 2015 DSH payments.[36]

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 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.[37]

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[30] *Id.* at 506.
[31] *Id.* at 507.
[32] 514 F. Supp. 249 (D.D.C. 2021).
[33] *Id.* at 255-56.
[34] *Id.* (quoting 79 Fed. Reg. 49854, 50018 (Aug. 22, 2014)).
[35] *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.
[36] *Id.*
[37] *Id.* at 262-64.

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."[38] 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.[39] 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.[40]

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.[41] 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*").[42] 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 exercise jurisdiction over their appeals.[43] 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."[44] The D.C. Circuit further dismissed the applicability of the Supreme Court's 2019 decision in *Azar v. Allina Health Servs*.[45] noting that "[t]he scope of the Medicare Act's notice-and-comment requirement would be relevant in

[38] *Id.* at 265.
[39] *Id.* (discussing *Leedom v. Kyne*, 358 U.S. 184, 188 (1958)).
[40] *Id.* at 264 (quoting *DCH v. Azar*, 925 F.3d at 509-510).
[41] *Id.* at 264-6511 (quoting *DCH v. Azar*, 925 F.3d at 509).
[42] Civ. No. 20-139, 2021 WL 3856621 (D.D.C. August 30, 2021).
[43] *Id*. at *4.
[44] *Id.* at *9.
[45] 139 S. Ct. 1804 (2019).

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***."[46]

The Board concludes that the same findings are applicable to the Provider's challenge to their FFY 2016 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 2016. 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 two (2) remaining issues in this case – (Issues 1 and 4). As no issues remain, the Board hereby closes Case No. 19-0861 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:

10/22/2024

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

[46] *Ascension* at *8 (bold italics emphasis added).

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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410-786-2671

Via Electronic Delivery

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

RE: ***Notice of Dismissal* – SSI Percentage (Provider Specific) Issue**
Moses Taylor Hospital, Prov. No. 39-0119
FYE 06/30/2015
Case No. 19-0826

Dear Mr. Summar:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 19-0826. 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).

Background

A. *Procedural History for Case No. 19-0826*

On **June 29, 2018**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end June 30, 2015. The Provider is commonly owned by Community Health Systems, Inc. ("CHS").

On **December 19, 2018**, 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 Payment – Medicaid Eligible Days[2]
4. Uncompensated Care ("UCC") Distribution Pool[3]
5. 2 Midnight Census IPPS Payment Reduction[4]

[1] On July 18, 2019, this issue was transferred to Case No. 18-0552GC.
[2] On October 10, 2024, the Provider withdrew this issue.
[3] On July 18, 2019, this issue was transferred to Case No. 18-0555GC.
[4] On July 18, 2019, this issue was transferred to Case No. 18-0554GC.

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 **July 18, 2019**, the Provider transferred Issues 2, 4, and 5 to CHS CIRP groups. On **January 28, 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 **March 27, 2019**, the Medicare Contractor timely filed a Jurisdictional Challenge[6] with the Board over Issues 1, 4 and 5 requesting that the Board dismiss these issues. 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 filed a ***late*** response on May 1, 2019.

On **August 7, 2019**, the Provider filed its preliminary position paper.

On **December 11, 2019**, the Medicare Contractor filed its preliminary position paper.

On **August 22, 2024,** the Provider filed its final position paper.

On **September 20, 2024,** the Medicare Contractor filed a second Jurisdictional Challenge, requesting dismissal of Issue 1: DSH Payment/SSI Provider Specific, and Issue 3: DSH Payment – Medicaid Eligible Days. The Medicare Contractor is requesting the Board dismiss Issue 1 as it is duplicative of Issue 2: DSH SSI Percentage (Systemic Errors), which was transferred to Case No. 18-0552GC. The MAC states the Board does not have jurisdiction over realignment, and the

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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).

Provider did not file a complete preliminary or final position paper with supporting exhibits in accordance with 42 C.F.R. § 405.1853(b)(2) and Board Rule 25 and 27. 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 **October 10, 2024**, the Provider withdrew Issue 3 from the appeal.

As a result of the case transfers and withdrawn issue, there is only one (1) remaining issue in the appeal: Issue 1 (DSH – SSI Percentage Provider Specific).

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 18-0552GC – QRS CHS CY 2015 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]

The Group issue Statement in Case No. 18-0552GC, to which the Provider transferred Issue No. 2, reads, in part:

> **Statement of the Issue:**
>
> Whether the Medicare/SSI fraction used in the Medicare Disproportionate Share Hospital and LIP payment calculations accurately and correctly counted the correct number of patient days to be included in the numerator and denominator of the Medicare/SSI fraction calculation per the Medicare Statute at 42 U.S.C. §1395ww(d)(5)(F)(vi)?

[7] Provider's Individual Appeal at Submission at 10 (Dec. 19, 2018).

Statement of the Legal Basis

The Provider(s) contend(s) that the Lead MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww (d)(5)(F)(vi). The Provider(s) contend(s) that the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") and used by the Lead MAC to settle their Cost Report were incorrectly computed.

The Provider(s) further contend(s) 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 0. Leavitt, 545 F. Supp. 2d 20, as amended, 587 F. Supp. 2d 37, 44 (D.D.C. 2008) and incorporate a new methodology inconsistent with the Medicare Statute.

