DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Leslie Goldsmith, Esq.
Bass, Berry & Sims, PLC
1201 Pennsylvania Ave., NW, Ste. 300
Washington, D.C. 20004

RE: ***Expedited Judicial Review Determination***
23-1228GC HonorHealth CY 2018 Capital DSH CIRP Group
24-0063GC Mount Sinai Health System CY 2019 Capital DSH CIRP Group
24-0088GC Yale-New Haven CY 2020 Capital DSH CIRP Group

Dear Ms. Goldsmith:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' November 16, 2023 consolidated request for expedited judicial review ("EJR")[1] in the above-referenced group appeals.[2] The decision with respect to EJR is set forth below.

Issue

In this group case, the Providers are challenging:

> [t]he validity of the regulation at 42 C.F.R. § 412.320(a)(1)(iii), which bars hospitals that are geographically urban and reclassify as rural under 42 C.F.R. § 412.103 from receiving a capital disproportionate share hospital ("DSH") add-on payment, known as the capital DSH adjustment. The Providers challenge the validity of 42 C.F.R. § 412.320(a)(1)(iii) on a number of grounds including that the regulation (a) is inconsistent with the controlling Medicare statute, (b) was adopted in violation of the Administrative Procedure Act, and (c) is arbitrary and capricious.[3]

[1] The consolidated EJR request also included four other group appeals, Case Nos. 22-1385GC (entitled "Kettering Health Network CY 2019 Capital DSH CIRP Group"), 23-1118GC (entitled "Ardent Health CY 2018 Capital DSH CIRP Group"), 23-1235GC (entitled "UPMC CY 2019 Capital DSH CIRP Group"), and 24-0026GC (entitled "UPMC CY 2021 Capital DSH CIRP Group"), for which the Board will issue decisions under separate cover.
[2] HonorHealth, Mount Sinai Health System, and Yale-New Haven are parent organizations with multiple hospitals and are subject to the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1) as it relates to the common issue in Case Nos. 23-1228GC, 24-0063GC, and 24-0088GC for the years 2018, 2019 and 2020, respectively. As HonorHealth, Mount Sinai Health System, and Yale-New Haven designated the CIRP groups fully formed, they are prohibited from pursuing this same issue for the same year in any other appeal (whether as part of an individual provider appeal or a group appeal) as explained in § 405.1837(e)(1): "When the Board has determined that a group appeal brought under paragraph (b)(1) . . . is fully formed, absent an order from the Board modifying its determination, no other provider under common ownership or control may appeal to the Board the issue that is the subject of the group appeal with respect to a cost reporting period that falls within the calendar year(s) covered by the group appeal."
[3] Request for Expedited Judicial Review, 1 (Nov. 16, 2023) ("Request for EJR").

Background

Under the inpatient prospective payment system ("IPPS"), Medicare pays hospitals predetermined rates for patient discharges and this system is comprised of two parts, one for operating costs ("operating IPPS") as set forth at § 1395ww(d); and one for capital costs ("capital IPPS") as set forth at 42 U.S.C. § 1395ww(g). The primary objective of IPPS is to create incentives for hospitals to operate efficiently, while providing adequate compensation to hospitals.[4] These cases focus on the capital IPPS.

A. Geographic Reclassification

In 1989, Congress created the Medicare Geographic Classification Review Board ("MGCRB") which implemented a geographic reclassification system in which IPPS hospitals can be reclassified to a different wage index area[5] for purposes of receiving a higher payment rate if they meet certain criteria related to proximity and average hourly wage.[6] This includes an IPPS hospital reclassifying from a rural to an urban labor market, or vice versa.

B. Operating DSH Adjustment Under Operating IPPS

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 operating IPPS.[7] Under the operating IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[8]

The statute governing operating IPPS contains a number of provisions that adjust reimbursement based on hospital-specific factors.[9] One of the adjustments is the hospital-specific Disproportionate Share Hospital ("DSH") adjustment as set forth at 42 U.S.C. § 1395ww(d)(5)(F), which requires the Secretary to provide an adjustment (*i.e.*, an increase in the operating IPPS payment) to hospitals that serve a significantly disproportionate number of low-income patients.[10]

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[4] Daniel R. Levinson, Department of Health and Human Services, Office of the Inspector General, *Significant Vulnerabilities Exist in the Hospital Wage Index System for Medicare Payments*, 1 (Nov. 2018), *available at* https://oig.hhs.gov/oas/reports/region1/11700500.pdf (last visited Nov. 29, 2023) ("*Significant Vulnerabilities*").
[5] *See* https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/wageindex.html (42 U.S.C. § 1395ww(d)(3)(E) requires that, as part of the methodology for determining prospective payments to hospitals, the Secretary must 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 and announced in December 2003. The wage index also reflects the geographic reclassification of hospitals to another labor market area, such as rural to urban or vice versa, in accordance with sections 1395ww(d)(8)(B) and 1395ww(d)(10).).
[6] Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, 103 Stat. 2106, 2154 (1989). *See also Significant Vulnerabilities* at 4-5.
[7] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[8] *Id.*
[9] *See* 42 U.S.C. § 1395ww(d)(5).
[10] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.

A hospital may qualify for a DSH adjustment to its operating IPPS payments based on its disproportionate patient percentage ("DPP").[11] 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.[12]

The DSH adjustment provided under operating IPPS is ***not*** at issue in this case. The DSH adjustment is relevant because certain standards set forth in 42 U.S.C. § 1395ww(d)(5)(F) for the DSH adjustment, the Secretary adopted for purposes of capital IPPS.

C. Capital DSH Adjustment Under Capital IPPS

A hospital's *capital* costs are paid separately under capital IPPS (*i.e*., separate and apart from payment for a hospital's *operating* costs under the operating IPPS). Specifically, on December 22, 1987, Congress enacted the Omnibus Budget Reconciliation Act of 1987 ("OBRA-87") and OBRA-87 § 4006(b) required the Secretary to establish the capital IPPS for cost reporting periods beginning in FY 1992.[13] OBRA-87 § 4006(b) was codified at 42 U.S.C. § 1395ww(g) which states, in pertinent part:

> **(g) Prospective payment for capital-related costs; return on equity capital for hospitals**
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> (1)(A) Notwithstanding section 1395x(v) of this title, instead of any amounts that are otherwise payable under this subchapter with respect to the reasonable costs of subsection (d) hospitals and subsection (d) Puerto Rico hospitals for capital-related costs of inpatient hospital services, the Secretary *shall,* for hospital cost reporting periods beginning on or after October 1, 1991, *provide for payments for such costs* in accordance with a prospective payment system established by the Secretary. . . .
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> (B) Such system— (i) shall provide for (I) a payment on a per discharge basis, and (II) an appropriate weighting of such payment amount as relates to the classification of the discharge;
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> (ii) *may provide for an adjustment to take into account variations in the relative costs of capital and construction for the different types of facilities or areas in which they are located*;
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> (iii) may provide for such exceptions (including appropriate exceptions to reflect capital obligations) as the Secretary determines to be appropriate, and

[11] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[12] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[13] Pub. L. 100-203, § 4006(b), 101 Stat. 1330, 1330-52 (1987).

