DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Notice of Dismissal***
St. Cloud Regional Medical Center (10-0302)
FYE 12/31/2016
Case No. 19-1308

Dear Mr. Summar,

The Provider Reimbursement Review Board ("Board" or "PRRB") has reviewed the Medicare Administrative Contractor Jurisdictional Challenge and Motion for Dismissal filed on December 27, 2019, regarding the above-captioned case. The Board's decision is set forth below.

Background

St. Cloud Regional Medical Center ("St. Cloud" or "Provider") is a hospital located in St. Cloud, Florida. On August 2, 2018, the Provider's Notice of Program Reimbursement ("NPR") was issued. The Provider filed its appeal with the Board ***187 days*** later on Tuesday February 5, 2019. The Provider filed its appeal request, which contained nine issues:

Issue 1: DSH, SSI (Provider-Specific)
Issue 2: DSH SSI
Issue 3: DSH – Part C Days in SSI Fraction
Issue 4: DSH – Dual Eligible Days in SSI Fraction
Issue 5: DSH- Medical Eligible Days
Issue 6: DSH- Part C Days in Medicaid Fraction
Issue 7: DSH – Dual Eligible Days in Medicaid Fraction
Issue 8: DSH – Uncompensated Care
Issue 9: Two Midnight Rule

On September 19, 2019, the Provider submitted requests to transfer Issues 2, 3, 4, 6, 7, 8, and 9 to group appeals. The issues were transferred as requested to group appeals as follows:

Issue	Transferred to:	Date of transfer:
2 – DSH SSI Percentage	19-0173GC	09/23/2019
3 – DSH Part C Days in SSI fraction	19-0175GC	09/23/2019
4 – DSH – Dual eligible days in SSI fraction	19-0198GC	09/23/2019
6 – DSH – Part C days in Medicaid fraction	19-0159GC	09/23/2019
7 – DSH – Dual eligible days in Medicaid fraction	19-0197GC	09/23/2019
8 – DSH – Uncompensated care	19-0177GC	09/23/2019
9 – Two Midnight Rule	19-0185GC	09/23/2019

Thereafter, the Provider and the Contractor timely filed their preliminary position papers on October 2, 2019, and January 10, 2020, respectively.

On December 27, 2019, the Medicare Contractor filed a Jurisdictional Challenge over the entire appeal, including the issues transferred to other groups. The Provider filed a response to the jurisdictional challenge on January 27, 2020.

Medicare Administrative Contractor's Jurisdictional Challenge

The Medicare Contractor contends that the appeal should be dismissed for untimely filing and cites 42 C.F.R. § 405.1835(a)(3), which sets forth the criteria for filing a timely appeal:

> Unless the provider qualifies for a good cause extension under § 405.1836, the date of receipt by the Board of the provider's hearing request must be no later than 180 days after the date of receipt by the provider of the final contractor or Secretary determination.

The Medicare Contractor points to the above regulation to support its argument that, to be considered timely, a Provider must file an appeal within 180 days of the final determination date, noting that, for an NPR, an additional five days is allowed to account for the provider's receipt of the NPR.

In its Jurisdictional Challenge, the Medicare Contractor states:

> In this circumstance, the 185-day deadline for filing the appeal was a Sunday. This means that the filing deadline for the Board to receive the appeal was on February 4, 2019.
>
> The NPR cited in the present appeal request is dated August 2, 2018 (*see* Exhibit C-1, page 6 of 33).[1] According to the Board's acknowledgment letter, the appeal request was received by the Board February 5, 2019 (*see* Exhibit C-4). This is 187 days from

[1] In accordance with 42 C.F.R. § 405.1801(a) and (d), it is presumed that the Provider received the NPR on Tuesday, August 7, 2018.

> the NPR (final determination) date to the date the appeal was received by the Board. The MAC notes that February 5, 2019 was a Tuesday, and that Monday, February 4, 2019, was a normal business day for the Board.[2]

The Medicare Contractor also argues that if the Board finds the appeal *was* filed timely, Issue 1 of the appeal should be dismissed because the Board lacks jurisdiction because the issue is duplicative or has been abandoned.

Provider's Response

On January 27, 2020, the Provider responded to the Medicare Contractor's Jurisdictional Challenge. However, the Provider only presented arguments related to whether the Board has jurisdiction over Issue 1. The Provider did not address its failure to file timely.

Board Decision:

Pursuant to 42 C.F.R. § 405.1868(b) and Board Rule 4.1, if a provider fails to meet a filing deadline or other jurisdictional requirement, the appeal will be dismissed. Pursuant to 42 C.F.R. § 405.1801(a) and Board Rule 4.5, the date of filing is the date of receipt by the Board, or the date of delivery by a nationally recognized next-day courier.

42 C.F.R. § 405.1835(a)(3) reads:

> Unless the provider qualifies for a good cause extension under § 405.1836, the date of receipt by the Board of the provider's hearing request must be no later than 180 days after the date of receipt by the provider of the final contractor or Secretary determination.

In this case, the 180-day deadline fell on Sunday, February 3, 2019. The Provider did not submit its Appeal Request to the Board until Tuesday, February 5, 2019, 187 days after the Provider's Notice of Program Reimbursement and final determination, dated August 2, 2018. Although the Provider's deadline fell on a Sunday, the Provider did not file the next day, Monday, February 4, 2019, which the Medicare Contractor correctly points out was a normal business day for the Board.

Board Rule 4.3.1 (Aug. 29, 2018) states:

> The date of receipt of a contractor final determination is presumed to be 5 days after the date of issuance. This presumption, which is otherwise conclusive, may be overcome if it is established by a

[2] MAC Jurisdictional Challenge at 5 (Dec. 27, 2019).

> preponderance of the evidence that such materials were actually received on a later date. *See* 42 C.F.R. § 405.1801(a)(1)(iii).

The Provider did not attempt to argue it received its Notice of Program Reimbursement on a later date than the presumptive date of receipt. Consequently, the Provider was required to file its appeal within the 185 days permitted under Board Rules. Notably, the Provider did not address its failure to file timely in its Jurisdictional Response at all.

Board Rules and regulations require that providers meet filing deadlines, or the Board may determine that jurisdictional requirements have not been met and dismiss the appeal.

Therefore, the Board finds that the Provider's appeal request is untimely. Furthermore, the Board ***denies*** the following transfer requests, and dismisses those issues from the appeal:

Issue	Transferred to:	Date of transfer:
2 – DSH SSI Percentage	19-0173GC	09/23/2019
3 – DSH Part C Days in SSI fraction	19-0175GC	09/23/2019
4 – DSH – Dual eligible days in SSI fraction	19-0198GC	09/23/2019
6 – DSH – Part C days in Medicaid fraction	19-0159GC	09/23/2019
7 – DSH – Dual eligible days in Medicaid fraction	19-0197GC	09/23/2019
8 – DSH – Uncompensated care	19-0177GC	09/23/2019
9 – Two Midnight Rule	19-0185GC	09/23/2019

Conclusion:

As the Board received the Provider's appeal after the applicable 180-day time limit, the Board denies jurisdiction over the Provider as having filed its initial appeal untimely pursuant to 42 C.F.R. § 405.1835(a).

The Board denies jurisdiction for this case, as well as the issues transferred to other cases. The Board hereby closes Case No. 19-1308 and removes it from the Board's docket. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

11/6/2023

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: Ratina S. Kelly -S

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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

RE: ***Request for Reinstatement***
Oregon Health & Science University, Prov. No. 38-0009, FYE 6/30/2009
Case No. 14-0833

Dear Mr. Loomis,

The Provider Reimbursement Review Board ("Board") has reviewed the Motion for Reinstatement of Appeal Due to Failure of MAC to Reopen Cost Report ("Motion for Reinstatement") submitted by Oregon Health & Science University ("OHSU" or "Provider") on August 1, 2023. The decision of the Board is set forth below.

Pertinent Facts:

On November 18, 2013, the Provider filed an Individual Appeal Request for the fiscal year ending June 30, 2009, related to its June 7, 2013 Notice of Program Reimbursement ("NPR"). The initial appeal request included a single issue, titled:

> Whether the Secretary properly calculated the Provider's Disproportionate Share Hospital ("DSH")/Supplemental Security Income ("SSI") percentage.[1]

On July 8, 2020, the Provider *withdrew* the entire appeal based on a reopening issued by the Medicare Contractor, Noridian Healthcare Solutions, to realign the SSI percentage for the provider, to reopen the cost report, and implement the results of the realignment.[2] The Provider and MAC agreed to utilize the August 29, 2018, Board Rules 46, 47.1, and 47.2 to resolve the appealed issue via a reopening. Accordingly, **on July 27, 2020**, the Board closed the case pursuant to the Issue withdrawal from the Agreement to Reopen the cost report.

On August 1, 2023 (*more than 3 years after the withdrawal was filed* ***and*** *more than 3 years after the case had been closed*), the Provider filed a Motion for Reinstatement for the withdrawn issue because the MAC failed to issue a revised NPR ("RNPR") after notifying the provider they would not be able to do so due to CMS' DSH hold for cost years 2013 and earlier after the closing of the 3-year reinstatement window.[3] However, the Provider's 3-year reinstatement window closed on

[1] Provider's Request for Hearing, at Tab 3, Issue Statement (Nov. 18, 2013).
[2] Request to Withdraw Appeal (July 8, 2020).
[3] 42 C.F.R. § 405.1885.

July 8, 2023 because, pursuant to Board Rule 47.1, a request for reinstatement must be filed "within three years of the Board's receipt of the provider's withdrawal of the issue(s)." Therefore, the Provider did not act in accordance with the August 29, 2018 Board Rules 46, 47.1, and 47.2 in effect at the time the case was withdrawn.

Statutory and Regulatory Background

A Medicare Contractor may reopen a cost report within three years of the date of the NPR.[4] A provider may withdraw an issue in an appeal for which the Medicare Contractor has agreed to reopen the final determination (*i.e.*, the cost report).[5] Following such a withdrawal, the provider may file a motion for reinstatement within three years of the Board's receipt of the provider's withdrawal of the issue or the appeal.[6] The motion must be in writing and include copies of the provider's reopening request and the Medicare Contractor's agreement to reopen the final determination.[7] The Board may grant the motion for reinstatement of the withdrawn issue/case if the Medicare Contractor fails to reopen the cost report and issue a RNPR for that issue as agreed.[8]

Board's Decision:

The Provider clearly filed its request for reinstatement outside the 3-year time frame of the appeal/issue withdrawal. As discussed above, the deadline for filing a request for reinstatement was July 8, 2023 (3 years after the withdrawal was filed[9]) but the request was not filed until August 1, 2023.[10] Therefore, the Board hereby denies the Provider's Motion for Reinstatement for Case No. 14-0833. Case No. 14-0833 remains closed. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

11/8/2023

X Clayton J. Nix

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

cc: Wilson C. Leong, Esq., Federal Specialized Services
Dana Johnson, Palmetto GBA c/o National Government Services, Inc. (J-M)

[4] *Id*.
[5] Board Rule 46 (Aug. 29, 2018).
[6] Board Rule 47.1.
[7] Board Rule 47.2.2.
[8] *Id.* ("Upon written motion, the Board *will* also grant reinstatement . . .") (emphasis added).
[9] Withdrawals are self-effectuating. *See* Board Rule 46 (stating ": A provider's request for withdrawal is self-effectuating and does not require any action by the Board once it is filed. Notwithstanding, the Board or Board Staff generally will issue a notice acknowledging the withdrawal when it results in the closure of a case. The Board does not issue a similar notice when the withdrawal does not result in the closure of the case.").
[10] Indeed, the reinstatement request was even filed more than 3 years after the Board closed the case on July 27, 2020.

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Quality Reimbursement Services
150 N. Santa Anita Avenue, Suite 570A
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Byron Lamprecht, Supervisor
Cost Report Appeals
WPS Government Health Administrators
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RE: ***Board Decision***
Tennova Healthcare – Cleveland (Provider Number 44-0185)
FYE: 08/31/2016
Case Number: 19-0973

Dear Mr. Ravindran and Mr. Lamprecht:

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the documentation in Case No. 19-0973 pursuant to a jurisdictional challenge filed by the Medicare Administrative Contractor ("MAC"). The Board's decision is set forth below.

Background:

Procedural History for Case No. 19-0973

On July 16, 2018, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end August 31, 2016.

On January 3, 2019, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained five (5) issues:

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

The DSH – SSI Percentage (Provider Specific) issue is the last issue pending in the appeal.

[1] This issue was transferred to PRRB Case No. 19-1409GC on July 17, 2019.
[2] This issue was withdrawn on September 15, 2023.
[3] This issue was withdrawn on October 17, 2023.
[4] This issue was transferred to PRRB Case No. 19-1410GC on July 17, 2019.

A. Description of Issue 1 in the Appeal Request

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]

On August 20, 2019, the Provider submitted its preliminary position paper to the MAC. 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 (August 31).
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.
>
> Similar to *Loma Linda Community Hospital v. Dept of Health and Human Services*, No. CV-94-0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records. However, at this time, the Provider has been unable to analyze the Medicare Part A data because it has not yet received the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR"), HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000 from CMS. *See* 65 Fed. Reg. 50,548 (2000). 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

[5] Issue Statement at 1 (Jan. 3, 2019).

> (September 30) when it determined the Provider's SSI. *See Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).[6]

On August 18, 2023, the Provider submitted its final position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> The Provider contends that its SSI percentage published by the Centers for Medicare and Medicaid Services ("CMS") was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation.
>
> The Provider is seeking a full and complete set of the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. See 65 Fed. Reg. 50,548 (2000). Although some MEDPAR data is now routinely made available to the provider community, what is provided lacks all data records necessary to fully identify all patients properly includable in the SSI fraction. The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' SSI percentage based on CMS's admission in Baystate Medical Center v. Leavitt, 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction. The hereby incorporates 8 all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra (Appellants' reply brief included as Exhibit P-2).[7]

MAC's Contentions:

Issue 1 – DSH – SSI Percentage (Provider Specific)[8]

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 appeal is premature:

> The decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election. It is not a final intermediary determination. A hospital must make a formal request to CMS in order to receive a realigned SSI percentage. Once the hospital

[6] Provider's Preliminary Position Paper at 8-9 (August 20, 2019).
[7] Provider's Final Position Paper at 7-8 (October 18, 2023).
[8] The MAC also challenged jurisdiction over the UCC and IPPS Payment issue, however the Provider has since withdrawn those issues.

> elects to use its own fiscal year end, it is bound by that decision, regardless of reimbursement impact.
>
> . . .
>
> The Provider's appeal is premature. The Provider has not formally requested to have its SSI percentage realigned in accordance with 42 C.F.R. § 412.106(b)(3). The Provider has not exhausted all available remedies prior to requesting a PRRB appeal to resolve this issue. The MAC requests that the PRRB dismiss this issue consistent with other jurisdictional decisions.[9]

In addition, the MAC argues the DSH – SSI Percentage (Provider Specific) issue and the DSH – SSI Percentage (Systemic Errors) issue are considered the same issue by the Board.[10]

Provider's Jurisdictional Response:

The Provider's response to the Jurisdictional Challenge was submitted after the 30-day deadline and was not taken into consideration.[11]

Board Determination:

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

A. DSH – SSI Percentage (Provider Specific)

The 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 Board finds that the Provider's Preliminary Position Paper failed to comply with Board Rule 25 governing the content of preliminary position papers.

In making this finding, the Board 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, the Provider has failed to explain how this argument is ***specific to this provider***, as the issue

[9] Jurisdictional Challenge at 6-7 (April 29, 2019).
[10] *Id*. at 5-6.
[11] The Jurisdictional Response was filed on May 31, 2019.

statement asserts. 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.[12] 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 and finds that the Provider's Final Position Paper also failed to comply with the Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" in its Preliminary Position Paper and include *all* exhibits.

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

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

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

> [b]eginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108–173), we will arrange to

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

> 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.[13]

Further highlighting the perfunctory nature of the briefing is the fact that providers *can* obtain certain data used to calculate their DSH SSI ratios directly from the Centers for Medicare and Medicaid Services ("CMS") and in some cases on a self-service basis as explained on the following webpage:

> https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH.[14]

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

> DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal.[15]

Accordingly, the Board must find that the Provider failed to properly brief the issue in its position papers in compliance with Board Rules.

2. *Second Aspect of Issue 1*

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

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[13] 70 Fed. Reg. 47278, 47439 (August 12, 2005) (Emphasis added).
[14] Last accessed October 30, 2023.
[15] Emphasis added.

****

In summary, the Board hereby dismisses the SSI Provider Specific issue as there is no final determination from which the Provider can appeal the SSI realignment portion of the issue, and the Provider failed to meet the Board requirements for position papers. As this is the only issue remaining in the appeal, the case will be 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:

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

For the Board:

11/8/2023

X Kevin D. Smith, CPA

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

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

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Via Electronic Delivery

Andrew Ruskin, Esq.
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RE: ***Expedited Judicial Review Determination***
Trinity Health 2014 IME Calculation – Labor & Delivery Beds CIRP Group
Case No. 17-0247GC

Dear Mr. Ruskin:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' request for expedited judicial review (EJR) filed on October 27, 2023 in the above-referenced group appeal. The Board's decision on jurisdiction and EJR are set forth below.

Issue:

The issue for which EJR has been requested is: Whether the Federal Fiscal Year ("FFY") 2013 regulatory change to 42 C.F.R. § 412.105(b), which removed the prior regulatory language that plainly excluded Labor & Delivery ("L&D") beds in the count of available beds used in the indirect medical education ("IME") adjustment calculation, is unlawful and therefore invalid.[1]

Statutory and Regulatory Background:

The operating costs of inpatient hospital services are reimbursed by Medicare primarily through the Inpatient Prospective Payment System ("IPPS"). The IPPS statute contains a number of provisions that adjust payment based on hospital specific factors.[2] One of those provisions creates payment for IME. The provision at 42 U.S.C. § 1395ww(d)(5)(B) provides that teaching hospitals that have residents in approved graduate medical education ("GME") programs receive an additional payment for each Medicare discharge to reflect the higher indirect patient care costs of teaching hospitals relative to non-teaching hospitals.[3] Regulations at 42 C.F.R. § 412.105 establish how the additional payment is calculated. The additional payment, known as the IME adjustment, is calculated using the hospital's ratio of full-time equivalent ("FTE") residents to available beds. This appeal concerns the count of available beds for the IME adjustment calculation, specifically the FFY 2013 regulatory change to § 412.105(b), which removed L&D beds from the regulatory list of beds excluded from the available bed count.

[1] Providers' EJR Request at 1-3, 9-10 (Oct. 27, 2023).
[2] *See* 42 U.S.C. § 1395ww(d)(5).
[3] *See also* Social Security Act § 1886(d)(5)(B).

The equation used to calculate the IME adjustment uses a hospital's ratio of residents to beds, which is represented as r, and a formula multiplier, which is represented as c, in the following equation: c x[{1+r{time} \.405\-1], or, it can also be written as, IME Multiplier x $[(1+r)^{0.405} -1]$.[4] Specifically, the statute at 42 U.S.C. § 1395ww(d)(5)(B) (2014) states, in pertinent part:

> (B) The Secretary shall provide for an additional payment amount for subsection (d) hospitals with indirect costs of medical education, in an amount computed in the same manner as the adjustment for such costs under regulations (in effect as of January 1, 1983) under subsection (a)(2), except as follows:
>
> (i) The amount of such additional payment shall be determined by multiplying (I) the sum of the amount determined under paragraph (1)(A)(ii)(II) (or, if applicable, the amount determined under paragraph (1)(A)(iii)) and, for cases qualifying for additional payment under subparagraph (A)(i), the amount paid to the hospital under subparagraph (A),[5] by (II) the indirect teaching adjustment factor described in clause (ii).
>
> (ii) For purposes of clause (i)(II), the indirect teaching adjustment factor is equal to c × (((1+r) to the nth power) −1), where "r" is the ratio of the hospital's full-time equivalent interns and residents to beds and "n" equals .405. Subject to clause (ix), for discharges occurring— . . . .
>
> (XII) on or after October 1, 2007, "c" is equal to 1.35.

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The formula is traditionally described in terms of a certain percentage increase in payment for every 10-percent increase in the resident-to-bed ratio.[6]

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[4] 74 Fed. Reg. 43753, 43898 (Aug. 27, 2009).

[5] This section of the statute, 42 U.S.C. § 1395ww(d)(1)(A), states, in pertinent part:

> (1)(A) Notwithstanding section 1395f(b) of this title but subject to the provisions of section 1395e of this title, the amount of the payment with respect to the operating costs of inpatient hospital services (as defined in subsection (a)(4)) of a subsection (d) hospital (as defined in subparagraph (B)) for inpatient hospital discharges in a cost reporting period or in a fiscal year—
>
> (i) beginning on or after October 1, 1983, and before October 1, 1984. . . .
>
> (ii) beginning on or after October 1, 1984, and before October 1, 1987. . . .
>
> (iii) beginning on or after April 1, 1988, is equal to
>
> (I) the national adjusted DRG prospective payment rate determined under paragraph (3) for such discharges, or
>
> (II) for discharges occurring during a fiscal year ending on or before September 30, 1996, ...

[6] 74 Fed. Reg. at 43898. In the FFY 2010 IPPS Final Rule, the formula multiplier, c, was changed to 1.35, which was estimated to result in an increase in IPPS payment of 5.5 percent for every approximately 10-percent increase in

The regulation at 42 C.F.R. § 412.105(b) provides the procedure for the determination of the number of beds for the "r" ratio in the IME adjustment factor calculation. The regulation states that the number of beds in a hospital is determined by counting the number of available bed days during the cost reporting period and dividing that number by the number of days in the cost reporting period. The count of available bed days excludes bed days associated with certain beds, as listed in the regulation, and until the FFY 2013 regulatory change, on that list of excluded beds was beds used for "ancillary labor/delivery services" at § 412.105(b)(4) (2011).[7] For purposes of the IME payment adjustment, an increase in a hospital's number of available beds results in a decrease in the resident-to-bed ratio. Thus, the FFY 2013 inclusion of bed days associated with L&D patients in the available bed count for IME will increase the available beds, decrease the resident-to-bed ratio, and, consequently, decrease IME payments to teaching hospitals.[8]

With regard to this regulatory change, CMS explains that its policy for counting hospital beds is to include bed days available for IPPS-level acute care hospital services.[9] Generally, beds would be considered available for IPPS-level acute care hospital services if the services furnished in that unit were generally payable under the IPPS.[10] Services furnished to an L&D patient are considered to be generally payable under IPPS.[11]

Significantly, to ensure consistency (as explained below), this regulatory change follows changes to policy that were made in prior years relating to the inclusion of L&D patient days in the Medicare DSH calculation.[12] Prior to FY 2010, CMS policy was to exclude from the count of inpatient days, for purposes of the Medicare DSH calculation, L&D patient days associated with beds used for ancillary L&D services when the patient did not occupy a routine bed prior to occupying an ancillary L&D bed. This policy applied whether the hospital maintained separate L&D rooms and postpartum rooms, or whether it maintained "maternity suites" in which labor, delivery, and postpartum services all occurred in the same bed. However, in the latter case, patient days were counted proportionally based on the proportion of (routine/ancillary) services furnished. In FY 2010, CMS revised regulations to include in the disproportionate patient percentage (DPP) of the Medicare DSH payment adjustment all patient days associated with patients occupying L&D beds once the patient has been admitted to the hospital as an inpatient regardless of whether the patient days are associated with patients who occupied a routine bed

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the hospital's resident-to-bed ratio. *Id.* The schedule of formula multipliers to be used in the calculation of the IME adjustment can be found in the regulation at 42 C.F.R. § 412.105(d)(3). *Id.*

[7] The regulatory change of now including L&D beds in the bed count, was effective for cost reporting periods beginning on or after October 1, 2012, and therefore first applied to the Provider Group's cost reporting period beginning on July 1, 2013 (with fiscal year end ("FYE") of June 30, 2014). 77 Fed. Reg. 53258, 53412 (Aug. 31, 2012); *see* Schedule of Providers, attached to this decision.

[8] 77 Fed. Reg. at 53734. CMS estimated that the inclusion of L&D beds in the available bed day count will decrease IME payments by $40 million in FY 2013. *Id.*

[9] 77 Fed. Reg. at 53411.

[10] *Id.*

[11] *Id.*, citing 74 Fed. Reg. at 43900 (the FY 2010 IPPS/RY 2010 LTCH PPS Final Rule).

[12] 77 Fed. Reg. at 53411.

prior to occupying an ancillary L&D bed. The rationale for this change was that the costs associated with L&D patient days are generally payable under the IPPS.[13]

Thereafter, CMS reexamined its policy under § 412.105(b)(4), and recognized that while the services furnished to an L&D patient are considered to be generally payable under the IPPS, under that regulatory provision, the bed where the services are furnished is not considered to be available for IPPS-level acute care hospital services.[14] CMS determined that if a patient day is counted because the services furnished are generally payable under the IPPS, then the bed in which the services were furnished should also be considered to be available for IPPS-level acute care hospital services. Accordingly, CMS found it was appropriate to extend its current approach of including L&D patient days in the DPP of the Medicare DSH payment adjustment to its rules for counting hospital beds for purposes of both the IME payment adjustment and the Medicare DSH payment adjustment.[15] CMS' intention was to align its patient day and bed day policies.[16] The rules for counting hospital beds for purposes of the IME payment adjustment, codified at § 412.105(b), are cross-referenced in § 412.106(a)(1)(i) for purposes of determining the DSH payment adjustment. CMS explains as follows:

> In light of the similar policy rationales for determining patient days in the calculation of the Medicare DSH payment adjustment, and for determining bed days for both the Medicare DSH payment adjustment and the IME payment adjustment, [CMS] proposed to include labor and delivery bed days in the count of available beds used in the IME and DSH calculations. Moreover, [CMS] stated that our proposal to treat labor and delivery patient days and bed days the same is consistent with our approach with respect to the observation, swing-bed, and hospice days, which are excluded from both the patient day count and the available bed count. Accordingly, [CMS] proposed to revise the regulations at § 412.105(b)(4) to remove from the list of currently excluded beds those beds associated with "ancillary labor/delivery services."[17]

While a number of commenters to the proposed rule stated that the current discrepancy in the treatment of L&D for purposes of the patient day count and the bed day count is appropriate because L&D services are typically not paid for by the Medicare program, which only pays for one percent of all births in the United States, CMS responded that whether the volume of L&D services paid by Medicare is as low as asserted by the commenters, it does not alter the fact that patients receiving these services are inpatients who are receiving an IPPS-level of care whether or not paid under the Medicare program.[18] CMS explained that a policy to exclude beds from a hospital's number of available beds based on the volume of services paid for by Medicare would create unpredictability with respect to DSH and IME payment adjustments and could impose an

[13] *Id.*
[14] *Id.* at 53412.
[15] *Id.*
[16] *Id.* at 53413.
[17] *Id.* at 53412.
[18] *Id.*

undue burden on the agency and hospitals to monitor the volume of individual services to determine appropriate exclusions.[19]

Commenters further pointed to the fact that the policy with respect to nursery days has this discrepancy in which patient stays are included in the patient day count for purposes of the DSH calculation but are excluded from the DSH and IME bed counts, which they indicated is appropriate, and that it would be appropriate to take a similar approach with L&D days. However, CMS responded that while it appreciated the commenters pointing out this potential discrepancy, it would consider addressing the issue in future rulemaking.[20]

In summary, CMS adopted its proposed policy and removed from the list of excluded beds in § 412.105(b)(4), those beds associated with "ancillary labor/delivery services."[21]

Providers' Position:

The Providers are requesting that the Board grant EJR as to the validity of the regulation at 42 C.F.R. § 412.105(b) as amended to implement the FFY 2013 regulatory change to include L&D beds in the IME bed count.[22] The Providers assert that the granting of EJR in this case is appropriate because the Providers are directly challenging the regulation that governs the list of beds that are excluded from the IME available bed count.[23] Specifically, that regulation, 42 C.F.R. § 412.105(b), no longer expressly excludes L&D beds from the available bed count, even though the IME formula memorialized at 42 U.S.C. § 1395ww(d)(5)(B)(ii) is based on data that excludes these beds[24] since "L&D beds were indisputably excluded from the bed count in the data sets relied on in setting the teaching factor."[25]

The Providers explain that central to the IME calculation is the interns and residents to beds ratio (the "IRB Ratio"), which is a measure of teaching intensity. The IME formula uses the IRB Ratio as a statistic that explains the increased costs that teaching hospitals incur in treating their Medicare patients, as compared with non-teaching hospitals. The IRB Ratio has a curvilinear relationship to increased costs, and the IME formula delineates that correlation, based on data available when the statute was enacted. At the time of the statute's enactment, L&D beds were expressly carved out from hospital bed counts for Medicare purposes. Therefore, the inclusion of these beds now undermines the integrity of the data-driven calculation carefully crafted by Congress. In other words, the term "bed" as used in the statutory description of the IRB Ratio must have a consistent meaning for the formula to work. The revision to the regulation contravenes that meaning, and the Providers contend that it is therefore unlawful.[26]

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[19] *Id.*
[20] *Id.*
[21] *Id.* at 53412.
[22] Providers' EJR Request at 1-2, *citing* 42 U.S.C. §§ 1395oo(f)(1); 42 C.F.R. § 405.1842(f).
[23] *Id.* at 2.
[24] *Id.* at 2-3.
[25] *Id*. at 9.
[26] *Id.* at 3.

The Providers assert that the Medicare program has offered no support as to how a ratio that includes the L&D beds better explains the increased costs teaching hospitals incur in treating Medicare patients.[27] The Providers assert that CMS mistakenly extrapolated the policy of excluding L&D days from the DSH calculation of inpatient days to the entirely unrelated IME calculation.[28] The Providers contend that implicit in CMS' reasoning for its decision, is the concept that the IRB Ratio bed count is based off of the number of beds available for services reimbursed under IPPS.[29] However, CMS does not explain how it arrived at that conclusion. The Providers assert that the statute requires the IRB Ratio bed count to be based on the methodology that CMS used to count beds in 1983.[30] While it may very well be that services to patients in these L&D beds could qualify, if they are Medicare beneficiaries, for reimbursement under IPPS, nowhere in the statute or the legislative history is that held out as a test for inclusion in the IRB Ratio bed count.[31] The Providers note that the IRB Ratio originated in a 1980 Federal Register that preceded the inception of the IPPS program in 1983, and that routine cost limitations, not IPPS, was in effect in 1983, the date specified in the statute. It would therefore be impossible for IPPS payment for services to patients in a particular bed to be the litmus test of inclusion in the IRB Ratio bed count.[32]

The Providers assert CMS' regulatory change is unlawful and must be overturned for four main reasons. First, it violates the plain meaning of the statute, which expressly states that the methodology to be followed for the IME calculation is the one that the Medicare program used in 1983 that excluded L&D beds as "ancillary." In terms of the delegation of authority to CMS by statute, CMS is not empowered to change the definition of bed.[33]

Second, it violates the statute's manifest intent. The stated purpose of the statute is to address patient costs that teaching hospitals incur indirectly relating to their teaching activities, as indicated by the IRB Ratio serving as a measure of the teaching industry. The use of the 0.405 teaching factor expresses a very precise curvilinear relationship based on empirical findings using defined variables. Definitional changes to those variables undermine the integrity of the whole formula. L&D beds were excluded from the bed count in the data sets relied on in setting the teaching factor.[34]

Third, it is otherwise arbitrary and capricious in that the agency has not articulated a satisfactory explanation for its action, including a rational connection between the facts found and the choice made. CMS has not indicated how the inclusion of L&D beds better reflects the methodology used by the Medicare program in 1983, or how it better correlates the resulting teaching intensity calculation to the undercompensated teaching hospital operating costs. The Providers note that it is as if CMS has simply forgotten that that the DSH calculation and the IME calculation are

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[27] *Id.*
[28] *Id.* at 8.
[29] *Id.*
[30] *Id.*
[31] *Id.*
[32] *Id.*
[33] *Id.* at 9.
[34] *Id.*

governed by different statutes, and that loyalty to both is required; the consistency in the definition of beds across the statutes must be a secondary concern.[35]

Fourth, it treats similar situations differently without sufficient explanation. The Medicare program has historically considered L&D beds to be ancillary beds, and in that way, they are like recovery beds. Patients in a recovery bed may be in an IPPS level stay, and yet those beds remain excluded. CMS has not explained how these two types of beds are different in a way that justifies the differences in their treatment, and agencies are not allowed to treat similarly situated circumstances differently without sufficient justification.[36]

Medicare Contractor's Response:

On November 3, 2023, the Medicare Contractor filed a response to the Providers' EJR Request, indicating that it had no jurisdictional or substantive claim challenges to this appeal, and that it agrees that the issue appealed by the Provider is one that the Board cannot decide.

Decision of the Board:

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

A. Jurisdiction: Appeals of Cost Report Periods Beginning Prior to January 1, 2016

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending on or after December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming it as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen* ("*Bethesda*").[37] In that case, the Supreme Court concluded that a cost report submitted in full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.[38]

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[35] *Id.*
[36] *Id.*
[37] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The Medicare Contractor's Notice of Program Reimbursement ("NPR") would not include any disallowance for the item. The provider effectively self-disallowed the item.).
[38] *Bethesda*, 108 S. Ct. at 1258-59.