Providers in this case are also seeking resolution of the following additional aspects of the Medicare fraction that were not addressed in the Baystate case:

1. Availability of MEDPAR and SSA records,
2. 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 August 22, 2024, the Board received the Provider's final position paper in Case No. 19-0826. 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

[8] Group Appeal Issue Statement in Case No. 18-0552GC.

> 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]

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $37,000.

MAC's Contentions

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

The MAC argues that the Board should dismiss the DSH – SSI Percentage (Provider Specific) issue for two reasons. First, the MAC argues that the appeal is duplicative:

> According to the Provider's appeal request, 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 portions of Issue 1 related to SSI data accuracy and individuals who are eligible for SSI but did not receive SSI payment are duplicates of Issue 2, which was transferred to Group Case No. 18-0552GC, "QRS CHS 2015 DSH SSI Percentage CIRP Group" and should be dismissed.
>
> With respect to the portion of Issue 1 related to SSI data accuracy, the Provider states:
>
> > 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. § 4 l 2.106(b)(2)(i) of the Secretary's Regulations. The Provider contends that its' SSI percentage

[9] Provider's Final Position Paper at 7-8 (Aug. 22, 2024).

> published by the Centers for Medicare and Medicaid Services ("CMS") was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation." The Provider contends that the SSI percentage issued by CMS is flawed.
>
> With respect to the portion of Issue 1 related to individuals who are eligible for SSI but did not receive SSI payment, the Provider states: 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 MAC contends that the Provider makes the same arguments in Issue 2 that was transferred to Case No. 18-0552GC. The Provider states in its appeal request for Issue 2.[10]

The MAC also argues that the appeal is premature because the Provider has not requested realignment in accordance with 42 C.F.R. § 412.106(b)(3):

> The decision to realign a hospital's SSI percentage with its fiscal year end is a Provider election. It is not a final MAC determination. A Provider must make a formal request to the MAC and CMS in order to receive a realigned SSI percentage. Once the hospital elects to use its own fiscal year end, it is bound by that decision, regardless of reimbursement impact.
>
> ****
>
> The Provider's appeal is premature. To date the Provider has not requested to have its SSI percentage realigned in accordance with 42 C.F.R. § 412.106(b)(3). Thus, the Provider has not exhausted all available remedies for this issue. The MAC requests that the Board dismiss this issue consistent with recent jurisdictional decisions.[11]

[10] Jurisdictional Challenge at 4-5 (Sept. 20, 2024).
[11] *Id.* at 7.

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.[12] The Provider did not file a response to the Jurisdictional Challenge during the time period for which they were required to respond. 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 remaining 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 Case No. 18-0552GC.

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."[13] 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)."[14] The Provider argues in its issue statement, which was included in the

[12] Board Rule 44.4.3, v. 2.0 (Aug. 2018).
[13] Issue Statement at 1.
[14] *Id.*

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."[15]

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 18-0552GC 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. 19-0826 is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 18-0552GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[16], 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.[17] 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 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 issue in Case No. 18-0552GC, 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.[18] 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.

---

[15] *Id.*
[16] PRRB Rules v. 2.0 (Aug. 2018).
[17] 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).
[18] 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.

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.[19]

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

> https://www.cms.gov/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh.[20]

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."[21]

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

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

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. 18-0552GC.

Accordingly, *based on the record before it*,[22] the Board finds that the SSI Provider Specific issue in Case No. 19-0826 and the group issue from the CHS CIRP group under Case No. 18-0552GC 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.

* * * * *

Based on the foregoing, the Board has dismissed the remaining issue in this case – Issue 1. As no issues remain, the Board hereby closes Case No. 19-0826 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:

10/23/2024

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

[22] Again, the Board notes that the Provider failed to respond to the September 20, 2024, Jurisdictional Challenge and the Board must make its determination based on the record before it.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Board Determination on Single Participant BS&W CY 2008 IPPS Understated Standardized Payment Amount CIRP Group, Case Number: 20-1974GC***

Specifically: Baylor Scott & White Medical Center Lake Pointe (Provider Number 45-0742)

Dear Mr. Ravindran, Mr. McGowan, and Mr. Redmond:

The Provider Reimbursement Review Board ("the Board") has reviewed the subject common issue related party ("CIRP") group appeal for the calendar year ("CY") 2008 which was filed by Quality Reimbursement Services, Inc. ("QRS") on behalf of Baylor Scott & White Health ("BS&W Health"). The background with regard to this provider and the group case, as well as the Board's determination, are set forth below.

Background:

On August 12, 2020, QRS filed the "BS&W Health CY 2008 IPPS Understated Standardized Payment Amount CIRP Group" under Case No. 20-1974GC.[1]

On August 21, 2020, BS&W Health requested the transfer of the Standardized Payment Amount issue from Case No. 20-0593, an individual appeal for Baylor Scott & White Medical Center Lake Pointe (Prov. No. 45-0742) ("Lake Pointe") for FYE 05/31/2008.

[1] Related groups were filed for the BS&W Health CY 2008 DSH SSI Fraction Dual Eligible Days, Medicaid Fraction Dual Eligible Days, SSI Percentage, Medicaid Fraction Managed Care Part C Days & SSI Fraction Managed Care Part C Days.