> (iv) may provide for suitable adjustment to reflect hospital occupancy rate.
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> (C) In this paragraph, the term ‘‘capital-related costs’’ has the meaning given such term by the Secretary under subsection (a)(4) as of September 30, 1987, and does not include a return on equity capital.[14]

Significantly, the statute governing capital IPPS does not specifically mandate or address the use of a capital DSH adjustment. Rather, it specifies generally that the Secretary "may provide for an adjustment to account variations in relative costs." As described below, the Secretary exercised his discretion to establish the c*apital* DSH adjustment at issue in this case which is limited in that it ***only*** applies to *urban* hospitals with 100 or more beds and that serve low income patients.[15]

1. Initial Implementation of Capital IPPS and the Capital DSH Adjustment

The Secretary published a final rule on August 30, 1991 to establish the capital IPPS.[16] In implementing the capital IPPS, the Secretary recognized that he had discretion on whether to apply many of the adjustments statutorily required under operating IPPS to capital IPPS:

> We are persuaded by the argument advanced by some commenters, including ProPAC, that in the long run the ***same*** adjustments should be applied to capital and operating payments and that the level of the adjustments should be determined by examining combined operating and capital costs. ProPAC recommended that the unified adjustments be calculated within two years. However, we believe that it would be most appropriate to implement these adjustments with respect to the capital prospective payment systems from the outset. *While the payment adjustments for the operating prospective payment system are determined by the Act (and therefore cannot be modified by the rulemaking process),* ***we have the latitude to develop adjustments based on combined costs for the capital prospective payment system***.
>
> We do not believe that it would be appropriate to use the current operating payment adjustments in the capital prospective payment system either permanently or on an interim basis until legislation is enacted changing the operating adjustments to the level appropriate for total costs. This is because the levels of the operating payment adjustments for serving a disproportionate share of low income patients (DSH) and for indirect medical education costs (IME)

[14] (Underline and italics emphasis added.)
[15] 42 C.F.R. § 412.320(a)(1). *See also* MedPAC, *Hospital Acute Inpatient Services Payment System: Payment Basics*, 2 (rev. Nov. 2021), *available at* https://www.medpac.gov/wp-content/uploads/2021/11/medpac_payment_basics_21_hospital_final_sec.pdf (last visited Nov. 29, 2023).
[16] 56 Fed. Reg. 43358 (Aug. 30, 1991).

> exceed the levels supported by empirical analysis. We believe the payment adjustments should be empirically supported and should reflect only the higher Medicare costs associated with teaching activity and treating low income patients.[17]

The Secretary did adopt a limited DSH adjustment to capital IPPS for urban hospitals with more than 100 beds. The proposal was described as follows:

> In the proposed rule, our regression results indicated that for urban hospitals with more than 100 beds, the disproportionate share percentage of low income patients has an effect on capital costs per case. We proposed that urban hospitals with 100 or more beds would receive an additional payment equal to $((1 + DSHP)^{0.4176} - 1))$, where DSHP is the disproportionate share patient percentage. There would be no minimum disproportionate share patient percentage required to qualify for the payment adjustment. A hospital would receive approximately a 4.2 percent increase in payments for each 10 percent increase in its disproportionate share percentage. This formula is similar to the one used for the indirect medical education adjustment under the operating prospective payment system.
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> Since we did not find a disproportionate share effect on the capital costs of urban hospitals with fewer than 100 beds or on rural hospitals, we did not propose to make a disproportionate share adjustment to the capital payment to these hospitals.[18]

In adopting his proposal, the Secretary gave the following justification:

> *Comment*: Many commenters believe that the disproportionate share patient percentage of 30 percent needed to qualify for the special exceptions payment under the proposal is too restrictive. Most of these commenters supported the use of 20.2 percent as the patient threshold percentage since that is the patient percentage above which operating disproportionate share payments become more generous. Some believe that any hospital that received DSH payments under the operating system should be eligible for the special exception.
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> *Response*: In the final rule, we are providing that urban hospitals with 100 or more beds and a disproportionate share patient percentage of 20.2 percent or higher will be eligible to receive exceptions payments based on a higher minimum payment level than other hospitals. For FY 1992, the minimum payment level is 80 percent. Urban hospitals with 100 or more beds that receive disproportionate share payments under § 412.106(C)(2) would also

[17] *Id.* at 43369-70 (emphasis added).
[18] *Id* at 43377.

> be eligible for the higher minimum payment level. We are not extending the special protection to other hospitals that receive disproportionate share payments under the operating prospective payment system. In urban areas, we believe that our criteria properly focuses on those hospitals that serve a large disproportionate share population. Other urban hospitals receiving disproportionate share payments tend to serve fewer low income patients either because of their smaller size (i.e., under 100 beds) or lower disproportionate share patient percentage. **In rural areas, we believe the more relevant criteria for determining whether a hospital should receive special payment protection is whether the hospital represents the sole source of care reasonably available to Medicare beneficiaries**.[19]

In response to comments, the Secretary rejected expanding the application of the capital DSH adjustment to rural hospitals with 500 or more beds:

> As part of our regression analysis for this final rule, we examined the relationship between total cost per case and disproportionate share patient percentages for rural hospitals with at least 500 beds, and found no statistically significant relationship. As a result, we are not implementing any disproportionate share adjustment to prospective payments for capital for these hospitals. Hospitals that qualify for additional operating disproportionate share payments under section 1886(d)(5)(F)(i)(II) of the Act will be deemed to have a disproportionate patient percentage equivalent to that which would generate their operating disproportionate share payment, using the formula for urban hospitals with at least 100 beds. For discharges occurring on or after October 1, 1991, these hospitals qualify for an operating adjustment of 35 percent, which is equivalent to having a disproportionate share patient percentage of 65.4. Urban hospitals with more than 100 beds that qualify for additional operating disproportionate share payments under section 1866(d)(5)(F)(i)(II) of the Act will be deemed to qualify for additional capital disproportionate share payments as well at the level consistent with their deemed disproportionate share patient percentage. The disproportionate share adjustment factor for these hospitals is 14.16 percent. The additional capital disproportionate share payments to these hospitals will be made at the same time that the additional operating disproportionate share payments are, that is, as the result of the application by these hospitals for payments under § 412.106(b)(l)(ii) of the regulations.[20]

Similarly, in response to comments, the Secretary rejected expanding the application of the capital DSH adjustment to other classes of hospitals such as "[a]ll small urban hospitals,

[19] *Id.* at 43409-10 (bold and underline emphasis added).
[20] *Id.* at 43377.

hospitals with high Medicare usage, rural hospitals, rural hospitals with at least 100 beds, rural referral centers, or those hospitals with high 'total government' usage":

> In developing the capital disproportionate share adjustment for this final rule, we examined the relationship between the disproportionate share patient percentage and total costs per case for each class of hospital that is currently receiving an operating payment adjustment. We believe that only those hospitals that merit the adjustment according to our regression analysis should receive additional capital payments for serving low income patients. The regression results did not indicate any significant relationship between total costs per case and disproportionate share patient percentage for any of the special groups mentioned above.[21]

In response to comments, the Secretary also looked at setting a threshold DSH percentage to qualify for a capital DSH adjustment but rejected that alternative approached based upon the following explanation:

> We examined closely the possibility of using a disproportionate share patient percentage threshold in our total cost regression analysis. We were unable to find any threshold level of disproportionate share percentage below which no payment adjustment was merited, or a threshold above which a higher adjustment was merited. As a result, we believe that it is most equitable to make a capital disproportionate share payment to all qualifying hospitals with a positive patient percentage, rather than penalize some hospitals that have a higher cost of treating low income patients but whose patient percentage is below the artificial level we would set.[22]

Further, in response to comments, the Secretary rejected not providing *any* capital DSH adjustment based on the explanation:

> We disagree with the commenter. The regression analyses show that serving low income patients (as defined in section 1886(d)(5)(F)(vi) of the Act) results in higher Medicare capital and total costs per case *for urban hospitals with at least 100 beds*. We believe that it is appropriate for Medicare's payment to recognize these higher Medicare patient care costs.[23]

Finally, the Secretary addressed how MGCRB reclassifications, in certain circumstances, affect whether an IPPS hospital qualifies for the capital DSH adjustment:

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[21] *Id.* at 43378.
[22] *Id.* at 43379.
[23] *Id.* (Emphasis added.)