On August 21, 2008, new regulations governing the Board were effective.[39] Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hospital v. Burwell* ("*Banner*").[40] In *Banner*, the provider filed its cost report in accordance with the applicable outlier regulations and did not protest the additional outlier payment it was seeking. The provider's request for EJR was denied because the Board found that it lacked jurisdiction over the issue. The District Court concluded that, under *Bethesda,* the 2008 self-disallowance regulation could not be applied to appeals raising a legal challenge to a regulation or other policy that the Medicare Contractor could not address.[41]

The Secretary did not appeal the decision in *Banner* and decided to largely apply the holding to certain similar administrative appeals. Effective April 23, 2018, the CMS Administrator implemented CMS Ruling CMS-1727-R which involves dissatisfaction with the Medicare Contractor determinations for cost report periods ending on December 31, 2008 and which began before January 1, 2016, Under this ruling, where the Board determines that the specific item under appeal was subject to a regulation or payment policy that bound the Medicare Contractor and left it with no authority or discretion to make payment in the manner sought by the provider on appeal, the protest requirements of 42 C.F.R. § 405.1835(a)(1)(ii) were no longer applicable. However, a provider could elect to self-disallow a specific item deemed non-allowable by filing the matter under protest.

The Board has determined that the Providers involved with the instant EJR request involves a cost report period which began prior to January 1, 2016, and is governed by CMS Ruling CMS-1727-R. The Board has found that it has jurisdiction pursuant to this Ruling because the Provider is challenging a regulation, and administrative review of that challenge is not precluded by statute or regulation. The Providers elected to self-disallow the L&D beds deemed non-allowable by filing the L&D beds under protest. The Board notes that, while not required for Board jurisdiction in this appeal, the Medicare Contractor made one or more adjustments to remove the L&D bed protested items from the Providers' cost reports at issue.

In addition, the Providers' jurisdictional documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal. The participants' appeals were timely filed. Based on the above, the Board finds that it has jurisdiction for the above-captioned appeal. The estimated amount in controversy is subject to recalculation by the Medicare Contractor for the actual final amount.

B. Board's Analysis of the Appealed Issue

The Providers are challenging the validity of the FFY 2013 change to 42 C.F.R. § 412.105(b), which removed the exclusion of L&D beds from the bed count determination in the procedure for

[39] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[40] 201 F. Supp. 3d 131 (D.D.C. 2016).
[41] *Id.* at 142.

carrying out the IME calculation. The Providers contend that this regulatory change is inconsistent with the enabling statute, 42 U.S.C. § 1395WW(d)(5)(B)(ii), which outlines the formula for the IME adjustment calculation, and was originally, at the time of enactment, based on data that otherwise excludes the L&D beds. The Providers maintain that the statute requires that the bed count in the IME calculation is to be based on the methodology that CMS used to count beds *in 1983*, which excluded L&D beds at that time. The Providers allege that CMS mistakenly extrapolated its policy change to include L&D beds in its DSH calculation of inpatient days, to the entirely unrelated IME calculation, and the definitional change to the bed count variable undermines the integrity of the whole IME formula to determine the costs that teaching hospitals incur indirectly relating to their teaching activities.

The Board finds that, pursuant to 42 C.F.R. § 405.1867, it must comply all the provisions of Title XVIII of the Act and regulations issued thereunder, including the challenged regulation, 42 C.F.R. § 412.105(b), as revised effective FFY 2013. Moreover, pursuant to 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R. § 405.1842(f)(1), the Board is required to grant an EJR request if it determines that: (i) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (ii) the Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute or to the substantive or procedural validity of a regulation or CMS Ruling.

As described above, the Board has jurisdiction to conduct a hearing on the specific matter at issue. However, the Board concludes that it lacks the authority to grant the relief sought by the Providers, *i.e.,* to reverse or otherwise invalidate the FFY 2013 modification to 42 C.F.R. § 412.105(b) that removed L&D beds from the list of beds excluded in the bed count determination. Consequently, the Board hereby grants the Providers' request for EJR for the issue and FFY under dispute.

Board's Decision Regarding the EJR Request:

The Board finds that:

1) It has jurisdiction over the matter for the subject year and that the Providers in this appeal are entitled to a hearing before the Board;

2) Based upon the Providers' assertions regarding 42 C.F.R. § 412.105(b), there are no findings of fact for resolution by the Board;

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

4) It is without the authority to decide the legal question of whether the FFY 2013 modification to 42 C.F.R. § 412.105(b) in regard to L&D beds is valid.

Accordingly, the Board finds that the question of the validity of the FFY 2013 change to 42 C.F.R. § 412.105(b) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for EJR for the issue and the subject year.

The Provider has 60 days from the receipt of this decision to institute the appropriate action for judicial review. The Board's jurisdictional determination is subject to review 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. Since this is the only issue under dispute in this group case, the Board hereby closes the case.

Board Members Participating:

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

FOR THE BOARD:

11/13/2023

X Clayton J. Nix

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

Enclosure: Schedule of Providers

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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RE: ***EJR Determination***
24-0075GC Texas Health Resources FFY 2024 Section 1115 Waiver Days Texas CIRP Group
24-0076GC Houston Methodist FFY 2024 Section 1115 Waiver Days Texas CIRP Group
24-0077GC Ascension Health FFY 2024 Section 1115 Waiver Days Texas CIRP Group

Dear Mr. Kenny:

The Provider Reimbursement Review Board ("Board") has reviewed the consolidated request for expedited judicial review ("EJR") filed on October 18, 2023 for the three (3) above referenced common issue related party ("CIRP") group cases. Set forth below is the decision of the Board to deny the EJR request and to dismiss the 3 group appeals.

Background:

On October 18, 2023, the Providers' Representative, King & Spalding, LLP ("King & Spaulding"), filed group appeal requests to establish the three (3) above-referenced CIRP group appeals. Each group appeal involves hospitals located in Texas and is based on an appeal of the FY 2024 IPPS Final Rule as it relates to the inclusion of § 1115 waiver days in the Medicaid fraction of the disproportionate share hospital ("DSH") payment calculation.[1] Specifically, each of the 3 group appeals contains the following issue statement:

> This appeal challenges CMS's final determination set forth in the Inpatient Prospective Payment System Final Rule for fiscal year 2024 to deny hospitals Medicare DSH payments attributable to the inpatient days of individuals whose inpatient hospital services were eligible to be covered in whole or in part by an uncompensated care pool established under a waiver approved by CMS pursuant to Section 1115 of the Social Security Act. 88 Fed. Reg. 58640, 59016 (Aug. 28, 2023) (adopting 42 C.F.R. § 412.106(b)(4)(iii)). **Beginning on October 1, 2023, newly adopted 42 C.F.R. § 412.106(b)(4)(iii) bars hospitals from claiming in the Medicaid fraction of their Medicare DSH calculations all patient days**

[1] 88 Fed. Reg. 58640, 59012-26 (Aug. 28, 2023) (excerpt from the preamble to the final rule addressing "Counting of Certain Days Associated With Section 1115 Demonstration in the Medicaid Fraction").

> **attributable to such individuals**. This determination is unlawful because CMS is required to include in the Medicaid fraction all patients it has regarded as eligible for Medicaid under a Section 1115 waiver. 42 U.S.C. § 1395ww(d)(5)(F)(vi). Patients whose care is eligible for coverage under an uncompensated care pool that was established under a CMS approved Section 1115 waiver are regarded as eligible for Medicaid. *See Forrest General Hospital v. Azar*, 926 F.3d 221, 229 (5th Cir. 2019); *Bethesda Health, Inc. v. Azar*, 389 F. Supp. 3d 32, 47 (D.D.C. 2019) *aff'd*, 980 F.3d 121 (D.C. Cir. 2020).[2]

On the *same* day as the filing of the appeal requests, King & Spalding filed a Consolidated Petition for Expedited Judicial Review ("EJR Request") for the 3 group cases.

Statutory and Regulatory Background:

A. Medicare DSH Payment

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the inpatient prospective payment system ("IPPS").[3] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[4]

The IPPS statute contains several provisions that adjust reimbursement based on hospital-specific factors.[5] This case involves the hospital-specific DSH adjustment, which requires the Secretary to provide increased IPPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[6]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[7] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.[8] The DPP is defined as the sum of two fractions expressed as percentages.[9] Those two fractions are referred to as the "Medicare/SSI fraction" and the "Medicaid fraction." Both of these fractions consider whether a patient was "entitled to benefits under part A."

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

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[2] (Bold emphasis added and italics emphasis in original.)
[3] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[4] *Id.*
[5] *See* 42 U.S.C. § 1395ww(d)(5).
[6] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[7] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I), (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[8] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv), (vii)-(xiii); 42 C.F.R. § 412.106(d).
[9] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).

> [T]he fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were entitled to benefits under part A of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were entitled to benefits under part A of this subchapter . . . .[10]

The Medicare/SSI fraction is computed annually by the Centers for Medicare and Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[11]

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

> The fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX [the Medicaid program], but who were not entitled to benefits under part A of this subchapter, and the denominator of which is the total number of the hospital's patient days for such period.
>
> In determining under [this subclause] the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX, the Secretary may, to the extent and for the period the Secretary determines appropriate, include patient days of patients not so eligible but who are regarded as such because they receive benefits under a demonstration project approved under subchapter XI.

The Medicare contractor determines the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A and divides that number by the total number of patient days in the same period.[12]

Until its recent amendment, the implementing regulation at 42 C.F.R. § 412.106(b)(4) (2022) reads, with regard to computing the Medicaid Fraction:

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[10] (Emphasis added.)
[11] 42 C.F.R. § 412.106(b)(2)-(3).
[12] 42 C.F.R. § 412.106(b)(4).

> (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 populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act.

B. Background on Medicaid State Plans and § 1115 Waivers

Medicaid is a joint Federal and state program, established in Title XIX of the Social Security Act (the "Act").[13] To participate in the Medicaid program and receive federal matching funds (commonly referred to as federal financial participation or "FFP"),[14] a state must enter into an agreement ("State Plan") with the Federal government, describing the individuals covered, services provided, reimbursement methodologies for providers, and other administrative activities.[15]

Federal law provides states flexibility in operating Medicaid programs through multiple waivers of federal law and demonstration programs. To address the medical needs of its residents, a State may choose to apply for, and include in its State Plan, a demonstration program under § 1115 of the Act (42 U.S.C. § 1315) which allows CMS to waive various Federal Medicaid eligibility and benefits requirements. These projects expand Medicaid eligibility to populations who would ordinarily be disqualified from receiving benefits under the State Plan. The costs of such a demonstration project, including the costs of patient treatment, are regarded as expenditures under the State Plan and thus eligible for Federal matching funds.[16]

Prior to 2000, "hospitals were to include in the Medicare DSH calculation ***only*** those days for populations *under the section 1115 waiver* who were or could have been made eligible under a

[13] 42 U.S.C. § 1396; 42 C.F.R. § 430.0.
[14] 42 U.S.C. § 1396b.
[15] 42 U.S.C. § 1396a.
[16] 42 U.S.C. § 1315(a)(2)(A).

State plan."[17] As a result, patient days of *expanded* eligibility groups were *not* included in the Medicare DSH calculation.

In 2000, the Secretary published an interim rule to address the DSH adjustment calculation policy in reference to § 1115 waiver days and allow for certain *expanded* eligibility groups to be included in the Medicare DSH calculation.[18] Specifically, the interim rule revised this policy "to allow hospitals to include the patient days of all populations eligible for Title XIX matching payments in a State's section 1115 waiver in calculating the hospital's Medicare DSH adjustment."[19] This change in policy was effective for discharges occurring on or after January 20, 2000 and was codified in the regulations at 42 C.F.R. § 412.106(b)(4)(ii).[20]

In 2003, the Secretary amended the DSH regulation to specify that a patient shall be "deemed eligible for Medicaid on a given day only if the patient is *eligible for inpatient hospital services* under a [State Plan] or under a waiver authorized under section 1115(a)(2)."[21] The rationale was that "certain section 1115 demonstration projects . . . serve expansion populations with benefit packages so limited that the benefits are not similar to the medical assistance available under a Medicaid State plan."[22] The purpose of the refinement was to include in the Medicaid Fraction only days of waiver populations where they were provided inpatient hospital benefits equivalent to the care provided to beneficiaries under a Medicaid State Plan.[23] To achieve this, the DSH regulation at 42 C.F.R. § 412.106(b)(4)(i) was amended to specify that "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 . . . ."[24]

In 2006, Congress passed the Deficit Reduction Act of 2005 and § 5002 amended 42 U.S.C. § 1395ww(d)(5)(F)(vi)[25] to add the following language below subclause (II):

> In determining under subclause (II) the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under title XIX, the Secretary may, to the extent and for the period the Secretary determines appropriate, include patient days of patients not so eligible but who are regarded as such because they receive benefits under a demonstration project approved under title XI.

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[17] 65 Fed. Reg. 3136, 3136(Jan. 20, 2000) (emphasis added).
[18] *Id.* The interim rule was followed by a final rule, as well. 65 Fed. Reg. 47054, 47086-87 (Aug. 1, 2000).
[19] 65 Fed. Reg at 3136-3137. *See also* 65 Fed. Reg. at 47086-47087.
[20] 65 Fed. Reg. at 3139.
[21] 68 Fed. Reg. 45346, 45470 (Aug. 1, 2003).
[22] *Id.* at 45420.
[23] *See* 88 Fed. Reg. 58460, 59014 (Aug. 28, 2023).
[24] (2022) (emphasis added).
[25] Pub. L. 109-171, § 5002, 120 Stat. 4, 31 (2006).

The Secretary has interpreted this amendment as confirming that: (1) waiver day groups' days are not *automatically* "eligible for Medicaid under a State plan"; (2) she has the discretion to determine both the extent to which patients are "not so eligible" and to what extent, if any, they may be "regarded as eligible" and thus included in the Medicaid fraction.[26]

On August 28, 2023 as part of the FY 2024 IPPS Final Rule, the Secretary finalized further revisions to the regulations governing the inclusion of § 1115 expansion days in the Medicare DSH calculation.[27] In making these revisions, the Secretary has noted a rise in § 1115 waiver demonstrations which authorize funding a limited and narrowly circumscribed set of payments to hospitals, such as § 1115 demonstrations which include funding for uncompensated/ undercompensated care pools. These pools do not extend health insurance to individuals or benefits similar to Medicaid beneficiaries under a State plan. Instead, they provide funds directly to hospitals to offset treatment costs for uninsured and underinsured patients.[28] As such, these days have been typically excluded from the Medicaid fraction of the DSH calculation because the days associated with these § 1115 demonstrations do not create inpatient hospital eligibility.

The Secretary acknowledged that several court decisions have disagreed with this approach and ruled that 42 C.F.R. § 412.106(b)(4) requires the inclusion of days for which hospitals received payment from a uncompensated/undercompensated care pool authorized by a § 1115 waiver.[29] Thus, in the FY 2022 IPPS/LTCH PPS proposed rule,[30] the Secretary proposed to revise the regulation "to more clearly state that in order for an inpatient day to be counted in the DPP Medicaid fraction numerator, the section 1115 demonstration must provide inpatient hospital insurance benefits directly to the individual whose day is being considered for inclusion."[31] After reviewing comments on the proposal, the Secretary proposed different revisions to the regulations in the FY 2023 IPPS/LTCH PPS proposed rule,[32] but opted not to finalize them after reviewing comments on the proposal.[33]

Finally, in a proposed rule published on February 28, 2023,[34] the Secretary proposed revisions to the regulations "on the counting of days associated with individuals eligible for certain benefits provided by section 1115 demonstrations[.]"[35] Thereafter in the FY 2024 IPPS Final Rule, he announced that "we are modifying our regulations to explicitly state our long-held view that only patients who receive health insurance through a section 1115 demonstration where State expenditures to provide the insurance may be matched with funds from title XIX can be 'regarded as' eligible for Medicaid."[36] He also finalized a proposed amendment "to state

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[26] 88 Fed. Reg. at 59014.
[27] *Id.* at 59012-26.
[28] *Id.* at 59015.
[29] *Id.* (citing *Bethesda Health, Inc.* v. *Azar*, 980 F.3d 121 (D.C. Cir. 2020); *Forrest General Hospital* v. *Azar*, 926 F.3d 221 (5th Cir. 2019); *HealthAlliance Hospitals, Inc.* v. *Azar*, 346 F. Supp. 3d 43 (D.D.C. 2018)).
[30] 86 Fed. Reg. 25070 (May 10, 2021).
[31] *Id.* at 25459.
[32] 87 Fed. Reg. 28108 (May 10, 2022).
[33] 87 Fed. Reg. 48780, 49051 (Aug. 10, 2022).
[34] 88 Fed. Reg. 12623 (Feb. 28, 2023).
[35] *Id.* at 12623.
[36] 88 Fed. Reg. at 59016.

specifically that patients whose inpatient hospital costs are paid for with funds from an uncompensated/undercompensated care pool authorized by a section 1115 demonstration are not patients "regarded as" eligible for Medicaid, and the days of such patients may not be included in the DPP Medicaid fraction numerator."[37]

Thus, effective October 1, 2023, 42 C.F.R. § 412.106(b)(4) (2023) now reads:

> (4) *Second computation*. **The fiscal intermediary <u>determines</u>**, for the same cost reporting period used for the first computation, **the number of the hospital's patient days of service for patients** who were not entitled to Medicare Part A, and **who were either eligible for Medicaid on such days** as described in paragraph (b)(4)(i) of this section **<u>or</u> who were regarded as eligible for Medicaid on such days** and the Secretary has determined to include those days in this computation as described in paragraph (b)(4)(ii)(A) or (B) of this section. The fiscal intermediary then 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 eligible for Medicaid on a given day if the patient is eligible on that day for inpatient hospital services under a State Medicaid plan approved under title XIX of the Act, regardless of whether particular items or services were covered or paid for on that day under the State plan.
>
> (ii) For purposes of this computation, a patient is regarded as eligible for Medicaid on a given day if the patient receives health insurance authorized by a demonstration approved by the Secretary under section 1115(a)(2) of the Act for that day, where the cost of such health insurance may be counted as expenditures under section 1903 of the Act, or the patient has health insurance for that day purchased using premium assistance received through a demonstration approved by the Secretary under section 1115(a)(2) of the Act, where the cost of the premium assistance may be counted as expenditures under section 1903 of the Act, and in either case regardless of whether particular items or services were covered or paid for on that day by the health insurance. Of these patients regarded as eligible for Medicaid on a given day, only the days of patients meeting the following criteria on that day may be counted in this second computation:

[37] *Id.*

> (A) Patients who are provided by a demonstration authorized under section 1115(a)(2) of the Act health insurance that [38]covers inpatient hospital services; or
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> (B) Patients who purchase health insurance that covers inpatient hospital services using premium assistance provided by a demonstration authorized under section 1115(a)(2) of the Act and the premium assistance accounts for 100 percent of the premium cost to the patient.

(iii) Patients whose health care costs, including inpatient hospital services costs, for a given day are claimed for payment by a provider from an uncompensated, undercompensated, or other type of funding pool authorized under section 1115(a) of the Act to fund providers' uncompensated care costs are not regarded as eligible for Medicaid for purposes of paragraph (b)(4)(ii) of this section on that day and the days of such patients may not be included in this second computation.

(iv) **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.

(v) For cost reporting periods beginning on or after October 1, 2009, the hospital must report the days in the numerator of the fraction in the second computation in a cost reporting period based on the date of discharge, the date of admission, or the dates of service. If a hospital seeks to change its methodology for reporting days in the numerator of the fraction in the second computation, the hospital must notify CMS, through its fiscal intermediary or MAC, in writing at least 30 days before the beginning of the cost reporting period in which the change would apply. The written notification must specify the methodology the hospital will use, the cost reporting period to which the requested change would apply, and the current methodology being used. Such a change will be effective only on the first day of a cost reporting period. If a hospital changes its methodology for reporting such days, CMS or the fiscal intermediary or MAC may adjust the number of days reported for a cost reporting period if it determines that any of those days have been counted in a prior cost reporting period.[39]

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[38] EJR Request at 10.

[39] 42 C.F.R. § 412.106(b)(4) (Oct. 1, 2023) (italics emphasis in original, and bold and underline emphasis added); 88 Fed. Reg. at 59332 (amending § 412.106(b)(4) by: (a) revising paragraphs (b)(4) introductory text and (b)(4)(i) and

Providers' Request for EJR:

"All the Providers filed their appeals under Sections [*sic* Section] 1878(a)(1)(A)(i) [of the Social Security Act, i.e., 42 U.S.C. § 1395oo(a)(1)(A)(i)]" from the FY 2024 IPPS Final Rule publishing these regulatory amendments. They assert that they have the right to directly appeal these regulatory amendments from the publication of that final rule because "[i]t is well settled that the publication in the Federal Register of a final rule that effectively fixes the amount of Medicare payment is a final determination is appealable to the Board pursuant to section 1878(a) [of the Social Security Act]. *See Washington Hosp. Ctr. v. Bowen*, 795 F.2d at 144-48 (D.C. Cir. 1986) ["*Washington Hospital*"]; *District of Columbia Hosp. Ass'n Wage Index Group Appeal*, HCFA Adm'r Dec., Medicare & Medicaid Guide (CCH) ¶ 41,025 (Jan. 15, 1993); *Cape Cod Hospital v. Sebelius*, 630 F.3d 203, 209 (D.C. Cir. 2011) [*"Cape Cod*"]. . . . By announcing in the Federal Register that he is excluding section 1115 uncompensated care pool patients from the numerator of the Medicaid fraction, the Secretary has made a final determination to deny Medicare DSH reimbursement attributable to those individuals (fixing payment at zero)."[40]

In the EJR request, King & Spalding argues that the "determination is unlawful because the Medicare statute does not afford the Secretary the discretion to exclude certain patients once he has conferred a benefit upon them by approving a section 1115 waiver."[41] King & Spalding claims claim that, once a section 1115 waiver is approved, all such patient days must be included in the Medicaid fraction without any exceptions or qualifications.[42]

King & Spalding claims that the justifications set forth by the Secretary to "[c]arve out a sub-population of patients who receive inpatient benefits through an approved section 1115 uncompensated care pool" have been rejected by federal courts.[43] King & Spalding argues that the amended regulations "[flout] prior contrary and binding interpretations of the very statute [the Secretary] believes gives him the discretion to exclude certain categories of section 1115 beneficiaries from calculating the Medicaid fraction."[44] Since the Board is bound by these new regulations, it therefore cannot provide the relief sought by the Providers and, as a result, they are requesting EJR in order to challenge them.

Medicare Contractor's Response to Request for EJR:

The Medicare Contractor filed a Response to Providers' EJR Request on October 23, 2023. It argues the appeal is premature because the rule being challenged is effective for discharges on or after October 1, 2023 and, therefore, the affected cost reporting periods have not yet ended. The

(ii); (b) redesignating paragraphs (b)(4)(iii) and (iv) as paragraphs (b)(4)(iv) and (v), respectively; and (c) adding a new paragraph (b)(4)(iii)).
[40] EJR Request at 11.
[41] *Id.* at 7 (citing *Forrest General Hospital*, 926 F.3d at 224 ("Once the Secretary authorizes a demonstration project, no take-backs.")).
[42] *Id.* at 8 (citing *Forrest Gen. Hosp.*, 926 F.3d at 228-229).
[43] *Id.* (citing *Bethesda Health*, 389 F. Supp. 3d at 46-47; *Forrest Gen. Hosp.*, 926 F.3d at 229).
[44] *Id.* at 9.

Medicare Contractor believes this situation is analogous to the Board's recent denial of EJR over a challenge to the retroactive Part C regulations:

> Though providers are challenging the legality of the final rule, because their DSH payment has not yet been computed – and won't be computed until final settlement of the cost reports that are not yet due – Providers cannot point to a final determination by either the MACs or the Secretary as to the amounts due. Likewise, they cannot demonstrate that they are dissatisfied with a final determination by the fiscal intermediary or the Secretary as required by 42 U.S.C. § 1395oo.
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> ****
>
> Like the post-Alina appeal, these providers are appealing an interpretative rule for one component of a multi-component calculation without noting how that calculation actually impacts them. Until they can demonstrate an actual, as opposed to purely hypothetical, impact, the appeal will be premature.

Providers' Response to the Medicare Contractor:

On October 25, 2023, King & Spalding filed the Providers' Response to MAC's Opposition to EJR and Jurisdictional Challenge and appear to now posit that their appeals are based on 42 U.S.C. § 1395oo(a)(1)(A)(ii). King & Spalding argues that the "Secretary's regulation constitutes a final determination that he will make no Medicare DSH payments to the Providers attributable to Section 1115 uncompensated care pool days."[45] King & Spalding continues its argument, stating that "[w]hen CMS adopts a rule or regulation that 'effectively fixes' an aspect of IPPS payments, it renders" an appealable final determination under § 1395oo(a)(1)(A)(ii).[46] King & Spalding asserts that, in the ***prior*** ten fiscal years, all of the providers in these appeals have received DSH payments[47] and that "*[i]n **some** years*, that reimbursement [from the *prior* ten fiscal years] included payments associated with Section 1115 days."[48] King & Spalding concludes that the new regulation "effectively fixes" reimbursement attributable to those days at zero.[49]

King & Spalding notes that 42 U.S.C. § 1395oo(a)(1) gives the Providers the statutory right to appeal from both a contractor determination (§ 1395oo(a)(1)(A)(i)) and, as a separate right, from a final determination of prospective payment made by the Secretary and the purpose behind it (§ 1395oo(a)(1)(A)(i)).[50] In response to the Medicare Contractor's argument that the appeals are

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[45] Response to MAC's Opposition to EJR and Jurisdictional Challenge, 1 (Oct. 25, 2023).
[46] *Id.* at 2 (citing *Cape Cod Hosp. v. Sebelius*, 630 F.3d 203, 205 (D.C. Cir. 2011); *Shands Jacksonville Med. Ctr. v. Burwell*, 139 F. Supp. 3d 240, 250 (D.D.C. 2015)).
[47] Exhibit P-1 (Providers' Medicare Empirical Payments For Last 10 Fiscal Years).
[48] Response to MAC's Opposition to EJR and Jurisdictional Challenge at 3.
[49] Response to MAC's Opposition to EJR and Jurisdictional Challenge at 2.
[50] *Id.* at 3 (citing 42 U.S.C. §1395oo(a)(1)(A)(ii); *Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 148 (D.C. Cir. 1986)).

premature because the Providers do not know the final amount it will be paid for the applicable FY, they note that challenges to any DRG rate is *always* unsettled because the rate applies to a prospective and unknown number of discharges.[51] They analogize the current policy to challenges related to the Two-Midnight Rule, as well as the rural floor budget neutrality adjustment, arguing that an appealable "final payment determination" under PPS is distinct from a notice of the final amount of payment due to a provider. Accordingly, they assert that they have a right to appeal the policy at issue adopted in the FY 2024 IPPS Final Rule pursuant to § 1395oo(a)(1)(A)(ii).

The Providers attempt to distinguish the current challenge to: (a) the March 25, 2022 decision of the D.C. District Court in *Memorial Hospital of Sout Bend v. Becerra* ("*Memorial Hospital*")[52] related to DSH SSI fractions; and (b) the recent dismissal by the Board in *Tampa General Hospital*[53] related to the June 2023 Final Rule on Part C days.[54] They claim the SSI ratios at issue in *Memorial Hospital* were deemed "not final" because they were subject to change, while the policy here is a final regulation that clearly states the reimbursement for the days at issue will be zero. Likewise, they argue that the Part C days appeal impacts "one of many variables" in calculating DSH payments, while the issue here fixes the payment rate for one category of days (Section 1115 waiver days) at zero and cannot be revised.[55] They contend that "[s]ettled law recognizes no distinction between Medicare rates and adjustments to those rates" and that "CMS, the PRRB and federal Courts have all recognized that prospective payment rates are 'inextricably intertwined' with their adjustments. *See Mercy Hospital, Inc. v. Azar*, 891 F.3d 1062, 1067 (D.C. Cir. 2018) (denying challenge to the LIP adjustment to IRF rates because '[a]s both a textual and a practical matter, the LIP adjustment is inextricably intertwined with the [PPS] rate.'); PRRB Jurisdictional Decision, McLaren Health CY 2015 LIP SSI Fraction Dual Eligible Days CIRP Group, PRRB Case No. 18-1741GC (Jan. 1, 2019) (same)."

Decision of the Board:

42 U.S.C. § 1395oo(a) sets forth a provider's right to appeal certain matters to the Board and states the following in pertinent part:

> **(a) Establishment**
>
> Any provider of services which has filed a required cost report within the time specified in regulations may obtain a hearing with respect to such cost report by a Provider Reimbursement Review

[51] *Id.* at 4 (citing *Georgetown University Hosp. v. Sullivan*, 934 F.2d 1280, 1284, n.6 (D.C. Cir. 1991)).
[52] *Memorial Hosp. of South Bend v. Becerra*, 2022 WL 888190 (D.D.C. Mar. 25, 2022).
[53] Board EJR Determination in Case No. 23-1438, Tampa Gen. Hosp. (July 9, 2023) (dismissing Case No. 23-14**3**8 without prejudice) (copy available at: https://www.cms.gov/regulations-and-guidance/review-boards/prrbreview/list-prrb-jurisdictional-decisions/1657096125/2023-07 (last visited Nov. 14, 2023)); Board EJR determination in 23-1498, Tampa Gen. Hosp. (Aug. 8, 2023) (Tampa Gen. Hosp. filed a new appeal under Case No. 23-14**9**8 attempting to cure the defects of its original appeal; however, the Board again dismissed for lack of jurisdiction) (copy available at: https://www.cms.gov/regulations-and-guidance/review-boards/prrbreview/list-prrb-jurisdictional-decisions/2023-08 (last visited Nov. 14, 2023)).
[54] Response to MAC's Opposition to EJR and Jurisdictional Challenge at 4-5.
[55] *Id.* at 5.

> Board (hereinafter referred to as the ‘‘Board’’) . . . *and* (except as provided in subsection (g)(2)) *any hospital* which receives payments in amounts computed under subsection (b) or (d) of section 1395ww of this title *and which has submitted such [cost] reports within such time as the Secretary may require in order to make payment under such section* may obtain a hearing with respect to such payment by the Board, if—
>
> (1) such provider—
>
> (A)(i) is dissatisfied with a final determination of the organization serving as its fiscal intermediary pursuant to section 1395h of this title as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under this subchapter for the period covered by such [cost] report, or
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> (ii) is dissatisfied with a final determination of the Secretary as to the amount of the payment under subsection (b) or (d) of section 1395ww of this title, . . .
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> (2) the amount in controversy is $10,000 or more, and
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> (3) such provider files a request for a hearing within 180 days after notice of the intermediary’s final determination under paragraph (1)(A)(i), or with respect to appeals under paragraph (1)(A)(ii), 180 days after notice of the Secretary’s final determination, or with respect to appeals pursuant to paragraph (1) (B) or (C), within 180 days after notice of such determination would have been received if such determination had been made on a timely basis.

42 U.S.C. § 1395oo(f)(1) requires, in pertinent part, “[a]ny appeal to the Board . . . by providers which are under common ownership or control . . . must be brough by such providers as a group with respect to any matter involving an issue common to such providers.”

The Secretary implemented these statutory provisions governing individual providers appeal rights and group appeal rights at 42 C.F.R. §§ 405.1835 and 405.1837, respectively.

Pursuant to 42 C.F.R. § 405.1837(a)(1), a group of providers generally have the right to a hearing before the Board “with respect to a final contractor or Secretary determination ***for the provider’s cost reporting period***"[56] if each provider satisfies individuals the requirements for a Board hearing under § 405.1835(a) and the group’s amount in controversy is $50,000 or more. Pursuant to 42 C.F.R. § 405.1835(a)(1), an individual provider generally has a right to a hearing before the

[56] (Emphasis added).

Board "with respect to a final contractor or Secretary determination ***for the provider's cost reporting period***"[57] if:

- It "is dissatisfied *with the contractor's final determination of the total amount of reimbursement* ***due the provider***, as set forth in the contractor's written notice specified under § 405.1803"[58] In other words, providers must appeal from a "final determination" that impacts payment for the period under appeal.[59]
- The request for a hearing is filed within 180 days of the date of receipt of the final determination.[60]

42 C.F.R. § 405.1837(c)(1) specifically notes that the hearing request must include "[a] demonstration that the request satisfies the requirements for a Board hearing as a group appeal, as specified in paragraph (a) [which includes the requirements of 42 C.F.R .§ 405.1835(a)]." Section 405.1835(a) states, in pertinent part, that a provider has a right to a Board hearing:

> [W]ith respect to a final … determination ***for the provider's cost reporting period***, if – (1) The provider is dissatisfied with the contractor's final *determination* of total amount *of reimbursement* ***due the provider***, as set forth in the contractor's written notice specified under § 405.1803.[61]

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

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

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[57] 42 C.F.R. § 405.1835(a) (emphasis added).
[58] 42 C.F.R. § 405.1835(a)(1) (emphasis added).
[59] *See also* 42 U.S.C. § 1395oo(a)(1)(A); *Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 144-146 (D.C. Cir. 1986) (stating: "Viewing the amendments as a whole, we are inescapably drawn to the same conclusion as the District Court: § 1395oo (a) 'clearly contemplates two different kinds of appeal. One begins when the intermediary issues an NPR; the other, when the intermediary issues a notice of ***what will be paid*** *under the PPS system*.' . . . . Under PPS, in contrast, ***payment amounts*** are independent of current costs and *can be determined with finality* prior to the beginning of the cost year. Id. § 412.71(d). Thus a year-end cost report is not a report which is necessary ***in order for the Secretary to make PPS payments***, and the appeals provision applicable to PPS recipients cannot be read to require hospitals to file cost reports and await NPRs prior to filing a PRRB appeal." (emphasis added and citations omitted)).
[60] 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835 – 1840.
[61] (Emphasis added.)