On August 12, 2021, QRS certified Case No. 20-1974GC to be fully formed with Lake Pointe as the only participant.[2]

Because the regulation at 42 C.F.R. § 405.1837(b) requires that a CIRP group have two or more providers, the Board issued a Request for Information ("RFI") on October 21, 2021 in which it requested the Parties to comment on its proposal to:

1. expand pending later year CIRP groups for both the SSI Percentage and IPPS Understated Standardized Payment Amount issues; and
2. consolidate various duplicate CY 2008 CIRP groups for the Dual Eligible Days issues.

The Board explained that, by expanding the later year BS&W Health CIRP groups to include CY 2008, Lake Pointe could be transferred from Case Nos. 20-1971GC, 20-1973GC and 20-1974GC, allowing the single participant groups to be closed.[3]

On November 5, 2021, QRS submitted its response to the Board's RFI and concurred with the Board's initial proposals. QRS' response did not, however, address the MAC's concerns regarding Tenet's ownership of Lake Pointe during the CY 2008. With regard to the Standardized Amount issue, QRS agreed with the expansion of the "BS&W Health CYs 2011-2013 IPPS Understated Standardized Payment Amount CIRP Group" under Case No. 19-2455GC.

Because of the concern raised by the Medicare Contractor regarding the ownership of Lake Pointe during CY 2008, on April 5, 2022, the Board issued a revised RFI requiring ***all*** Parties, including Tenet Health and BS&W Health, to address the potential disposition of Lake Pointe's CY 2008 group issues in relation to Tenet Health's ownership during that time. On April 19, 2022, Tenet Health filed its response to the Board's revised RFI indicating that "[t]here exists no Tenet 2008 CIRP group appeal for this issue as Tenet is not intending to pursue this matter for the CY 2008. As Tenet is the responsible party for filing appeals on behalf of Lake Pointe for FYE 05/31/2008, the provider ***should also not be transferred to an individual appeal***." (emphasis added.)[4]

On May 26, 2022, QRS responded to the Board's revised RFI. QRS advised that it, along with BS&W Health had conferred with both Tenet Health and Tenet Health's legal department, and all agreed the appeal rights for Lake Pointe's 5/31/2008 period belong to BS&W Health. Therefore, QRS requested that Lake Pointe remain a participant in the BS&W Health CY 2008

[2] The related CY 2008 BS&W Health CIRP groups under Case Nos. 20-1969GC, 20-1971GC and 20-1973GC were also certified to be fully formed with Lake Pointe as the sole participant. The Board will address each of those single participant groups under separate cover.
[3] The Medicare Contractor replied to the Board's RFI on October 29, 2021. The response did not address the Standardized Amount issue, but it did raise a question regarding the ownership of Lake Pointe for the period in question.
[4] Tenet Response to Request for Information at 2 (Apr. 19, 2022).

IPPS Understated Standardized Payment Amount CIRP Group under Case No. 20-1974GC.[5] QRS' correspondence did not address the fact that Lake Pointe was the sole provider in the CY 2008 BS&W Health CIRP groups.

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 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.

Further, Board Rule 4.6.1 indicates that Providers "may not appeal an issue from a single final determination in more than one appeal."[6] The Board has reviewed the pertinent facts in each group and has considered the comments fromTenet Health, QRS and the MAC.

The Board finds that Lake Pointe was part of Tenet for its CY 2008. In fact, according to Tenet's correspondence dated April 19, 2022, Tenet did not divest its minority interest in Lake Pointe until March 2018. The Board previously advised the Parties that it was aware of group activity that shows the appeal rights for Lake Pointe have been controlled by Tenet through 2020 as evidenced by the following:

- Lake Pointe was directly added to the "Tenet 2008 Post-1498-R DSH SSI Proxy CIRP" under Case No. 14-3154GC on January 15, 2020;
- Lake Pointe was directly added to the "Tenet 2010 DSH Eligible Days CIRP Group" under Case No. 14-1411GC on February 18, 2014;
- Lake Pointe was directly added to the "Tenet Healthcare CY 2015 DRG Transfer Adjustment Factor CIRP Group" under Case No. 18-1642GC on September 12, 2018.

In QRS' response to the Board it simply stated that "[o]n May 24, 2022, QRS and Baylor Scott & White Health confirmed with Steve Hernandez, Appeals Manager of Tenet Health, in association with Tenet's legal department, that the Lake Pointe (45-0742) cost report appeal rights for 5/31/2008 belong to Baylor Scott & White Health."[7] There was no documentation to support QRS' statement. Additionally, QRS' statement only represents that BS&W **PRESENTLY** controls appeal rights for Lake Pointe.