> *Comment*: Many commenters sought clarification of the effect of reclassification by the Medicare Geographic Classification Review Board (MGCRB) on eligibility for capital disproportionate share payments.
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> *Response*: Any hospital that is reclassified to an urban area by the MGCRB for purposes of its standardized amount is considered to be urban for all prospective payment purposes other than the wage index. As such, if any hospital reclassified by the MGCRB to an urban area for purposes of the standardized amount has at least 100 beds, it would be eligible for capital disproportionate share payments. We note that a rural hospital reclassified for purposes of the wage index only is still considered a rural hospital, and as such, will not be eligible for capital disproportionate share payments.[24]

The resulting regulations governing capital IPPS were codified at 42 C.F.R. Part 412, Subpart M (§§ 412.300 to 412.374). The regulation governing the capital DSH adjustment was codified at § 412.320 which, at initial implementation, stated:

> **§ 412.320 Disproportionate share adjustment factor.**
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> (a) *Criteria for classification*. A hospital is classified as a "disproportionate share hospital" for the purposes of capital prospective payments if the hospital is located, for purposes of receiving payment under § 412.63(a), in an urban area, has 100 or more beds as determined in accordance with § 412.105(b) and serves low-income patients, as determined under § 412.106(b), or if the hospital meets the criteria in § 412.106(c)(2).
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> (b) *Payment adjustment factor*. (1) <u>If a hospital meets the criteria in paragraph (a) of this section for a disproportionate share hospital for purposes of capital prospective payments</u>, the disproportionate share payment adjustment factor equals [e raised to the power of (.2025 X the hospital's disproportionate patient percentage as determined under § 412.106(b)(5)), —1], where e is the natural antilog of 1.
>
> (2) If a hospital meets the criteria in § 412.106(c)(2) for purposes of inpatient hospital operating prospective payments, the disproportionate share adjustment factor equals 14.16 percent.[25]

[24] *Id.*
[25] *Id*. at 43452-53.

2. Reclassification of Certain IPPS Urban Hospitals as Rural for Purposes of Operating IPPS Pursuant to BBRA § 401 and Impact on Capital IPPS Adjustments

On November 29, 1999, Congress enacted the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 ("BBRA") and BBRA § 401 amended 42 U.S.C. § 1395ww(d)(8) to require that certain urban IPPS hospitals be reclassified as rural *for purposes of operating IPPS* if an application is submitted to the MGCRB and certain criteria are met.[26] IPPS hospitals are reclassified per BBRA § 401 are often referred to as "§ 401 hospitals."

On August 1, 2000, the Secretary published the interim final rule to, in part, implement BBRA § 401 and stated in the preamble that a hospital reclassified as rural pursuant to § 401 is treated as rural for ***all*** purposes under operating IPPS, including the DSH adjustment for operating IPPS:

> *A hospital that is reclassified as rural* under section 1886(d)(8)(E) of the Act, as added by section 401(a) of Public Law 106–113, ***is treated as rural for all purposes*** *of payment under the Medicare inpatient hospital prospective payment system* (section 1886(d) of the Act), *including* standardized amount (§§ 412.60 et seq.), wage index (§ 412.63), and ***disproportionate share calculations*** (§ 412.106) as of the effective date of the reclassification.[27]

On August 1, 2000, the Secretary also published the FY 2001 IPPS Final Rule which included the following discussion on the effect of reclassification of a hospital from urban to rural pursuant to BBRA § 401:

> In the May 5, 2000 proposed rule, we indicated that we are concerned that section 1886(d)(8)(E) might create an opportunity for some urban hospitals to take advantage of the MGCRB process by first seeking to be reclassified as rural under section 1886(d)(8)(E) (and receiving the benefits afforded to rural hospitals) and in turn seek reclassification through the MGCRB back to the urban area for purposes of their standardized amount and wage index and thus also receive the higher payments that might result from being treated as being located in an urban area. ***That is, we were concerned that some hospitals might inappropriately seek to be treated as being located in a rural area for some purposes and as being located in an urban area for other purposes***. In light of the Conference Report language noted above discussing the House bill and what appears to be the potential for inappropriately inconsistent treatment of the same hospital on the other hand, in the May 5 proposed rule, we solicited public comment on this issue, and indicated that we might impose a limitation on such MGCRB reclassifications in this final rule for FY 2001, if such action appears warranted. We also sought specific

[26] BBRA, Pub. L. 106-113, App. F, § 401, 113. Stat. 1501A-321, 1501A-369 (1999).
[27] 65 Fed. Reg. 47026, 47030 (Aug. 1, 2000) (emphasis added).

comments on how such a limitation, if any, should be imposed and provided several examples and alternatives.

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Consistent with the statutory language, we are providing that a hospital reclassified as rural under section 1886(d)(8)(E) of the Act will be treated as being located in a rural area for purposes of section 1886(d) of the Act, and cannot subsequently be reclassified under the MGCRB process to an urban area (in order to be treated as being located in an urban area for certain purposes under section 1886(d) of the Act).

This policy is consistent not only with the statutory language but also with the policy considerations underlying the MGCRB process. The MGCRB process permits a hospital to be reclassified from one geographic area to another if it is significantly disadvantaged by its geographic location and would be paid more appropriately if it were reclassified to another area. We believe that it would be illogical to permit a hospital that applied to be reclassified from urban to rural under section 1886(d)(8)(E) of the Act because it was disadvantaged as an urban hospital to then utilize a process that was established to enable hospitals significantly disadvantaged by their rural or small urban location to reclassify to another urban location. *If an urban hospital applies under section 1886(d)(8)(E) of the Act in order to be treated as being located in a rural area, then it would be anomalous at best for the urban hospital to subsequently claim that it is significantly disadvantaged by the rural status for which it applied and should be reclassified to an urban area.*

Furthermore, permitting hospitals the option of seeking rural reclassification under section 1886(d)(8)(E) of the Act for certain payment advantages, coupled with the ability to pursue a subsequent MGCRB reclassification back to an urban area, could have implications beyond those originally envisioned under Public Law 106–113. In particular, we are concerned about the potential interface between rural reclassifications under section 401 and section 407(b)(2) of Public Law 106– 113, which authorizes a 30-percent expansion in a rural hospital's resident full-time equivalent count for purposes of Medicare payment for the indirect costs of medical education (IME) under section 1886(d)(5)(B) of the Act. (Reclassification from urban to rural under section 1886(d)(8)(E) of the Act can affect IME payments to a hospital, which are made under section 1886(d)(5)(B) of the Act, but not payments for the direct costs of GME, which are made under section 1886(h) of the Act.)