> its fiscal intermediary," "Secretary's final determination" and "final determination of the Secretary," as those phrases are used in section 1878(a) of the Act, and with the phrases "final contractor determination" and "final Secretary determination" as those phrases are used in this subpart.[62]

Similarly, Paragraph (c)(2) of 42 C.F.R. § 405.1837 requires certain information relative to each specific item under appeal with respect to the final determination under appeal:

> (2) An explanation (for each specific item at issue) of each provider's dissatisfaction with the final contractor or Secretary determination under appeal, including an account of:
>
> (i) *Why the provider believes Medicare* ***payment*** *is incorrect for each disputed item*;
>
> (ii) How and why the provider believes Medicare payment must be determined differently for each disputed item; and
>
> (iii) If the provider self-disallows a specific item (as specified in § 413.24(j) of this chapter), an explanation of the nature and amount of each self-disallowed item, the reimbursement sought for the item, and why the provider self-disallowed the item instead of claiming reimbursement for the item.

42 C.F.R. § 405.1837(a)(3) also states that a group must demonstrate that the amount in controversy is $50,000 or more. Satisfying the criteria set out in 42 C.F.R. §§ 405.1835(a) and 1837(a) is required before the Board can exercise jurisdiction over an appeal.[63]

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

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[62] (Emphasis added.)

[63] 42 C.F.R. § 405.1840(a), (b). The Board notes that 42 C.F.R. § 405.1840 is entitled "Board Jurisdiction" but it also addresses certain claim filing requirements such as timelines or filing deadlines. However, whether an appeal was timely is not a jurisdictional requirement but rather is a claim filing requirement as the Supreme Court made clear in *Sebelius v. Auburn Reg. Med. Ctr.*, 568 U.S. 145 (2013). *See also* Board Rule 4.1 ("The Board will dismiss appeals that fail *to meet the timely filing requirements* ***and/or*** *jurisdictional requirements*. Similarly, the Board notes that 42 C.F.R. § 405.1835(b) addresses claim filing requirements.

In their EJR request, the Providers contend that their right to appeal the policy at issue (as adopted and codified in the FY 2024 IPPS Final Rule) is *based on 42 U.S.C. § 1395oo(a)(1)(A)(i)*.[64] However, ***without explanation***, the Providers in their Response to the Medicare Contractor's Opposition to EJR and Jurisdictional Challenge only discuss appeal rights in § 1395oo(a)(1)(A)(ii) relating to "the amount of payment under subsection . . . (d)" and, thus, appear to ***now*** maintain that their appeal rights are based on § 1395oo(a)(1)(A)(ii).[65] Accordingly, the following are the relevant excerpts from 1395oo(a)(1)(A) that could relate to "the amount of payment under subsection . . . (d)":

> *[A]ny hospital* which receives payments in amounts computed under subsection (b) or (d) of section 1395ww of this title *and which has submitted such [cost] reports within such time as the Secretary may require in order to make payment under such section* may obtain a hearing with respect to such payment by the Board, if—
>
> (1) such provider—
>
> (A)(i) is dissatisfied with *a final determination* ***of the organization serving as its fiscal intermediary*** pursuant to section 1395h of this title *as to the amount of total program reimbursement due the provider* for the items and services furnished to individuals for which payment may be made under this subchapter for the period covered ***by such [cost] report***, or
>
> (ii) is dissatisfied with a final determination of the Secretary as to the amount of the payment under subsection (b) or (d) of section 1395ww of this title, ...[66]

The Board notes that the "final determination" being appealed in this case is a change in policy adopted in a final rule published in the Federal Register, namely the FY 2024 IPPS Final Rule. However, as set forth below, the adoption and codification of this policy in the FY 2024 IPPS Final Rule is not a "final determination" directly appealable to the Board under 42 U.S.C. § 1395oo(a)(1)(A)(i) or (ii). Rather, the Providers' appeals of the group issue are premature.

Here, unlike DRG rates and other adjustments such as the wage index, a hospital's eligibility for a DSH payment (and, if eligible, the amount of that payment) is not *prospectively* set on an annual basis as part of the relevant IPPS final rule. Rather, 42 U.S.C. § 1395ww(d)(5)(F) refers to the DSH adjustment being calculated "with respect to a [hospital's] cost reporting period."[67]

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[64] EJR Request at 10 (stating: "All the Providers filed their appeals under Sections 1878(a)(1)(A)(i) [of the Social Security Act].").

[65] The Providers' Response to the Medicare Contractor's Opposition to EJR and Jurisdictional Challenge contains 9 references to § 1395oo(a)(1)(A)(ii) and only discusses appeal rights under § 1395oo(a)(1)(A)(ii) (*i.e.*, there is no reference to or discussion of § 1395oo(a)(1)(A)(i)).

[66] (Emphasis added.)

[67] The Board notes that the Medicare DSH adjustment provision under 42 U.S.C. § 1395ww(d)(5)(F) was enacted by § 9105 of the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") and became effective for

To this end, DSH eligibility and payment, if any, is determined, calculated, and finalized *annually* through the cost report audit/settlement process as made clear in 42 C.F.R. § 412.106(i) which sets forth the following instructions regarding the determination of a hospital's eligibility for a DSH payment for each fiscal year and, if so, how much:

> (i) *Manner and timing of [DSH] payments*. (1) Interim [DSH] payments are made **during the payment year to each hospital that is estimated to be eligible** for payments under this section at the time of the annual final rule for the hospital inpatient prospective payment system, **subject to the final determination of eligibility at the time of cost report settlement for each hospital**.
>
> (2) **Final payment determinations are made at the time of cost report settlement**, based on the **final** determination of each hospital's eligibility for payment under this section.[68]

To highlight what types of determinations are being made during the cost report audit/settlement process, the Board notes that any potential § 1115 waiver days for the fiscal years at issue would be included in the numerator of the Medicaid fraction used in each Provider's DSH adjustment calculation for each of the relevant fiscal years; however, in order for a day to be included in the numerator of the Medicaid fraction, 42 C.F.R. § 412.106(b)(4) (Oct. 1, 2023) specifies that the Medicare contractor (a/k/a fiscal intermediary[69]) "*determines*" the days to be included in the numerator of a hospital's Medicaid fraction based on the hospital's "burden" of "prov[ing]" Medicaid eligibility on each day being claimed for the relevant cost reporting period:

> (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 patients who were not entitled to Medicare Part A, and who were either eligible for Medicaid on such days** as described in paragraph (b)(4)(i) of this section **or who were regarded as eligible for Medicaid on such days** and the Secretary has determined to include those days in this computation as described in paragraph (b)(4)(ii)(A) or (B) of this section. The fiscal intermediary then divides that number by the total number of patient days in the same period. For purposes of this second computation, the following requirements apply:
>
> ****

discharges occurring on or after May 1, 1986. Pub. L. 99-272, § 9105, 100 Stat. 82, 158-60. As such, it was enacted several years after the initial legislation that established the IPPS.

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

[69] CMS' payment and audit functions under the Medicare program were historically contracted to organizations known as fiscal intermediaries ("FIs") and these same functions are now contracted with organizations known as Medicare administrative contractors ("MACs"). The term "Medicare contractor" refers to both FIs and MACs.

> (iv) **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.[70]

Accordingly, unlike DRG rates and wage index rates, a hospital's eligibility for a DSH payment (and, if so, the amount) is determined through the following *italicized* phrase in 42 U.S.C. § 1395oo(a) and, as such, is a prerequisite to the Providers' appeal:

> (a) . . . any hospital which receives payments in amounts computed under subsection (b) or (d) of section 1395ww of this title *and which has submitted such [cost] reports* within such time as the Secretary may require *in order to make payment under such section* may obtain a hearing with respect to such payment by the Board, if—
>
> (1) such provider—
>
> (A)(i) is dissatisfied with a final determination of the organization serving as its fiscal intermediary pursuant to section 1395h of this title as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under this subchapter for the period covered by such [cost] report, or
>
> (ii) is dissatisfied with a final determination of the Secretary as to the amount of the payment under subsection (b) or (d) of section 1395ww of this title, . . .

Specifically, a hospital that is eligible for a DSH payment must "submit[] such [cost] report[] within such time as the Secretary may require *in order to make payment under such section* [*i.e*., subsection (d)]" as confirmed in the above quote of 42 C.F.R. § 412.106(i). This is what makes this case

---

[70] 88 Fed. Reg. at 59332; 42 C.F.R. 412.106 (Oct. 1, 2023). *See also id.* at 59023 (stating: "We are unsure why some commenters have significant concerns with verifying an individual's section 1115 eligibility and the amount of premium assistance when hospitals are already communicating with their state Medicaid office to verify an individual's eligibility. We do not understand why it is unclear who would furnish this data to hospitals or how hospitals would obtain the patient-specific data that they would need to prove eligibility for each patient under the proposed premium assistance rule. The states have this information as part of the section 1115 demonstration requirements. Finally, as a commenter recognizes, *it **remains the hospitals' burden** to furnish data adequate **to prove eligibility for each Medicaid patient day it claims** in the DPP Medicaid fraction numerator*, and we believe that the state will continue to be able to furnish hospitals with the eligibility data necessary for the hospitals to do so." (emphasis added)); 63 Fed. Reg. 40954, 40985 (Jul. 31, 1998) (revising 42 C.F.R. § 412.106 to codify HCFA Ruling 97-2); HCFA Ruling 97-2 at 4 (Feb. 1997) (stating: "Pursuant to this Ruling, Medicare fiscal *intermediaries will **determine*** the amounts due and make appropriate payments through normal procedures. Claims must, of course, meet all other applicable requirements. This includes the requirement for data that are adequate to document the claimed days. ***The hospitals bear the burden of proof** and must verify with the State that a patient was eligible for Medicaid* (for some covered services) *during **each** day of the patient's inpatient hospital stay*. As the intermediaries may require, hospitals are responsible for and must furnish appropriate documentation to substantiate the number of patient days claimed. *Days for patients that can**not** be verified by State records* to have fallen within a period wherein the patient was eligible for Medicaid *can**not** be counted*." (emphasis added)).

distinguishable from the facts presented in the D.C. Circuit's decisions in *Washington Hospital*[71] and *Cape Cod*.

The D.C. District Court's 2022 decision in *Memorial Hospital* is instructive as it concerns another variable used in the DSH adjustment calculation. In that case, certain providers appealed the publication of their DSH SSI ratios. The providers in *Memorial Hospital* argued that there are certain instances where a provider can appeal prior to receiving an NPR and gave citations to certain D.C. Circuit cases in support. However, the Court distinguished these cases because "the secretarial determination at issue was either the only determination on which payment depended or clearly promulgated as a final rule."[72] The D.C. District Court ultimately agreed with the Board that this was not an appealable final determination. In its discussion, the Court agreed with the Secretary that the publication of the SSI ratios, *even if final*, could not be a final determination "as to the amount of payment" because they are "just one of the variables that determines whether hospitals receive a DSH payment ***and***, ***if so***, *for how much*."[73] The Court concluded:

> A challenge to *an* ***element*** *of payment* under 42 U.S.C. § 1395oo(a)(1)(A)(ii) is ***only*** *appropriate* ***if***, as the D.C. Circuit has explained, "*the Secretary ha[s] firmly established '****the only variable factor*** in the final determination as to the amount of payment under § 1395ww(d).'" *Monmouth Med. Ctr. v. Thompson*, 257 F.3d 807, 811 (D.C. Cir. 2001) (quoting *Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 147 (D.C. Cir. 1986)) (emphasis added); *see also Samaritan Health Serv. v. Sullivan*, 1990 WL 33141 at *3 (9th Cir. 1990) (unpublished table decision) ("We have held that if the Secretary's classification of a hospital effectively fixes the hospital's reimbursement rate, then that decision is a 'final determination' as referred to 42 U.S.C. § 1395oo(a)(1)(A)(ii).").[74]

Accordingly, the Court upheld the Board's decision to dismiss because the DSH SSI fraction was only one of the variables that determine whether a hospital receives a DSH payment (and, if so, for how much) and the publication of a hospital's SSI fraction is not a determination as to the amount of payment received.[75]

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[71] The type of situation presented in the above-captioned cases is unlike the type of situation addressed by the D.C. Circuit in *Washington Hosp.* where the determination that was appealed finalized the only hospital-specific variable used in setting the per-patient payment amount. *See Washington Hosp.*, 795 F.2d at 143, 147 (the hospitals appealed their "Final Notice of Base Period Cost and Target Amount Per Discharge" and the Court found: (a) "the ***only variable*** *factor* in the final determination as to the amount of payment under § 1395ww(d) is the hospital's target amount . . . ." (emphasis added); and (b) "The amount is the per-patient amount calculated under § 1395ww(d) and is final once the Secretary has published the DRG amounts (as has) and finally determined the hospital's target amount. Here each of the hospitals has received a 'Final Notice of Base Period Cost and Target Amount per Discharge.' The statute requires no more to trigger the hospital's right to appeal PPS Payments to the PRRB." (footnote omitted)).
[72] 2022 WL 888190 at *8.
[73] *Id.* at *9 (emphasis added).
[74] *Id.* at *8.
[75] *Id.* at *9. The Board also recognizes that the Providers reference the D.C. Circuit's decision in *Mercy Hospital, Inc. v. Azar*, 891 F.3d 1062, 1067 (D.C. Cir. 2018) ("*Mercy*"). However, the *Mercy* decision is not applicable for 2 separate

Similar to the D.C. District Court's decision in *Memorial Hospital*, while the policy at issue in this case was promulgated as part of the FY 2024 IPPS Final Rule, it is ***not*** a final determination as to the amount of payment received by the Providers but rather is "just one of the variables that determines whether hospitals receive a DSH payment ***and***, ***if so***, *for how much*" and any "***final*** *payment* determination"[76] on whether a hospital receives a DSH payment for a particular fiscal year and, if so, for how much is made during the cost report audit/settlement process as explained at 42 C.F.R. § 412.106(i).[77] More specifically, here, each of the Providers are asserting that certain unspecified § 1115 waiver days[78] must be included in the numerator of the Medicaid fraction for their DSH adjustment calculation yet to be calculated for the fiscal years at issue. However, the following factual gaps or flaws demonstrate that the promulgation of the policy at issue in the final rule was not an appealable reimbursement "determination" which will not occur until a "***final*** *[DSH] payment* determination"[79] is made consistent with 42 C.F.R. § 412.106(i) as part of the cost report audit/settlement process:

1. *Are the Providers Eligible for a DSH Payment for the Periods at Issue?*—The Providers have asserted that they have received DSH for the prior 10 years based on a table listing by year the DSH payments they say they received. If true, that does not mean that the Providers will continue to qualify for a DSH payment in the fiscal years at issue[80] since: (a) the Providers' assigned Medicare contractor has not yet made a "***final [DSH]*** *payment* determination"[81] *for the periods at issue* under the process set forth in 42 C.F.R. § 412.106; and (b) many of the variables that factor into that determination have not yet been calculated/determined because the periods at issue have either barely begun or have not yet begun.[82]

2. *What § 1115 Waiver Program(s) Apply to the Periods at Issue for the Period at Issue Apply?*—The FY 2024 IPPS Final Rule does not identify, or apply the policy at issue to, any *specific* State Medicaid programs which *currently* have § 1115 waiver programs that are otherwise covered by the "bar" described in the group issue statements. To this end, the

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reasons. First, it does not address the DSH payment calculation under IPPS for short term acute care hospitals, but rather addresses the low-income payment ("LIP") for inpatient rehabilitation hospitals ("IRFs"). Second, it does not address the scope of the provider's right to appeal *under 42 U.S.C. § 1395oo(a)* but rather concerns substantive jurisdiction, *i.e.*, whether a specific statute enacted by Congress precludes the Board from conducting administrative review of the LIP issue appealed by the IRF in *Mercy*, regardless of how the provider appealed (*i.e.*, regardless of whether the appeal was based on a cost report, NPR or final rule). Finally, the Board recognizes that, in *Battle Creek Health Sys. v. Becerra*, No. 17-0545, 2023 WL 7156125 (D.D.C. Oct. 31, 2023) ("*Battle Creek*"), the D.C. District Court addressed a jurisdictional issue involving DSH SSI fractions ***similar to*** the jurisdictional issue in *Memorial Hospital* but reached a different conclusion. However, the Board disagrees with the *Battle Creek* decision and maintains that *Memorial Hospital* is a better-reasoned and more thoughtful decision. Indeed, the *Battle Creek* decision does not even discuss (much less reference) the *Memorial Hospital* decision that was issued 19 months earlier.

[76] 42 C.F.R. § 412.106(i)(2) (emphasis added).

[77] 2022 WL 888190 at *9 (emphasis added).

[78] *See infra* notes 87 and 89 and accompanying text.

[79] 42 C.F.R. § 412.106(i)(2) (emphasis added).

[80] While the Providers' eligibility in prior years suggests continued eligibility, it does not establish it for the years at issue which have not yet been completed or, in some instances have not even begun. Thus, it is not clear that, even if successful in this appeal, they would qualify for a DSH payment *in the periods appealed*. *See infra* note 89.

[81] 42 C.F.R. § 412.106(i)(2) (emphasis added).

[82] *See infra* note 89 and accompanying text.

Providers have not identified any specific ***current*** § 1115 waiver program(s) that are relevant to their appeal in either the issue statement included with the appeal request or the text of the EJR Request. It is only presumed to be one *or* more Texas Medicaid 1115 waiver programs and *only* Texas because the Providers are located in Texas and the title for each group includes "Texas" in the title.[83] However, even if the appeal relates only to one or more Texas § 1115 programs, it is unclear from the record whether Texas ***currently*** has one or more § 1115 waiver day programs,[84] much less one that is precluded under the policy at issue[85] because neither the final rule nor the appeal request nor the EJR request address this fact.

3. *Will the Providers have any § 1115 waiver days for the periods at issue?*—Even if one assumes the Providers would qualify for a DSH payment *in the periods at issue*, it is not clear that *any* of the Providers would have patients during those periods that would, in fact, be covered under a § 1115 waiver program, much less one that is precluded under the policy at issue. To this end, the Providers only assert (without any evidence or further explanation) that "*[i]n **some** years*, that reimbursement [from the *prior* ten fiscal years] included payments associated with Section 1115 days" but do not identify the *specific* § 1115 program(s) associated with those days, much less confirm whether those programs are still in effect.[86] Similarly, each of the Providers have included an estimated reimbursement impact but it is unclear what those estimates are based on since these would appear to be based on prospective estimates of certain *anticipated* § 1115 uncompensated care pool days that they believe would be precluded from the numerator of the DSH Medicaid fraction by the policy at issue.[87] Indeed, § 1115 waiver days are one type of Medicaid eligible day and 42 C.F.R. § 412.106(b)(4)(iv) specifies that "[t]he 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." None of the Providers has met this burden of proof relative to the fiscal years at issue because ***none*** of the days that could or would be at issue were known/provided when the alleged determination (*i.e*., the FY 2024 IPPS Final Rule) was issued. Indeed, whether the policy at issue precludes a *specific* day from being counted in the numerator of the DSH Medicaid fraction for a *particular* fiscal year is *a mixed question of fact and law* that is made by the Medicare contractor as part of the cost report

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[83] That said, there could be out-of-state § 1115 waiver programs at issue since hospitals may provide care to out-of-state residents. While any such days are unlikely to be in significant number, it is not clear from the Providers' filings and one cannot determine this from the 4 corners of the alleged "determination" (*i.e*., the FY 2024 IPPS Final Rule).
[84] At any point in time, a state Medicaid program may have ***multiple*** approved § 1115 waiver programs. The landscape of approved § 1115 waiver programs also is not static as states periodically modify, phase-in and/or phase out programs.
[85] The EJR request focuses on § 1115 waiver programs for uncompensated care pools but it is unclear whether Texas has such a program and, if so, whether days for that *particular* program would otherwise be precluded from being counted in the numerator of the Medicaid fraction *pursuant to the policy at issue*.
[86] Response to MAC's Opposition to EJR and Jurisdictional Challenge at 3.
[87] Each estimated reimbursement impact uses a specific number of "1115 days" in its calculation (*e.g*., 4,376 for Ascension Providence in Case No. 24-0077GC vs. 11,664 for The Methodist Hospital in Case No. 24-0076GC). The document states that this number is based on "Information from client." However, it is unclear on what this number is based on since the periods at issue have ***either*** barely begun ***or*** have not even begun as demonstrated by the discussion in *infra* note 89 and the fact that it has barely been a month since the policy at issue became effective for discharges occurring on or after October 1, 2023.

audit/settlement process for that year. In particular, based on the documentation furnished by the provider (per 42 C.F.R. § 412.106(b)(4)(iv)), if a day is verified to be a § 1115 waiver day, the Medicare contractor would also need to review the relevant § 1115 waiver program to determine whether or not the policy at issue applies to that program and precludes the day from being counted in the numerator of the DSH Medicaid fraction.

4. *The relevant Medicare contractors have not yet determined the value of the numerator to the DSH Medicaid fraction for the periods at issue*.—To the extent any § 1115 waiver days are included in the numerator of the DSH Medicaid fraction for a hospital that is eligible for a DSH payment, the § 1115 waiver days would be just one category of Medicaid eligible days that would be included in the numerator and the relevant Medicare contractors again must review/audit any days claimed on the as-field cost report for the periods at issue to confirm Medicaid eligibility on each day claimed because again, per 42 C.F.R. § 412.106(b)(4), the hospital has the burden of proof to establish Medicaid eligibility for each day claimed.

As discussed above, the Board finds that the adoption and codification of the policy at issue in the FY 2024 IPPS Final Rule is not an appealable final payment determination within the context of 42 U.S.C. § 1395oo(a)(1)(A)(ii) and 42 C.F.R. § 405.1835 42 C.F.R. § 405.1837(a)(1) makes clear each group participant must be meet. Since satisfying the criteria set out in 42 C.F.R. §405.1835 is required before the Board can exercise jurisdiction over an appeal (whether as an individual provider appeal or as part of group appeal),[88] and since the Providers have failed to demonstrate in their hearing requests that those criteria have been met *for the fiscal years under appeal*,[89] the Board hereby dismisses these 3 CIRP group appeals (and the participants therein) ***with prejudice*** and removes them from the Board's docket.[90] As such, the Board also denies the EJR request.

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

Board Members Participating:

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

For the Board:

11/14/2023

X Clayton J. Nix

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

[88] 42 C.F.R. § 405.1840(a), (b).
[89] FFY 2024 runs from October 1, 2023 through September 30, 2024. Some of the Providers in these 3 CIRP group cases appealed fiscal years that coincide with FFY 2024 (and, as such, the appealed period has only just begun). However, the remaining Providers in these CIRP group cases appealed fiscal years that did not coincide with FFY 2024 and, as a result, appealed the 2 fiscal years that straddled FFY 2024. *For example*, if a provider's fiscal year ended December 31st, the provider appealed both its fiscal year ending December 31, 2023 (*i.e*., its FY 2023 but only the last quarter of 2023 that began Oct. 1, 2023 when the policy at issue became effective) and its fiscal year ending December 31, 2024 (*i.e*., its FY 2024). *In this example*, the provider's FY 2023 has not yet concluded and its FY 2024 has not yet begun.
[90] *See* 42 C.F.R. § 405.1835(b).

cc: Michael Redmond, Novitas Solutions, Inc. (J-H)
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DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Dismissal of SSI Percentage (Provider Specific) & Medicaid Eligible Days Issues & Determination Regarding Duplicate Appeals***
West Virginia University Hospitals, Inc. (Provider No. 51-0001), FYE 12/31/2016
Case Nos. 22-0892 and 22-0919

Dear Mr. Ravindran and Ms. Goldsmith,

The Provider Reimbursement Review Board ("Board") has reviewed the documentation in the above referenced appeals filed on behalf of West Virginia University Hospitals, Inc. ("Provider"). The background of these cases and the decision of the Board is set forth below.

Background:

A. *Procedural History for Case No. 22-0892*

On September 9, 2021, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end December 31, 2016.

On February 24, 2022, Quality Reimbursement Services, Inc. ("QRS") filed the Provider's individual appeal request. The appeal request contained six (6) issues:

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

[1] On September 27, 2022, this issue was transferred to PRRB Case No. 21-1434GC.
[2] On September 27, 2022, this issue was transferred to PRRB Case No. 21-1544GC.
[3] On September 27, 2022, this issue was transferred to PRRB Case No. 21-1546GC.
[4] On September 27, 2022, this issue was transferred to PRRB Case No. 21-1435GC.

As the Provider is owned by West Virginia University Health Systems (hereinafter "WVU Health") and, thereby, subject to the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1), the Provider transferred Issues 2, 4, 5 and 6 to WVU Health groups on September 27, 2022. As a result, the remaining issues in Case No. 22-0892 are Issues 1 and 3.

On October 11, 2022, the QRS filed the Provider's preliminary position paper.

On January 12, 2023, the Medicare Contractor filed its preliminary position paper.

On January 26, 2023, the Medicare Contractor filed a jurisdictional challenge, requesting the dismissal of Issues 1 and 3. Under Board Rule 44.4.3, the Provider's response was due within 30 days of the jurisdictional challenge being filed. In other words, it was due on Monday, February 27, 2023.[5] However, QRS did not timely file a response but rather filed its response ***9 days late***, *on Wednesday, March 8, 2023*.

On August 18, 2023, QRS and Bass, Berry & Sims, PC ("Bass Berry") filed correspondence advising the Board that, unknowingly, two Representatives had filed individual appeals on behalf of the Provider for FY 12/31/2016. Therefore there were two appeals for the Provider, Case Nos. 22-0892 and 22-0919, pending with the Board.

B. Procedural History for Case No. 22-0919

On March 4, 2022, the Board received Bass Berry's appeal request on behalf of the Provider. The appeal request contained one (1) issue: Medicare Indigent Bad Debts.

On October 5, 2022, Bass Berry filed the Provider's preliminary position paper.

On January 17, 2023, the Medicare Contractor filed its preliminary position paper.

On May 27, 2023, Bass Berry filed the Provider's optional response to the Medicare Contractor's preliminary position paper.

C. Description of Issue 1 in the Case No. 22-0892 and the Provider's Participation in Case No. 21-1434GC

In Case No. 22-0892, filed by QRS, the DSH Payment/SSI Percentage (Provider Specific) issue is summarized 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.

[5] As the 30th day fell on Saturday February 25, 2023, the deadline automatically is moved to the next business day, Monday, February 27, 2023.

> . . .
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[6]

As the Provider is commonly owned by WVU Health, QRS transferred the Provider's Issue 2 – DSH – SSI Percentage to the CIRP group under 21-1434GC, "WVU Medicine CY 2016 DSH SSI Percentage CIRP Group," on September 27, 2022. The Group Issue Statement in Case No. 21-1434GC reads, in part:

> **Statement of the Issue:**
>
> Whether the Secretary properly calculated the Provider's [DSH]/[SSI] percentage, and whether CMS should be required to recalculate the SSI percentages using a denominator based solely upon covered and paid for Medicare Part A days, or alternatively, expand the numerator of the SSI percentage to include paid/covered/entitled as well as unpaid/non-covered/eligible SSI days?
>
> **Statement of the Legal Basis**
>
> The Provider(s) contend(s) that the MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). The Provider(s) further contend(s) that the SSI percentages calculated by [CMS] and used by the MAC to settle their Cost Reports incorporates a new methodology inconsistent with the Medicare statute.
>
> The Providers challenge their SSI percentages based on the following reasons:
>
> 1. Availability of MEDPAR and SSA records,
> 2. Paid days vs. Eligible days,
> 3. Not in agreement with provider's records,
> 4. Fundamental problems in the SSI percentage calculation,
> 5. Covered days vs. Total days and

[6] Issue Statement at 1 (July 25, 2022).

6. Failure to adhere to required notice and comment rulemaking procedures.[7]

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $159,156.

On March 20, 2023, QRS filed the Provider's preliminary position paper. The following is the Provider's ***complete*** position on the SSI Percentage Provider Specific issue set forth therein:

> **Provider Specific**
>
> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation.
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's coser report by the MAC are both flawed.
>
> Similar to *Loma Linda Community Hospital v. Dept of Health and Human Services*, No. CV-94-0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records. However, at this time, the Provider has been unable to analyze the Medicare Part A 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 both be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS based on the Federal Fiscal Year End (September 30) when it determined the Provider's SSI. *See Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).[8]

D. Filings Concerning the Jurisdictional Challenge Raised in Case No. 22-0892

Medicare Contractor's Contentions

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

[7] Group Issue Statement, Case No. 21-1434GC.
[8] Provider's Preliminary Position Paper at 8-9 (Oct. 11, 2022).

The Medicare Contractor argues that the Board lacks jurisdiction over the DSH – SSI Percentage (Provider Specific) issue for three reasons: 1) it is duplicative of the SSI Percentage issue previously transferred to a CIRP group, 21-1434GC; 2) there was no final determination over the SSI realignment so the appeal is premature as the Provider has not exhausted all administrative remedies; and 3) the Provider failed to file a complete position paper including all supporting exhibits to document the merits of its arguments on the issue.

The Medicare Contractor contends the Provider has made the same arguments for the DSH – SSI Percentage (Provider Specific) issue and the DSH – SSI Percentage (Systemic Errors) issue. In both issues, ". . . the Provider is disputing the accuracy of its SSI percentage and individuals who are eligible for SSI, but did not receive payment."[9] Because the SSI Percentage issue has been transferred to a group, the Provider is prohibited from pursuing the flawed SSI Percentage issue (appealed from the same determination) in more than one appeal.

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

> The decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election. It is not a final contractor determination. A hospital must make a formal request to CMS in order to receive a realigned SSI percentage. Once the hospital elects to use its own fiscal year end, it is bound by that decision, regardless of reimbursement impact.
>
> . . .
>
> The MAC has not made a determination on the realignment of the SSI percentage to the hospital fiscal year end, as the Provider has not yet requested realignment. Since the Provider did not request SSI realignment, as required by 42 C.F.R. § 412.106(b)(3), the MAC could not have made a final determination of this issue. The Provider's appeal is premature. 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 subsidiary realignment issue consistent with recent jurisdictional decisions.[10]

Finally, the Medicare Contractor argues that the SSI realignment portion of the issue has been abandoned by the Provider:

> . . .the MAC asserts that the Provider did not file a complete preliminary position paper in accordance with 42 C.F.R. § 405.1853 and Board Rules Rule 25 and 27.1.

[9] MAC Jurisdiction Challenge at 5.
[10] *Id*. at 7.

. . .

> In its Preliminary Position Paper for the instant appeal, the Provider's sole argument consists of an identical, generic passage previously deemed insufficient by the Board in *City Hospital, Inc*. Here, the Provider only offered a single exhibit reflecting its estimated impact to be a 25% increase to the SSI percentage in its appeal request. In its Preliminary Position Paper, it only offered the total amount in controversy and not the actual calculation. Like *City Hospital, Inc*., the Provider had access to its MEDPAR data prior to filing its position paper of this issue, yet failed to supply any documentation utilizing that data to support the alleged inaccuracy of its published SSI percentage, or explain why the documents remain unavailable, describe efforts to obtain any additional documents or advise when the documents will become available. Accordingly, the MAC contends that the sole relevant exhibit lacks the requisite narrative description to provide a thorough understanding of the parties' positions or basis for this estimate. Like the provider in City Hospital, Inc., the Board should find that the Provider in the instant case has failed to submit a complete Preliminary Position Paper with all exhibits as required by the Board Rules. Therefore, the MAC respectfully requests that the issue be dismissed.[11]

Issue 3 – DSH Payment – Medicaid Eligible Days

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

> The MAC contends that the Provider was in violation of Board Rule 25.3 when it failed to sufficiently develop and set forth the relevant facts and arguments regarding the merits of its claim in its preliminary position paper. Moreover, the Provider neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2. Accordingly, the DSH – Medicaid Eligible Days issue should be dismissed.
>
> Within its Provider's preliminary position paper, the Provider makes the broad allegation, ". . . the Provider contends that the total number of days reflected in its' [sic] 2016 cost report does not reflect an accurate number of Medicaid eligible days. . ." The Provider has failed to include any evidence to establish the material facts in this

[11] *Id* at 10.

> case relating to inaccuracies in the Medicaid Percentage calculation at issue. The Provider merely repeats their appeal request.[12]

Provider's Jurisdictional Response

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

The Representative does not address the Medicare Contractor's contention regarding the SSI Provider Specific and SSI Percentage issues as being duplicative. Instead, QRS argues that

> "[t]he MAC overlooks, however, that CMS will not release the SSI data. Although CMS does make certain SSI data available, this data is inadequate and does not provide all patient payment status codes and other necessary information required to fully support this issue. At this time, CMS has not made this additional information available and has provided no process through which the provider could obtain this necessary information. Indeed, the refusal of CMS to release SSI data is currently being litigated before the United States Court of Appeals for the District of Columbia. See Pomona Valley Hospital Medical Center v. Becerra, No. 20-5350, 20- 5351.[13]

Issue 3 – DSH Payment – Medicaid Eligible Days

QRS argues that it is not clear whether the Medicare Contractor relies on current Board rules version 3.1 or Version 2.0, which was in effect when the Preliminary Position was filed.[14] QRS posits this relevant because:

> Under Board Rules Version 2.0, a Final Position Paper is required for appeals filed prior to the effective date of Version 2.0. Rule 27.1. It was the reasonable understanding and expectation of the Provider, therefore, that the outside date for submission of the listing of additional Medicaid eligible days was the Final Position Paper deadline.
>
> Just as the operations of the Board and the MAC were disrupted by the COVID pandemic, as witnessed by the issuance of Alert 19, the operations of the Provider likewise were disrupted. Indeed, the Provider face, and continues to face, the challenge of providing life-saving health services to patients suffering from COVID (and, more recently children suffering from life-threatening respiratory disease).[15]

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[12] *Id*. at 13.
[13] Jurisdictional Response at 1. (March 8, 2023)
[14] *Id*. at 3.
[15] *Id*.