The Board finds that QRS has not met its burden of proof. Further, the record before the Board suggests that Lake Pointe's appeal rights were controlled by Tenet as late as 2018. Consequently, based on Lake Pointe's ownership under Tenet during CY 2008, and Tenet's statements that it is not pursuing the IPPS Standardized Amount issue for CY 2008 AND that the

[5] QRS' response also requested that Lake Pointe remain a participant in Case Nos. 20-1971GC and 20-1973GC for the BS&W Health CY 2008 SSI & Medicaid Fraction Dual Eligible Days issues; Case No. 20-1969GC for the BS&W Health CY 2008 SSI Percentage issue and that its individual appeal under Case No. 20-0593 remain pending.
[6] Board Rules (Aug 29, 2018).
[7] QRS Response to Request for Information at 2 (May 26, 2022).

issue should not be transferred to the individual appeal, the Board dismisses Lake Pointe's appeal of the issue in Case No. 20-1974GC. Since there are no remaining participants in the group, the Board dismisses Case No. 20-1974GC and removes it from the 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
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Shakeba DuBose, Esq.

For the Board:

10/25/2024

X Kevin D. Smith, CPA

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

cc: Wilson C. Leong, Federal Specialized Services
William Galinsky, Baylor Scott & White

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RE: ***Board Determination on Single Participant BS&W CY 2008 DSH SSI Percentage CIRP Group, Case Number: 20-1969GC***

Specifically: Baylor Scott & White Medical Center Lake Pointe (Provider Number 45-0742)

Dear Mr. Ravindran, Mr. Redmond and Mr. McGowan:

The Provider Reimbursement Review Board ("the Board") has reviewed the subject common issue related party ("CIRP") group appeal for the calendar year ("CY") 2008 which was filed by Quality Reimbursement Services, Inc. ("QRS") on behalf of Baylor Scott & White Health ("BS&W Health"). The background with regard to this provider and the group case in which it is a participant, as well as the Board's determination, are set forth below.

Background:

On August 12, 2020, QRS filed the "BS&W Health CY 2008 DSH SSI Percentage CIRP Group" under Case No. 20-1969GC.[1]

On August 21, 2020, BS&W Health requested the transfer of the DSH SSI Percentage issue from Case No. 20-0593, an individual appeal for Baylor Scott & White Medical Center Lake Pointe (Prov. No. 45-0742/"Lake Pointe") for FYE 05/31/2008.

[1] Related groups were filed for the BS & W Health CY 2008 DSH SSI Fraction Dual Eligible Days, Medicaid Fraction Dual Eligible Days, IPPS Understated Standardized Payment Amount, Medicaid Fraction Managed Care Part C Days & SSI Fraction Managed Care Part C Days.

On August 12, 2021, QRS certified Case No. 20-1969GC to be fully formed with Lake Pointe as the only participant.[2]

Because the regulation at 42 C.F.R. § 405.1837(b) requires that a CIRP group have two or more providers, the Board issued a Request for Information ("RFI") on October 21, 2021 in which it requested the Parties to comment on its proposal to:

1. expand pending later year CIRP groups for both the SSI Percentage and IPPS Understated Standardized Payment Amount issues; and
2. consolidate various duplicate CY 2008 CIRP groups for the Dual Eligible Days issues.

The Board explained that, by expanding the later year BS&W Health CIRP groups to include CY 2008, Lake Pointe could be transferred from Case Nos. 20-1971GC, 20-1973GC and 20-1974GC, allowing the single participant groups to be closed.

On October 29, 2021, in response to the Board's RFI, the Medicare Contractor ("MAC") noted that Lake Pointe was actually a participant in two separate groups for the CY 2008 SSI issue:

- Case No. 14-3154GC (Tenet 2008 Post 1498-R DSH SSI Proxy CIRP) and
- Case No. 20-1969GC (BS&W Health CY 2008 DSH SSI Percentage CIRP Group).

Therefore, rather than agreeing with the Board's proposal to expand a later year group, the MAC suggested that, based on Tenet's ownership of Lake Pointe for CY 2008, Case No. 20-1969GC be dismissed as a duplication of Case No. 14-3154GC.[3]

A week later, on November 5, 2021, QRS submitted its response to the Board's RFI and concurred with the Board's initial proposals. QRS' response did not, however, address the MAC's subsequent concerns regarding Tenet's ownership of Lake Pointe during the CY 2008, nor did it address the duplication of Lake Pointe's participation in the two SSI groups under Case Nos. 14-3154GC and 20-1969GC.

Consequently, on April 5, 2022, the Board issued a revised RFI requiring ***all*** Parties, including Tenet Health and BS&W Health, to address the potential disposition of Lake Pointe's CY 2008 group issues in relation to Tenet Health's ownership during that time. Both the MAC, on April 8, 2022, and Tenet Health, on April 19, 2022, filed responses to the Board's revised RFI indicating that Lake Pointe should remain a participant in the Tenet 2008 Post 1498-R DSH SSI Proxy CIRP Group under Case No. 14-3154GC.

On May 26, 2022, QRS responded to the Board's revised RFI. QRS advised that it, along with BS&W Health, had conferred with both Tenet Health and Tenet Health's legal department, and

[2] The related CY 2008 BS&W Health CIRP groups under Case Nos. 20-1971GC, 20-1973GC and 20-1974GC were also certified to be fully formed with Lake Pointe as the sole participant. The Board will address each of those single participant groups under separate cover.
[3] Medicare Contractor's Response to Board RFI at 1-2 (Oct. 29, 2021).

all agreed the appeal rights for Lake Pointe's 5/31/2008 period belong to BS&W Health. Therefore, QRS requested that Lake Pointe remain a participant in the BS&W Health CY 2008 SSI Percentage CIRP group under Case No. 20-1969GC.[4] QRS' correspondence did not address the fact that Lake Pointe was the sole provider in the CY 2008 BS&W Health CIRP groups.