Congress clearly intended hospitals that become rural under section 1886(d)(8)(E) of the Act to receive some benefit as a result.

> For example, some hospitals currently located in very large urban counties are in fact fairly small, isolated hospitals. Some of these hospitals will now be able to be designated a rural hospital and become eligible to be designated a critical access hospital.
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> ****
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> We are not permitting hospitals redesignated as rural under section 1886(d)(8)(E) of the Act to be eligible for subsequent reclassification by the MGCRB, and are revising the regulations governing MGCRB reclassifications (§ 412.230) accordingly.
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> ****
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> *We wish to emphasize that urban to rural reclassification under section 1886(d)(8)(E) of the Act is entirely voluntary*. ***Each hospital anticipating that it may qualify under this provision should determine the impact of Medicare payment policies if it were to reclassify***. As discussed above, we believe that our policies here are consistent with the Secretary's broad authority under section 1886(d)(10) of the Act, the statutory language in section 1886(d)(8)(E) of the Act, as well as our understanding of the intent underlying the description of the House bill in the Conference Report.[28]

Thus, both the August 1, 2000 interim final rule and the FY 2001 IPPS Final Rule confirmed that urban hospitals reclassified as rural pursuant to BBRA § 401 would be treated as rural for all purposes of operating IPPS, including DSH adjustments. The Secretary memorialized this policy in regulation at 42 C.F.R. § 412.103 (2000) which states in pertinent part:

> **§ 412.103 Special treatment: Hospitals located in urban areas and that apply for reclassification as rural**.
>
> (a) *General criteria*. A prospective payment hospital that is located in an urban area (as defined in § 412.62(f)(1)(ii)) may be reclassified as a rural hospital if it submits an application in accordance with paragraph (b) of this section and meets any of the following conditions:
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> 1) The hospital is located in a rural census tract of a Metropolitan Statistical Area (MSA) as determined under the most recent version of the Goldsmith Modification as determined by the Office of Rural Health Policy (ORHP) of the Health Resources and Services Administration which is available via the ORHP website at http://www.nal.usda.gov/orph or from the U.S. Department of Health and Human Services, Health Resources and Services

[28] 65 Fed. Reg. 47054, 47087-89 (Aug. 1, 2000).

> Administration, Office of Rural Health Policy, 5600 Fishers Lane, Room 9–05, Rockville, MD 20857.
>
> (2) The hospital is located in an area designated by any law or regulation of the State in which it is located as a rural area, or the hospital is designated as a rural hospital by State law or regulation.
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> (3) The hospital would qualify as a rural referral center as set forth in § 412.96, or as a sole community hospital as set forth in § 412.92, if the hospital were located in a rural area.[29]

Neither the August 1, 2000 interim final rule nor the FY 2001 IPPS Final Rule explicitly discussed the impact on capital DSH adjustments under capital IPPS. However, through operation of the cross-reference in 42 C.F.R. § 412.320(a) to § 412.63(a) in the phrase "the hospital is located, for purposes of receiving payment under § 412.63(a), in an urban area", it would appear that hospitals reclassified from urban to rural were ***not*** eligible for capital DSH adjustments under capital IPPS. In this regard, the Board notes that, following the 2000 rulemaking process, § 412.63(a)-(b) (2001) read, in pertinent part:

> (a) *General rule*. (1) HCFA determines a national adjusted prospective payment rate for inpatient operating costs for each inpatient hospital discharge in a Federal fiscal year after fiscal year 1984 involving inpatient hospital services of a hospital in the United States subject to the prospective payment system, and determines a regional adjusted prospective payment rate for operating costs for such discharges in each region, for which payment may be made under Medicare Part A.
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> (2) **Each such rate is determined for hospitals located in urban <u>or</u> rural areas** within the United States and within each such region respectively, **as described in paragraphs (b)** through (g) of this section.
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> (b) *Geographic classifications*. (1) For purposes of this section, the definitions set forth in § 412.62(f) apply, **except that**, effective January 1, 2000, **a hospital reclassified as rural may mean** a reclassification that results from a geographic redesignation as set forth in § 412.62(f)(1)(iv) or **a reclassification that results from an urban hospital applying for reclassification as rural as set forth in § 412.103**.[30]

The specific reference in § 412.63(b) to urban to rural reclassifications made under § 412.103 makes clear that capital DSH adjustments would not apply to hospitals reclassified from urban to rural pursuant to BBRA § 401 which as noted above was implemented at § 412.103.

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[29] *Id*. at 47048.
[30] *Id.* at 47047 (Bold and underline emphasis added.)

3. Changes to Operating IPPS Required by MMA § 401 and Their Effect on Capital IPPS

On December 8, 2003, Congress enacted the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 ("MMA") and MMA § 401 to equalize operating IPPS payments between urban and rural hospitals.[31] Specifically, § 401 specifies that, beginning with FY 2004, all IPPS hospitals are paid on the basis of the large urban standardized amount under operating IPPS.

The Office of Management and Budget publishes information on core-based statistical areas ("CBSAs") and the Secretary has used this information for purposes of defining labor market areas for use in the wage index for operating IPPS.[32] On June 6, 2003, OMB announced the new CBSAs, comprised of metropolitan statistical areas ("MSAs") and the new Micropolitan Areas based on Census 2000 data.[33]

On August 11, 2004, the Secretary published the FY 2005 IPPS Final Rule and this rule finalized revisions to the operating IPPS regulations to both implement MMA § 401 as well as adopt OMB's new CBSA designations.[34] With respect to implementing MMA § 401, the Secretary revised 42 C.F.R. § 412.63 to apply only to years through 2004 and added a new § 412.64 to implement MMA § 401 for federal rates for FYs 2005 forward. Specifically, § 412.64 reads in pertinent part:

> **§ 412.64 Federal rates for inpatient operating costs for Federal fiscal year 2005 and subsequent fiscal years.**
>
> (a) *General rule*. CMS determines a national adjusted prospective payment rate for inpatient operating costs for each inpatient hospital discharge in Federal fiscal year 2005 and subsequent fiscal years involving inpatient hospital services of a hospital in the United States subject to the prospective payment system for which payment may be made under Medicare Part A.
>
> (b) *Geographic classifications*. (1) For purposes of this section, the following definitions apply:
>
> (i) The term region means one of the 9 metropolitan divisions comprising the 50 States and the District of Columbia, established by the Executive Office of Management and Budget for statistical and reporting purposes.
>
> (ii) The term *urban area* means—

[31] Pub. L. 108–173
[32] 69 Fed. Reg. 48916, 49026-27 (Aug. 11, 2004).
[33] *Id.*
[34] 69 Fed. Reg. 48916 (Aug. 11, 2004).