Board Analysis and Decision:

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

A. DSH Payment/SSI Percentage (Provider Specific)

The Board finds that it does not have jurisdiction over the DSH Payment/SSI Percentage (Provider Specific) issue. The jurisdictional analysis for Issue No. 1 has 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. 21-1434GC.

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

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 21-1434GC 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 Case No. 22-0892 is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 21-1434GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[19], the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

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[16] Issue Statement at 1.
[17] *Id.*
[18] *Id.*
[19] PRRB Rules v. 2.0 (Aug. 2018).

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 21-1434GC. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[20] The Provider 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. 21-1434GC.

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 21-1434GC, 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.[21] 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 and explain the nature of the any alleged "errors" in its Preliminary Position Paper and include *all* exhibits.[22]

Moreover, the Provider has failed to comply with Board Rule 25.2.2 to explain why the MEDPAR data is unavailable or explain what is wrong with the data available. 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

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

[21] It is also not clear whether this is a systemic issue for WVU Health 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.

[22] For example, in its response to the jurisdictional challenge, the Provider refers to the *Pomona Valley* case, but yet fails as part of its position paper filing to develop the merits around such a case. As demonstrated in the D.C. Circuit's decision in that case, the provider has to come forward with significant documentation and information before the evidentiary burden shifts from the provider to the CMS. *See Pomona Valley Hosp. Med. Ctr. v. Becerra*, No. 20-5350, 2023WL5654315 (D.C. Cir., Sept. 1, 2023).

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

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

> https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH.[23] 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."[24]

Indeed, the D.C. Circuit affirmed in *Advocate Christ Med. Ctr. v. Becerra*, No. 22-5214, 2023WL5654312 (D.C. Cir., Sept. 1, 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 Providers do not explain what information it needs or is waiting on or claims that it should have access to.

Accordingly, *based on the record before it*, the Board finds that the SSI Provider Specific issue in Case No. 22-0892 and the group issue from Group Case 21-1434GC are the same issue. In making this determination, the Board refuses to consider the Provider's Response to the Jurisdictional Challenge because it was not timely but rather was filed 9 days late (as explained above).[25] Because the issue is duplicative, and duplicative issues appealed from the same final

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[23] Last accessed February 24, 2023.
[24] Emphasis added.
[25] Regardless, the Response fails to provide any meaningful response. The information included therein should have been included in its preliminary position paper *along with the information required under Board Rule 25.2.2 for*

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.

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.[26]

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unavailable or omitted documents. As such, it is doubly untimely as the Response was itself untimely filed and the information contained therein was late as it should have been included in the preliminary position paper filing. *See also supra* note 21 (describing potential CIRP group issues).

[26] Individual Appeal Request, Issue 3.

QRS, on behalf of the Provider, failed to include a list of additional Medicaid eligible days they expect to be included in the Provider's Medicaid percentage and DSH computations, with their appeal request. Additionally, The Provider's preliminary position paper indicated that it would be sending the eligibility listing under separate cover, although a listing was not submitted.[27]

Board Rule 7.3.1.2 (Version 3.1, effective November 1, 2021 and in effect as of the date of the appeal request filing) states:

> **No Access to Data**
>
> 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.

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 did ***not*** include a list of additional Medicaid eligible days with its preliminary position paper or under separate cover as promised in its preliminary position paper. The Provider has essentially *abandoned* the issue by failing to file a preliminary position paper that properly developed its arguments and to provided supporting documents or explained why it cannot produce those documents, as required by the regulations and the Board Rules.[28]

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

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

[27] Provider's Preliminary Position Paper at 8.
[28] *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.

> *timeframe to be decided by the Board through a schedule applicable to a specific case or through general instructions*.[29]

With regard to the filing of an individual appeal, Board Rule 7 (Support for Appealed Final Determination, Issue-Related Information and Claim of Dissatisfaction) (Jul. 2015) 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.

Similarly, with regard to position papers,[30] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[31] This requirement is consistent with 42 C.F.R. § 405.1853(b)(3).

Consistent with that regulation, Board Rule 25.2.2 provides the following instruction on the content of position papers as it relates to unavailable documentation/exhibits:

> *If documents necessary to support your position are still unavailable,* then provide the following information in the position papers:
>
> 1. Identify the missing documents;
> 2. Explain why the documents remain unavailable;
> 3. State the efforts made to obtain the documents; and
> 4. Explain when the documents will be available.
>
> Once the documents become available, promptly forward them to the Board and the opposing party.[32]

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.

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:

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

> 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,
> • if the Board is unable to contact the provider or representative at the last known address, or
> • upon failure to appear for a scheduled hearing.

The 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)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[33] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. *Based on the record before the Board*, the Board finds that the Provider has failed to provide a listing or other supporting documentation for the Medicaid Eligible Days issue as required by the controlling regulations and Board Rules. Nor has the Provider provided any explanation as to why the documentation was absent or what is being done to obtain it consistent with Board Rule 25.2.2. Indeed, *without* ***any*** *days identified in the position paper filing*, the Board assumes that there are no days in dispute and that the actual amount in dispute is $0 for this issue.

Finally, the Board finds that the Provider's arguments in its March 8, 2023 jurisdictional response were not timely filed as it was filed 9 days late (as explained above). In that *untimely* filing, the Provider asserts that it has not "abandoned" the Medicaid eligible days issue. However, when the preliminary position paper was perfunctory and failed to comply with Board Rules as explained above[34] ***and*** then the Response to the Jurisdictional Challenge itself is both filed last and again fails to identify any days at issue,[35] it is clear that the Medicaid eligible days issue was abandoned. Indeed, the Response to the Jurisdictional Challenge makes some generic references to the Covid-

[33] (Emphasis added).
[34] The Provider is misplaced in believing it could file its listing with the final position paper since the Rules and regulations cited above regarding position papers were in effect well before August 29, 2018. Moreover, the Provider appears to be well aware of the August 29, 2018 revised rules since it complied with those changes and filed it complete preliminary position paper. Finally, this appeal was filed on February 24, 2022 well after the Board issued revised Board Rules effective November 1, 2021.
[35] Further, QRS fails to explain why the information is unavailable and fails to even identify one day in dispute.

19 pandemic to suggest it may have played a part in why no eligible days listing was provided with the preliminary position paper filing; however, that explanation is fatally flawed because: (1) it provides no justification *for the late filing of its Response* to the Jursidctional Challenge in the first instance; and (2) if the pandemic truly affected its ability to include the listing with the position paper, it is unclear why was that information not included with that that filing (which was done voluntarily[36]) in the first instance in compliance with Board Rule 25.2.2.

Based on the above reasons, the Board hereby dismisses the Medicaid eligible days issue. The Board takes administrative notice that it has made similar dismissals in other cases in which QRS was the designated representative.[37] Notwithstanding, QRS and WVU Health failed to include the Medicaid eligible days listing with its preliminary position paper or even file a copy following the MAC's Jurisdictional Challenge.

* * * * *

In summary, the Board hereby dismisses the DSH Payment/SSI Percentage (Provider Specific) issue from Case No. 22-0892 as it is duplicative of the issue in Case No. 21-1434GC 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)(iii) and 405.1853(b)(2)-(3) and Board Rule 25. As no issues remain pending, the Board hereby closes Case No. 22-0892 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.

With the closure of Case No. 22-0892, the Board finds the August 18, 2023 request to "merge" the two individual appeals filed on behalf of West Virginia University Hospital under Case Nos. 22-0892 and 22-0919 to be moot. Consequently, Bass Berry will remain the designated representative in Case No. 22-0919, which remains pending for the Medicare Indigent Bad Debts issue.

Finally, as a result of our review of the record, the ***Board admonishes WVU Medicine*** *for filing two (2) separate Designation of Representation letters, within a week of each other, permitting both representatives to file* ***individual provider appeals*** *for the same Provider and FYE. It is this error the resulted in the prohibited duplicate* ***individua****l provider appeals in violation of Board Rule 4.6. The Board reminds WVU Medicine that it has a responsibility to ensure that it (through its agents) manages its appeals in accordance with the Board Rules;* ***and that they do not improperly file duplicate appeals****. The Board orders WVU Medicine to come into compliance with Board Rules 5.1 and 4.6. Board Rule 5.1 specifies that "The case representative may be an*

[36] Indeed, the Board notes that Alert 19 issued in connection with the COVID-19 pandemic has ***no*** relevance here because the Alert pertained to *filing deadlines* (and not the ***content*** of those filings if made).

[37] Examples of cases in which QRS was the designated representative and which the Board dismissed for failure of the Provider to provide a listing of Medicaid eligible days at issue include, but are not limited to: Case No. 14-2674 (by Board letter dated 5/5/2022); Case No. 16-2521 (by Board letter dated 5/5/2022); Case No. 16-0054 (by Board letter dated 5/5/2022); Case Nos. 13-3022, 13-3211, 14-2506, 14-4313, The Board's attention to the filing deficiency was brought to the Board's attention via a motion to dismiss filed by the Medicare Contractor in its position paper (on December 10, 2020, December 11, 2020, March 12, 2021, March 12, 2021 respectively).

external party (e.g., attorney or consultant) or an internal party (e.g., employee or officer of the provider or its parent organization), but there may be only one case representative per appeal (see Rule 4.6 prohibiting duplicate appeals).” Further, Board Rule 4.6 specifies that there may not be duplicate appeals:

> **4.6 No Duplicate Filings**
>
> **4.6.1 Same Issue from One Determination**
> A provider may not appeal and pursue the same issue from a single final determination in more than one appeal (individual or group).
>
> **4.6.2 Same Issue from Multiple Determinations**
> Appeals of the same issue from distinct determinations covering the same time period must be pursued in a single appeal. For example, a provider may not appeal an issue from a Medicare contractor’s failure to issue a timely Notice of Program Reimbursement (“NPR”) and then appeal the same issue from the NPR covering the same time period in separate appeals. See Rule 6.3 for instruction on how to add a new determination to a pending individual appeal covering the same time period.
>
> **4.6.3 Issue Previously Dismissed or Withdrawn**
> Once an issue is dismissed or withdrawn, the provider may not appeal or pursue that issue in any other case. For example, if the provider has an issue dismissed from its individual appeal, it may not appeal or pursue that same issue in a group appeal covering the same time period. Refer to Rule 47 for motions for reinstatement.

If this recurs, the Board may consider taking other remedial action such as dismissal.

Finally, *the Board reminds **QRS** and **Bass Berry** that, to the extent they are designated as a representative for a particular provider for a particular year to file an individual provider appeal* (*i.e.*, not a group appeal), they have an obligation to confirm with their provider client that they are the sole authorized representative for that provider for that year for purposes of filing the individual provider appeal.

Board Members Participating:

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

For the Board:

11/15/2023

X Clayton J. Nix

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

cc: Wilson C. Leong, Esq., Federal Specialized Services
Dana Johnson, Palmetto GBA c/o National Govt. Services, Inc. (J-M)
Amy Stephens, West Virginia University Hospitals

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

James Ravindran
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Arcadia, CA 91006

RE: ***Board Decision***
Forrest City Medical Center (Provider Number 04-0019)
FYE: 09/30/2016
Case Number 19-2044

Dear Mr. Ravindran,

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the documentation in Case No. 19-2044, pursuant to a Jurisdictional Challenge filed by the Medicare Contractor ("MAC"). The Board's decision is set forth below.

Background:

A. Procedural History for Case No. 19-2044

Forrest City Medical Center submitted a request for hearing on June 6, 2019, from a Notice of Program Reimbursement ("NPR") dated December 4, 2018. The hearing request included the following issues:

- Issue 1: Disproportionate Share Hospital (DSH) Payment Supplemental Security Income (SSI) Percentage- Provider Specific
- Issue 2: Disproportionate Share Hospital (DSH) Payment Supplemental Security Income (SSI) Percentage
- Issue 3: DSH- Medicaid Eligible Days
- Issue 4: Uncompensated Care ("UCC") Distribution Pool
- Issue 5: 2 Midnight Census IPPS Payment Reduction

After all transfers and withdrawals, one issue remains: Issue 1: DSH SSI Percentage (Provider Specific).

As the Provider is owned by Quorum Health and, thereby, subject to the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1), the Provider transferred Issue 2 to a Quorum Health group on January 23, 2020.

On March 18, 2020, the MAC filed a Jurisdictional Challenge over Issue 1- DSH SSI Provider Specific The Provider did not file a response to the MAC's Jurisdictional Challenge. [1]

[1] The MAC also filed a jurisdictional challenge over issue 3 on March 2, 2023, but that challenge is moot as issue 3 was withdrawn from the appeal on August 23, 2023.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 19-1503GC

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

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

The amount in controversy was listed as $4,000.

The Provider issue #2, was also transferred into a mandatory group under Case No. 19-1503GC entitled "*Quorum Health CY 2010 & CY 2016 DSH SSI Percentage CIRP Group*." This CIRP group has the following issue statement:

> **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?

[2] Provider's Request for Hearing, Issue Statement (June 6, 2019)

Statement of the Legal Basis:

The Provider(s) contend(s) that the MAC's determination of Medicare Reimbursement for their DSH payments are not in accordance with the Medicare statute at 42 U.S.C. §1395ww(d)(5)(F)(vi)(I). The Provider(s) further contend(s) that the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") and used by the MAC to settle their Cost Reports incorporates a new methodology inconsistent with the Medicare statute.

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

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

On January 29, 2020, the Provider filed its preliminary position paper. 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. This is based on certain data from the State of Arkansas and the Provider that does not support the SSI percentage issued by CMS.

The Provider has worked with the State of Arkansas 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,

[3] See Group Issue Statement, PRRB Case No. 19-1503GC.

> 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 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.

Medicare Contractor's Contentions

Issue 1 – DSH SSI Percentage (Provider Specific)

On March 18, 2020, the Medicare Contractor filed a Jurisdictional Challenge over Issue 1. The MAC contends that the portion of Issue 1 concerning SSI data accuracy should be dismissed because it is duplicative of an issue which was transferred into Group Case No. 19-1503GC, *Quorum Health CY 2010 & CY 2016 DSH SSI Percentage CIRP Group*. The Portion of Issue 1 concerning realignment should be dismissed because "[t]here was no final determination over SSI realignment and the appeal is premature as the Provider has not exhausted all available remedies."[4]

Provider's Response

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

Board Analysis and Decision:

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

A. 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.

[4] MAC's Jurisdictional Challenge, at 2.

1. First Aspect of Issue 1

The Board finds that the first aspect of Issue 1 (the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage – identified as the DSH/SSI (Provider Specific) issue) in this appeal is duplicative of the DSH/SSI (Systemic Errors) issue that was transferred into Group Case No. 19-1503GC, *Quorum Health CY 2010 & CY 2016 DSH SSI Percentage CIRP Group*. The first aspect of Issue 1 in the present appeal concerns "[w]hether the Medicare Administrative Contractor used the correct [SSI] percentage in the [DSH] Calculation."[5] The Provider's legal basis for this aspect of Issue 1 is simply that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[6] Similarly, the Provider argues that "its' SSI percentage published by [CMS] was incorrectly computed . . ." and it ". . . [s]pecifically . . . disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[7] The DSH systemic issue transferred into Case No. 19-1503GC, similarly alleges that the Medicare Contractor and CMS improperly calculated the DSH/SSI Percentage, the DSH/SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F).

Thus, the Board finds that the first aspect of Issue 1 in this appeal is duplicative of the group issue in Case No. 19-1503GC, for this same provider and fiscal year. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (Mar. 1, 2013), the Board dismisses this aspect of the DSH/SSI (Provider Specific) issue.

In making this finding, the Board further notes that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, the Provider is pursuing that issue as part of the group under Case No. 19-1503GC. 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.[8] The Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) in its appeal request of how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue, rather than being subsumed into the "systemic" issue appealed in Case No. 19-1503GC.

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. 19-1503GC, 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

[5] Individual Appeal Request, Issue 1.
[6] *Id.*
[7] *Id.*
[8] The types of systemic errors documented in the *Baystate* case 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).

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. Common examples of unavailable documentation include pending discovery requests, pending requests filed under the federal Freedom of Information Act (also known as FOIA requests), or similar requests for information pending with a state Medicaid agency.

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

> https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH.[9]

[9] (Last accessed Nov. 20, 2023.)

This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows: "DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[10]

Accordingly, the Board must find that Issues 1 and the group issue in Group 19-1503GC are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (2015), the Board dismisses this component of the DSH/SSI (Provider Specific) issue. As an alternative basis the Board dismisses Issue 1 for failure of the Provider to properly brief the issue in its position paper in compliance with Board Rules.

2. Second Aspect of Issue 1

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

****

In summary, the Board hereby dismisses the SSI Provider Specific Issue from this appeal as it is duplicative of the issue in Case No. 19-1503GC, there is no final determination from which the Provider can appeal the SSI realignment portion of the issue, and the Provider failed to meet the Board requirements for position papers.

As there are no more issues still pending in the appeal, the case 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:

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

For the Board:

11/20/2023

X Kevin D. Smith, CPA

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

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

[10] (Emphasis added.)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Board Dismissal of SSI Percentage (Provider Specific) & Medicaid Eligible Days Issues***
Navarro Regional Hospital (Provider Number 45-0447)
FYE: 12/31/2015
Case Number: 19-1824

Dear Mr. Ravindran and Mr. Lamprecht,

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

Background:

A. *Procedural History for Case No. 19-1824*

On September 21, 2018, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end December 31, 2015.

On March 20, 2019, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained five (5) issues:

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

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 Provider transferred Issues 2, 4, and 5 to Community Health groups on October 22, 2019. As a result, the remaining issues in this appeal are Issues 1 and 3.

[1] On October 22, 2019, this issue was transferred to PRRB Case No. 18-0552GC.
[2] On October 22, 2019, this issue was transferred to PRRB Case No. 18-0555GC.
[3] On October 22, 2019, this issue was transferred to PRRB Case No. 18-0554GC.

On November 12, 2019, the Provider filed its preliminary position paper.

On March 10, 2020, the Medicare Contractor filed its preliminary position paper.

On March 24, 2020, the Medicare Contractor filed a jurisdictional challenge, requesting the dismissal of Issue 1.

On January 6, 2023, the Medicare Contractor filed a Final Request for the Medicaid Eligible Days Listing in connection with Issue 3 and requested a response within 30 days. On July 17, 2023, the Medicare Contractor filed its Motion to Dismiss Issue 3 as the Provider failed to file any response.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 18-0552GC

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.[4]

As the Provider is commonly owned by Community Health, the Provider transferred its Issue 2 – DSH – SSI Percentage to the CIRP group under 18-0552GC, QRS CHS 2015 DSH SSI Percentage CIRP Group, on October 22, 2019. The Group Issue Statement in Case No. 18-0552GC 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 number of patient days to be included in the numerator and denominator of the Medicare/SSI

[4] Issue Statement at 1 (Mar. 20, 2019).

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 [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 [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 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[5]

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

On November 22, 2019, 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 (December 31).

[5] Group Issue Statement, Case No. 18-0552GC.

> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.
>
> Similar to *Loma Linda Community Hospital v. Dept of Health and Human Services*, No. CV-94-0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records. However, at this time, the Provider has been unable to analyze the Medicare Part A 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).[6]

C. Filings Concerning the Jurisdictional Challenge

1. 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 appeal 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 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

[6] Provider's Preliminary Position Paper at 8-9 (Nov. 12, 2019).

> 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.[7]

In addition, the MAC argues that the DSH – SSI Percentage (Provider Specific) issue and the DSH – SSI Percentage (Systemic Errors) issue are considered the same issue by the Board.[8]

Issue 3 – DSH Payment – Medicaid Eligible Days

The MAC requests that the Board find that the Provider abandoned the DSH – Medicaid Eligible Days issue, and enter an Order providing the following:

> 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.[9]

Accordingly, the Medicare Contractor requests that the Board dismiss Issue 3.

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.[10] 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 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

[7] Jurisdictional Challenge at 6 (Mar. 24, 2020).
[8] *Id*. at 4-5.
[9] Motion to Dismiss at 4-5 (July 17, 2023).
[10] Board Rule 44.4.3, v. 2.0 (Aug. 2018).

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.

A. DSH Payment/SSI Percentage (Provider Specific)

The Board finds that it does not have jurisdiction over the DSH Payment/SSI Percentage (Provider Specific) issue. The jurisdictional analysis for Issue No. 1 has 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. 18-0552GC.

The DSH – SSI Percentage (Provider Specific) issue in the present appeal concerns "whether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation."[11] The Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[12] The Provider argues that "its' SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[13]

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 18-0552GC also alleges that the Medicare Contractor and CMS incorrectly 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

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

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

In making this finding, the Board further notes that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations, and, to that end, the Provider is pursuing that issue as part of the group under Case 18-0552GC. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[15] The Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 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:

> **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.

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

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

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

This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows: "DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[17]

Indeed, the D.C. Circuit affirmed in *Advocate Christ Med. Ctr. v. Becerra*, No. 22-5214, 2023WL5654312 (D.C. Cir., Sept. 1, 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 Providers do not explain what information it needs or is waiting on or what information it claims that it should have access to.

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 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.

[16] Last accessed February 24, 2023.
[17] 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 with which the Provider can be dissatisfied for appeal purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding DSH SSI Percentage realignment. Therefore, the Board finds that it lacks jurisdiction in this aspect of the appeal.

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.[18]

The Provider failed to include a list of additional Medicaid eligible days that 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.[19]

Board Rule 7.3.2 states:

> **No Access to Data**

[18] Individual Appeal Request, Issue 3.
[19] 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.[20]

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*.[21]

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.

---

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

[21] (Emphasis added).

Similarly, with regard to position papers,[22] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[23] 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 opposing party.[24]

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,
> • 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.

---

[22] The minimum requirements for Final Position Paper narratives and exhibits are the same as those for Preliminary Position Papers. *See* Board Rule 27.2.
[23] (Emphasis added).
[24] (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"[25] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. Based on the record before the Board, the Board finds that the Provider has failed to provide a listing or other supporting documentation for the Medicaid Eligible Days issue as required by the controlling regulations and Board Rules. Nor has the Provider provided any explanation as to why the documentation was absent or what is being done to obtain it consistent with Board Rule 25.2.2. Indeed, without any days identified in the position paper filing, the Board assumes that there are no days or amount in dispute for this issue.

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 Board takes administrative notice that it has made similar dismissal in other cases in which QRS was the designated representative[26] as well as cases involving CHS providers.[27] Notwithstanding, QRS and CHS failed to include the Medicaid eligible days listing with its preliminary position paper or even to file a copy following the MAC's Motion to Dismiss.

****

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 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. As no issues remain pending, the Board hereby closes Case No. 19-1824 and removes it from the Board's docket.

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[25] (Emphasis added).

[26] Examples of cases in which QRS was the designated representative and which the Board dismissed for failure of the Provider to provide a listing of Medicaid eligible days at issue include, but are not limited to: Case No. 14-2674 (by Board letter dated 5/5/2022); Case No. 16-2521 (by Board letter dated 5/5/2022); Case No. 16-0054 (by Board letter dated 5/5/2022); Case Nos. 13-3022, 13-3211, 14-2506, 14-4313, The Board's attention to the filing deficiency was brought to the Board's attention via a motion to dismiss filed by the Medicare Contractor in its position paper (on December 10, 2020, December 11, 2020, March 12, 2021, March 12, 2021 respectively).

[27] Examples of CHS individual provider cases which the Board dismissed for failure of the Provider to provide a listing of Medicaid eligible days include, but are not limited to: Case No. 22-0676 (dismissed by Board letter dated December 7, 2022 based on a MAC July 13, 2022 request for dismissal of the Medicaid eligible days issue for failure to file Medicaid eligible days listing with the preliminary position paper);

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

Board Members Participating:

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

For the Board:

11/20/2023

X Kevin D. Smith, CPA

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

James Ravindran
Quality Reimbursement Services, Inc.
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RE: ***Board Decision***
Phoenixville Hospital (Provider Number 39-0127)
FYE: 06/30/2016
Case Number: 19-0942

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the documentation in Case No. 19-0942 pursuant to a jurisdictional challenge filed by the Medicare Administrative Contractor ("MAC"). The Board's decision is set forth below.

Background

A. Procedural History for Case No. 19-0942

On July 13, 2018, the Provider, Phoenixville Hospital, was issued a Notice of Program Reimbursement ("NPR") for fiscal year end June 30, 2016.

On January 3, 2019, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained five (5) issues:

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

As the Provider is commonly owned by Community Health Systems, Inc. ("CHS"), and, thereby, subject to the mandatory Common Issue Related Party ("CIRP") regulation at 42 C.F.R. § 405.1837(b)(1), the Provider transferred Issues 2 and 5 to CHS groups on July 22, 2019. The

[1] On July 22, 2019, this issue was transferred to PRRB Case No. 19-1409GC.
[2] On September 15, 2023, the Provider withdrew this issue.
[3] On October 17, 2023, the Provider withdrew this issue.
[4] On July 22, 2019, this issue was transferred to PRRB Case No. 19-1410GC.

Provider also withdrew Issues 3 and 4. The DSH – SSI Percentage (Provider Specific), issue is the last issue pending in the appeal.

On March 28, 2019, the Medicare Contractor filed a jurisdictional challenge with the Board over Issues 1, 2, 4, and 5. This decision only addresses the challenge to the SSI Provider Specific issue, as that is the only issue that remains in the appeal. The Provider timely filed its jurisdictional response with the Board on April 24, 2019.

On October 18, 2023, the Provider filed its final position paper.

On November 16, 2023, the Medicare Contractor filed its final position paper.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 19-1409GC

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. *See* 42 U.S.C. 1395(d)(5)(F)(i).[5]

On October 18, 2023, the Board received the Provider's final position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

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

[5] Provider's Appeal Request at Tab 3 (Jan. 3, 2019).

> of the SSI percentage. *See* 65 Fed. Reg. 50,548 (2000). Although some MEDPAR data is now routinely made available to the provider community, what is provided lacks all data records necessary to fully identify all patients properly includable in the SSI fraction. The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' SSI percentage based on CMS admission in *Baystate Medical Center v. Leavitt,* 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction. The hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra (Appellants' reply brief included as Exhibit P-2).[6]

MAC's Contentions

Issue 1 – DSH – SSI Percentage (Provider Specific)[7]

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 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,"…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.*[8]

The MAC also notes that the Provider repeats the same Issue Statement from Issue 1 in Issue 2:

> In Issue 1 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

[6] Provider's Final Position Paper at 7-8 (Oct. 18, 2023).
[7] The MAC also challenged jurisdiction over Issues 2, 4, and 5, however the Provider has since withdrawn or transferred those issues.
[8] Jurisdictional Challenge at 2 (Mar. 28, 2019). (Emphasis added).

> 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…yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment.

This statement is repeated by the Provider in Issue 2.[9]

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 hospital election. It is not a final intermediary determination. A hospital must make a formal request to CMS in order to receive a realigned SSI percentage. Once the hospital elects to use its own fiscal year end, it is bound by that decision, regardless of reimbursement impact.
>
> . . .
>
> The Provider's appeal is premature. 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 PRRB dismiss this issue consistent with recent jurisdictional decisions.[10]

Provider's Jurisdictional Response

The Provider filed a jurisdictional response on April 24, 2019.

In response to whether the issues are duplicative, the Provider contends that the issues are distinct, stating:

> Board Rule 8.1 states, "Some issues may have multiple components. To comply with the regularity requirement to specifically identify the items in dispute, each contested component must be appealed as a separate issue and described as narrowly as possible…" Appeal issues #1 and 2 represent different components of the SSI issue, which was specifically adjusted during the audit. Since these specific appeal issues represent

[9] *Id.* at 3.
[10] *Id.* at 3-4.

different aspects/components of the SSI issue, Provider contends the Board should find jurisdiction over both the SSI Systemic and SSI Provider Specific/Realignment issues.[11]

The Provider did not make any arguments related to whether the appeal is premature.

Analysis and Recommendation

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

A. DSH – SSI Percentage (Provider Specific)

The 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 "whether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital 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 that was included in the appeal request 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."[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 the DSH Payment/SSI

[11] Provider's Jurisdictional Response at 1 (Apr. 24, 2019).
[12] Issue Statement at 1.
[13] *Id.*
[14] *Id.*

Percentage (Provider Specific) issue in Case No. 19-0942 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[15], the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

In making this finding, the Board 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 the Provider has failed to explain how this argument is ***specific to this provider***, as the Provider's jurisdictional response asserts. 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 Final Position Paper to see if it further clarified Issue 1 and finds that the Provider's Final Position Paper failed to comply with 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" 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 (Nov. 1, 2021)**
>
> If documents necessary to support your position are still unavailable, then provide the following information in the position papers:
>
> 1. Identify the missing documents;
> 2. Explain why the documents remain unavailable;
> 3. State the efforts made to obtain the documents; and
> 4. Explain when the documents will be available.
>
> Once the documents become available, promptly forward them to the Board and the opposing party. Common examples of unavailable documentation include pending discovery requests,

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

> pending requests filed under the federal Freedom of Information Act (also known as FOIA requests), or similar requests for information pending with a state Medicaid agency.

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

> https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH.[17]

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."[18]

Indeed, the D.C. Circuit affirmed in *Advocate Christ Med. Ctr. v. Becerra*, No. 22-5214, 2023WL5654312 (D.C. Cir., Sept. 1, 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 Providers do not explain what information it needs or is waiting on or what claims it believes that it should have access to.

Accordingly, *based on the record before it*, the Board finds that the SSI Provider Specific issue in Case No. 19-0942 and the group issue from Group Case 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.

[17] Last accessed November 8, 2023.
[18] 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.

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

****

In summary, the Board hereby dismisses the SSI Provider Specific issue as there is no final determination from which the Provider can appeal the SSI realignment portion of the issue, and the Provider failed to meet the Board requirements for position papers.

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

Board Members Participating:

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For the Board:

11/21/2023

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Byron Lamprecht, WPS Government Health Administrators (J-5)

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RE: ***Board Decision***
Mountain View Regional Medical Center (Provider Number 32-0085)
FYE: 03/31/2016
Case Number: 19-0970

Dear Mr. Summar:

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the documentation in Case No. 19-0970 pursuant to a jurisdictional challenge filed by the Medicare Administrative Contractor ("MAC"). The Board's decision is set forth below.

Background

A. Procedural History for Case No. 19-0970

On July 16, 2018, the Provider, Mountain View Regional Medical Center, was issued a Notice of Program Reimbursement ("NPR") for fiscal year end March 31, 2016.

On January 3, 2019, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained five (5) issues:

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

As the Provider is commonly owned by Community Health Systems, Inc. ("CHS"), and, thereby, subject to the mandatory Common Issue Related Party ("CIRP") regulation at 42 C.F.R. § 405.1837(b)(1), the Provider transferred Issues 2 and 5 to CHS groups on July 22, 2019. The

[1] On July 22, 2019, this issue was transferred to PRRB Case No. 19-1409GC.
[2] On September 18, 2023, the Provider withdrew this issue.
[3] On October 17, 2023, the Provider withdrew this issue.
[4] On July 22, 2019, this issue was transferred to PRRB Case No. 19-1410GC.

Provider also withdrew Issues 3 and 4. The DSH – SSI Percentage (Provider Specific), issue is the last issue pending in the appeal.

On April 29, 2019, the Medicare Contractor filed a jurisdictional challenge with the Board over Issues 1, 2, 4, and 5. This decision only addresses the challenge to the SSI Provider Specific issue, as that is the only issue that remains in the appeal. The Provider did not file a response to the challenge.

On October 18, 2023, the Provider filed its final position paper.

On November 16, 2023, the Medicare Contractor filed its final position paper.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 19-1409GC

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. *See* 42 U.S.C. 1395(d)(5)(F)(i).[5]

On October 18, 2023, the Board received the Provider's final position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

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

[5] Provider's Appeal Request at Tab 3 (Jan. 3, 2019).

> of the SSI percentage. *See* 65 Fed. Reg. 50,548 (2000). Although some MEDPAR data is now routinely made available to the provider community, what is provided lacks all data records necessary to fully identify all patients properly includable in the SSI fraction. The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt,* 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction. The hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra (Appellants' reply brief included as Exhibit P-2).[6]

MAC's Contentions

Issue 1 – DSH – SSI Percentage (Provider Specific)[7]

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 appeal is duplicative:

> 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 Provider Specific issue and the DSH – SSI Percentage issue.*[8]

The MAC also notes that the Provider repeats the same Issue Statement from Issue 1 in Issue 2:

> In Issue 1 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

[6] Provider's Final Position Paper at 7-8 (Oct. 18, 2023).
[7] The MAC also challenged jurisdiction over Issues 2, 4, and 5, however the Provider has since withdrawn or transferred those issues.
[8] Jurisdictional Challenge at 5-6 (April 29, 2019). (Emphasis added).

> 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.

This statement is repeated by the Provider in Issue 2.[9]

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

Provider's Jurisdictional Response

The Provider did not file a response to the Jurisdictional Challenge, and the time to do so has passed.