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.

Further, Board Rule 4.6.1 indicates that Providers "may not appeal an issue from a single final determination in more than one appeal."[5] The Board has reviewed the pertinent facts in each group and has considered the comments fromTenet Health, QRS and the MAC.

The Board finds that Lake Pointe was part of Tenet for its CY 2008. In fact, according to Tenet's correspondence dated April 19, 2022, Tenet did not divest its minority interest in Lake Pointe until March 2018. The Board previously advised the Parties that it was aware of group activity that shows the appeal rights for Lake Pointe have been controlled by Tenet through 2020 as evidenced by the following:

- Lake Pointe was directly added to the "Tenet 2008 Post-1498-R DSH SSI Proxy CIRP" under Case No. 14-3154GC on January 15, 2020;
- Lake Pointe was directly added to the "Tenet 2010 DSH Eligible Days CIRP Group" under Case No. 14-1411GC on February 18, 2014;
- Lake Pointe was directly added to the "Tenet Healthcare CY 2015 DRG Transfer Adjustment Factor CIRP Group" under Case No. 18-1642GC on September 12, 2018.

In QRS' response to the Board's revised RFI, it simply stated that "[o]n May 24, 2022, QRS and Baylor Scott & White Health confirmed with Steve Hernandez, Appeals Manager of Tenet Health, in association with Tenet's legal department, that the Lake Pointe (45-0742) cost report appeal rights for 5/31/2008 belong to Baylor Scott & White Health."[6] There was no documentation to support QRS' statement. Additionally, QRS' statement only represents that BS&W **PRESENTLY** controls appeal rights for Lake Pointe. The statement does NOT include any representation on who controlled Lake Pointe's appeal rights in 2016 when the Board dismissed the original Tenet Dual Eligible Days group in which it was a participant under Case No. 10-0374GC.

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[4] QRS' response also requested that Lake Pointe remain a participant in Case Nos. 20-1971GC and 20-1973GC for the BS&W Health CY 2008 SSI & Medicaid Fraction Dual Eligible Days issues; Case No. 20-1974GC for the BS&W Health CY 2008 IPPS Understated Standardized Payment Amount issue and that its individual appeal under Case No. 20-0593 remain pending.

[5] Board Rules. (Aug 29, 2018).

[6] QRS' Response to Request for Information (May 26, 2022).

The Board finds that QRS has not met its burden of proof. Further, the record before the Board suggests that Lake Pointe's appeal rights were controlled by Tenet as late as 2018. Consequently, based on Lake Pointe's ownership under Tenet during CY 2008, the Board finds that Lake Pointe's participation in both Case Nos. 20-1969GC and 14-3154GC is duplicative and is prohibited under Board Rule 4.6.1. Therefore, the Board dismisses Lake Pointe from Case No. 20-1969GC. Since Lake Pointe was the sole participant in that group, Case No. 20-1969GC is closed and removed from the Board's docket. Lake Pointe remains a participant in the Tenet 2008 Post 1498-R DSH SSI Proxy CIRP Group under Case No. 14-3154GC.

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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For the Board:

10/29/2024

X Kevin D. Smith, CPA

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

cc: Wilson C. Leong, Federal Specialized Services
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Omaha, NE 68114-2708

RE: Own Motion Dismissal of SSI P/S issue - Failure to Transfer to CIRP
Delta Health-Northwest Regional
Provider Number: 25-0042
Appealed Period: FYE 05/31/2019
PRRB Case Number: 23-1763

Dear Mr. Summar and Mr. Lamprecht:

On September 23, 2024 the Provider Reimbursement Review Board (the "Board") issued a determination on its jurisdiction over the last remaining issue in the subject appeal, the SSI Percentage (Provider Specific) ("SSI Provider Specific") issue. The Board found that there are two aspects of the SSI Provider Specific issue under appeal:
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.

With regard to the first aspect, the Board found it to be duplicative of the SSI (Systemic Errors) issue pending in Case No. 22-1031GC. The Board referenced 42 C.F.R. § 405.1837(b)(1)(i), which requires two or more providers appealing a common issue to pursue the issue in a group. Because the Board found this aspect of the issue was "duplicative" of the specific matter appealed in the "CHS CY 2019 DSH SSI Percentage CIRP Group" under Case No. 22-1031GC, for which there were other commonly owned providers, and the group had not yet been designated to be fully formed, the Board directed CHS to transfer the SSI Provider Specific issue from Case No. 23-1763 to the Group Case No. 22-1031GC. The Board's determination required the transfer to be effectuated within 15 days (i.e., October 8, 2024). The Board informed CHS that failure to timely respond would result in the Board deeming the SSI Provider Specific issue to have been abandoned.

The Board notes that CHS has failed to respond to the deadline established in the September 23, 2024 determination, requiring the transfer of the first aspect of the SSI Provider Specific issue to Case No. 22-1031GC. Pursuant to Board Rule 41.2, the Board may dismiss a case if it has a reasonable basis to believe that the issues have been abandoned, or the group fails to comply with Board filing deadlines. The Board finds that the Provider has effectively abandoned the appeal of the SSI Provider Specific issue through a failure to respond by the October 8, 2024 deadline.