> (A) A Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget; or
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> (B) The following New England counties, which are deemed to be parts of urban areas under section 601(g) of the Social Security Amendments of 1983 (Public Law 98–21, 42 U.S.S. 1395ww (note)): Litchfield County, Connecticut; York County, Maine; Sagadahoc County, Maine; Merrimack County, New Hampshire; and Newport County, Rhode Island.
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> (C) The term *rural area* means any area outside an urban area.
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> (D) The phrase *hospital reclassified as rural* means a hospital located in a county that, in FY 2004, was part of an MSA, but was redesignated as rural after September 30, 2004, as a result of the most recent census data and implementation of the new MSA definitions announced by OMB on June 6, 2003.
>
> (2) For hospitals within an MSA that crosses census division boundaries, the MSA is deemed to belong to the census division in which most of the hospitals within the MSA are located.
>
> (3) For discharges occurring on or after October 1, 2004, a hospital located in a rural county adjacent to one or more urban areas is deemed to be located in an urban area and receives the Federal payment amount for the urban area to which the greater number of workers in the county commute if the rural county would otherwise be considered part of an urban area, under the standards for designating MSAs if the commuting rates used in determining outlying counties were determined on the basis of the aggregate number of resident workers who commute to (and, if applicable under the standards, from) the central county or central counties of all adjacent MSAs. These EOMB standards are set forth in the notice of final revised standards for classification of MSAs published in the Federal Register on December 27, 2000 (65 FR 82228), announced by EOMB on June 6, 2003, and available from CMS, 7500 Security Boulevard, Baltimore, Maryland 21244.
>
> (4) For purposes of this section, any change in an MSA designation is recognized on October 1 following the effective date of the change. Such a change in MSA designation may occur as a result of redesignation of an MSA by the Executive Office of Management and Budget.[35]

[35] *Id.* at 49242. *See also id.* at 49103 (discussing implementation of MMA § 401).

Significantly, § 412.64 does not reference the provisions of § 412.103 regarding the urban-to-rural reclassifications, as was previously found in § 412.63(b)(1).

The Secretary also amended 42 C.F.R. § 412.320(a). As previously noted, § 412.320(a) originally only referenced § 412.63: "A hospital is classified as a 'disproportionate share hospital' for the purposes of capital prospective payments if the hospital is located, *for purposes of receiving payment under § 412.63(a)*, in an urban area."[36] As a result of the FY 2005 IPPS Final Rule, § 412.320(a) was updated to reference § 412.64 as it relates to FYs 2005 forward:

> **§ 412.320 Disproportionate share adjustment factor.**
>
> (a) *Criteria for classification*. A hospital is classified as a ''disproportionate share hospital'' for the purposes of capital prospective payments if either of the following conditions is met:
>
> (1) The hospital is located in an urban area, has 100 or more beds as determined in accordance with § 412.105(b), and serves low-income patients as determined under § 412.106(b).
>
> (i) For discharges occurring on or before September 30, 2004, the payment adjustment under this section is based on a hospital's location, for the purpose of receiving payment, under § 412.63(a).
>
> (ii) For discharges occurring on or after October 1, 2004, the payment adjustment under this section is based on the geographic classifications specified under § 412.64.[37]

Again, as previously noted, § 412.64 does not reference the provisions of § 412.103 regarding the urban-to-rural reclassifications, as was previously found in § 412.63(b)(1).

Finally, in the preamble to the FY 2005 IPPS Final Rule, the Secretary included the following discussion on the impact of the new CBSAs on geographic reclassifications:

> Currently, the large urban location adjustment under § 412.316(b) and the DSH adjustment for certain urban hospitals under § 412.320 for payments for capital-related costs rely on the existing geographic classifications set forth at § 412.63. Because we proposed to adopt OMB's new CBSA designations for FY 2005 and thereafter, under proposed new § 412.64, we proposed to revise § 412.316(b) and § 412.320(a)(1) to specify that, for discharges on or after October 1, 2004, the payment adjustments under these sections, respectively, would be based on the geographic classifications at proposed new § 412.64.

[36] (Emphasis added.)
[37] 42 C.F.R. § 412.320 (2004) (underline emphasis added). *See also* 69 Fed. Reg. at 49250.

> ****
>
> The commenter is correct that as a result of the implementation of the new MSA definitions, hospitals that had previously been located in a large urban area under the current MSA definitions, but will now be located in another urban or rural area under the new MSA definitions will no longer qualify for certain payment adjustments that they previously qualified for under the prior MSA definitions, including the 3-percent large urban add-on payment adjustment at § 412.312(b)(2)(ii) and § 412.316(b). As discussed previously, in the May 18, 2004 proposed rule, we solicited comments on the effect of the equalization of the operating IPPS standardized amount. Specifically, we discussed that rural and other urban hospitals that were previously eligible to receive the large urban add-on payment adjustment (and DSH payment adjustment) under the IPPS for capital-related costs if they reclassified to a large urban area for the purpose of the standardized amount under the operating IPPS, will no longer be reclassified and, therefore, will not be eligible to receive those additional payments under the IPPS for capital-related costs beginning in FY 2005. As we noted previously, we received no comments on that clarification.
>
> ****
>
> As previously discussed, we proposed and adopted as final our policy that, beginning in FY 2005 and thereafter, only those hospitals geographically located in a large urban area (as defined in revised § 412.63(c)(6)) will be eligible for the large urban add-on payment adjustment provided under § 412.312(b)(2)(ii) and § 412.316(b). *Similarly, beginning in FY 2005 and thereafter, to receive capital IPPS DSH payments under § 412.320, a hospital will need to be geographically located in an urban area (as defined in new § 412.64) and meet all other requirements of § 412.320.* Accordingly, we are adopting our proposed revisions as final without change.[38]

4. August 18, 2006 Revisions to the Capital DSH Adjustment

In the FY 2007 Proposed IPPS Rule, the Secretary[39] announced that he was proposing technical changes to 42 C.F.R. §§ 412.316(b) and 412.320(a)(1) to clarify that hospitals reclassified as rural under § 412.103 are not eligible for the large urban add-on payment or for the capital DSH adjustment. These proposed changes reflected the historic policy that hospitals reclassified as rural under § 412.103 also would be considered rural under the capital IPPS. Since the genesis of the capital IPPS in FY 1992, the same geographic classifications used under the operating IPPS also have been used under the capital IPPS.[40]

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[38] 69 Fed. Reg. 48916, 49187-88 (Aug. 11, 2004).
[39] of the Department of Health and Human Services.
[40] 71 Fed. Reg. 23995, 24122 (Apr. 25, 2006).