Analysis and Recommendation

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.

[9] *Id.* at 6.
[10] *Id.* at 6-7.

A. DSH – 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 used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation."[11] Per the appeal request, the Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[12] The Provider argues in its issue statement that was included in the appeal request that "its' SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[13]

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 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 the DSH Payment/SSI Percentage (Provider Specific) issue in Case No. 19-0970 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[14], the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

In making this finding, the Board 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, the Provider has failed to explain how this argument is ***specific to this provider.*** Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[15] The Provider's reliance

[11] Issue Statement at 1.
[12] *Id.*
[13] *Id.*
[14] PRRB Rules v. 2.0 (Aug. 2018).
[15] The types of systemic errors documented in the *Baystate* did not uniformly impact the SSI calculation for all providers but that does not make the errors any less systemic. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). *See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).

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 and finds that the Provider's Final Position Paper failed to comply with 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" 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 (Nov. 1, 2021)**
>
> If documents necessary to support your position are still unavailable, then provide the following information in the position papers:
>
> 1. Identify the missing documents;
> 2. Explain why the documents remain unavailable;
> 3. State the efforts made to obtain the documents; and
> 4. Explain when the documents will be available.
>
> Once the documents become available, promptly forward them to the Board and the opposing party. Common examples of unavailable documentation include pending discovery requests, pending requests filed under the federal Freedom of Information Act (also known as FOIA requests), or similar requests for information pending with a state Medicaid agency.

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

than a Federal fiscal year. The data set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year." Further highlighting the perfunctory nature of the briefing is the fact that providers *can* obtain certain data used to calculate their DSH SSI ratios directly from the Centers for Medicare and Medicaid Services ("CMS") and in some cases on a self-service basis as explained on the following webpage:

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

This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows: "DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[17]

Indeed, the D.C. Circuit affirmed in *Advocate Christ Med. Ctr. v. Becerra*, No. 22-5214, 2023WL5654312 (D.C. Cir., Sept. 1, 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 which claims that it believes it should have access to.

Accordingly, *based on the record before it*, the Board finds that the SSI Provider Specific issue in Case No. 19-0970 and the group issue from Group Case 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 SSI Percentage (Provider Specific) issue—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—must be dismissed as premature. Under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request…" Without this written request, the Medicare Contractor cannot issue a final determination with which the Provider can be dissatisfied for appeal purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding the Provider's DSH SSI Percentage realignment as such there is no "determination" to appeal and the appeal of this issue is otherwise premature.

****

In summary, the Board hereby dismisses the SSI Provider Specific issue as there is no final determination from which the Provider can appeal the SSI realignment portion of the issue, the issue is duplicative of the issue in Case No. 19-1409GC, and the Provider failed to meet the

[16] Last accessed November 13, 2023.
[17] Emphasis added.

Board requirements for position papers. Case No. 19-0970 is hereby closed and removed from the Board's docket.

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

Board Members Participating:

Clayton J. Nix, Esq.
Robert A. Evarts, Esq.
Kevin D. Smith, CPA
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For the Board:

11/21/2023

X Kevin D. Smith, CPA

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

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

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RE: ***Board Dismissal of SSI Percentage (Provider Specific), Medicaid Eligible Days & Uncompensated Care Distribution Pool Issues***
Moberly Regional Medical Center (Provider Number 26-0074)
FYE: 10/31/2016
Case Number: 20-0254

Dear Mr. Ravindran and Mr. Lamprecht,

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

Background:

A. *Procedural History for Case No. 20-0254*

On April 18, 2019, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end October 31, 2016.

On October 16, 2019, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained five (5) issues:

1. DSH Payment/SSI Percentage (Provider Specific)
2. DSH/SSI Percentage (Systemic Errors)[1]
3. DSH Payment – Medicaid Eligible Days
4. 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 Provider transferred Issues 2 and 5 to Community Health groups on May 26, 2020. As a result, the remaining issues in this appeal are Issues 1, 3 and 4.

[1] On May 26, 2020, this issue was transferred to PRRB Case No. 19-1409GC.
[2] On May 26, 2020, this issue was transferred to PRRB Case No. 19-1410GC.

On June 8, 2020, the Provider submitted its preliminary position paper.

On July 31, 2020, the Medicare Contractor filed a jurisdictional challenge, requesting the dismissal of Issues 1 and 4.

On September 18, 2020, the Medicare Contractor filed its preliminary position paper.

On July 24, 2023, the Medicare Contractor filed a Motion to Dismiss Issue 3. In it, the MAC cited prior requests to the Provider for a DSH package on June 18, 2020, and January 6, 2023. The Provider has failed to respond to any of the requests.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 19-1409GC

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.[3]

As the Provider is commonly owned by Community Health, the Provider transferred its Issue 2 – DSH/SSI Percentage to the CIRP group under 19-1409GC, CHS CY 2016 DSH SSI Percentage CIRP Group, on May 26, 2020. The Group Issue Statement in Case No. 19-1409GC reads, in part:

> **Statement of the Issue:**
>
> Whether the Secretary properly calculated the Provider's [DSH]/[SSI] percentage, and whether CMS should be required to recalculate the SSI percentages using a denominator based solely upon covered and paid for Medicare Part A days, or alternatively, expand the numerator of the SSI percentage to include

[3] Issue Statement at 1 (Oct. 16, 2019).

> 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.[4]

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $7,000.

On June 8, 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 (October 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

[4] Group Issue Statement, Case No. 19-1409GC.

> 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).[5]

C. Filings Concerning the Jurisdictional Challenge

1. 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 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 MAC contends that the Board does not have jurisdiction over the realignment portion of Issue 1 and respectfully requests the Board to dismiss this issue consistent with recent jurisdictional decisions.[6]

In addition, the MAC argues the DSH – SSI Percentage (Provider Specific) issue and the DSH – SSI Percentage (Systemic Errors) issue are duplicates.[7]

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[5] Provider's Preliminary Position Paper at 8-9 (June 8, 2020).
[6] Jurisdictional Challenge at 6-7 (July 31, 2020).
[7] *Id*. at 6.

Issue 3 – DSH Payment – Medicaid Eligible Days

The MAC requests that the Board find the Provider abandoned the DSH – Medicaid Eligible Days issue, and requests that the Board make the following findings:

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.[8]

Accordingly, the Medicare Contractor requests that the Board dismiss Issue 3.

Issue 4 – UCC Distribution Pool

The MAC argues that "[t]he 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]

2. <u>Provider's Jurisdictional Response</u>

The Board Rules require that Provider Responses to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[10] The Provider has not filed a response to the Jurisdictional Challenge or the 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." 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."

[8] Motion to Dismiss at 4-5 (July 24, 2023).
[9] Jurisdictional Challenge at 10.
[10] Board Rule 44.4.3, v. 2.0 (Aug. 2018).

Board Analysis and Decision:

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

A. DSH Payment/SSI Percentage (Provider Specific)

The Board finds that it does not have jurisdiction over the DSH Payment/SSI Percentage (Provider Specific) issue. The jurisdictional analysis for Issue No. 1 has 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. 19-1409GC.

The DSH Payment/SSI Percentage (Provider Specific) issue in the present appeal concerns "[w]hether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation."[11] The Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[12] The Provider argues that "its' SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[13]

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 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 the DSH Payment/SSI Percentage (Provider Specific) issue in this appeal 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

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

PRRB Rule 4.6[14], the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

In making this finding, the Board further notes that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations, and to that end, the Provider is pursuing that issue as part of the group under Case 19-1409GC, 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.[15] The Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 19-1409GC.

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. 19-1409GC, 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 documents, and explain when the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.[16]

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

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

https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH.[17]

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."[18]

Indeed, the D.C. Circuit affirmed in *Advocate Christ Med. Ctr. v. Becerra*, No. 22-5214, 2023WL5654312 (D.C. Cir., Sept. 1, 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 which claims that it believes it should have access to.

Accordingly, *based on the record before it*, the Board finds that first aspect of Issue #1 in the instant appeal and the group issue from Group Case 19-1409GC are the same issue.[19] 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.

[17] Last accessed February 24, 2023.
[18] Emphasis added.
[19] 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 Community Health CIRP group per 42 C.F.R. § 405.1837(b)(1).

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.

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

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.[20]

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

[20] Individual Appeal Request, Issue 3.

The Provider's preliminary position paper indicated that it would be sending the eligibility listing under separate cover.[21]

Board Rule 7.3.2 states:

> **No Access to Data**
>
> 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.[22]

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*.[23]

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[21] Provider's Preliminary Position Paper at 8.
[22] *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.
[23] (Emphasis added).

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.

Similarly, with regard to position papers,[24] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[25] 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.[26]

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:

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

> • 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.

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"[27] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. Based on the record before the Board, the Board finds that the Provider has failed to provide a listing or other supporting documentation for the Medicaid Eligible Days issue as required by the controlling regulations and Board Rules. Nor has the Provider provided any explanation as to why the documentation was absent or what is being done to obtain it consistent with Board Rule 25.2.2. Indeed, without any days identified in the position paper filing, the Board must assume that there are no days and that the actual amount in dispute is $0 for this issue. Indeed, based on these facts plus the Provider's failure to respond to either the Medicare Contractor's requests for the listing or the Medicare Contractor's Motion to Dismiss on this issue, the Board assumes that the Provider has abandoned this issue.

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 Board takes administrative notice that it has made similar dismissals in other cases involving CHS providers.[28] Notwithstanding, CHS has, again, 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).

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[27] (Emphasis added).

[28] Examples of CHS individual provider cases which the Board dismissed for failure of the Provider to provide a listing of Medicaid eligible days include, but are not limited to: Case No. 22-0676 (dismissed by Board letter dated December 7, 2022 based on a MAC July 13, 2022 request for dismissal of the Medicaid eligible days issue for failure to file Medicaid eligible days listing with the preliminary position paper);

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).[29]
>
> (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*"),[30] the U.S. Court of Appeals for the District of Columbia Circuit ("D.C. Circuit") upheld the D.C. District Court's decision[31] 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."[32] 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.[33]

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[29] 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.
[30] 830 F.3d 515 (D.C. Cir. 2016).
[31] 89 F. Supp. 3d 121 (D.D.C. 2015).
[32] 830 F.3d 515, 517.
[33] *Id.* at 519.

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.[34]

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*").[35] 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."[36] 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.[37]

c. Scranton Quincy Hosp. Co. v. Azar

Recently, in *Scranton Quincy Hosp. Co. v. Azar* ("*Scranton*"),[38] 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.[39] 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.[40] 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.[41] Nevertheless, the Secretary used each

[34] *Id.* at 521-22.
[35] 925 F.3d 503 (D.C. Cir. 2019) ("*DCH v. Azar*").
[36] *Id.* at 506.
[37] *Id.* at 507.
[38] 514 F. Supp. 249 (D.D.C. 2021).
[39] *Id.* at 255-56.
[40] *Id.* (quoting 79 Fed. Reg. 49854, 50018 (Aug. 22, 2014)).
[41] *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-

hospital's shorter cost reporting period in calculating the Factor 3 values for their FY 2015 DSH payments.[42]

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.[43]

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."[44] 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.[45] 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.[46]

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.[47] The D.C. District Court ultimately upheld the Board's decision that it lacked jurisdiction to consider the providers' appeals.

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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.

[42] *Id.*

[43] *Id.* at 262-64.

[44] *Id.* at 265.

[45] *Id.* (discussing *Leedom v. Kyne*, 358 U.S. 184, 188 (1958)).

[46] *Id.* at 264 (quoting *DCH v. Azar*, 925 F.3d at 509-510).

[47] *Id.* at 264-6511 (quoting *DCH v. Azar*, 925 F.3d at 509).

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*").[48] 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.[49] 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."[50] The D.C. Circuit further dismissed the applicability of the Supreme Court's 2019 decision in *Azar v. Allina Health Servs*.[51] 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***."[52]

The Board finds that the same findings are applicable to the Provider's challenge to their FFY 2016 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 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 be 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 *DCH v. Azar*, finding that the methodology was just as "inextricably intertwined" with the actual estimates as the underlying data, and barred from review.

****

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. 19-1409GC 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

[48] Civ. No. 20-139, 2021 WL 3856621 (D.D.C. August 30, 2021).
[49] *Id*. at *4.
[50] *Id.* at *9.
[51] 139 S. Ct. 1804 (2019).
[52] *Ascension* at *8 (bold italics emphasis added).

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. 20-0254 and removes it from the Board's docket.

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

Board Members Participating:

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

For the Board:

11/21/2023

X Kevin D. Smith, CPA

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

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

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RE: ***Board Dismissal of SSI Percentage (Provider Specific) & Medicaid Eligible Days***
Eastern New Mexico Medical Center (Provider Number 32-0006)
FYE: 05/31/2017
Case Number: 20-0496

Dear Mr. Ravindran and Mr. Lamprecht,

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

Background:

A. *Procedural History for Case No. 20-0496*

On June 20, 2019, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end May 31, 2017.

On November 27, 2019, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained five (5) issues:

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

As the Provider is 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 Provider transferred Issues 2 and 5 to Community Health groups on June 15, 2020. After the withdrawal of Issue 4, the remaining issues in this appeal are Issues 1 and 3.

[1] On June 15, 2020, this issue was transferred to PRRB Case No. 20-0997GC.
[2] This issue was withdrawn on June 10, 2020.
[3] On June 15, 2020, this issue was transferred to PRRB Case No. 20-0999GC.

On July 20, 2020, the Provider submitted its preliminary position paper.

On September 10, 2020, the Medicare Contractor filed a jurisdictional challenge, requesting the dismissal of Issue 1.

On November 19, 2020, the Medicare Contractor filed its preliminary position paper.

On August 3, 2023, the Medicare Contractor filed a Motion to Dismiss Issue 3. In it, the MAC cited correspondence to the Provider regarding resolving the Eligible Day issue on May 1, 2020, May 8, 2020, and January 4, 2023.

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

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

> The Provider contends that its' 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.[4]

As the Provider is commonly owned by Community Health, the Provider transferred its Issue 2 – DSH/SSI Percentage to the CIRP group under 20-0997GC, CHS CY 2017 DSH SSI Percentage CIRP Group, on June 15, 2020. The Group Issue Statement in Case No. 20-0997GC reads, in part:

> **Statement of the Issue:**
>
> Whether the Secretary properly calculated the Provider's [DSH]/[SSI] percentage, and whether CMS should be required to recalculate the SSI percentages using a denominator based solely upon covered and paid for Medicare Part A days, or alternatively, expand the numerator of the SSI percentage to include

[4] Issue Statement at 1 (Nov. 27, 2019).

> 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.[5]

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $30,000.

On July 20, 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.
>
> Similar to *Loma Linda Community Hospital v. Dept of Health and Human Services*, No. CV-94-0055 (C.D. Cal. June 2, 1995), the

[5] Group Issue Statement, Case No. 20-0997GC.

> 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 believe 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).[6]

C. Filings Concerning the Jurisdictional Challenge

1. 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 hospital election. It is not a final contractor determination. A hospital must make a formal request to CMS in order to receive a realigned SSI percentage. Once the hospital elects to use its own fiscal year end, it is bound by that decision, regardless of reimbursement impact.
>
> . . .
>
> The Provider's appeal is premature. To date the Provider has not requested to have its SSI percentage realigned in accordance with 42 C.F.R. § 412.106(b)(3). Thus, the Provider has not exhausted all available remedies for this issue. The MAC requests that the Board dismiss this issue consistent with recent jurisdictional decisions.[7]

[6] Provider's Preliminary Position Paper at 8-9 (July 20, 2020).
[7] Jurisdictional Challenge at 6-7 (Sept. 10, 2020).

In addition, the MAC argues the DSH – SSI Percentage (Provider Specific) issue and the DSH – SSI Percentage (Systemic Errors) issue are duplicates.[8]

Issue 3 – DSH Payment – Medicaid Eligible Days

The MAC requests that the Board find the Provider abandoned the DSH – Medicaid Eligible Days issue, requesting the Board issue an order stating the following:

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.[9]

Accordingly, the Medicare Contractor requests that the Board dismiss Issue 3.

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.[10] 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." 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

[8] *Id*. at 4-6.
[9] Motion to Dismiss at 4-5 (Aug. 3, 2023).
[10] Board Rule 44.4.3, v. 2.0 (Aug. 2018).

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

1. First Aspect of Issue 1

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

The DSH Payment/SSI Percentage (Provider Specific) issue in the present appeal concerns "[w]hether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation."[11] The Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[12] The Provider argues that "its' SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[13]

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

In making this finding, the Board further notes that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI

[11] Issue Statement at 1.
[12] *Id.*
[13] *Id.*
[14] PRRB Rules v. 2.0 (Aug. 2018).

calculations, and to that end, the Provider is pursuing that issue as part of the group under Case 20-0997GC, 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.[15] The Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 20-0997GC.

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 20-0997GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with the Board Rule 25 (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 documents, and explain when the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.[16]

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

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

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.[17]

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."[18]

Indeed, the D.C. Circuit affirmed in *Advocate Christ Med. Ctr. v. Becerra*, No. 22-5214, 2023WL5654312 (D.C. Cir., Sept. 1, 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 which claims it believes that it should have access to.

Accordingly, *based on the record before it*, the Board finds that Issue #1 in the instant appeal and the group issue from Group Case 20-0997GC are the same issue.[19] 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.

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

[17] Last accessed November 21, 2023.
[18] Emphasis added.
[19] 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 Community Health CIRP group per 42 C.F.R. § 405.1837(b)(1).

written request, the Medicare Contractor cannot issue a final determination with which the Provider can be dissatisfied for appeal purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding DSH SSI Percentage realignment. Therefore, the Board finds that it lacks jurisdiction in this aspect of the appeal.

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.[20]

The Provider failed to include a list of the 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.[21]

Board Rule 7.3.2 states:

> **No Access to Data**
>
> 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

[20] Individual Appeal Request, Issue 3.
[21] Provider's Preliminary Position Paper at 8.

> 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.[22]

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*.[23]

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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[22] *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.

[23] (Emphasis added).

With regard to position papers,[24] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[25] 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.[26]

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

The Board concurs with the Medicare Contractor that the Provider is required to identify and provide documentation to prove which 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"[27] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. Based on the record before the Board, the Board finds that the Provider has failed to provide a listing or other supporting documentation for the Medicaid Eligible Days issue as required by the controlling regulations and Board Rules, even after multiple requests by the Medicare Contractor. Nor has the Provider provided any explanation as to why the documentation was absent or what is being done to obtain it consistent with Board Rule 25.2.2. Indeed, without any days identified in the position paper filing, the Board must assume that there are no days and that the actual amount in dispute is $0 for this issue. Indeed, based on these facts, plus the Provider's failure to respond to either the Medicare Contractor's requests for the listing or the Medicare Contractor's Motion to Dismiss on this issue, the Board assumes that the Provider has abandoned this issue.

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 Board takes administrative notice that it has made similar dismissals in other cases involving CHS providers.[28] Notwithstanding, CHS has, again, 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.

****

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. 20-0997GC 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. As no issues remain pending, the Board hereby closes Case No. 20-0496 and removes it from the Board's docket.

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[27] (Emphasis added).

[28] Examples of CHS individual provider cases which the Board dismissed for failure of the Provider to provide a listing of Medicaid eligible days include, but are not limited to: Case No. 22-0676 (dismissed by Board letter dated December 7, 2022 based on a MAC July 13, 2022 request for dismissal of the Medicaid eligible days issue for failure to file Medicaid eligible days listing with the preliminary position paper);

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

Board Members Participating:

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

For the Board:

11/21/2023

X Kevin D. Smith, CPA

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

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

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. Jonathan Mason
Southwest Consulting Associates
14555 Dallas Parkway, Suite 300
Dallas, TX 75254

RE: ***Duplicate Filings of Individual Appeals***
Vanderbilt University Medical Center (Provider Number 44-0039)
FYE: 04/29/2016
Case Numbers: 24-0182 and 24-0183

Dear Mr. Mason:

The following appeals were filed with the Provider Reimbursement Review Board ("Board") via the Office of Hearings Case and Document Management System ("OH CDMS"). Upon review of the facts outlined below, the Board has determined that the above-captioned appeals are duplicate filings. The Board's review and determination is set forth below.

BACKGROUND:

Case Number 24-0182:

On November 16, 2023, Southwest Consulting Associates ("Southwest") filed an appeal for the above referenced provider for its fiscal year end ("FYE") 04/29/2016 and based on the Notice of Program Reimbursement ("NPR") dated May 30, 2023. The appeal request identified a sole issue in dispute: *DSH Medicare Part C Days*.

The Letter of Representation filed with the appeal designated Jonathan Mason of Southwest Consulting Associates as the provider representative of record. The letter was dated November 6, 2023 and was signed by Michael J. Regier, J.D., General Counsel and Secretary, Vanderbilt University Medical Center.

On November 17, 2023, the Parties were issued the Board's Acknowledgement and Critical Due Dates notice setting forth position paper due dates.

Case Number 24-0183:

On the same date as above, November 16, 2023, Southwest Consulting Associates filed a second appeal request for the same Provider, same FYE and based on the same NPR dated May 30, 2023. This second appeal request also identified a sole issue in dispute: *DSH Post 1498R Medicare Part A/SSI%.*

The Letter of Representation in this second filing also designated Jonathan Mason of Southwest Consulting Associates as the provider representative of record, was also dated November 6,

2023, and also signed by Michael J. Regier, J.D. General Counsel and Secretary, Vanderbilt University Medical Center.

Because CN: 24-0183 appeared to be duplicative of case number 24-0182, the Board elected not to issue its Acknowledgement and Critical Due Dates notice, pending further review.

BOARD REVIEW AND DETERMINATION:

As the Parties are aware, it is the Board's policy to establish ***only*** one (1) individual appeal per Provider per fiscal year end.[1] Since both case numbers 24-0182 and 24-0183 are disputing issues involving FYE 04/29/2016 and are based on the same NPR dated May 30, 2023, the Board has determined that case numbers 24-0182 and 24-0183 are duplicate filings. Therefore, the Board hereby incorporates case number 24-0183 into case number 24-0182. As a result, the Board hereby closes case number 24-0183.

As a result of our review of the record, the Board admonishes Vanderbilt University Medical Center for filing two (2) separate appeal requests and Letters of Representation, which were dated on the same dates, for the same Provider, same FYE and based on the same final determination. The Board reminds Vanderbilt University Medical Center that it has a responsibility to oversee its designated agents that pursue the claims of Vanderbilt University Medical Center and its providers for additional Medicare reimbursement before the Board. Vanderbilt University Medical Center has a responsibility to ensure that it complies with the Board's Rules and filing requirements and does not pursue improper or duplicative claims/appeals.

Board Members:

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

FOR THE BOARD:

11/22/2023

X Kevin D. Smith, CPA

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

cc: Wilson C. Leong, Federal Specialized Services
Cecile Huggins, Palmetto GBA (J-J)
Michael J. Regier, J.D., Vanderbilt University Medical Center

[1] *See* Board Rules 4.6, 5.4, 7.1.1. *See also* 42 C.F.R. § 405.1835(a).

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
7500 Security Boulevard
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Via Electronic Delivery

Mr. Jonathan Mason
Southwest Consulting Associates
14555 Dallas Parkway, Suite 300
Dallas, TX 75254

RE: ***Duplicate Filings of Individual Appeals***
Vanderbilt University Medical Center (Provider Number 44-0039)
FYE: 06/30/2017
Case Numbers: 24-0184 and 24-0185

Dear Mr. Mason:

The following appeals were filed with the Provider Reimbursement Review Board ("Board") via the Office of Hearings Case and Document Management System ("OH CDMS"). Upon review of the facts outlined below, the Board has determined that the above-captioned appeals are duplicate filings. The Board's review and determination is set forth below.

BACKGROUND:

Case Number 24-0184:

On November 16, 2023, Southwest Consulting Associates ("Southwest") filed an appeal for the above referenced provider for its Fiscal Year End ("FYE") 6/30/2017 and based on the Notice of Program Reimbursement ("NPR") dated May 31, 2023. The appeal request identified a sole issue in dispute: *DSH Medicare Part C Days*.

The Letter of Representation designated Jonathan Mason of Southwest Consulting Associates as the provider representative of record. The letter was dated November 6, 2023, and was signed by Michael J. Regier, J.D., General Counsel and Secretary, Vanderbilt University Medical Center.

On November 17, 2023, the Parties were issued the Board's Acknowledgement and Critical Due Dates notice setting forth position paper due dates. In its acknowledgement notice, the Board requested that the Provider submit an updated Representation Letter since the one filed with the initial appeal request identified an incorrect FYE in dispute.

Case Number 24-0185:

On the same date as above, November 16, 2023, Southwest Consulting Associates filed a second appeal request for the same Provider, same FYE and based on the same NPR dated May 31, 2023. This appeal request also identified a sole issue in dispute: *DSH Post 1498R Medicare Part A/SSI%.*

The Letter of Representation in this appeal also designated Jonathan Mason of Southwest Consulting Associates as the provider representative of record, dated November 13, 2023, and was also signed by Michael J. Regier, J.D. General Counsel and Secretary, Vanderbilt University Medical Center.

Since CN: 24-0185 appeared to be duplicative of case number 24-0184, the Board elected not to issue an acknowledgement notice, pending further review.

BOARD REVIEW AND DETERMINATION:

As the Parties are aware, it is the Board's policy to establish ***only*** one (1) individual appeal per Provider per fiscal year end.[1] Since both case numbers 24-0184 and 24-0185 are disputing issues involving FYE 06/30/2017, and are based on the same NPR dated May 31, 2023, the Board has determined that case numbers 24-0184 and 24-0185 are duplicate filings. Therefore, the Board hereby incorporates case number 24-0185 into case number 24-0184. As a result, the Board hereby closes case number 24-0185.

As a result of our review of the record, the Board admonishes Vanderbilt University Medical Center for filing two (2) separate Letters of Representation and appeal requests, which were dated on the same dates, for the same Provider, same FYE and based on the same final determination. The Board reminds Vanderbilt University Medical Center that it has a responsibility to oversee its designated agents that pursue the claims of Vanderbilt University Medical Center and its providers for additional Medicare reimbursement before the Board. Vanderbilt University Medical Center has a responsibility to ensure that it complies with the Board's Rules and filing requirements and does not pursue improper or duplicative claims/appeals.

Board Members:

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

FOR THE BOARD:

11/22/2023

X Kevin D. Smith, CPA

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

cc: Wilson C. Leong, Federal Specialized Services
Cecile Huggins, Palmetto GBA (J-J)
Michael J. Regier, J.D., Vanderbilt University Medical Center

[1] *See* Board Rules 4.6, 5.4, 7.1.1. *See also* 42 C.F.R. § 405.1835(a).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Board Dismissal of SSI Percentage (Provider Specific) & Medicaid Eligible Days Issues***
Mountain View Regional Medical Center (Provider Number 32-0085)
FYE: 03/31/2017
Case Number: 21-0138

Dear Mr. Ravindran and Mr. Lamprecht,

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

Background:

A. *Procedural History for Case No. 21-0138*

On January 15, 2020, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end March 31, 2017.

On July 7, 2020, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained four (4) issues:

1. DSH Payment/SSI Percentage (Provider Specific)
2. DSH/SSI Percentage (Systemic Errors)[1]
3. DSH Payment – Medicaid Eligible Days
4. 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 Provider transferred Issue 2 to a Community Health group on February 23, 2021. As a result, the remaining issues in this appeal are Issues 1 and 3.

On February 25, 2021, the Provider filed its preliminary position paper.

[1] On February 23, 2021, this issue was transferred to PRRB Case No. 20-0997GC.
[2] On February 17, 2021, this issue was withdrawn.

On June 3, 2021, the Medicare Contractor filed a jurisdictional challenge, requesting the dismissal of Issue 1.

On June 18, 2021, the Medicare Contractor filed its preliminary position paper.

On January 6, 2023, the Medicare Contractor filed a Final Request for the Medicaid Eligible Days Listing in connection with Issue 3 and requested a response within 30 days. On July 24, 2023, the Medicare Contractor filed its Motion to Dismiss Issue 3 as the Provider failed to file any response.

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

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

> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> . . .
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[3]

As the Provider is commonly owned by Community Health, the Provider transferred its Issue 2 – DSH – SSI Percentage to the CIRP group under 20-0997GC, CHS CY 2017 DSH SSI Percentage CIRP Group, on February 23, 2021. The Group Issue Statement in Case No. 20-0997GC reads, in part:

> **Statement of the Issue:**
>
> Whether the Secretary properly calculated the Provider's [DSH]/[SSI] percentage, and whether CMS should be required to recalculate the SSI percentages using a denominator based solely upon covered and paid for Medicare Part A days, or alternatively, expand the numerator of the SSI percentage to include paid/covered/entitled as well as unpaid/non-covered/eligible SSI days?

[3] Issue Statement at 1 (July 7, 2020).

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 [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.[4]

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $66,000.

On February 25, 2021, 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 (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 State records. However, at this time, the Provider has been unable to

[4] Group Issue Statement, Case No. 20-0997GC.

> 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).[5]

C. Filings Concerning the Jurisdictional Challenge

1. 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 appeal is premature:

> The decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election. It is not a final contractor determination. A hospital must make a formal request to CMS in order to receive a realigned SSI percentage. Once the hospital elects to use its own fiscal year end, it is bound by that decision, regardless of reimbursement impact.
>
> . . .
>
> The Provider's appeal is premature. To date the Provider has not requested to have its SSI percentage realigned in accordance with 42 C.F.R. § 412.106(b)(3). Thus, the Provider has not exhausted all available remedies for this issue. The MAC requests that the Board dismiss this issue consistent with recent jurisdictional decisions.[6]

In addition, the MAC argues the DSH – SSI Percentage (Provider Specific) issue and the DSH – SSI Percentage (Systemic Errors) issue are considered the same issue by the Board.[7]

---

[5] Provider's Preliminary Position Paper at 8-9 (Feb 25, 2021).
[6] Jurisdictional Challenge at 6-7 (June 3, 2021).
[7] *Id*. at 4-6.

Issue 3 – DSH Payment – Medicaid Eligible Days

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

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.[8]

Accordingly, the Medicare Contractor requests that the Board dismiss Issue 3.

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.[9] The Provider has not filed a response to the Jurisdictional Challenge or the 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." 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.

[8] Motion to Dismiss at 4-5 (July 24, 2023).
[9] Board Rule 44.4.3, v. 2.0 (Aug. 2018).

A. DSH Payment/SSI Percentage (Provider Specific)

The Board finds that it does not have jurisdiction over the DSH Payment/SSI Percentage (Provider Specific) issue. The jurisdictional analysis for Issue No. 1 has 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. 20-0997GC.

The DSH – SSI Percentage (Provider Specific) issue in the present appeal concerns "[w]hether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation."[10] 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 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."[12]

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

[10] Issue Statement at 1.
[11] *Id.*
[12] *Id.*
[13] PRRB Rules v. 2.0 (Aug. 2018).

as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[14] The Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue, rather than being subsumed into the "systemic" issue appealed in Case No. 20-0997GC.

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 20-0997GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with the Board Rule 25 (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 documents, and explain when the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.

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,

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

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.[15]

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."[16]

Accordingly, *based on the record before it*, the Board finds that the first aspect of issue #1 in the instant appeal and the group issue from Group Case 20-0997GC are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

2. Second Aspect of Issue 1

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

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

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:

[15] Last accessed November 21, 2023.
[16] Emphasis added.

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.[17]

The Provider failed to include a list of the 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.[18]

Board Rule 7.3.2 states:

No Access to Data

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 nor has the Provider submitted such list under separate cover. The

[17] Individual Appeal Request, Issue 3.
[18] Provider's Preliminary Position Paper at 8.

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.[19]

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*.[20]

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.

Similarly, with regard to position papers,[21] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[22] 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.

---

[19] *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.

[20] (Emphasis added).

[21] The minimum requirements for Final Position Paper narratives and exhibits are the same as those for Preliminary Position Papers. *See* Board Rule 27.2.

[22] (Emphasis added).

> Once the documents become available, promptly forward them to the opposing party.[23]

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,
> • if the Board is unable to contact the provider or representative at the last known address, or
> • upon failure to appear for a scheduled hearing.

The 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"[24] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. Based on the record before the Board, the Board finds that the Provider has failed to provide a listing or other supporting documentation for the Medicaid Eligible Days issue as required by the controlling regulations and Board Rules. Nor has the Provider provided any explanation as to why the documentation was absent or what is being done to obtain it consistent with Board Rule 25.2.2. Indeed, without any days identified

[23] (Emphasis added).
[24] (Emphasis added).

in the position paper filing, the Board assumes that there are no days or amount in dispute for this issue.

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 Board takes administrative notice that it has made similar dismissals in other cases in which QRS was the designated representative[25] as well as cases involving CHS providers.[26] Notwithstanding, QRS and CHS have, again, failed to include the Medicaid eligible days listing with the Provider's preliminary position paper or even file a copy following the MAC's requests and/or the MAC's Motion to Dismiss.

****

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. 20-0997GC 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. As no issues remain pending, the Board hereby closes Case No. 21-0138 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.

[25] Examples of cases in which QRS was the designated representative and which the Board dismissed for failure of the Provider to provide a listing of Medicaid eligible days at issue include, but are not limited to: Case No. 14-2674 (by Board letter dated 5/5/2022); Case No. 16-2521 (by Board letter dated 5/5/2022); Case No. 16-0054 (by Board letter dated 5/5/2022); Case Nos. 13-3022, 13-3211, 14-2506, 14-4313, The Board's attention to the filing deficiency was brought to the Board's attention via a motion to dismiss filed by the Medicare Contractor in its position paper (on December 10, 2020, December 11, 2020, March 12, 2021, March 12, 2021 respectively).