Because the Board previously dismissed the second aspect of the issue related to the SSI realignment portion of the SSI Provider Specific issue in its September 23, 2024 determination, and the first aspect of

the SSI Provider Specific issue has been abandoned, there are no issues remaining in Case No. 23-1763, which is hereby dismissed and removed from the Board's docket.

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

FOR THE BOARD:

Kevin D. Smith, CPA
Acting Board Chair

cc: Wilson C. Leong, Federal Specialized Services

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RE: ***Board Decision* – SSI Percentage (Provider Specific), Medicaid Eligible Days & Uncompensated Care Distribution Pool Issues**
Santa Rosa Medical Center (Provider No. 10-0124)
FYE 05/31/2017
Case No. 20-0083

Dear Messrs. Ravindran and Lamprecht,

The Provider Reimbursement Review Board ("Board") has reviewed the documentation in the above referenced appeal. 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. 20-0083*

On **April 3, 2019**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end May 31, 2017.

On **September 30, 2019**, the Board received 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 – SSI Fraction/Medicare Managed Care Part C Days[2]
4. DSH Payment – SSI Fraction/Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)[3]

[1] On Apr. 21, 2020, this issue was transferred to PRRB Case No. 20-1332GC.
[2] On Apr. 21, 2020, this issue was transferred to PRRB Case No. 20-1333GC.
[3] On Apr. 21, 2020, this issue was transferred to PRRB Case No. 20-1334GC.

5. DSH Payment – Medicaid Eligible Days[4]
6. DSH Payment – Medicaid Fraction/Medicare Managed Care Part C Days[5]
7. DSH Payment – Medicaid Fraction/Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)[6]
8. Uncompensated Care ("UCC") Distribution Pool[7]
9. 2 Midnight Census IPPS Payment Reduction[8]

As 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. § 405.1837(b)(1). For that reason, on **April 21, 2020**, the Provider transferred Issues 2, 3, 4, 6, 7 and 9 to CHS groups. As a result, there are three (3) remaining issues in this appeal: Issue 1 (DSH Payment/SSI Percentage (Provider Specific)), Issue 5 (DSH Payment – Medicaid Eligible Days), and Issue 8 (UCC Distribution Pool).

On **October 9, 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 **May 22, 2020**, the Provider timely submitted its preliminary position paper.

On **August 14, 2020**, the Medicare Contractor filed a jurisdictional challenge, requesting the dismissal of Issues 1 and 8.

On **September 10, 2020**, the Medicare Contractor timely submitted its preliminary position paper.

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[4] In OH CDMS, this was entered as Issue No. 9.
[5] In OH CDMS, this was entered as Issue No. 5. On Apr. 21, 2020, this issue was transferred to PRRB Case No. 20-1335GC.
[6] In OH CDMS, this was entered as Issue No. 6. On Apr. 21, 2020, this issue was transferred to PRRB Case No. 20-1336GC.
[7] In OH CDMS, this was entered as Issue No. 7.
[8] In OH CDMS, this was entered as Issue No. 8. On Apr. 21, 2020, this issue was transferred to PRRB Case No. 20-1337GC.
[9] (Emphasis added).

On **April 29, 2021**, the Medicare Contractor requested from the Provider all documentation necessary to resolve Issue 5 (DSH Payment – Medicaid Eligible Days).

On **July 14, 2021**, the Medicare Contractor requested for a second time from the Provider all documentation necessary to resolve Issue 5.

On **January 4, 2023**, the Medicare Contractor requested for the third and final time from the Provider all documentation necessary to resolve Issue 5.

On **June 21, 2023**, the Medicare Contractor filed a Motion to Dismiss, requesting the dismissal of Issue 5 (DSH Payment – Medicaid Eligible Days).

On **November 13, 2023**, the Provider submitted a listing of Redacted Medicaid Eligible Days.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 20-1332GC

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.
>
> . . .
>
> 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.[10]

The group issue statement in Case No. 20-1332GC, CHS CY 2017 HMA 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,

[10] Issue Statement at 1 (Sept. 30, 2019).

> 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.[11]

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $17,000.

On May 22, 2020, 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' 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 (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.

[11] Group Issue Statement, Case No. 20-1332GC.

> Similar to *Loma Linda Community Hospital v. Dept of Health and Human Services*, No. CV-94-0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records. However, at this time, the Provider has been unable to analyze the Medicare Part A data because it has not yet received the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR"), HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000 from CMS. *See* 65 Fed. Reg. 50,548 (2000). Upon release of the complete MEDPAR data, the Provider will seek to reconcile its' records with that of CMS, and identify patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS based on the Federal Fiscal Year End (September 30) when it determined the Provider's SSI. *See Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).[12]

C. 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.
>
> 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): 4,15,16,S-D

[12] Provider's Preliminary Position Paper at 8-9 (May 22, 2020).