The Secretary believed that these proposed changes and clarifications were necessary because the agency's capital IPPS regulations had been updated to incorporate the Office of Management and Budget's ("OBM's") new CBSA definitions for IPPS hospital labor market areas beginning in FY 2005.[41]

In the FY 2007 IPPS Final Rule published on August 18, 2006, the Secretary finalized these technical changes to 42 C.F.R. §§ 412.316(b) and 412.320(a)(1) to clarify that hospitals reclassified as rural under § 412.103 are not eligible for the large urban add-on payment or for the capital DSH adjustment:

> These changes were proposed to reflect our historic policy that hospitals reclassified as rural under § 412.103 also are considered rural under the capital PPS. Since the genesis of the capital PPS in FY 1992, the same geographic classifications used under the operating PPS also have been used under the capital PPS.
>
> These changes and clarifications are necessary because we inadvertently made an error when we updated our capital PPS regulations to incorporate OMB's new CBSA definitions for IPPS hospital labor market areas beginning in FY 2005. In the FY 2005 IPPS final rule (69 FR 49187 through 49188), in order to incorporate the new CBSA designations and the provisions of the newly established § 412.64, which incorporated the CBSA-based geographic classifications, we revised § 412.316(b) and § 412.320 to specify that, effective for discharges occurring on or after October 1, 2004, the capital PPS payment adjustments are based on the geographic classifications under § 412.64. However, § 412.64 does not reference the provisions of § 412.103 regarding the urban-to-rural reclassifications, as was previously found in § 412.63(b)(1).
>
> We believe that this error must be corrected in order to maintain our historic policy for treating urban-to-rural hospital reclassifications under the operating PPS the same for purposes of the capital PPS. Therefore, we proposed to specify under §§ 412.316(b)(2) and (b)(3) and 412.320(a)(1)(ii) and (a)(1)(iii) that, for discharges on or after October 1, 2006, hospitals that are reclassified from urban to rural under § 412.103 would be considered rural.[42]

In adopting these changes, the Secretary noted that it did not receive any public comments on the proposed change as published in the proposed rule published on May 17, 2006.[43]

As a result of the FY 2007 IPPS Final Rule, the regulation, subparagraph (iii) was added to 42 C.F.R. § 412.320(a)(1) so that revised § 412.320(a) read, in pertinent part:

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[41] *Id.*
[42] *Id.*
[43] *Id.*

> (a) *Criteria for classification*. A hospital is classified as a "disproportionate share hospital" for the purposes of capital prospective payments if either of the following conditions is met:
>
> (1) The hospital is located in an urban area, has 100 or more beds as determined in accordance with § 412.105(b), and serves low-income patients as determined under § 412.106(b).
>
> (i) For discharges occurring on or before September 30, 2004, the payment adjustment under this section is based on a hospital's location, for the purpose of receiving payment, under § 412.63(a).
>
> (ii) For discharges occurring on or after October 1, 2004, the payment adjustment under this section is based on the geographic classifications specified under § 412.64, except as provided for in paragraph (a)(1)(iii) of this section.
>
> **(iii) For purposes of this section, the geographic classifications specified under § 412.64 apply, except that, effective for discharges occurring on or after October 1, 2006, for an urban hospital that is reclassified as rural as set forth in § 412.103, the geographic classification is rural.[44]**

5. *Litigation Challenging the Validity of 42 C.F.R. § 412.320(a)(1)(iii) as Added by the FY 2007 IPPS Final Rule*

The validity of 42 C.F.R. § 412.320(a)(1)(iii) was addressed in *Toledo Hosp. v. Becerra* ("*Toledo*"),[45] wherein the hospital made the following contentions:

> Toledo Hospital contends that the Secretary's 2006 rulemaking is arbitrary and capricious and thus unreasonable for two principal reasons. First, it charges the Secretary with misrepresenting the regulatory history in claiming that the 2006 Rule merely restored a previously implemented policy. Second, the hospital argues that the Secretary failed to "take into account" relative costs of capital for various hospital types and areas of location, as subsection (g) requires.[46]

In *Toledo*, U.S. District Court for the District of Columbia ("D.C. District Court") outlined the legislative history surrounding the creation of the MGCRB in 1989 which, as noted above, can redesignate IPPS hospitals to different labor market areas in order to receive a different wage

[44] (Bold emphasis added.)
[45] 2021 WL 4502052 (D.D.C. 2021).
[46] *Id.* at *8 (citations omitted).

reimbursement rate.[47] The Court also noted how Congress enacted legislation in 1999[48] allowing IPPS hospitals to reclassify from an urban labor market area to a rural one for various reasons. Thus, a geographically urban hospital can be classified as rural, but then redesignate itself back into an urban labor market area for the purposes of fixing its wage index.[49] The Court also noted the separate IPPS payment for a hospital's *capital* costs at 42 U.S.C. § 1395ww(g) (compared to the IPPS payment for *operating* costs), as well as the capital IPPS adjustments found at 42 C.F.R. § 412.320 for large urban hospitals (the capital DSH payment).[50] The Court explained that, following the 2006 rulemaking, a geographically urban hospital which reclassifies as rural under § 401 loses its eligibility for the capital DSH adjustment.[51]

The appellants in *Toledo* were geographically located in an urban labor market area, but applied to the Secretary (and were approved) to reclassify as rural under § 401. The appellants thereafter applied to the MGCRB to reclassify their wage index to an urban labor market area. The appellants' Medicare Contractor later denied their requests for capital DSH adjustments due to their § 401 rural reclassifications. Before the D.C. District Court, the hospitals argued that 42 C.F.R. § 412.320(a)(1)(iii) violated the plain language of the Medicare Act and that it was promulgated in an arbitrary and capricious manner.[52]

The D.C. District Court rejected the argument that the capital DSH policy in 42 C.F.R. § 412.320(a)(1)(iii) violated the Medicare Act on its face, finding that the Secretary was not prohibited from treating § 401 reclassified hospitals as rural for operating PPS purposes while denying urban status for the purposes of the capital DSH adjustment.[53] The Court next examined, however, whether the Secretary's decision to do so was reasonable. The D.C. District Court made the following findings:

1. "if the Secretary had any policy concerning Section 401 reclassifications before 2006, he never announced such a policy, much less explained the basis for it."[54]

2. The Secretary's decision to not provide a capital DSH adjustment was arbitrary because:

    - "The Secretary has not put forth evidence that the agency took these costs into account, either in 1991, 2000, 2004, or 2006."[55]

    - "[T]he record does not show that the Secretary articulated a consistent policy of treating these reclassified hospitals as rural for capital DSH adjustment purposes, he

[47] *Id.* at *2.
[48] 42 U.S.C. § 1395ww(d)(8)(E). *See* Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, § 401, Pub. L. No. 106-113, 113 Stat. 1501 (1999). Since the amendment was made via § 401 of this legislation, a hospital which receives the new rural reclassification is often referred to a "§ 401" hospital.
[49] *Toledo* at *3.
[50] *Id.* at *3-4.
[51] *Id.* at *4.
[52] *Id.* at *5.
[53] *Id.* at *6-8.
[54] *Id.* at *11.
[55] *Id.*

cannot fall back on any purported general policy of using operating PPS geographic classifications for capital PPS reimbursements."[56]

- "The Secretary also has not explained, even as a general matter, why classification uniformity outweighs the value of more accurate cost reimbursements. *Cf. Anna Jacques Hosp*., 797 F.3d at 1161 (upholding Secretary's regulation where the Secretary explained why 'added precision' 'would not justify the added complication') (quotation omitted)."[57]

- "The agency cannot 'entirely fail[ ] to consider' the "relevant data" and the factors that Congress directed it to review. *State Farm*, 63 U.S. at 43. Here, the Secretary did not perform a cost analysis to determine whether reclassified rural hospitals should receive a capital DSH adjustment, nor did he take costs into account at all."[58]

Notwithstanding these findings, the D.C. District Court declined to vacate 42 C.F.R. § 412.320(a)(1)(iii) because "vacatur of a rule is not an appropriate remedy on review of an adjudication."[59] Instead, the Court remanded the case to the Medicare Contractor for a redetermination on the appellants' eligibility for a capital DSH adjustment.[60]