[26] Examples of CHS individual provider cases which the Board dismissed for failure of the Provider to provide a listing of Medicaid eligible days include, but are not limited to: Case No. 22-0676 (dismissed by Board letter dated December 7, 2022 based on a MAC July 13, 2022 request for dismissal of the Medicaid eligible days issue for failure to file Medicaid eligible days listing with the preliminary position paper);

Board Members Participating:

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

For the Board:

11/22/2023

X Kevin D. Smith, CPA

Kevin D. Smith, CPA
Boare Member
Signed by: Kevin D. Smith -S

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Donna Hendrix
Dayspring Hospice
1275 James Drive, Suite A
Enterprise, AL 36330

RE: ***Board Determination on Request for Reconsideration of Dismissal/Reinstatement***
Dayspring Hospice, Prov. No. 01-1603
Pd. Ended 12/31/2021
Case No. 23-1059

Dear Ms. Hendrix:

The Provider Reimbursement Review Board (the "Board") has reviewed the above-captioned appeal in response to October 31, 2023 correspondence from Dayspring Hospice ("Dayspring"/"Provider") in which it requests that the Board reconsider the October 30, 2023 "Dismissal for Untimely Filing." The pertinent facts of the case and the Board's determination are set forth below.

Pertinent Facts:

On **March 1, 2023,** Dayspring filed its individual appeal, based on the September 26, 2022 "Notice of Quality Reporting Program Noncompliance Decision Upheld" for its fiscal year ("FY") 2023 Annual Payment Update ("APU") under Case No. 23-1059.

On **March 3, 2023,** the Board issued a "Case Acknowledgement and Critical Due Dates Notice" ("Critical Due Dates Notice") setting the Provider's preliminary position paper deadline for October 27, 2023 and the Medicare Contractor's preliminary position paper deadline for February 24, 2024. Significantly, the Critical Due Dates Notice stated that "[t]he parties ***must*** *meet* the . . . due dates regardless of any outstanding jurisdictional challenges, motions, or subpoena requests" and that [i]f the provider misses any of its due dates, the Board ***will*** *dismiss* the appeal."[1] Further, the Critical Dues Dates Notice stated the following regarding the content of the Provider's Final 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

[1] (Emphasis added.)

> Provider will use to support its position and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. *See* Board Rule 25.[2]

On **October 30, 2023**, following the expiration of the preliminary position paper deadline, the Board dismissed Case No. 23-1059 because the Provider failed to timely file the preliminary position paper.

On **October 31, 2023**, Dayspring filed a request for reconsideration, asking for reinstate its case. In its request, DaySpring contends that, because it had already filed all supportive documentation when it filed its initial appeal request, it did not understand that additional documentation was required, even after receiving the Board's Critical Due Dates Notice. The Provider also advised that this is its first appeal in over 20 years so it has been a learning experience for their agency.

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.

Dayspring has filed a *motion* requesting that the Board reinstate the case. 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 the reasons for reinstatement (see Rule 44 governing motions). The Board will ***not*** reinstate an issue(s)/case if the provider was at fault. If an issue(s)/case was remanded pursuant to a CMS ruling (*e.g.*, CMS Ruling 1498-R), the provider must address whether the CMS ruling permits reinstatement of such issue(s)/case. If the Board reinstates an issue(s) or case, the provider will have the same rights (no greater and no less) that it had in its initial appeal. . . .
>
> ****

[2] (Emphasis added.)

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*. If the dismissal was for failure to file with the Board a required position paper, Schedule of Providers, or other filing, the motion for reinstatement must, as a prerequisite, include the required filing before the Board will consider the motion.[3]

Board Rule 47.1 states that the Board will not reinstate if the provider was at fault and Board Rule 47.3 further clarifies that, when the dismissal is based on the failure to comply with Board Procedures (such a filing a required position paper), the Board may reinstate for good cause which does ***not*** include administrative oversight. Here, the Board finds that the Provider was at fault since it failed to meet the preliminary position paper deadline due to its own admitted misunderstanding. Further, contrary to Board Rule 44 governing motions, Dayspring's motion for reconsideration is deficient because: (1) it failed to include a statement confirming it had contacted the Medicare Contractor prior to filing the motion to see if the Medicare Contractor would concur or oppose the motion; and (2) while the Provider has attached the missing position paper to its request for reinstatement, this attachment is flawed as it does not include "a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853" as required in the Critical Due Dates Notice and Board Rule 25.3.

In making denying the request, the Board notes that the Critical Due Dates Notice clearly stated that Provider had to file the Preliminary Position Paper and that failure to do so would result in dismissal. Specifically, it stated that "[t]he parties must meet the . . . due dates regardless of any outstanding jurisdictional challenges, motions, or subpoena requests" and that [i]f the provider misses any of its due dates, the Board will dismiss the appeal." Similarly, Board Rule 23.4 states: "The provider's preliminary position paper due date will be set on the same day as the PJSO due date. Accordingly, if neither a PJSO nor the provider's preliminary position paper is filed by the filing due date, *the Board will dismiss the case*."[4] The Board requirements are consistent with 42 C.F.R. § 405.1853(b). The Board acknowledges that the Provider is claiming in its request for reinstatement that its appeal request included all information and supporting documentation. However, this does not change the fact that it was required to make the position paper filing including "a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853."[5] The Provider failed to follow the process set fort in the Critical Due Dates Notice and Board Rules. The representative is charged with being familiar

[3] (Emphasis added.)
[4] (Emphasis added.)
[5] A provider cannot file an appeal request and simply therein that it serves as future yet-to-be-filed position paper. Rather, the Board requires parties to file a fully-developed complete, fully-developed preliminary position paper to ensure that the position paper reflects discussions between the parties to narrow the issues and to organize the merits of its position and supporting exhibits as part of one filing. To this end, the Board's Critical Due Dates Notice requires the position paper include "a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853."

with Board Rules and deadlines and failure of the representative to carry out his responsibilities as a representative is not considered good cause for failing to meet filing deadlines:

> **5.2 Responsibilities**
>
> *The case representative is responsible for being familiar with the following rules and procedures for litigating before the Board*:
>
> - The Board's governing statute at 42 U.S.C. § 1395oo;
> - The Board's governing regulations at 42 C.F.R. Part 405, Subpart R; and
> - These Rules, which include any relevant Orders posted at https://www.cms.gov/Regulations-and-Guidance/ReviewBoards/PRRBReview/PRRB-Instructions (see Rule 1.1).
>
> *Further, the case representative is responsible for*:
>
> - Ensuring his or her contact information is current with the Board, including a current email address and phone number;
> - *Meeting the Board's deadlines*; and
> - *Responding timely to correspondence or requests from the Board* or the opposing party.
>
> *Failure of a case representative to carry out his or her responsibilities is not considered by the Board to be good cause for failing to meet any deadlines*. Withdrawal of a case representative or the recent appointment of a new case representative will also not be considered good cause for delay of any deadlines or proceedings.[6]

In summary, pursuant to its authority under 42 C.F.R. § 405.1868(a)-(b), the Board denies Dayspring's request for reinstatement of Case No. 23-1059. The Board finds that the Provider was a fault and failed to establish good cause under Board Rules 47.1 and 47.3 as it admitted fault for missing the position paper filing deadline and its request for reinstatement is deficient as it failed to: (a) provide a statement confirming whether the Medicare Contractor concurred or opposed the reinstatement request as required by Board Rules 47.1 and 44; and (b) provide a statement in the position paper filing attached to the request for reinstatement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853" as required in the Critical Due Dates Notice. Therefore, the Board declines to exercise its discretion to reinstate Case No. 23-1059 and it thereby remains closed. The Board denial is consistent with numerous cases in which federal

[6] (Bold emphasis in original and italics and underline emphasis added.)

courts have upheld the Board's authority to dismiss cases for failure of the provider to timely file position papers or other Board filings.[7] Accordingly, this case remains closed.

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

For the Board:

11/24/2023

X Clayton J. Nix

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

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services
Dana Johnson, Palmetto GBA c/o National Government Services, Inc. (J-M)

[7] *Kaiser Found. Hosps. v. Sebelius*, 649 F.3d 1153 (9th Cir. 2011) (upholding dismissal for failure to file preliminary position paper); *Baptist Mem'l Hosp.-Golden Triangle v. Sebelius*, 566 F.3d 226 (2009) (upholding dismissal for failure to file preliminary position paper); *High Country Home Health Inc. v. Thompson*, 359 F.3d 1307 (10th Cir. 2004); *Inova Alexandria Hosp. v. Shalala*, 244 F.3d 342, 351 (4th Cir. 2001) (upholding dismissal for failure to file preliminary or final position papers and stating "The Hospital argues that the Board irrationally concluded that administrative oversight is not a valid excuse. We disagree. Because the Hospital's failure to file timely position papers was due to circumstances entirely within its own control, the Board had a rational basis for its decision."); *UHI, Inc. v. Thompson*, 250 F.3d (6th Cir. 2001); *Lutheran Med. Ctr. v. Burwell*, No. 14-VC-731, 2016 WL 3882896 (E.D. N.Y. July 13, 2016); *Rapid City Reg. Hosp. v. Sebelius*, 681 F. Supp. 2d 56 (D.D.C. 2010) (upholding dismissal for failure to file preliminary position paper and citing to "the general proposition that legitimate procedural rules can be relied upon to control the Board's docket by dismissing appeals that are not timely filed" (citations omitted) and upholding Board denial based on the); *S.C. San Antonio Inc. v. Leavitt*, No. SA-07-CA-527-OG, 2008 WL 4816611(W.D. Tex. Sept. 30, 2008); *Lutheran Med. Ctr. v. Thompson*, No. 02-CV- 6144, 2006 WL 2853870 (E.D. N.Y. Oct. 2, 2006); *Novacare, Inc. v. Thompson*, 357 F. Supp. 2d 268, 272-273 (D.D.C. 2005) (upholding denial of reinstatement where the Board explained that "failure to communicate clearly with its counsel was insufficient basis to justify reinstatement"); *Saint Joseph Hosp. v. Shalala*, No. 99-C7775, 2000 WL 1847976 (N.D. Ill. Dec. 15, 2000).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Kelly Carroll, Esq.
Hooper, Lundy and Bookman
401 9th Street, NW, Ste. 550
Washington, D.C. 20004

RE: ***Expedited Judicial Review Determination***
23-0686GC Care New England FFY 2023 Area Wage Index Standardized Amount Reduction CIRP
22-0644GC Emory Healthcare FFY 2023 Area Wage Index Standardized Amount Reduction CIRP
22-0645GC Yale-New Haven FFY 2023 Area Wage Index Standardized Amount Reduction CIRP
22-0646GC UNC Health FFY 2023 Area Wage Index Standardized Amount Reduction CIRP Group
22-0647GC HCA FFY 2023 Area Wage Index Standardized Amount Reduction CIRP Group
22-0682G Hooper Lundy & Bookman FFY 2023 Area Wage Index Standardized Amount Reduction

Dear Ms. Carroll:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' consolidated request for expedited judicial review (EJR) filed on October 30, 2023, in the 6 above-referenced group appeals, as well as one other group appeal (Case No. 22-0679GC) that will be decided under separate cover. The Board's decision on jurisdiction and EJR for the 6 above-referenced group appeals are set forth below.

Issue:

The issue for which EJR has been requested is:

> [W]hether the Providers' FFY 2023 standardized amount and hospital-specific operating IPPS [inpatient prospective payment system] payment rate[s] were improperly reduced by approximately 0.1854% for FFY 2023.[1]

Statutory and Regulatory Background:

The statute, 42 U.S.C. § 1395ww(d), sets forth a system of payment for the operating costs of acute care hospital inpatient stays under Medicare Part A based on prospectively set rates[2] known as the Inpatient Prospective Payment System (IPPS). Under IPPS, Medicare payments for hospital inpatient operating costs are made at predetermined, specific rates for each hospital discharge. Discharges are classified according to a list of diagnosis-related groups (DRGs). The

[1] Providers' EJR Request at 2.
[2] 84 Fed. Reg. 42044, 42052 (Aug. 16, 2019).

base payment rate is comprised of a standardized amount[3] for all subsection (d) hospitals located in an "urban" or "rural" area.[4]

As part of the methodology for determining prospective payments to hospitals, 42 U.S.C. § 1395ww(d)(3)(E) requires that the Secretary[5] adjust the standardized amounts "for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level." This adjustment factor is the wage index. The Secretary currently defines hospital geographic areas (labor market areas) based on the definitions of Core-Based Statistical Areas (CBSAs) established by the Office of Management and Budget. The wage index also reflects the geographic reclassification of hospitals to another labor market area in accordance with 42 U.S.C. §§ 1395ww(d)(8)(B) and 1395ww(d)(10).[6]

The statute further requires that the Secretary update the wage index annually, based on a survey of wages and wage-related costs of short-term, acute care hospitals. Data included in the wage index derive from the Medicare Cost Report, the Hospital Wage Index Occupational Mix Survey, hospitals' payroll records, contracts, and other wage-related documentation. In computing the wage index, the Secretary derives an average hourly wage for each labor market area (total wage costs divided by total hours for all hospitals in the geographic area) and a national average hourly wage (total wage costs divided by total hours for all hospitals in the nation). A labor market area's wage index value is the ratio of the area's average hourly wage to the national average hourly wage. The wage index adjustment factor is applied only to the labor portion of the standardized amounts.[7]

A. Changes to the Wage Index Calculation

In the FFY 2019 IPPS proposed rule,[8] the Secretary invited the public to submit comments, suggestions, and recommendations for regulatory and policy changes to the Medicare wage index. The Secretary discussed the responses it received from this request for information ("RFI") as part of the FFY 2020 IPPS proposed rule.[9] Therein, the Secretary noted that many respondents expressed: (1) "a common concern that the current wage index system perpetuates

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[3] The standardized amount is based on per discharge averages from a base period and are updated in accordance with 42 U.S.C. §1395ww(d). Sections 1395ww(d)(2)(C) and (d)(2)(B)(ii) require that updated base-year per discharge costs be standardized in order to remove the cost data that effects certain sources of variation in costs among hospitals. These include case mix, differences in area wage levels, cost of living adjustments for Alaska and Hawaii, indirect medical education costs, and payments to disproportionate share hospitals. 59 Fed. Reg. 27433, 27765-27766 (May 27, 1994). 42 U.S.C. § 1395ww(d)(3)(E) requires the Secretary from time-to-time to estimate the proportion of the hospitals' costs that are attributable to wages and wage-related costs. The standardized amount is divided into labor-related and nonlabor-related amounts; only the portion considered the labor-related amount is adjusted by the wage index. 71 Fed. Reg. 47870, 48146 (Aug. 18, 2006).

[4] 42 U.S.C. § 1395ww(d)(2)(A)-(D).

[5] of the Department of Health and Human Services.

[6] https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/wage-index (last visited Nov. 13, 2023).

[7] *Id.*

[8] 83 Fed. Reg. 20164 (May 7, 2018).

[9] 84 Fed Reg 19158, 19393-94 (May 3, 2019).

and exacerbates the disparities between high and low wage index hospitals"; and (2) "concern that the calculation of the rural floor has allowed a limited number of states to manipulate the wage index system to achieve higher wages for many urban hospitals in those states at the expense of hospitals in other states, which also contributes to wage index disparities."[10] Based on these concerns, the Secretary proposed "[t]o help mitigate the wage index disparities" by "reduc[ing] the disparity between high and low wage index hospitals by increasing wage index values for certain low wage index hospitals with low wage index values and decreasing the wage index values for certain hospitals with high wage index values to maintain budget neutrality, and changing the calculation of the rural floor . . . ."[11]

In the FY 2020 IPPS final rule, the Secretary summarizes his proposal as follows:

> [N]otwithstanding the challenges associated with comprehensive wage index reform, we agree with respondents to the request for information who indicated that some current wage index policies create barriers to hospitals with low wage index values from being able to increase employee compensation due to the lag between when hospitals increase the compensation and when those increases are reflected in the calculation of the wage index. (We noted that this lag results from the fact that the wage index calculations rely on historical data.) We also agreed that addressing this systemic issue did not need to wait for comprehensive wage index reform given the growing disparities between low and high wage index hospitals, including rural hospitals that may be in financial distress and facing potential closure." Therefore, in response to these concerns, in the FFY 2020 LTCH PPS proposed rule . . . , we proposed a policy that would provide certain low wage index hospitals with an opportunity to increase employee compensation without the usual lag in those increases being reflected in the calculation of the wage index.[12]

In the FFY 2020 IPPS final rule, the Secretary finalized the "proposal to increase the wage index for hospitals with a wage index value below the 25th percentile wage index by half the difference between the otherwise applicable final wage index value for a year for that hospital and the 25th percentile wage index value across all hospitals is 0.8457."[13] In doing so, the Secretary determined that "quartiles are a reasonable method of dividing the distribution of hospitals' wage index values" and that "identifying hospitals in the lowest quartile as low wage index hospitals, hospitals in the second and third 'middle' quartiles as hospitals with wages index values that are neither low nor high, and hospitals in the highest quartile as hospitals with high wage index values, is a reasonable method of determining low wage index and high wage index hospitals for purposes of our proposals . . . addressing wage index disparities."[14]

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[10] *Id.*
[11] *Id.*
[12] 84 Fed. Reg. at 42326 (citations omitted).
[13] *Id.* at 42328.
[14] *Id.* at 42326

The Secretary acknowledged that "there is no set standard for identifying hospitals as having low or high wage index values"; however, he believes his "proposed quartile approach is reasonable for this purpose, given that . . . quartiles are a common way to divide distributions, and that our approach is consistent with approaches used in other areas of the Medicare program." The Secretary stated in the proposed rule that, based on the data for the proposed rule, for FY 2020, the 25th percentile wage index value across all hospitals was 0.8482 and that this number would be updated in the final rule based on the final wage index values.[15] When the FFY 2020 IPPS final rule was published the 25th percentile wage index value across all hospitals for FFY 2020 was 0.8457.[16]

Under the Secretary's methodology, he decided to increase the wage index for hospitals with a wage index value below the 25th percentile wage index. The increase in the wage indices for these hospitals would be equal to half of the difference between the otherwise applicable final wage index value for a year for that hospital and the 25th percentile wage index value for that year for all hospitals.[17] The Secretary announced that this policy would be in effect for at least 4 years beginning in FFY 2020, in order to allow employee compensation increases implemented by low wage index value hospitals sufficient time to be reflected in the wage index calculation. The Secretary explained that, for the FFY 2020 wage index, data from 2016 cost reports was used to calculate the wage indices and 4 years is the minimum time before increases in employee compensation included in Medicare cost reports could be reflected in the wage index. The Secretary acknowledged that additional time may be necessary to determine the duration of the policy.[18]

In the FFY 2021 IPPS Final Rule, the Secretary indicated he was continuing the low wage index hospital policy for FY 2021, and also applying this policy in a budget neutral manner by applying an adjustment to the standardized amounts.[19] Based on the data for this final rule, for FFY 2021, the 25th percentile wage index value across all hospitals was 0.8465, which was later corrected to 0.8469.[20]

Thereafter, in the FY 2022 IPPS Final Rule, the Secretary again indicated he was continuing the low wage index hospital policy for FY 2022, and also applying this policy in a budget neutral manner by applying an adjustment to the standardized amounts.[21] Based on the data for this final rule, for FY 2022, the 25th percentile wage index value across all hospitals was 0.8437.[22]

Relevant here, in the FY 2023 IPPS Final Rule, the Secretary again indicated he was continuing the low wage index hospital policy for FY 2023, and also applying this policy in a budget neutral manner by applying an adjustment to the standardized amounts.[23] Based on the data for this final rule, for FY 2023, the 25th percentile wage index value across all hospitals was 0.8427.[24]

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[15] *Id.*
[16] *Id.*
[17] *Id.*
[18] *Id.* at 42326-7
[19] 85 Fed. Reg. 58432, 58436 (Sept. 18, 2020).
[20] *Id.* at 58768; 85 Fed. Reg. 78748, 78754 (Dec. 7, 2020) (Correction).
[21] 86 Fed. Reg. 44774, 44778 (Aug. 13, 2021).
[22] *Id.* at 45178.
[23] 87 Fed. Reg. 48780, 49006 (Aug. 10, 2022).
[24] *Id.*

B. Budget Neutrality and the Wage Index

In the 2020 Proposed IPPS Rule, the Secretary explained that he believed that while it would not be appropriate to create a wage index floor or a wage index ceiling, it would be appropriate to provide a mechanism to increase the wage index of low wage index hospitals while maintaining budget neutrality for that increase through an adjustment to the wage index of high wage index hospitals. The Secretary maintains that this action has two key merits: (1) "by compressing the wage index for hospitals on the high and low ends, that is, those hospitals with a low wage index and those hospitals with a high wage index, such a methodology increases the impact on existing wage index disparities more than by simply addressing one end;" and (2) "such a methodology ensures those hospitals in the middle, that is, those hospitals whose wage indices are not considered high or low, do not have their wage index values affected by this proposed policy."[25] Thus, the Secretary concludes that, "given the growing disparities between low wage index hospitals and high wage index hospitals, . . .it would be appropriate to maintain budget neutrality for the low wage index policy proposed . . . by adjusting the wage index for high wage index hospitals."[26]

Following significant criticism from commenters to the proposed rule, the Secretary acknowledged that "some commenters have presented reasonable policy arguments that we should consider further regarding the relationship between the proposed budget neutrality adjustment targeting high wage hospitals and the design of the wage index to be a relative measure of the wages and wage-related costs of subsection (d) hospitals in the United States."[27] Based on this feedback, the Secretary decided to "finalize a budget neutrality adjustment for our low wage hospital policy but . . . not [to] finaliz[e] our proposal to target that budget neutrality adjustment on high wage hospitals" given that: (1) budget neutrality is required under [§ 1395ww(d)(3)(E)]; (2) even if it were not required, he believes that it would be inappropriate to use the wage index to increase or decrease overall IPPS spending; and (3) he wished to consider further the policy arguments raised by commenters regarding the budget neutrality proposal.[28] Specifically, "consistent with the Secretary's current methodology for implementing wage index budget neutrality under [§1395ww(d)(3)(E)] and the alternative approach we considered in the proposed rule (84 FR 19672), we are finalizing a budget neutrality adjustment to the national standardized amount for all hospitals so that the increase in the wage index for low wage index hospitals, as finalized in the rule, was implemented in a budget neutral manner."[29]

The Secretary has continued the low wage index hospital policy the following three years, for FFY 2021, FFY 2022 and FFY 2023, and continues to apply this policy in a budget neutral manner by applying an adjustment to the labor portion of the standardized amounts.[30]

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[25] 84 Fed. Reg. at 42329.
[26] *Id.* at 42328-9.
[27] *Id.* at 42331.
[28] *Id*.
[29] *Id*.
[30] 85 Fed. Reg. at 58436 (Sept. 18, 2020); 86 Fed. Reg. at 44778 (Aug. 13, 2021); 87 Fed. Reg. at 49006 (Aug. 10, 2022).

Providers' Position:

The Providers are challenging their IPPS payments for FFY 2023 on the grounds that those payments were and continue to be improperly understated as a result of the reduction to the standardized amount, which the Secretary allegedly unlawfully imposed as part of the new policy increasing the Area Wage Index ("AWI") values of hospitals with an AWI value in the lowest quartile.

The Providers explain that the Secretary continues to implement, without any changes, his policy that increases the AWI values of hospitals with an AWI in the lowest quartile, nationally (the "Low Wage Index Redistribution") that he first adopted for FFY 2020. The Low Wage Index Redistribution was implemented in 2020 to address what the Secretary called "wage index disparities" by impacting the AWI values and the IPPS Medicare reimbursement that hospitals receive. Specifically, the Providers contend that the Low Wage Index Redistribution increases the AWI values of hospitals with AWI values in the lowest quartile, nationally, by half of the difference between their accurately calculated AWI and the 25th percentile of AWI values.

The Providers note that in the FFY 2023 IPPS Final Rule, the Secretary reiterated his assertion that he had the authority to implement this new policy under 42 U.S.C. § 1395ww(d)(3)(E) despite acknowledging that the district court in *Bridgeport Hospital, et al. v. Becerra,* No. 1:20-cv-01574 (D.D.C.) held that the Secretary did not have the legal authority under 42 U.S.C. §§ 1395ww(d)(3)(E) or 1395ww(d)(5)(I)(i) to adopt the FFY 2020 Low Wage Index Redistribution. This section of the statute authorizes the Secretary to adjust the labor-related portion of IPPS payments to account "for area differences in hospital wage levels" by a "factor" (the wage index) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level, citing 42 U.S.C. § 1395ww(d)(3)(E). The Secretary must "update" the wage index annually "on the basis of a survey . . . of the wages and wage-related costs of [IPPS-participating] hospitals in the United States." *Id.*

The Providers contend that the Secretary again elected to implement his Low Wage Index Redistribution in a budget neutral manner for FFY 2023. As a result, the Providers allege, the Secretary decreased the standardized payment amounts of all IPPS hospitals by 0.1854 percent to offset the AWI increases to those hospitals in the lowest AWI quartile.

The Providers point out that the Secretary continues to assert that he had the authority to implement this budget neutrality adjustment under 42 U.S.C. § 1395ww(d)(3)(E), however, he noted that even if he did not have such authority under § 1395ww(d)(3)(E), he would invoke is statutory "exceptions and adjustments" authority in support of such a budget neutrality adjustment. This "exceptions and adjustments" authority provision, codified at 42 U.S.C. § 1395ww(d)(5)(I)(i), addresses IPPS payments and states: "The Secretary shall provide by regulation for such other exceptions and adjustments to such payment amounts under this subsection as the Secretary deems appropriate." The Providers contend that there is no statute that precludes administrative or judicial review of the Secretary's adjustments for different area wage levels under 42 U.S.C. § 1395ww(d)(3)(E) or adjustments under 42 U.S.C. § 1395ww(d)(5)(I).

The Providers argue that the Secretary lacks the authority to (a) continue the Low Wage Index Redistribution in the manner set forth in the FFY 2022 Final IPPS Rule; and, (b) continue to

implement such policy in a budget neutral manner under the AWI statutory provision, the exceptions or adjustments authority, or otherwise. Therefore, the Providers are challenging the adjustment to the standardized amount on several grounds, including, but not limited to, that it exceeds statutory authority, contradicts the AWI congressional mandate, was developed in an arbitrary and capricious manner, lacks support from substantial evidence, and is otherwise defective both procedurally and substantively.

The immediate detrimental effect will be a 0.1854 percent negative adjustment of the standardized amount and the hospital-specific operating payment rate for FFY 2023 for every IPPS hospital, resulting in a reduction in overall IPPS payments for all IPPS hospitals, including the Providers. Further, as this is the fourth year of the implementation of the Low Wage Index Redistribution and the related budget neutrality adjustment, the Providers already suffered an unlawful negative adjustment in FFY 2020, FFY 2021 and FFY 2022.

Based on the foregoing, the Providers are challenging the Low Wage Index Redistribution in this group appeal for several reasons, including but not limited to, whether the Secretary (1) improperly exercised the authority granted through 42 U.S.C. § 1395ww(d)(3)(E) and 42 U.S.C. § 1395ww(d)(5)(I); and (2) improperly reduced FFY 2023 IPPS payments to IPPS hospitals, including the Providers, as a result of the budget neutral implementation of the Low Wage Index Redistribution, which has been in effect since October 1, 2019, and continues through FFY 2023. The Providers seek their proper IPPS payments plus interest calculated under 42 U.S.C. § 1395oo(f)(2) and/or 42 U.S.C. § 1395g(d).

The Providers believe EJR is appropriate because the Board has jurisdiction over the appeals, the Providers are dissatisfied with the final determination of the Secretary, but lacks the authority to decide the question at issue and cannot grant the relief sought. Pursuant to 42 C.F.R. § 405.1867, the Board must comply with all the provisions of Title XVIII of the Social Security Act and is therefore, bound to apply the 0.1854% reduction issued by the Secretary in the FFY 2023 IPPS Final Rule.

Decision of the Board:

The participants that comprise the group appeals within this EJR request have filed an appeal involving FFY 2023 based on their appeal from the FFY 2023 IPPS Final Rule.

A. Jurisdiction and Request for EJR

As previously noted, all of the participants in all of the group cases at issue appealed from the FFY 2023 IPPS Final Rule.[31] The Board has determined that (1) the participants' documentation in each of the group appeals shows that the estimated amount in controversy exceeds $50,000, as required

[31] The CMS Administrator confirmed that, consistent with the D.C. Circuit's decision in *Washington Hosp. Ctr. v. Bowen*, 795 F.3d 139 (D.C. Cir. 1986, a wage index notice published in the Federal Register is a final determination from which a provider may appeal to the Board within the meaning of 42 U.S.C. § 1395oo(a)(1)(A)(ii). *See District of Columbia Hosp. Ass'n Wage Index Grp. Appeal*, HCFA Adm'r Dec. (Jan. 15, 1993*)*, *rev'g*, PRRB Juris. Dec. (Case No. 92-1200G, Nov. 18, 1992). *See also* 80 Fed. Reg. 70298, 70569-70 (Nov. 13, 2015); 42 C.F.R. § 405.1837.

for a group appeal;[32] (2) the appeals were timely filed; and (3) Board review of the matter in these appeals is not precluded by statute or regulation. In finding that the groups meet the $50,000 amount in controversy, the Board recognizes that the Group Representative has explained that the amount in controversy (AiC) calculation is simply based on the estimated IPPS payments for the period at issue multiplied by 0.1854 percent (*i.e.,* the adjustment to the wage index that they are challenging in this appeal) and this AiC unmistakably demonstrates each of the groups more than clears the minimum $50,000 AiC hurdle. Based on the above, the Board finds that it has jurisdiction for the above-captioned appeals and the underlying Providers. The estimated amount in controversy is subject to recalculation by the Medicare contractors for the actual final amounts in each case.

B. Application of 42 C.F.R. § 405.1873

1. Regulatory Background

For cost report periods beginning on or after January 1, 2016, the regulations at 42 C.F.R. §§ 405.1873 and 413.24(j) are applicable. The regulation 42 C.F.R. § 413.24(j) requires that:

> (1) *General Requirement*. In order for a provider to receive or potentially qualify for reimbursement for a specific item for its cost reporting period, the provider's cost report, whether determined on an as submitted, as amended, or as adjusted basis (as prescribed in paragraph (j)(3) of this section), **must include an appropriate claim for the specific item**, by either—
>
> (i) Claiming full reimbursement in the provider's cost report for the specific item in accordance with Medicare policy, if the provider seeks payment for the item that it believes comports with program policy; or
>
> (ii) Self-disallowing the specific item in the provider's cost report, if the provider seeks payment that it believes may not be allowable or may not comport with Medicare policy (for example, if the provider believes the contractor lacks the authority or discretion to award the reimbursement the provider seeks for the item), by following the procedures (set forth in paragraph (j)(2) of this section) for properly self-disallowing the specific item in the provider's cost report as a protested amount.
>
> (2) *Self-disallowance procedures*. In order to properly self-disallow a specific item, the provider must—
>
> (i) Include an estimated reimbursement amount for each specific self-disallowed item in the protested amount line (or lines) of the provider's cost report; and

[32] *See* 42 C.F.R. § 405.1837.

> (ii) Attach a separate work sheet to the provider's cost report for each specific self-disallowed item, **explaining** why the provider self-disallowed each specific item (instead of claiming full reimbursement in its cost report for the specific item) **and describing** how the provider calculated the estimated reimbursement amount for each specific self-disallowed item.[33]

In conjunction with the regulation above, 42 C.F.R. § 405.1873(a) states:

> (a) *General*. In order to receive or potentially receive reimbursement for a specific item, the provider **must include in its cost report an appropriate claim for the specific item** (as prescribed in § 413.24(j) of this chapter). If the provider files an appeal to the Board seeking reimbursement for the specific item and any party to such appeal questions whether the provider's cost report included an appropriate claim for the specific item, the Board must address such question in accordance with the procedures set forth in this section.
>
> (b) *Summary of Procedures*.
>
> ***
>
> (2) Limits on Board actions. The Board's specific findings of fact and conclusions of law (pursuant to paragraph (b)(1) of this section) **must not be invoked or relied on by the Board as a basis to deny, or decline to exercise, jurisdiction** over a specific item or take any other of the actions specified in paragraph (c) of this section. . . .
>
> ***
>
> (d) *Two types of Board decisions that must include any factual findings and legal conclusions under paragraph (b)(1) of this section-*
>
> ***
>
> (2) Board expedited judicial review (EJR) decision, where EJR is granted. **If the Board issues an EJR decision where EJR is granted** regarding a legal question that is relevant to the specific item under appeal (in accordance with § 405.1842(f) (1)), **the Board's specific findings of fact and conclusions of law** (reached under paragraph (b)(1) of this section), on the question of whether the provider's cost report included an appropriate claim for the specific item, **must be included in such EJR decision** along with the other matters prescribed by 405.1842(f)(1). . . .

[33] (Bold and underline emphasis added.)

> (e) *Two other types of Board decisions that must not include the Board's factual findings and legal conclusions under paragraph (b)(1) of this section-*
>
> (1) Board jurisdictional dismissal decision. **If the Board issues a jurisdictional dismissal decision** regarding the specific item under appeal (pursuant to § 405.1840(c)), **the Board's specific findings of fact and conclusions of law** (in accordance with paragraph (b)(1) of this section), on the question of whether the provider's cost report included an appropriate claim for the specific item, **must not be included in such jurisdictional dismissal decision**.[34]

These regulations are applicable to the cost reporting periods in these group cases.