Estimated Reimbursement Amount: $47,000[13]

Regarding the Medicaid eligible days issue, the Provider argues in its Preliminary Position Paper that pursuant to the Jewish Hospital case[14] 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.[15]

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 two reasons. First, the MAC argues that the SSI realignment portion of the issue is premature:

> The decision to realign a hospital's SSI percentage with its fiscal year end is a provider election. It is not a final MAC determination. The provider must make a formal request to the MAC and 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 the 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.[16]

In addition, the MAC argues the DSH – SSI Percentage (Provider Specific) issue and the DSH – SSI Percentage (Systemic Errors) issue are duplicates.[17]

Issue 5 – DSH Payment – Medicaid Eligible Days

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

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[13] Appeal Request at Issue 5.
[14] *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F.3d 270 (6th Cir. 1994).
[15] Provider's Preliminary Position Paper at 7-8.
[16] Jurisdictional Challenge at 7 (Aug. 14, 2020).
[17] *Id*. at 6.

a. That the Provider has failed to furnish documentation in support of its claim for additional Medicaid Eligible Days or describe why such documentation was and continues to be unavailable.
b. That the Provider has made affirmative statements in its Preliminary Position Paper that it was submitting such supporting documentation to the MAC.
c. That the Provider's failure to furnish such documentation (or describe why such documentation is unavailable) is in violation of PRRB Rules 7, 25.2.1 and 25.2.2.
d. That the Provider has effectively abandoned its claim for additional Medicaid Eligible Days.
e. That the Provider's claim for additional Medicaid Eligible Days is therefore dismissed.[18]

Accordingly, the Medicare Contractor requests that the Board dismiss Issue 5.

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)."[19]

The MAC also contends that this issue is a duplicate of PRRB Case Nos. 16-0769GC and 17-1042GC and should therefore, be dismissed.[20]

Provider's Response

Issue 1 – DSH Payment/SSI Percentage (Provider Specific) and *Issue 8 – UCC Distribution Pool*

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.[21] The Provider has not filed a response to the Jurisdictional Challenge or Motion to Dismiss 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. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

Issue 5 – DSH Payment – Medicaid Eligible Days

Similarly, 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

[18] Motion to Dismiss at 5 (Jun. 21, 2023).
[19] Jurisdictional Challenge at 10.
[20] *Id*. at 11.
[21] Board Rule 44.4.3, v. 2.0 (Aug. 2018).

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

On November 13, 2023, the Provider filed a "Supplement to Position Paper/Redacted Medicaid Eligible Days Listing Submission". The letter contained no explanation as to why this was submitted almost 3.5 years after the filing of the Preliminary Position Paper, nor any additional information other than a redacted listing.

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.

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 PRRB Case No. 20-1332GC.

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."[22] 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 that "its' SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[24]

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 20-1332GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage,

[22] Issue Statement at 1.
[23] *Id.*
[24] *Id.*

the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds the DSH Payment/SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 20-1332GC. 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.

In making this finding, the Board further notes that CMS regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, is pursuing that issue as part of the group under Case 20-1332GC, which is required since it is subject to the CIRP group regulations under 42 C.F.R. § 405.1837(b)(1). 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] Provider is misplaced in referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 20-1332GC.

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 20-1332GC, 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,* identify the missing documents, explain why the documents remain unavailable, state the efforts made to obtain the

[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).

> documents, and explain when the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.[27]

The Board further notes that the Provider only cites to the 2000 Federal Register but additional issuances and developments on the availability of data underlying the SSI fraction, such MEDPAR data, have occurred. For example, as noted in the FY 2006 IPPS Final Rule, "[b]eginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108–173), we will arrange to furnish, consistent with the Privacy Act, MedPAR LDS data for a hospital's patients eligible for both SSI and Medicare at the hospital's request, regardless of whether there is a properly pending appeal relating to DSH payments. *We will make the information available for either the Federal fiscal year or, if the hospital's fiscal year differs from the Federal fiscal year, for the* ***months included in the 2 Federal fiscal years that encompass the hospital's cost reporting period***. Under this provision, *the hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year*. The data set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year." Further highlighting the perfunctory nature of the briefing is the fact that providers *can* obtain certain data used to calculate their DSH SSI ratios directly from the Centers for Medicare and Medicaid Services ("CMS") 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.[28]

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.[29]

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 20-1332GC are the same issue.[30] 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.

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[27] (Emphasis added).
[28] Last accessed August 14, 2024.
[29] Emphasis added.
[30] 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).

The Board finds that, under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." Without this written request, the Medicare Contractor cannot issue a final determination from which the Provider can be dissatisfied with for appealing purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding DSH SSI Percentage realignment. Therefore, the Board finds that it lacks jurisdiction in 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.[31]

The Provider failed to include a list of additional Medicaid eligible days they expect to be included in their Medicaid percentage and DSH computations, with their appeal request.

The Provider's preliminary position paper indicated that it would be sending the eligibility listing under separate cover.[32]

Board Rule 7.3.2 states:

> **No Access to Data**

[31] Individual Appeal Request, Issue 5.
[32] Provider's Preliminary Position Paper at 8.

> If the provider elects not to 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.

Notably, the Provider has not included a list of additional Medicaid eligible days with its preliminary position paper or submitted such list under separate cover. The Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it cannot produce those documents, as required by the regulations and the Board Rules.[33]

42 C.F.R. § 405.1853(b) 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*.[34]

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:

> 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.