Providers' Request for EJR

As background, each of the Providers is an acute care hospital paid by Medicare pursuant to the inpatient and capital prospective payment systems. During the years under appeal, the hospitals were all geographically located in urban areas, operated more than 100 beds, served low-income patients and received § 401 rural reclassifications pursuant to 42 C.F.R. § 412.103.[61]

The Providers are challenging the validity of 42 C.F.R. § 412.320(a)(1)(iii), which states that urban hospitals may qualify for capital DSH payments unless, on or after October 1, 2006, the urban hospital is reclassified as rural. The Providers assert that this regulation is inconsistent with the underlying operating PPS statute, in particular 42 U.S.C. § 1395ww(d)(8)(B), which states that hospitals that have undergone a rural reclassification are rural only for purposes of this subsection 1395ww(d). The capital DSH provisions are found at 42 U.S.C. § 1395ww(g), an entirely different section of the statute, and therefore a rural reclassification under the subsection (d) operating PPS provisions does not apply for subsection (g) capital PPS purposes.[62]

The Providers believe that the promulgation of 42 C.F.R. § 412.320(a)(1)(iii) is, therefore, beyond the authority granted under 42 U.S.C. §§ 1395ww(d)(8)(B) and 1395ww(g), and the regulation must be found invalid.[63] The Providers assert that the Secretary has implicitly acknowledged that he cannot apply rural status for hospitals that have undergone a rural

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[56] *Id.*
[57] *Id.*
[58] *Id.* at *11-12.
[59] *Id.* at *12.
[60] *Id.*
[61] Request for EJR at 7.
[62] *Id.* at 1, 7.
[63] *See id.* at 7.

reclassification to payment provisions outside of subsection (d), and provides as an example, that the Secretary has stated with respect to direct graduate medical education ("GME") that no adjustment to the direct GME cap are available for urban hospitals that have reclassified as rural because subsection (d) reclassification "affects only payments under section 1886(d) of the Act . . . [and] payment for direct GME are made under section 1886(h) of the Act."[64] Further, the regulation fails to take into account any variation in cost based on location, as the capital PPS statute permits at 42 U.S.C. § 1395ww(g)(1)(B)(ii).[65]

The Providers assert that the Secretary's adoption of the regulation was arbitrary and capricious and violates the Administrative Procedure Act because he failed to establish that the adoption of the exception to the capital DSH adjustment, for providers that reclassified as rural, took into account variations in the relative costs of capital and construction for the different types of facilities or areas in which they are located.[66]

Though 42 C.F.R. § 412.320(a)(1)(iii) has not been vacated, the Providers argue that the merits of their position were adopted by the D.C. District Court in *Toledo*.[67] Further, the Providers contend that the Secretary adopted the FY 2024 hospital IPPS proposed rule in which the Secretary, in response to *Toledo*, proposed to amend 42 C.F.R. § 412.320(a)(1)(iii). Specifically, effective for discharges occurring on or after October 1, 2023, an urban hospital that is reclassified as rural under § 412.103 will no longer be considered rural for purposes of determining capital DSH eligibility. Instead, for purposes of § 412.320, the geographic classifications specified under § 412.64 will apply.[68] However, the Providers explain that for the period under appeal, CMS and its contractors will continue to apply the 2006 regulation, denying capital DSH to the Providers for this period.[69]

The Providers further contend that since the Board is bound by the regulation being challenged,[70] namely, the validity of 42 C.F.R. § 412.320(a)(1)(iii), it lacks the authority to decide the legal question presented in the Providers' Request for EJR. Since the additional criteria for EJR have also been met, the Providers request the Board grant the request.[71]

Board Decision

Pursuant to 42 U.S.C. § 1395oo(f)(1) and the regulation 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.

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[64] *Id.* at 8, citing 70 Fed. Reg. 47278, 47437 (Aug. 12, 2005).
[65] *Id.*
[66] *Id.* at 8-9.
[67] *Id.* at 9-12.
[68] *Id.* at 9-10, *citing* Medicare Program: Hospital IPPS Fiscal Year 2024 Payment Rates & Policy Changes, 88 Fed. Reg. 58,640, 59,117, 59,334 (Aug. 28, 2023).
[69] *Id.* at 10, 11-12, *citing* 88 Fed. Reg. at 27,058-59.
[70] *See* 42 C.F.R. § 405.1867.
[71] Request for EJR at 10-12.

A. Jurisdiction

In the November 13, 2015 Final Outpatient Prospective Payment Rule,[72] the Secretary finalized new cost reporting regulations related to the substantive reimbursement requirement of an appropriate cost report claim.[73] The Secretary revised the Medicare cost reporting regulations in 42 C.F.R. part 413, subpart B, by requiring a provider to include an appropriate claim for a specific item in its Medicare cost report *beginning on or after January 1, 2016* in order to receive or potentially qualify for Medicare payment for the specific item. If the provider's cost report does not include an appropriate claim for a specific item, the Secretary stated that payment for the item will not be included in the Notice of Program Reimbursement ("NPR") issued by the Medicare Contractor or in any decision or order issued by a reviewing entity (as defined in 42 C.F.R. § 405.1801(a)) in an administrative appeal filed by a provider. In addition, the Secretary revised the appeals regulations in 42 C.F.R. part 405, subpart R, by eliminating the requirement that a provider must include an appropriate claim for a specific item in its cost report in order to meet the dissatisfaction requirement for jurisdiction before the Board (hereinafter the "claim-specific dissatisfaction requirement"), again, for cost reports beginning on or after January 1, 2016. As all of the participants in these three cases have fiscal years that began after January 1, 2016, the claim-specific dissatisfaction requirement is not applicable.

The participants that comprise these group appeals have filed appeals involving fiscal years ending in 2018, 2019 and 2020. All of the participants have appealed from an original NPR or from the failure of the Medicare contractor to issue an NPR within twelve (12) months from the submission of the cost report or amended cost report.

Based on its review of the record, the Board finds that all of the providers in these group appeals filed their appeals within 180 days of the issuance of their respective final determinations as required by 42 C.F.R. § 405.1835, or more than 12 months after the submission of their amended cost report and a final determination has not yet been issued under 42 C.F.R. § 405.1835(c)(1). The providers each appealed the issue in the EJR request, and the Board is not precluded by regulation or statute from reviewing the issue. Finally, the amount in controversy meets the $50,000 amount in controversy requirement for a group appeal pursuant to 42 C.F.R. § 405.1837(a)(3) in the cases at issue. Therefore, the Board has jurisdiction over the providers.

B. Compliance with the Reimbursement Requirement of an Appropriate Cost Report Claim Pursuant to 42 C.F.R. § 405.1873 (Cost Reports Beginning on or After January 1, 2016)

For cost report periods beginning on or after January 1, 2016, the regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 are applicable. The regulation, § 413.24(j), specifies that, in order for a specific item to be eligible for potential reimbursement, the provider must include an appropriate cost report claim for that specific item:

> (j) **Substantive reimbursement requirement of an appropriate cost report claim**—

[72] 80 Fed. Reg. 70298, 70551-70580 (Nov. 13, 2015).
[73] *Id.* at 70555.