2. Appropriate Cost Report Claims: Findings of Fact and Conclusions of Law

As explained above, at issue in this appeal are cost reports beginning after January 1, 2016, which are subject the regulations on the "substantive reimbursement requirement" for an appropriate cost report claim.[35] The regulation at 42 C.F.R. § 405.1873 dictates that, for fiscal years beginning January 1, 2016 and later, the Board's findings with regard to whether or not a provider "include[d] in its cost report an appropriate claim for the ***specific*** item [under appeal] (as prescribed in § 413.24(j))"[36] may not be invoked or relied on by the Board to decline jurisdiction. *Instead, 42 C.F.R. § 413.24(j) makes this a requirement for reimbursement*, rather than a jurisdictional one. Nevertheless, when granting EJR, 42 C.F.R. § 405.1873(d)(2) requires the Board to include its specific findings of fact and conclusions of law findings as to whether an appropriate claim was included.

The Board interprets the regulation at 42 C.F.R. § 405.1873 to only require the Board to review a provider's "compliance"[37] with the reimbursement requirement of an appropriate cost report claim for the specific item under appeal (and the supporting factual evidence and legal argument) ***if*** a party to the appeal questions whether there was an appropriate claim made.[38]

However, the Board notes that, when the participants in a group have not filed their cost report, then § 405.1873(b) would not be triggered because the issue of whether the relevant participants' cost reports included an appropriate claim for the specific item under appeal would not yet be ripe.[39] Section 405.1873(b) sets forth the procedures for Board review of Substantive Claim Challenges:

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[34] (Bold and underline emphasis added.)
[35] 42 C.F.R. § 413.24(j) (entitled "Substantive reimbursement requirement of an appropriate cost report claim"). *See also* 42 C.F.R. § 405.1873 (entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim").
[36] (Emphasis added.)
[37] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."
[38] *See* 42 C.F.R. § 405.1873(a),
[39] The preamble to the final rule that adopted the substantive claim regulations at 42 C.F.R. §§ 413.24(j) and 405.1973 responded to a comment about appeals from the Federal Register and confirmed that the substantive claim regulations applied to them. 80 Fed. Reg. 70298, 70569-70 (Nov. 13, 2015). However, this preamble discussion does not address the

> The Board must give the parties an adequate opportunity to submit factual evidence and legal argument regarding the question of whether the provider's cost report included an appropriate claim for the specific item under appeal. Upon receipt of timely submitted factual evidence or legal argument (if any), the Board must review such evidence and argument and prepare written specific findings of fact and conclusions of law on the question of whether the provider's cost report complied with, for the specific item under appeal, the cost report claim requirements prescribed in § 413.24(j) of this chapter.

Significantly, the regulation simply directs the Board to give an adequate opportunity to take in evidence and argument and does not discuss staying appeals based on Federal Register to allow future review and consideration of Substantive Claim Challenges. In this regard, the fact that a cost report has not been filed, it would not stop or delay the Board proceedings as set forth in § 405.1873(b). Accordingly, it is the Board's position that in these instances, any Substantive Claim Challenge would be premature.

That said, *if subsequent to the Federal Register appeal being filed*, one or more participants files its cost report, then any party may raise a Substantive Claim Challenge regarding those participants and submit argument and evidence supporting their position. Here, for the above-captioned appeals, no party has asserted that any of the participants in these Federal Register appeals later filed its cost report and failed to properly make a cost report substantive claim for the matter at issue.[40]

Moreover, all of the participants in the above-referenced group cases are appealing the FFY 2023 Federal Register Notice and the cost reports impacted by such notice appear to have not yet been filed to trigger § 413.24(j)'s general substantive payment requirement for cost reports.[41] Accordingly, the Board is not obligated under 42 C.F.R. § 405.1873 to include findings on substantive claim challenges in these cases for any of the participants.

C. Analysis Regarding Appealed Issue

As set forth below, the Board finds that the Secretary's determination to finalize a budget neutrality adjustment to the national standardized amount for all hospitals so that the increase in the wage index for low wage index hospitals was implemented in a budget neutral manner was

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manner in which they apply. Rather, the response concludes with the following directive in § 405.1873(a)-(b): "if a party to an appeal questions whether there was an appropriate cost report claim for a specific PPS item, the Board must take evidence and argument on that question; issue findings of fact and conclusions of law on such matter; and include those findings and conclusions in both the administrative record and certain types of overall Board decisions." *Id.* at 70570.

[40] By letter dated November 3, 2023, the Medicare Contractor noted it is impossible to make a determination at this time as to whether the Providers filed an appropriate cost report claim since they have not yet filed their cost report for the relevant fiscal year. Accordingly, the Medicare Contractor states that, once the cost reports are filed, it will make a determination as to whether the substantive claim requirements in 42 C.F.R. § 413.24(j) have been met. By letter dated November 14, 2023, the Board confirmed that: (1) "the fact that a cost report for the impacted fiscal year(s) has not been filed would not stop or delay the Board proceedings in a Federal Register appeal when an EJR request is filed"; and (2) "it is the Board's position that in these instances, any Substantive Claim Challenge would be premature and the Board declines to stay these proceedings until the Providers in this case file the referenced cost reports."

[41] *See* 80 Fed. Reg. at 70556, 70569-70.

made through notice and comment in the form of an uncodified regulation.[42] Specifically, in the preamble to FFY 2020 IPPS Final Rule, the Secretary announced the following wage index issues:

1. "To help mitigate . . . wage index disparities [between high and low wage index hospitals], including those resulting from the inclusion of hospitals with rural reclassifications under 42 CFR 412.103 in the calculation of the rural floor, . . . we . . . reduce the disparity between high and low wage index hospitals by increasing wage index values for certain low wage index hospitals with low wage index values and decreasing the wage index values for certain hospitals with high wage index values to maintain budget neutrality, and changing the calculation of the rural floor . . . .";[43] and

2. "[A]ddressing this systemic issue does not need to wait for comprehensive wage index reform given the growing disparities between low and high wage index hospitals, including rural hospitals that may be in financial distress and facing potential closure."

The Secretary did not incorporate the above new policy setting forth a modification to the wage index calculation determination by finalizing a budget neutrality adjustment to the national standardized amount for all hospitals so that there was an increase in the wage index for low wage index hospitals into the Code of Federal Regulations. However, it is clear from the use of the following language in the preamble to the FFY 2020 IPPS Final Rule that the Secretary intended to bind the regulated parties and establish a binding uniform payment policy through formal notice and comment:

> We acknowledge, however, that some commenters have presented reasonable policy arguments that we should consider further regarding the relationship between our proposed budget neutrality adjustment targeting high wage hospitals and the design of the wage index to be a relative measure of the wages and wage-related costs of subsection (d) hospitals in the United States. Therefore, given that budget neutrality is required under section 1886(d)(3)(E) of the Act, given that even if it were not required, we believe it would be inappropriate to use the wage index to increase or decrease overall IPPS spending, and given that we wish to consider further the policy arguments raised by commenters regarding our budget neutrality proposal, we are finalizing a budget neutrality adjustment for our low wage hospital policy, but we are not finalizing our proposal to target that budget neutrality adjustment on high wage hospitals. Instead, consistent with CMS's current methodology for implementing wage index budget neutrality under section 1886(d)(3)(E) of the Act and the alternative approach we considered in the proposed rule . . . we are finalizing a budget neutrality adjustment to the national standardized amount for all hospitals so

[42] *See* 84 Fed. Reg. 42044, 42325-36 "II. Changes to the Hospital Wage Index for Acute Care Hospitals, N. Policies to Address Wage Index Disparities Between High and Low Wage Index Hospitals."
[43] *Id.* at 42326.

> that the increase in the wage index for low wage index hospitals, as finalized in this rule, is implemented in a budget neutral manner.[44]

Accordingly, the Board finds that the Secretary intended this policy change to be a binding but uncodified regulation and will refer to the above policy as the "Uncodified Regulation on Wage Index." Indeed, this finding is consistent with the Secretary's obligations under 42 U.S.C. § 1395hh(a)(2) to promulgate any "substantive legal standard governing . . . the payment of services" as a regulation."[45]

While this appeal involves the FFY 2023 IPPS Final Rule, the continuation of this policy was implemented in the same way as it was initially for FFY 2020.[46] The proposed rule did not propose any changes to this policy.[47] The Final Rule for FFY 2023 refers to the responses to comments provided in the FFY 2020 Final Rule, and applied the policy in the same manner as it was applied in FFY 2020.[48] Therefore, the Board finds that this policy continues to be a binding but uncodified regulation for FFY 2023.

Pursuant to 42 C.F.R. § 405.1867, the Board is bound to apply the statutory and regulatory provisions governing the Medicare program. Consequently, the Board finds that it is bound to apply the Uncodified Regulation on Wage Index published in the FFY 2023 IPPS Final Rule and the Board does not have the authority to grant the relief sought by the Providers, namely invalidating the Uncodified Regulation on Wage Index which they allege improperly reduces the standardized amount of 0.1854 percent for FFY 2023. As a result, the Board finds that EJR is appropriate for the issue for the fiscal year under appeal in these cases.

D. Board's Decision Regarding the EJR Request

The Board finds that:

1) It has jurisdiction over the AWI Issue for the subject year in these cases and that the Providers in these group appeals are entitled to a hearing before the Board;

2) While the Providers appealed cost reporting periods beginning after January 1, 2016, no substantive claim challenges[49] have been filed pursuant to 42 C.F.R. § 405.1873(a) to trigger either Board review under § 405.1873(b) or reporting under § 405.1873(d)(2);

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[44] 84 Fed. Reg. at 42331.
[45] 42 U.S.C. § 1395hh(a)(2) states "[n]o rule, requirement, or other statement of policy . . . that establishes or changes a substantive legal standard governing . . . the payment of services . . . shall take effect unless it is promulgated by the Secretary by regulation . . . ."
[46] 87 Fed. Reg. at 49006 (Aug. 10, 2022).
[47] *Id.* at 49006-08.
[48] *Id.* at 49007-08.
[49] As the Board explained in Board Rule 44.5, "[t]he Board adoption of the term "Substantive Claim Challenge' simply refers to any question raised by a party concerning whether the cost report at issue included an appropriate claim for one or more of the specific items being appealed in order to receive or potentially qualify for reimbursement for those specific items."

3) Based upon the Providers' assertions regarding the FFY 2023 IPPS Final Rule, there are no findings of fact for resolution by the Board;

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

5) It is without the authority to decide the legal question of whether the Uncodified Regulation on Wage Index published in the FFY 2023 IPPS Final Rule is valid.

Accordingly, the Board finds that the question of the validity of the Uncodified Regulation on Wage Index as published in the FFY 2023 IPPS Final Rule properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' requests for EJR for the issue and the subject year.

The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in these group cases, the Board hereby closes these cases.

Board Members Participating:

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

FOR THE BOARD:

11/24/2023

X Clayton J. Nix

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

Enclosure: Schedules of Providers

cc: Danelle Decker, National Government Services, Inc. (J-K)
Cecile Huggins, Palmetto GBA (J-J)
Dana Johnson, Palmetto GBA c/o National Government Services, Inc. (J-M)
Byron Lamprecht, WPS Government Health Administrators (J-5)
Jacqueline Vaughn, CMS OAA

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Stephanie Webster, Esq.
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RE: ***Decision re: Request for Reconsideration***
Tampa General Hospital, Prov. No. 10-0128, FYE 9/30/2009
Case No. 23-1498

Dear Ms. Webster:

The above-captioned case involves Tampa General Hospital ("Tampa" or "Provider") and its fiscal year ("FY") 2009. The Provider Reimbursement Review Board ("Board") has reviewed Tampa's Request for Reconsideration of the Board's Dismissal that was filed on October 9, 2023 following the Board's dismissal of this case and denial of Tampa's request for expedited judicial review ("EJR"). Set forth below is the Board's decision denying Tampa's Request for Reconsideration.

Issue in Dispute

On July 11, 2023, Tampa filed its appeal request concerning the final rule that the Secretary of Health and Human Services ("Secretary") published in the June 9, 2023 Federal Register ("June 2023 Final Rule") as it relates to Tampa's yet-to-be-finalized FY 2009 Medicare disproportionate share hospital ("DSH") reimbursement.[1] *On the same day*, within minutes of filing the appeal request, Tampa filed a request for EJR.

Tampa's appeal request includes a "Statement of Jurisdiction" wherein it asserts that it has the right to appeal directly from the June 2023 Final Rule and that it need not wait until its Notice of Program Reimbursement ("NPR") is issued for FY 2009. Specifically, Tampa asserts that it "has a right to appeal this determination [*i.e.*, the June 2023 Final Rule] under 42 U.S.C. § 1395oo(a)(1)(A)(ii), which provides the right to appeal where a provider is 'dissatisfied with a final determination of the Secretary as to the amount of the payment under subsection . . . (d) of section 1395ww.'"

The ***sole*** issue in this appeal is the proper treatment in the Medicare DSH calculation of days for patients who were enrolled in Medicare Advantage plans under Part C of the Medicare statute ("Part C days") in the aftermath of the *Allina* litigation discussed *infra*. In the June 2023 Final Rule, the Secretary adopted and finalized its policy to include Part C days in the SSI fraction as used in the DSH calculation for Part C discharges occurring prior to October 1, 2013. Tampa

[1] 88 Fed. Reg. 37772 (June 9, 2023).

challenges this policy and contends that Part C days must be *excluded* in their entirety from the DSH SSI fraction and that, instead, those days must be included in the numerator of the DSH Medicaid fraction (for patients eligible for Medicaid).[2]

Tampa sought EJR to challenge in Federal court the policy that the Secretary adopted/finalized in the June 2023 Final Rule which is being applied *retroactively* to certain periods prior to October 1, 2013, including Tampa's FY 2009 for which no NPR has yet been issued. Tampa estimates the amount in controversy as $1,230,772 for its FY 2009.[3]

Tampa's Appeal Request and EJR Request

Tampa *previously* filed an appeal for FY 2009 based on the June 2023 Final Rule and the Board dismissed that case *without* prejudice. Accordingly, the Board discusses the procedural history of both the prior appeal under Case No. 23-14**3**8 as well as the instant appeal under Case No. 23-14**9**8.

A. Proceedings in Prior Appeal under Case No. 23-1438

On June 9, 2023, Tampa filed an appeal request[4] appealing the June 2023 Final Rule as it pertains to its FY 2009.[5] Within minutes of filing the appeal, Tampa filed a request for EJR challenging the validity of the June 2023 Final Rule. The issue appealed concerned the proper treatment in the Medicare DSH calculation of days for Medicare Part C patients in the aftermath of the *Allina* litigation. Tampa contended that, contrary to the policy finalized in the June 2023 Final Rule, its FY 2009 Part C days must be included in the numerator of the Medicaid fraction and excluded from the numerator and denominator of the SSI fraction.

On July 3, 2023, the Board dismissed the case *without* prejudice and denied the request for EJR. The Board found that Tampa had not demonstrated that the criteria set out in 42 C.F.R. § 405.1835 had been satisfied "***for the provider's cost reporting period***[.]" There was nothing in Tampa's request for a hearing which demonstrated that the cost report for the fiscal year at issue in Case No. 23-1438 (*i.e.*, FY 2009) remained open or had not yet been finally settled and, as such, Tampa had not demonstrated that the June 2023 Final Rule was a "final … determination ***for the provider's cost reporting period***" which involved "*reimbursement* ***due the provider***."[6]

B. Proceedings in the Instant Appeal under Case No. 23-1498 Resulting in the Board's August 9, 2023 Dismissal

On July 11, 2023, following the Board's dismissal of Case No. 23-1438, Tampa established a new case under Case No. 23-14**9**8 by concurrently filing: (1) a new appeal request based, again, on the

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[2] Issue Statement.
[3] The Board's August 9, 2023 EJR Determination gives more detail on the statutory/regulatory background on how Part C Days are treated in the DSH calculation and the lengthy procedural history of Tampa's appeal of the June 2023 Final Rule.
[4] Case No. 23-1438.
[5] 88 Fed. Reg. 37772 (June 9, 2023).
[6] Consistent with the requirement that the determination being appealed must involve "reimbursement due the provider," 42 C.F.R. § 405.1840(b)(2) requires a description of the "payment" at issue and how it must be determined differently.

June 2023 Final Rule; and (2) a new EJR Request over the issue. In its appeal request, Tampa included information confirming that the NPR for its FY 2009 has ***not*** yet been issued and, as a result, the June 2023 Final Rule may impact its FY 2009. Tampa also reemphasized its contention that it is appealing from the ***Secretary's*** "final determination" in the June 2023 Final Rule. Tampa maintains that, pursuant to 42 U.S.C. § 1395oo(a)(1)(A)(ii) and *Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 149 (D.C. Cir. 1986) ("*Washington Hospital*"), it "need not wait until an NPR has been issued" to appeal this "final determination."

Tampa argued that appealing the June 2023 Final Rule is appropriate because the Secretary announced he will apply this final rule to NPRs which have been held open (like Tampa's FY 2009). It argued that appealing this final rule is no different than appealing from different final rules where the Board has found jurisdiction, such as appeals from final rule announcing CMS' Two-Midnight Rule. It claimed that appealing the June 2023 Final Rule is not the same as appealing from the publication of SSI fractions in the *Memorial Hospital*[7] case, where the Board found it did not have jurisdiction because the SSI fractions at issue in *Memorial Hospital* were immediately rescinded and never used, and an accompanying transmittal made clear that CMS was only providing data and that the publication was not a final determination. Here, Tampa noted that CMS has made clear that the June 2023 Final Rule is a "final action" which will be used for recalculation of DSH payments for open cost reports, including Tampa's own, still-open FY 2009 cost report.

On August 9, 2023, the Board denied the second EJR Request and dismissed Case No. 23-1498. The Board discussed *Memorial Hospital*, in which certain providers appealed the publication of SSI ratios. In its discussion, the D.C. District Court specifically found that the SSI ratios, *even if final*, could not be a final determination "as to the amount of payment" because they are just one component of the DSH adjustment.[8] It explained that challenging the SSI ratios was a challenge to *one element* that eventually flows into the amount of payment for a final determination. Appealing such an element prior to payment is only appropriate if it was the only variable element as to the amount of payment due.[9]

The providers in *Memorial Hospital* also argued that there are certain instances where a provider can appeal prior to receiving an NPR. The District Court distinguished these cases because "the secretarial determination at issue was either the only determination on which payment depended or clearly promulgated as a final rule."[10] It reiterated that SSI ratios are just one of the variables that determine whether hospitals receive a DSH payment and, if so, for how much.

While the June 2023 Final Rule being appealed in the instant case was clearly promulgated as a final rule, it is ***not*** the only determination or variable on which the Provider's DSH payment depends. Just like the publication of SSI ratios, the policy at issue impacts one of many variables in calculating Tampa's DSH payment (*e.g.*, Medicaid eligible days in the numerator of the Medicaid fraction) and is thus not an appealable final determination "as to the amount of the payment under subsection (b)

[7] *Memorial Hospital of South Bend v. Becerra*, No. 20-3461, 2022 WL 888190 (D.D.C. 2022).
[8] *Id.* at *7.
[9] *Id.* at *8.
[10] *Id.*

or (d) of section 1395ww of this title" (as set forth in 42 U.S.C. § 1395oo(a)(1)(A)(ii)) or as to "the total amount of reimbursement due the provider" (as set forth in 42 C.F.R. § 405.1835(a)).

In making this dismissal, the Board noted that Tampa's FY 2009 appeal was premature as it would later have an opportunity to file an appeal for FY 2009 challenging the Secretary's policy as finalized in the June 2023 Final Rule. Specifically, as noted in the preamble to the June 2023 Final Rule, providers such as Tampa may challenge that policy by filing an appeal based on the relevant NPR/revised NPR that will ***soon*** be issued reflecting this policy (*i.e.*, the FY 2009 NPR).[11]

Based on the foregoing, the Board found that the June 2023 Final Rule appealed in the instant case is not an appealable "final determination" within the context of 42 U.S.C. § 1395oo(a)(1)(A)(ii) and 42 C.F.R. § 405.1835. It denied Tampa's EJR Request and dismissed Tampa's appeal.

C. Tampa's Request for Reconsideration

On October 9, 2023, Tampa filed a Request for Reconsideration of the Board's Dismissal. It asks the Board to reinstate and reopen Case No. 23-1498 pursuant to 42 C.F.R. § 405.1885(a)(1)(i) and then reverse its August 9, 2023 dismissal decision and grant EJR. Tampa maintains the Board has jurisdiction over its appeal from "the Secretary's determination in the *Federal Register*" and insists it has the right to appeal from the June 2023 Final Rule without waiting for an NPR.[12]

Tampa acknowledges that the Board dismissed the appeal and denied EJR because, while the "determination" under appeal was a promulgated final rule, it is also "one of many variables in calculating" its DSH payment. However, Tampa contends that the Board has found jurisdiction over similar final rules and issues in the past, such as the Two-Midnight Rule.[13] It also argues that *Memorial Hospital* "actually supports jurisdiction over the Provider's appeal here."[14] It notes that the SSI ratios at issue in *Memorial Hospital* were "'immediately rescinded' and never 'used in calculating' [the appellants'] DSH payments" and also notes that the transmittal accompanying the publication of those ratios stated it was not a final determination.[15] In contrast, the June 2023 Final Rule repeatedly characterizes itself as the agency's "final action" and "clearly dictates that payment standard for Part C days in the DSH calculation for open cost reports, including the Provider's still-open [FY] 2009 cost report."[16]

Finally, Tampa claims that, in the cases underlying *Allina II*, "the Board found jurisdiction over the plaintiffs' challenge to the readoption of the DSH Part C payment standard through the 2014 publication of FFY 2012 SSI fractions, which were binding on Medicare contractors."[17] In support of its contention, Tampa cites to *Allina Health Servs. v. Price*, 863 F.3d 937, 940–43 (D.C. Cir.

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[11] Board's Dismissal Letter at 20 n.83 (Aug. 9, 2023).
[12] Provider's Request for Reconsideration of Board's Dismissal, 1 (Oct. 9, 2023) (citing 42 U.S.C. § 1395oo(a)(1)(A)(ii)).
[13] *Id.* at 2.
[14] *Id.*
[15] *Id.* at 2-3 (quoting *Memorial Hospital*, 2022 WL 888190 at *4).
[16] *Id.* (citing 88 Fed. Reg. 37,772, 37,772–93 37,790 (June 9, 2023)).
[17] *Id.* at 3.

2017), *aff'd sub nom. Azar v. Allina Health Servs.*, 139 S. Ct. 1804 (2019) ("*Allina II*").[18] Accordingly, Tampa insists that 42 U.S.C. § 1395oo(a)(1) permits an appeal from the June 2023 Final Rule and that the Board should reinstate its appeal and grant EJR.

D. Tampa's Notice of Supplemental Authority

On November 15, 2023, Tampa filed Notice of Supplemental Authority, attaching the October 31, 2023 decision of the U.S. District Court for the District of Columbia ("D.C. District Court") in *Battle Creek Health System v. Becerra*, No. 17-cv-0545, 2023 WL 7156125 (D.D.C. Oct. 31, 2023) ("*Battle Creek*"). Tampa maintains that "[t]his decision provides further support for the Board's exercise of jurisdiction over the Provider's challenge to the June 2023 final rule governing Part C days in the Medicare [DSH] calculation."[19] Tampa notes that the providers in *Battle Creek* did not wait for their NPRs to be issued but rather appealed from CMS' treatment of Part C days in the Medicare DSH calculation based on an appeal of CMS' 2009 publication of the SSI fractions. Tampa concludes that, consistent with *Battle Creek*, the Board is incorrectly finding in this case that the June 2023 Final Rule is not a "final determination" within the meaning of 42 U.S.C. § 1395oo.

Decision of the Board:

As set forth below, the Board hereby ***denies*** Tampa's Request for Reconsideration.

Tampa appealed based on the finalization of the policy at issue in the June 2023 Final Rule, claiming it is a "final determination" of "the amount of payment under subsection . . . (d)" that is appealable to the Board pursuant to 42 U.S.C. § 1395oo(a)(1)(A)(ii). The following are the relevant excerpts from 1395oo(a) that could relate to "the amount of payment under subsection . . . (d)":

> **(a) Establishment**
>
> . . . *[A]ny hospital* which receives payments in amounts computed under subsection (b) or (d) of section 1395ww of this title *and which has submitted such [cost] reports within such time as the Secretary may require in order to make payment under such section* may obtain a hearing with respect to such payment by the Board, if—
>
> (1) such provider—
>
> (A) . . .
>
> (ii) is dissatisfied with a final determination of the Secretary *as to the amount of the payment* under subsection (b) or (d) of section 1395ww of this title, ...[20]

[18] *Id.*
[19] Provider's Notice of Supplemental Authority at 1.
[20] (Bold emphasis in original and italics and underline emphasis added.)

The "final determination" being appealed in this case is a change in policy adopted/finalized in the June 2023 Final Rule. However, the adoption/finalization of this policy in the June 2023 Final Rule is not a "final determination" directly appealable to the Board *for purposes of 42 U.S.C. § 1395oo(a)(1)(A)(ii)*. Rather, Tampa's appeal is premature as described below.

Unlike DRG rates and other adjustments such as the wage index, a hospital's eligibility for a DSH payment (and, if eligible, the amount of that payment) during a particular fiscal year is not ***prospectively*** set or determined as part of the relevant IPPS final rule. In this regard, 42 U.S.C. § 1395ww(d)(5)(F) refers to the DSH adjustment being calculated "with respect to a [hospital's] cost reporting period" and uses days associated with inpatients stays *occurring during that cost reporting period*.[21] To this end, DSH eligibility ***and*** payment, if any, is determined, calculated, and finalized *annually* through the cost report audit/settlement process as made clear in 42 C.F.R. § 412.106(i) which sets forth the following instructions regarding the determination of a hospital's eligibility for a DSH payment for each fiscal year and, if so, how much:

> (i) *Manner and timing of [DSH] payments*. (1) **Interim** [DSH] **payments** are made **during the payment year to each hospital that is estimated to be eligible** for payments under this section at the time of the annual final rule for the hospital inpatient prospective payment system, **subject to the final determination of eligibility at the time of cost report settlement for each hospital**.
>
> (2) **Final payment determinations are made at the time of cost report settlement**, based on the **final** determination of each hospital's eligibility for payment under this section.[22]

The Secretary makes clear that this regulation is based on "our ***longstanding*** *process* of making ***interim*** *eligibility* determinations for Medicare DSH payments *with* ***final*** *determination* ***at cost report settlement***."[23] As a NPR has not yet been issued to Tampa for FY 2009, it is clear that

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[21] The Board notes that the Medicare DSH adjustment provision under 42 U.S.C. § 1395ww(d)(5)(F) was enacted by § 9105 of the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") and became effective for discharges occurring on or after May 1, 1986. Pub. L. 99-272, § 9105, 100 Stat. 82, 158-60. As such, it was enacted several years after the initial legislation that established the IPPS.

[22] (Italics emphasis in original and bold and underline emphasis added.) This section was added as part of the FY 2014 IPPS Final Rule. 78 Fed. Reg. 50496, 50646, (Aug. 19, 2013). It was initially codified at § 412.106(h) (*id.*), but was later redesignated as § 412.106(i) (87 Fed. Reg. 48780, 49049 (Aug. 10, 2022)).

[23] 78 Fed. Reg. at 50627. *See also* Provider Reimbursement Manual, CMS Pub. 15-1 ("PRM 15-1"), § 2807.2(B)(5) (last revised Aug. 1993, Transmittal 371) (stating: "*At* ***final*** ***settlement*** *of the cost report*, the intermediary determines the final disproportionate share adjustment based on the actual bed size and disproportionate share patient percentage for the cost reporting period." (emphasis added)). In the preamble to the FY 2014 IPPS Final Rule, the Secretary discussed the DSH eligibility and payment process and the following are excerpts from that discussion:

> *Comment*: Several commenters requested that CMS undertake additional audits to verify the data used to compute the 25-percent empirically justified Medicare DSH payment adjustments. Other commenters requested that CMS grant additional time for hospitals to verify the data and adjust their cost reports to ensure that the data used to compute the adjustment are accurate and up to date. Some

Tampa has not yet had a "final determination" issued for FY 2009 consistent with 42 C.F.R. § 412.106(i) addressing both: (1) whether the Provider is eligible for a DSH payment *for FY 2009*; and (2) if so, how much.[24] In particular, if Tampa's assigned Medicare contractor determines that Tampa is eligible for a DSH payment ***for FY 2009***, then the SSI fraction is just one variable that the Medicare contractor will use in determining Tampa's FY 2009 DSH payment as explained in the Board's August 9, 2023 determination. For example, 42 C.F.R. § 412.106(b)(4) addresses another variable and specifies that the Medicare Contractor determines the Medicaid eligible days to be included in the numerator of a hospital's DSH Medicaid fraction based on the number of such days claimed in the relevant as-filed cost report and that, as part of the cost report audit and settlement process, "[t]he hospital has the burden of furnishing data adequate to prove eligibility for ***each*** Medicaid patient day claimed."[25]

> commenters requested that CMS establish procedures to allow a hospital initially determined not to be eligible for Medicare DSH payments to begin receiving empirically justified Medicare DSH payments if data become available that indicate that the hospital would be eligible.
> *Response*: As we have emphasized, we are maintaining the well-established methodology and payment processes used under the current Medicare DSH payment adjustment methodology for purposes of making the empirically justified Medicare DSH payment adjustments. Hospitals are quite familiar with the cost reporting requirements and auditing procedures employed under the current Medicare DSH payment adjustment methodology. Hospitals are also familiar with the current process of determining **interim eligibility** for Medicare DSH payments **with final determination at cost report settlement**. Therefore, we do not believe that it would be warranted to add additional complexity to these procedures by adopting any of these recommendations.
>
> ****
>
> **For the reasons discussed above regarding the empirically justified Medicare DSH payments** [*i.e.*, the DSH payment calculation made under 42 U.S.C. § 1395ww(d)(5)(F)], **we do not believe that it is necessary or advisable to depart from our longstanding process of making interim eligibility determinations for Medicare DSH payments with final determination at cost report settlement.** As we discuss in greater detail in section V.E.3.f. of the preamble to this final rule, we will make interim eligibility determinations based on data from the most recently available SSI ratios and Medicaid fractions prior to the beginning of the payment year. We will then make final determinations of eligibility at the time of settlement of each hospital's cost report. Therefore, we proposed that, at cost report settlement, the fiscal intermediary/MAC will issue a notice of program reimbursement that includes a determination concerning whether each hospital is eligible for empirically justified Medicare DSH payments and, therefore, eligible for uncompensated care payments in FY 2014 and each subsequent year. In the case where a hospital received interim payments for its empirically justified Medicare DSH payments and uncompensated care payments for FY 2014 or a subsequent year on the basis of estimates prior to the payment year, but is determined to be ineligible for the empirically justified Medicare DSH payment at cost report settlement, the hospital would no longer be eligible for either payment and CMS would recoup those monies. For a hospital that did not receive interim payments for its empirically justified Medicare DSH payments and uncompensated care payments for FY 2014 or a subsequent year, but at cost report settlement is determined to be eligible for DSH payments, the uncompensated care payment for such a hospital is calculated based on the Factor 3 value determined prospectively for that fiscal year.

Id. at 50626-27 (emphasis added).

[24] The fact that a hospital has received a DSH payment in ***prior*** fiscal years, does not mean or guarantee that the hospital will (or continue to) be eligible for and receive a DSH payment in subsequent fiscal year. For each fiscal year, the Medicare contractor determines whether a hospital is eligible for a DSH payment and, if so, how much based on multiple variables associated with that fiscal year (*e.g.*, the number of Medicaid eligible days in the relevant fiscal year).

[25] 42 C.F.R. § 412.106(b)(4)(iii) (emphasis added). *See also* HCFA Ruling 97-2 (Feb. 1997).

While the Board has found jurisdiction and granted EJR to challenge *other* policies set forth in the Federal Register such as the Two-Midnight Rule, it already addressed and distinguished that from the current challenge based on this same principle.[26] Indeed, a hospital that is potentially eligible for a DSH payment must "submit[] such [cost] report[] within such time as the Secretary may require *in order to make payment under such section* [*i.e.*, subsection (d)]" as confirmed in the above quote of 42 C.F.R. § 412.106(i). Examples of other adjustments to IPPS payment rates that are based, in whole or in part, on certain data/costs claimed on the as-filed cost report and then determined and reimbursed through the cost report audit and settlement process include bad debts,[27] direct graduate medical education ("GME"),[28] and indirect GME.[29] This is what makes this case distinguishable from the facts presented in the D.C. Circuit's decisions in *Washington Hospital* where the determination that was appealed finalized the only hospital-specific variable used in setting the per-patient payment amount. Specifically, the hospitals in *Washington Hospital* appealed their "Final Notice of Base Period Cost and Target Amount Per Discharge" and the D.C. Circuit found: (a) "the ***only variable*** *factor* in the final determination as to the amount of payment under § 1395ww(d) is the hospital's target amount . . . .";[30] and (b) "The amount is the per-patient amount calculated under § 1395ww(d) and is final once the Secretary has published the DRG amounts (as has) and finally determined the hospital's target amount. Here each of the hospitals has received a 'Final Notice of Base Period Cost and Target Amount per Discharge.' The statute requires no more to trigger the hospital's right to appeal PPS Payments to the PRRB."[31]

In the instant case, the Board declines to follow D.C. District Court's decision in *Battle Creek*[32] and instead continues to find the D.C. District Court's 2022 decision in *Memorial Hospital* to be instructive. *Memorial Hospital* concerns another variable used in the DSH adjustment calculation.