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[33] *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.

[34] (Emphasis added).

Similarly, with regard to position papers,[35] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[36] This requirement is consistent with 42 C.F.R. § 405.1853(b)(3).

Similarly, 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,* 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.[37]

When determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(4)(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.

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 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.

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[35] The minimum requirements for Final Position Paper narratives and exhibits is the same as those for Preliminary Position Papers. *See* Board Rule 27.2.
[36] (Emphasis added).
[37] (Emphasis added).

The Board concurs with the Medicare Contractor that the Provider is required to identify and provide documentation to prove what additional Medicaid Eligible days are at issue and to which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3) and 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"[38] 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***.

The Board finds that the November 13, 2023 submission of the "Supplement to Position Paper/Redacted Medicaid Eligible Days Listing" was untimely and an improper attempt to respond to the Motion to Dismiss. The listing of the Medicaid Eligible Days was to be filed with the Provider's Preliminary Position Paper. As the Provider did not even attempt to establish good cause under Board Rule 35.3, the Board will not consider the listing in its decision.

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 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, which the Provider has failed to do. The Provider has failed to include the Medicaid eligible days listing with its preliminary position paper or even file a copy following the MAC's Motion to Dismiss.

C. UCC Distribution Pool

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).[39]

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:

[38] (Emphasis added).
[39] The Provider was also a participant in PRRB Case Nos. 16-0769GC (appealing from the Fed. Reg. dated Aug. 17, 2015 and covers service dates Apr. 1, 2016 through Sept. 30, 2016) and 17-1042GC (appealing from the Fed. Reg. dated Aug. 22, 2016 and covers service dates Oct. 1, 2016 through Mar. 31, 2017). Both CIRP Group appeals have been dismissed for a lack of jurisdiction.

> (A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).[40]
>
> (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*"),[41] the U.S. Court of Appeals for the District of Columbia Circuit ("D.C. Circuit") upheld the D.C. District Court's decision[42] 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."[43] 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.[44]

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.[45]

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[40] 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 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.
[41] 830 F.3d 515 (D.C. Cir. 2016).
[42] 89 F. Supp. 3d 121 (D.D.C. 2015).
[43] 830 F.3d 515, 517.
[44] *Id.* at 519.
[45] *Id.* at 521-22.

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*").[46] 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."[47] 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.[48]

c. Scranton Quincy Hosp. Co. v. Azar

Recently, in *Scranton Quincy Hosp. Co. v. Azar* ("*Scranton*"),[49] 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.[50] 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.[51] 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.[52] Nevertheless, the Secretary used each hospital's shorter cost reporting period in calculating the Factor 3 values for their FY 2015 DSH payments.[53]

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

[46] 925 F.3d 503 (D.C. Cir. 2019) ("*DCH v. Azar*").
[47] *Id.* at 506.
[48] *Id.* at 507.
[49] 514 F. Supp. 249 (D.D.C. 2021).
[50] *Id.* at 255-56.
[51] *Id.* (quoting 79 Fed. Reg. 49854, 50018 (Aug. 22, 2014)).
[52] *Id.* One provider had a cost report for the six-month period from July 1, 2011 to December 31, 2011 and another for the twelve-month period from July 1, 2012 to June 30, 2013, while the second had a cost report for the nine-month period from October 1, 2011 to June 30, 2012 and another for the twelve-month period from July 1, 2012 to June 30, 2013.
[53] *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.[54]

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."[55] 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.[56] 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.[57]

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.[58] 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*").[59] 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

[54] *Id.* at 262-64.
[55] *Id.* at 265.
[56] *Id.* (discussing *Leedom v. Kyne*, 358 U.S. 184, 188 (1958)).
[57] *Id.* at 264 (quoting *DCH v. Azar*, 925 F.3d at 509-510).
[58] *Id.* at 264-6511 (quoting *DCH v. Azar*, 925 F.3d at 509).
[59] Civ. No. 20-139, 2021 WL 3856621 (D.D.C. August 30, 2021).

exercise jurisdiction over their appeals.[60] 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."[61] The D.C. Circuit further dismissed the applicability of the Supreme Court's 2019 decision in *Azar v. Allina Health Servs*.[62] 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***."[63]

The Board finds that the same findings are applicable to the Provider's challenge to their FFY 2017 UCC payments. The Providers here are 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.

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In summary, the Board hereby dismisses the DSH Payment/SSI Percentage (Provider Specific) issue from this appeal as it is duplicative of the issue in Case No. 20-1332GC and there is no final determination from which the Provider can appeal the SSI realignment portion of the issue. The Board also dismisses the DSH Payment - Medicaid Eligible Days issue as the Provider failed to meet the Board requirements for position papers for this issue in compliance with 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25. Finally, the Board dismisses the UCC Distribution Pool issue as the Board does not have jurisdiction 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. As no issues remain pending, the Board hereby closes Case No. 20-0083 and removes it from the Board's docket.

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

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[60] *Id*. at *4.
[61] *Id.* at *9.
[62] 139 S. Ct. 1804 (2019).
[63] *Ascension* at *8 (bold italics emphasis added).

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10/30/2024

X Ratina Kelly

Ratina Kelly, CPA
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Signed by: PIV

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