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[26] *See* EJR Determination at 19 n.78 and accompanying text (Aug. 9, 2023).

[27] 42 C.F.R. §§ 412.2(f)(4), 412.115(a) (stating: "An additional payment is made to each hospital in accordance with § 413.89 of this chapter for bad debts attributable to deductible and coinsurance amounts related to covered services received by beneficiaries.).

[28] 42 C.F.R. § 412.2(f)(7) (stating that hospitals receive an additional payment for "[t]he direct graduate medical education costs for approved residency programs in medicine, osteopathy, dentistry, and podiatry as described in §§413.75–413.83 of this chapter.").

[29] 42 C.F.R. §§ 412.2(f)(2), 412.105. *See also* PRM 15-1 § 2807.2(B)(6) (stating: "*At* ***final settlement*** *of the cost report*, the intermediary determines the indirect teaching adjustment based on the actual number of full time equivalent residents and average daily census for the cost reporting period. (emphasis added)).

[30] 795 F.2d at 143 (emphasis added).

[31] *Id.* at 147 (footnote omitted).

[32] The Board recognizes that, in *Battle Creek*, the D.C. District Court addressed a jurisdictional issue involving DSH SSI fractions ***similar to*** the jurisdictional issue that the *same* Court (different judge) issued in *Memorial Hospital* but reached a different conclusion. However, the Board disagrees with the *Battle Creek* decision and maintains that *Memorial Hospital* is a better-reasoned decision and, in particular, provides a more thoughtful analysis and application of the D.C. Circuit's decision in *Washington Hospital*. Indeed, the *Battle Creek* decision does not even discuss (much less reference) the *Memorial Hospital* decision that was issued 19 months earlier by a different judge in the ***same*** Court. Finally, *Battle Creek* is distinguishable from the case at hand. *Battle Creek* addressed whether the publication of SSI fractions is a final determination. In contrast, Tampa did not appeal the publication of SSI fractions but rather a final rule adopting and finalizing the policy at issue ***prior to*** the issuance of new SSI fractions to be used in the yet-to-be issued FY 2009 NPR. To this end, in finalizing that policy adoption in the June 2023 Final Rule, the Secretary announced that "CMS must calculate DSH payments for periods that include discharges occurring before the effective date of the prospective FY 2014 IPPS final rule for hundreds of hospitals whose DSH payments ***for those periods are still open or have not yet been finally settled*** . . . ." 88 Fed. Reg. at 37774 (emphasis added).

Specifically, the providers in that case appealed ***the publication of their DSH SSI ratios*** (which is one step *after* the case at hand where Tampa is appealing the final rule adopting/finalizing a policy ***prior to*** the publication of the DSH SSI ratios reflecting that final rule). The providers in *Memorial Hospital* argued that there are certain instances where a provider can appeal prior to receiving an NPR and gave citations to certain D.C. Circuit cases in support. However, the D.C. District Court distinguished these cases because "the secretarial determination at issue was either the only determination on which payment depended or clearly promulgated as a final rule."[33] The D.C. District Court ultimately agreed with the Board that this was not an appealable final determination. In its discussion, the D.C. District Court agreed with the Secretary that the publication of the SSI ratios, *even if the publication of the SSI fractions had been issued as "final,"* it could and would not be a final determination "as to the amount of payment" because the SSI fractions are "just one of the variables that determines whether hospitals receive a DSH payment ***and***, ***if so***, *for how much*."[34] The D.C. District Court concluded:

> A challenge to *an* ***element*** *of payment* under 42 U.S.C. § 1395oo(a)(1)(A)(ii) is ***only*** *appropriate* ***if***, as the D.C. Circuit has explained, "*the Secretary ha[s] firmly established '****the only variable factor*** in the final determination as to the amount of payment under § 1395ww(d).'" *Monmouth Med. Ctr. v. Thompson*, 257 F.3d 807, 811 (D.C. Cir. 2001) (quoting *Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 147 (D.C. Cir. 1986)) (emphasis added); *see also Samaritan Health Serv. v. Sullivan*, 1990 WL 33141 at *3 (9th Cir. 1990) (unpublished table decision) ("We have held that if the Secretary's classification of a hospital effectively fixes the hospital's reimbursement rate, then that decision is a 'final determination' as referred to 42 U.S.C. § 1395oo(a)(1)(A)(ii).").[35]

Accordingly, the Court upheld the Board's decision to dismiss because the DSH SSI fraction was only one of the variables that determine whether a hospital receives a DSH payment (and, if so, for how much) and the publication of a hospital's SSI fraction is not a determination as to the amount of payment received.[36]

Similar to the D.C. District Court's decision in *Memorial Hospital*, while the policy at issue in this case was promulgated/finalized in the June 2023 Final Rule, it is ***not*** a "final determination" as to the amount of payment received by Tampa for FY 2009. Rather, the June 2023 Final Rule reflects "just one of the variables that determines whether hospitals receive a DSH payment [for the relevant fiscal year] ***and***, ***if so***, *for how much*"; and any "***final*** *payment* determination"[37] on whether a hospital receives a DSH payment for a particular fiscal year and, if so, for how much *is made during the cost report audit/settlement process as explained at 42 C.F.R. § 412.106(i)*.[38]

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[33] 2022 WL 888190 at *8.
[34] *Id.* at *9 (emphasis added).
[35] *Id.* at *8.
[36] *Id.* at *9.
[37] 42 C.F.R. § 412.106(i)(2) (emphasis added).
[38] 2022 WL 888190 at *9 (emphasis added).

The Board recognizes that the Provider points to the *Allina II* litigation and alleges that "the Board found jurisdiction over the plaintiffs' challenge to the readoption of the DSH Part C payment standard through the 2014 publication of FFY 2012 SSI fractions" and granted EJR over that challenge.[39] The Board disagrees with Tampa's characterization of the *Allina II* litigation and finds that *Allina II* has absolutely no relevance to the ***jurisdictional*** issue that the Board addressed in its August 9, 2023 dismissal of the instant appeal. First, that litigation does *not* address the Board's *jurisdiction* over the underlying appeals of the nine (9) Plaintiff hospitals in *Allina II* (*e.g.*, it does not address whether the publication of the SSI ratios was a "final determination" *for purposes of 42 U.S.C. § 1395oo(a)(1)(A)(ii)*).[40] Further, it is clear from the Complaint filed to establish the *Allina II* litigation that ***none*** of the 9 Plaintiff hospitals based their right to appeal on the publication of the SSI fractions pursuant to 42 U.S.C. § 1395oo***(a)(1)(A)(ii)***.[41] Rather, the Complaint makes clear that each of the 9 Plaintiff hospitals based their right to appeal *on the failure of the Medicare Contractor to timely issue an NPR as set forth in 42 U.S.C. § 1395oo**(a)(1)(B)***[42] as implemented at 42 C.F.R. § 405.1835(c) (2014).[43] Accordingly, it is clear that the *Allina II* litigation has no relevance to the ***jurisdictional*** question addressed by the Board in the instant case, namely whether Tampa has the right to appeal the policy at issue published in the June 2023 Final Rule pursuant to 42 U.S.C. § 1395oo***(a)(1)(A)(ii)***.

Finally, in further support of its finding that Tampa's appeal is premature, the Board looks to the four corners of the June 2023 Final Rule to confirm both that: (1) it is ***not*** a final determination appealable to the Board; *and* (2) the Secretary did ***not*** otherwise intend for it to be a final determination appealable to the Board. The June 2023 Final Rule simply finalizes the adoption of the Part C days policy at issue for open and prospective cost reporting periods. It does not make any determination on *any* hospital's DSH eligibility (much less Tampa's) and, if so, how much. Moreover, it does not publish *any* hospital's SSI percentage (much less Tampa's) that would be used in DSH calculations for those hospitals whose eligibility would later be determined as part of their cost report settlement process for the relevant fiscal year. Further, the following excerpts from

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[39] Provider's Request for Reconsideration of Board's Dismissal, 3 (Oct. 9, 2023) (citing to *Allina Health Servs. v. Price*, 863 F.3d 937, 940–43 (D.C. Cir. 2017), *aff'd sub nom. Azar v. Allina Health Servs.*, 139 S. Ct. 1804 (2019)).

[40] Rather, it addresses the Board's "no-authority determination" when it granted EJR. This is not a *jurisdictional* issue under 42 U.S.C. § 1395oo(a)(1), but rather an issue relating to whether the Board appropriately granted EJR pursuant to 42 U.S.C. § 1395oo(f)(1).

[41] *Allina II* began as *Allina Health Servs. v. Burwell*, No. 14-01415, (D.D.C. Aug. 19, 2014) resulting in *Allina Health Servs. v. Burwell*, 201 F. Supp. 3d 94 (D.D.C. 2016), *reversed Allina Health Servs. v. Price*, 863 F.3d 937 (D.C. Cir. 2017), *aff'd sub nom. Azar v. Allina Health Servs.*, 139 S. Ct. 1804 (2019) ("*Allina II*").

[42] *Allina Health Servs. v. Burwell*, No. 14-01415, Complaint at ¶¶ 38-39 (D.D.C. Aug. 19, 2014) (stating: 38. . . . None of the [9] plaintiff Hospitals has received an NPR reflecting final Medicare DSH payment determinations for their cost reporting periods beginning in federal fiscal years 2012. 39. As a result, *the [9] plaintiff Hospitals timely filed appeals to the Board*, ***pursuant to 42 U.S.C. §§ 1395oo(a)(1)(B)***, to challenge the agency's treatment of Medicare part C days as Medicare part A days for purposes of the part A/SSI fraction and the Medicaid fraction of the Medicare DSH calculation for their 2012 cost years." (footnote omitted and emphasis added)).

[43] *Allina Health Servs. v. Burwell*, No. 14-01415, Complaint at ¶¶ 38-39 (D.D.C. Aug. 19, 2014) (stating: 38. . . . None of the [9] plaintiff Hospitals has received an NPR reflecting final Medicare DSH payment determinations for their cost reporting periods beginning in federal fiscal years 2012. 39. As a result, *the [9] plaintiff Hospitals timely filed appeals to the Board*, ***pursuant to 42 U.S.C. §§ 1395oo(a)(1)(B)***, to challenge the agency's treatment of Medicare part C days as Medicare part A days for purposes of the part A/SSI fraction and the Medicaid fraction of the Medicare DSH calculation for their 2012 cost years." (footnote omitted and emphasis added)).

the June 2023 Final Rule discussing a hospital's right to challenge the Part C days policy adopted therein make clear that the Secretary did not consider the final rule to be an appealable "final determination":

1. "Additionally, the Secretary has determined that it is in the public interest for CMS to adopt a retroactive policy for the treatment of MA patient days in the Medicare and Medicaid fractions through notice and comment rulemaking for discharges before October 1, 2013 (the effective date of the FY 2014 IPPS final rule). *CMS must calculate DSH payments for periods that include discharges occurring before the effective date of the prospective FY 2014 IPPS final rule for hundreds of hospitals* ***whose DSH payments for those periods are still open or have not yet been finally settled, encompassing thousands of cost reports***. *In order to calculate these payments, CMS* ***must*** *establish Medicare fractions for* ***each*** *applicable cost reporting period* during the time period for which there is currently no regulation in place that expressly addresses the treatment of Part C days."[44]

2. "We do not agree that it is arbitrary or capricious to treat hospitals' Part C days differently on the basis of the timing of their appeals vis-a-vis Supreme Court and lower court decisions. The instructions to contractors that issued after the *Northeast* decision cannot control over the holding of the Supreme Court in *Allina II.* It is also not unusual for cost reports to be finalized differently from one another with respect to a legal issue depending on the outcome of litigation raising that issue and the status of a hospital's appeal at the time of a final non-appealable decision. Providers will also be able to request to have their Medicare fraction realigned to be based on their individual cost reporting periods rather than the Federal fiscal year, in accordance with the normal rules. **Providers who remain dissatisfied after receiving NPRs and revised NPRs that reflect the interpretation adopted in this final action retain appeals rights and can challenge the reasonableness of the Secretary's interpretation set forth in this final action**."[45]

3. "Providers who have pending appeals reflecting fractions calculated in the absence of a valid rule will receive NPRs or revised NPRs reflecting DSH fractions calculated pursuant to this new final action and *will have appeal rights with respect to the treatment of Part C days in the calculation of the DSH fractions* ***contained in the NPRs or revised NPRs***. Providers whose appeals of the Part C days issue have been remanded to the Secretary *will likewise receive NPRs or revised NPRs* reflecting fractions calculated pursuant to this new final action, *with attendant appeal rights*. Because NPRs and revised NPRs will reflect the application of a new DSH Part C days rule, CMS will have taken action under the new action, and *the new or revised* ***NPRs*** *will provide hospitals with a* ***vehicle to appeal*** *the new final action* even if the Medicare fraction or DSH payment does not change numerically."[46]

4. "*When the Secretary's treatment of Part C days in this final action is reflected* ***in NPRs and revised NPRs****, providers*, including providers whose appeals were remanded under the

[44] 88 Fed. Reg. at 37774-75 (emphasis added).
[45] *Id.* at 37787 (underline and bold emphasis added and italics emphasis in original).
[46] *Id.* at 37788 (emphasis added).

> [CMS] Ruling [1739-R], *will be able to challenge the agency's interpretation* ***by appealing those NPRs and revised NPRs***. While some providers have already received reopening notices and had their NPRs held open for resolution of the Part C days issue, the issuance of new NPRs and revised NPRs pursuant to remands under the Ruling are not reopenings."[47]

Rather, the above discussion in the preamble to the June 2023 Final Rule makes clear that hospitals would be able to appeal the application of that finalized policy to the relevant fiscal year since the preamble's discussion of a hospital's right to challenge that finalized policy is only in the context of yet-to-be issued NPRs (original or revised) following the publication of new SSI percentages that would apply the finalized policy and then be used in determining: (a) DSH eligibility for a hospital's prior period that is still open and has not yet been finally settled; and (b) if so, the amount of the DSH payment. Here, Tampa's appeal is premature as it will have an opportunity to later file an appeal to challenge the policy at issue once its FY 2009 NPR is issued consistent with the above excerpts from the preamble to the June 2023 Final Rule and 42 C.F.R. § 412.106(i).

* * * * *

In summary, the Board has considered the arguments presented by the Provider in its Request for Reconsideration and hereby affirms its August 9, 2023 decision to both deny EJR and dismiss the appeal as premature.

Board Members Participating:

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

For the Board:

11/27/2023

X Clayton J. Nix

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

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

[47] *Id.* (emphasis added).

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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RE: ***Board Decision***
Lakeway Regional Hospital (Prov. No. 44-0067)
FYE: 05/31/2016
Case No.: 19-0444

Dear Mr. Summar and Mr. Lamprecht:

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the documentation in Case No. 19-0444 pursuant to a jurisdictional challenge filed by the Medicare Administrative Contractor ("MAC"). The Board's decision is set forth below.

Background

A. *Procedural History for Case No. 19-0444*

On May 16, 2018, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end May 31, 2016.

On November 16, 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 (Systemic Errors)[1]
3. DSH Payment – Medicaid Eligible Days[2]
4. UCC Distribution Pool
5. 2 Midnight Census IPPS Payment Reduction[3]

The Provider is owned by Community Health Systems, Inc. (hereinafter "Community Health") and, therefore, is subject to the mandatory Common Issue Related Party ("CIRP") group regulation at 42 C.F.R. § 405.1837(b)(1). The Provider transferred Issues 2 and 5 to Community Health CIRP groups on June 14, 2019. After the withdrawal of Issue 3, the remaining issues in this appeal are Issues 1 and 4.

[1] On June 14, 2019, this issue was transferred to PRRB Case No. 19-1409GC.
[2] This issue was withdrawn on March 2, 2023.
[3] On June 14, 2019, this issue was transferred to PRRB Case No. 19-1410GC.

On January 9, 2019, the Medicare Contractor filed a jurisdictional challenge, requesting the dismissal of Issues 1, 2 (the portion regarding the low-income payment), 4 and 5.[4] The Provider filed a Jurisdictional Response on February 6, 2019.

On June 28, 2019, the Provider submitted its preliminary position paper.

On November 1, 2019, the Medicare Contractor filed its preliminary position paper.

A. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 19-1409GC

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]

As the Provider is commonly owned by Community Health, the Provider transferred its Issue 2 – DSH/SSI Percentage to the CIRP group under 19-1409GC, CHS CY 2016 DSH SSI Percentage CIRP Group, on June 14, 2019. The Group Issue Statement in Case No. 19-1409GC reads, in part:

> **Statement of the Issue:**
>
> Whether the Secretary properly calculated the Provider's [DSH]/[SSI] percentage, and whether CMS should be required to recalculate the SSI percentages using a denominator based solely upon covered and paid for Medicare Part A days, or alternatively, expand the numerator of the SSI percentage to include paid/covered/entitled as well as unpaid/non-covered/eligible SSI days?

[4] As previously noted, Issue No. 2 and 5 were subsequently transferred to Community Health CIRP groups on June 14, 2019.
[5] Issue Statement at 1 (Nov. 16, 2018).

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.[6]

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $7,000.

On June 28, 2019, 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.

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

[6] Group Issue Statement, Case No. 19-1409GC.

> 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 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 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.[8]

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

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[7] Provider's Preliminary Position Paper at 8-9 (June 28, 2019).
[8] Jurisdictional Challenge at 5-6 (Jan. 9, 2019).
[9] *Id*. at 3-5.
[10] *Id*. at 9.

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."[11] 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."[12]

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, because of its understated SSI percentage due to errors of omission and commission."[13]

Issue 4 – UCC Distribution Pool

The Board Rules require that a timely response to a Jurisdictional Challenge must be filed within thirty (30) days from the Medicare contractor's jurisdictional challenge.[14] While the Provider did file a timely response to the Jurisdictional Challenge, it did not include a reply to the MAC's challenge of the UCC Distribution Pool issue.

Analysis and Recommendation

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2016), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

A. DSH – SSI Percentage (Provider Specific)

The Board finds that it does not have jurisdiction over the DSH Payment/SSI Percentage (Provider Specific) issue. The jurisdictional analysis for Issue No. 1 has 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*

[11] Jurisdictional Response at 1 (Feb. 6, 2019).
[12] *Id*. at 2.
[13] *Id*.
[14] Board Rule 44.4.3, v. 2 (Aug. 2018).

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. 19-1409GC.

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."[15] The Provider's legal basis for its DSH – 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 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."[17]

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 the DSH Payment/SSI Percentage (Provider Specific) issue in this appeal 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, 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 19-1409GC. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[18] 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. 19-1409GC.

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. 19-1409GC, but instead refers to systemic *Baystate* data matching

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

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

> https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH.[20]
> This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows: "DSH is now a self-service application. This ***new***

[19] (Emphasis added).
[20] Last accessed February 24, 2023.

> ***self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[21]

Indeed, the D.C. Circuit affirmed in *Advocate Christ Med. Ctr. v. Becerra,* No. 22-5214, 2023WL5654312 (D.C. Cir., Sept. 1, 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 Providers do not explain what information it needs or is waiting on or claims that it should have access to.

Accordingly, the Board finds that the remaining issue in the instant appeal and the group issue from Group Case 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—should be dismissed by the Board.

The Board finds that, under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." Without this written request, the Medicare Contractor cannot issue a final determination 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. 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).

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:

[21] Emphasis added.

(A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).[22]

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

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.[27]

b. DCH Regional Med. Ctr. v. Azar

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[22] 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.
[23] 830 F.3d 515 (D.C. Cir. 2016).
[24] 89 F. Supp. 3d 121 (D.D.C. 2015).
[25] 830 F.3d 515, 517.
[26] *Id.* at 519.
[27] *Id.* at 521-22.

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*").[28] 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."[29] 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.[30]

c. Scranton Quincy Hosp. Co. v. Azar

Recently, in *Scranton Quincy Hosp. Co. v. Azar* ("*Scranton*"),[31] 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.[32] 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.[33] 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.[34] Nevertheless, the Secretary used each hospital's shorter cost reporting period in calculating the Factor 3 values for their FY 2015 DSH payments.[35]

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

[28] 925 F.3d 503 (D.C. Cir. 2019) ("*DCH v. Azar*").
[29] *Id.* at 506.
[30] *Id.* at 507.
[31] 514 F. Supp. 249 (D.D.C. 2021).
[32] *Id.* at 255-56.
[33] *Id.* (quoting 79 Fed. Reg. 49854, 50018 (Aug. 22, 2014)).
[34] *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.
[35] *Id.*

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.[36]

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."[37] 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.[38] 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.[39]

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.[40] 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*").[41] 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.[42] 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*

[36] *Id.* at 262-64.
[37] *Id.* at 265.
[38] *Id.* (discussing *Leedom v. Kyne*, 358 U.S. 184, 188 (1958)).
[39] *Id.* at 264 (quoting *DCH v. Azar*, 925 F.3d at 509-510).
[40] *Id.* at 264-6511 (quoting *DCH v. Azar*, 925 F.3d at 509).
[41] Civ. No. 20-139, 2021 WL 3856621 (D.D.C. August 30, 2021).
[42] *Id*. at *4.

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."[43] The D.C. Circuit further dismissed the applicability of the Supreme Court's 2019 decision in *Azar v. Allina Health Servs*.[44] 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***."[45]

The Board concludes that the same findings are applicable to the Provider's challenge to their FFY 2016 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 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.

Decision

The Board hereby dismisses the DSH Payment/SSI Percentage (Provider Specific) issue from appeal as it is duplicative of the issue in PRRB Case No. 19-1409GC and there is no final determination from which the Provider can appeal the SSI realignment portion of the issue.

The Board also 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 there are no issues remaining in the appeal, this case is now closed. 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.

[43] *Id.* at *9.
[44] 139 S. Ct. 1804 (2019).
[45] *Ascension* at *8 (bold italics emphasis added).

Board Members Participating:

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Robert A. Evarts, Esq.
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For the Board:

11/27/2023

X Robert A. Evarts, Esq.

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

cc: Wilson Leong, Federal Specialized Services

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RE: ***Duplicative DSH SSI MMA 951 and SSI Accuracy Issues***

Sutter Roseville Medical Center (Provider Number 05-0309)
FYE: 12/31/2018
Case Number: 23-1544

Sutter Health FFY 2018 DSH SSI Ratio – Inaccurate Data CIRP Group
Case Number: 22-1293GC

Dear Mr. Jaeger and Ms. Frewert:

The Provider Reimbursement Review Board (the Board) has reviewed the subject appeals in response to an October 13, 2023 request from Sutter Health ("Sutter") to transfer the "Medicare DSH SSI Ratio - MMA Sec 951" issue to Case No. 22-1293GC. The pertinent facts of the groups and the Board's determination are set forth below.

Pertinent Facts:

On July 25, 2023, Sutter filed the individual appeal for Sutter Roseville Medical Center ("Sutter Roseville"/Provider Number 05-0309) for FYE 12/31/2018 under Case Number 23-1544. The appeal included 10 issues:

1) Medicare DSH SSI Ratio - Inaccurate Data
2) Medicare DSH SSI Ratio Part C Days
3) Medicare DSH SSI Ratio - Part A Days
4) Medicare DSH SSI Ratio - MMA Sec 951
5) Medicare DSH RAC 2 and 3 Days
6) Medicare DSH Medicaid Ratio - Part C Days
7) Medicare DSH Medicaid Ratio - Part A Days
8) Medicare DSH - Medicaid Eligible Days
9) Predicate Facts
10) Inpatient PPS Unrestored ATRA/MACRA Reduction

On October 13, 2023, Sutter requested the transfer of Issue #1 (Medicare DSH SSI Ratio -

Inaccurate Data) and Issue # 4 (Medicare DSH SSI Ratio - MMA Sec 951) to "the Sutter Health FFY 2018 DSH SSI Ratio - Inaccurate Data CIRP Group" under Case No. 22-1293GC. Sutter also transferred all other issues, except #3, #7 and #8, which were withdrawn from Case No. 23-1544.

Board Determination:

The Board finds that the SSI MMA § 951 issue is duplicative of the Medicare DSH SSI Ratio - Inaccurate Data issue, which has already been transferred to a DSH SSI Ratio - Inaccurate Data CIRP group.

Section 951 of the Medicare Modernization Act provides:

> Beginning not later than 1 year after the date of the enactment of this Act, the Secretary shall arrange to furnish to subsection (d) hospitals (as defined in section 1886(d)(1)(B) of the Social Security Act, 42 U.S.C. 1395ww(d)(1)(B)) the data necessary for such hospitals to compute the number of patient days used in computing the disproportionate patient percentage under such section for that hospital for the current cost reporting year. Such data shall also be furnished to other hospitals which would qualify for additional payments under Part A of title XVIII of the Social Security Act on the basis of such data.

In the Medicare DSH SSI Ratio - MMA Sec 951 issue (#4), the Provider argues that CMS has not complied with this provision in terms of both releasing the data to begin with, as well as releasing all of the data that the Providers believe should be released. The Provider made a very similar argument in the corresponding Medicare DSH SSI Ratio - Inaccurate Data issue (#1) which is now pending in Case No. 22-1293GC. Part of the issue statement in the SSI Accuracy group reads:

> The Provider contends that CMS did not use the best data available at the time of settlement to calculate the SSI fraction because of various reasons including but not limited to: not using updated current data, using data that excluded inactive claims, retroactive claims and what is sometimes referred to as forced or manual pay claims.

Both the SSI MMA § 951 issue and the SSI - Inaccurate Data issue raise the issue that CMS has failed to disclose the underlying patient data related to the SSI ratio. Therefore, having two issues that make the same argument related to the SSI ratio is duplicative, and in violation of PRRB Rule 4.6.[1]

There are several other indicators that the two issues are duplicative. First, Sutter Roseville has calculated the same amount in controversy in the respective SSI MMA § 951 and SSI - Inaccurate Data issue. Second, the Provider is ultimately seeking the same remedy from the two

[1] Board Rule 4.6.1 indicates "[a] provider may not appeal and pursue the same issue from a single determination in more than one appeal (individual or group).

issues – it wants access to the underlying data so it can determine that its ratio is understated and it can, therefore, receive a new SSI ratio. Further, the Provider is attempting to transfer both issues to the same single-issue CIRP group, thus implying they are the same issue.

Based on these factors, the Board finds that the SSI MMA § 951 issue and the SSI – Inaccurate Data issue are duplicative. Therefore, the Board hereby dismisses the SSI MMA § 951 issue (#4) and denies the transfer to the Sutter Health FFY 2018 DSH SSI Ratio - Inaccurate Data CIRP Group, Case No. 22-1293GC. Since there are no remaining issues in the individual appeal, the Board closes Case No. 23-1544 and removes it from the Board's docket.

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

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

For the Board:

11/29/2023

X Kevin D. Smith, CPA

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

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

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RE: ***Board Decision***
Hall Render FFY 2021 Uncompensated Care Payments Group
Case No.: 21-1012G

Dear Ms. Elias:

The Provider Reimbursement Review Board ("Board") reviewed the documentation in Case No. 21-1012G pursuant to a jurisdictional challenge filed by the Medicare Administrative Contractor ("MAC"). The Board's decision is set forth below.

Background

On March 10, 2021, the Board received the optional group appeal request for the DSH Uncompensated Care Units payment issue for fiscal year end 2021. The group was formed with two participants that both appealed from the Medicare Inpatient Prospective Payment System (IPPS) Final Rule, published in the Federal Register on September 18, 2020. The group was fully formed a year later with the same two participants.

On July 15, 2022, the Medicare Contractor filed a Jurisdictional Challenge contending the Board does not have jurisdiction over the DSH UCC payment issue. On August 12, 2022, the Providers filed their Jurisdictional Response.

MAC's Contentions

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)."[1]

The MAC also notes the Board has denied jurisdiction in similar cases, citing *Fla. Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health and Human Serv. ("Tampa General")*, 830 F. 3d. 515 (D.C. Cir. 2016), in which the Court concluded that preclusion was absolute. The MAC quotes the Board as follows:

[1] Jurisdictional Challenge at 2.

> Further, the D.C. Circuit Court upheld the D.C. District Court's decision that there is no judicial or administrative review of uncompensated care DSH payments. In *Tampa General*, 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 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 District Court found that there was specific language in the statute that precluded administrative or judicial review of Tampa General'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 Court went on to hold that, "the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well." The Court also rejected Tampa General'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.

Provider's Jurisdictional Response

The Providers filed a response to the Jurisdictional Challenge on August 12, 2022. In their response, the Providers argue:

> The Medicare Administrative Contractor (MAC) via the Appeals Support Coordinator (ASC) has challenged the Provider Reimbursement Board's jurisdiction to consider the question asked by the Providers in this appeal: whether CMS can base its Uncompensated Care Disproportionate Share Hospital (UCDSH) payment on Worksheet S-10 data it required the MACs to audit and amend if CMS refused to publish the audit protocol as required by 42 U.S.C. § 1395hh. The Providers contend that CMS cannot—that the MACs' use of unpublished audit protocol(s) to change their UCDSH costs is clearly prohibited by statute. The Providers were clear in their Issue Statement that they challenged this notice-and-comment failure: "This Appeal centers on the procedurally unlawful policy of performing audits on Worksheet S-10 . . . without going through adequate notice and comment requirements as required under the Medicare Act."

> To highlight the haphazard and illegal implementation of an unpublished S-10 audit protocol, the Providers described some of the categories of changes made by the MACs to their S-10 Worksheets, such as imposing bad debt documentation requirements for charity care accounts that were not required by the hospitals' financial assistance policies. 42 U.S.C. § 1395hh requires such a rule or protocol to be promulgated through notice-and-comment publication. Interestingly, the MAC's jurisdictional challenge ignores this paragraph of the issue statement. Instead of grappling with CMS's underlying notice-and-comment failure, the MAC frames the Providers' challenge as a challenge to the data used by CMS to calculate the UCDSH payment after the MAC's audit was completed.

Analysis and Recommendation

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

A. 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).

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).[2]
>
> (B) Any period selected by the Secretary for such purposes.

[2] 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. d/b/a Tampa Gen. Hosp. v. Sec'y of Health & Human Servs*. ("*Tampa General*"),[3] the U.S. Court of Appeals for the District of Columbia Circuit ("D.C. Circuit") upheld the D.C. District Court's decision[4] 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."[5] 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.[6]

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.[7]

b. DCH Regional Med. Ctr. v. Azar

The D.C. Circuit Court revisited the judicial and administrative prohibition of review of uncompensated care DSH payments again in *DCH Regional Med. Ctr. v. Azar* ("*DCH v. Azar*").[8] 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

[3] 830 F.3d 515 (D.C. Cir. 2016).
[4] 89 F. Supp. 3d 121 (D.D.C. 2015).
[5] 830 F.3d 515, 517.
[6] *Id.* at 519.
[7] *Id.* at 521-22.
[8] 925 F.3d 503 (D.C. Cir. 2019) ("*DCH v. Azar*").

itself."[9] 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.[10]

c. Scranton Quincy Hosp. Co. v. Azar

Recently, in *Scranton Quincy Hosp. Co. v. Azar* ("*Scranton*"),[11] the D.C. District Court considered a similar challenge and, again, held that administrative review was precluded. In *Scranton*, the providers challenged how the Secretary determined the amount of uncompensated care that would be used in calculating Factor 3 for their FY 2015 DSH adjustments.[12] 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.[13] 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.[14] Nevertheless, the Secretary used each hospital's shorter cost reporting period in calculating the Factor 3 values for their FY 2015 DSH payments.[15]

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.[16]

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

[9] *Id.* at 506.
[10] *Id.* at 507.
[11] 514 F. Supp. 249 (D.D.C. 2021).
[12] *Id.* at 255-56.
[13] *Id.* (quoting 79 Fed. Reg. 49854, 50018 (Aug. 22, 2014)).
[14] *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.
[15] *Id.*
[16] *Id.* at 262-64.

D.C. District Court found that, in the context of the prohibition of 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."[17] 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.[18] 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.[19]

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.[20] 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*").[21] 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.[22] 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 Court 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."[23] The D.C. Circuit further dismissed the applicability of the Supreme Court's 2019 decision in *Azar v. Allina Health Servs*.[24] 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

[17] *Id.* at 265.
[18] *Id.* (discussing *Leedom v. Kyne*, 358 U.S. 184, 188 (1958)).
[19] *Id.* at 264 (quoting *DCH v. Azar*, 925 F.3d at 509-510).
[20] *Id.* at 264-6511 (quoting *DCH v. Azar*, 925 F.3d at 509).
[21] Civ. No. 20-139, 2021 WL 3856621 (D.D.C. August 30, 2021).
[22] *Id*. at *4.
[23] *Id.* at *9.
[24] 139 S. Ct. 1804 (2019).

substantive legal standard within the meaning of § 1395hh(a)(2)—***but has no bearing on whether these claims are barred by the Preclusion Provision***."[25]

The Board finds that the same findings are applicable to the Providers' challenge to their FFY 2021 UCC DSH payments. The Providers here are challenging their UCC DSH Payment amounts, as well as the general rules governing the methodology used in calculating those amounts, for FFY 2021. 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 be 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 appropriately barred from review.

Decision

The Board hereby 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. Accordingly, Case No. 21-1012G 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.

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11/30/2023

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