> (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
>
> (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.

In conjunction with the regulation above, 42 C.F.R. § 405.1873(a) addresses when the Board must examine a provider's compliance with § 413.24(j):

> (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.[74]

These regulations are applicable to the cost reporting periods under appeal, which end after December 31, 2016. The regulation at § 405.1873(b) sets out certain procedures that must be followed in the event a party questions whether the cost report included an appropriate claim for a specific item under appeal. *In such situations where a party raises that question*, the regulation requires the Board to give the parties an adequate opportunity to submit factual evidence and legal arguments regarding whether the provider's cost report included an appropriate claim for the specific item under appeal, and upon receipt of the factual evidence or legal argument (if any), the Board must review the 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 the cost report claim requirements of § 413.24(j).

The Board interprets the regulation at 42 C.F.R. § 405.1873 to only require the Board to review a provider's "compliance"[75] 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.[76] Board Rule 42.4[77] provides that if the Medicare Contractor opposes an EJR request filed by a provider or group of providers, which includes a Substantive Claim Challenge,[78] then it must file its response within five (5) business days of the filing of the EJR request. Five (5) business days have passed since the Providers filed the EJR request, and the Medicare Contractors have not filed a Substantive Claim Challenge in these three group appeals.

As such, since no party to the appeal has questioned, pursuant to § 405.1873(a), whether an appropriate claim was made, the Board finds there is no regulatory obligation for the Board to affirmatively, on its own, review the appeal documents to determine whether an appropriate claim was made. As a result, Board review under 42 C.F.R. § 405.1873(b) has not been triggered. Accordingly, the Board need not include any findings regarding compliance with the substantive claim requirements and may proceed to rule on the EJR request pursuant to 42 C.F.R. § 405.1873(d).

C. Board's Analysis Regarding the Appealed Issue

The Providers in these cases are challenging the application of 42 C.F.R. § 412.320(a)(1)(iii), which states in effect that urban hospitals may qualify for Capital DSH payments unless, on or after October 1, 2006, the urban hospital is reclassified as rural. The Providers contend that this regulation is inconsistent with the enabling statute, 42 U.S.C. § 1395ww(d)(8)(B), which concerns rural status. The Providers contend that §1395ww(d)(8)(B) specifically notes that the hospitals that have undergone a rural reclassification are rural only for "purposes of this subsection [1395ww(d)]."

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[74] (Bold emphasis added.)
[75] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."
[76] *See* 42 C.F.R. § 405.1873(a).
[77] The Board notes that Board Rule 10.2 states: "If the Medicare contractor opposes a provider's expedited judicial review request, . . . its response must be timely filed in accordance with Rules 42, 43, and 44."
[78] *See also* Board Rules 44.5.2 and 44.6.

Additionally, the Providers assert that the Capital DSH provisions are found at 42 U.S.C. § 1395ww(g), not § 1395ww(d), and, accordingly, the literal wording of the rural reclassification statutory provision identifies that rural status does not reach the Capital DSH calculation. The Providers maintain that the promulgation of 42 C.F.R. § 412.320(a)(1)(iii) is, therefore, beyond the authority granted under 42 U.S.C. § 1395ww(d)(8)(B), and the regulation must be found invalid.

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. § 412.320(a)(1)(iii). 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.

Accordingly, the Board concludes that it lacks the authority to grant the relief sought by the Providers, *i.e.,* to reverse or otherwise invalidate 42 C.F.R. § 412.320(a)(1)(iii). Consequently, the Board hereby grants the Providers' request for EJR for the issue and federal fiscal years under dispute.

D. Board's Decision Regarding the EJR Request

The Board finds that:

1) It has jurisdiction over the matter for the subject years and that all of the participants in the group appeals are entitled to a hearing before the Board;

2) The review process in 42 C.F.R. § 405.1873(a)-(b) has not been triggered, and therefore, there are no findings regarding whether the Providers' cost reports included appropriate claims for the specific item at issue in these appeals;

3) Based upon the participants' assertions regarding 42 C.F.R. § 412.320(a)(1)(iii), 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 42 C.F.R. § 412.320(a)(1)(iii), as promulgated in the FY 2007 IPPS Final Rule, is substantively or procedurally valid.

Accordingly, the Board finds that the question of the validity of 42 C.F.R. § 412.320(a)(1)(iii) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' EJR request for the issue and the subject years.

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 cases, the Board hereby closes the cases.

Board Members Participating:

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

FOR THE BOARD:

12/1/2023

X Clayton J. Nix

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

Enclosures: Schedule of Providers

cc: John Bloom, Noridian Healthcare Solutions (J-F)
Danelle Decker, National Government Services, Inc. (J-K)
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Nicholas Putnam
Strategic Reimbursement Group, LLC
360 West Butterfield Rd., Ste. 310
Elmhurst, IL 60126

RE: ***Jurisdictional Decision***
SRI Aurora 2006 Medicaid Eligible Medicare Unmatched Days CIRP Group
Case No. 14-3032GC

Dear Mr. Putnam:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above referenced appeal for the common issue related party ("CIRP") group in response to the Medicare Contractor's Jurisdictional Challenges. The Board's decision is set forth below.

Background

On March 25, 2014, the Providers' Representative, Strategic Reimbursement Group, LLC ("SRG"), filed this Group Appeal Request which contained two CIRP group participants:

1. Participant No. 1, Aurora Sinai Medical Center (Prov. No. 52-0064) appealing NPR dated February 28, 2013 for FY 2006 (transferred in from individual Case No. 13-3392); and
2. Participant No. 2, Aurora Medical Center Baycare (Prov. No. 52-0193) appealing an RNPR dated February 18, 2013 for FY 2006 (transferred in from Case No. 13-3007).

On April 25, 2014, SRG filed a Model Form D – Request to Transfer Issue to a Group Appeal for a third participant, Aurora Medical Center of Oshkosh (Prov. No. 52-0198) for FY 2006. Participant 3 was transferred from individual Case No. 13-3004 and is appealing from an RNPR dated February 25, 2013.

The group appeal request describes the following issues:

> Medicaid Eligible Medicare Unmatched Days:
>
> The Provider challenges *the exclusion* of days pertaining to patients with Medicaid coverage and initially identified as Medicare recipients *from the calculation of the Provider's Medicaid ratio* used in the determination of the Providers Operating Disproportionate Share Hospital, Low Income Payment, and Capital Disproportionate Share Hospital adjustment calculations (collectively "Calculations"). The Provider contends that these days have been incorrectly

> identified as Medicare days and *that they are **not** included in the Medicare Fraction (or SSI ratio)* of the DSH calculation *as indicated by CMS*. Provider requests that the necessary files be provided to review the Medicare Fraction and determine if the omitted days were or were not included in the Medicare Fraction. The Provider requests any days omitted from their Calculations on the premise that these days were in fact included in the Medicare Fraction, but as a result of review were identified to have not been included in the Medicare Fraction, be instead properly included in the hospital's Calculations in order to correct the Calculations to be consistent with statute 42 U.S C. 1395ww(d)(5)(F)(vi)(II).[1]

On April 25, 2014, the Medicare Contractor filed a letter notifying the Board that the group has ***not*** appealed a single common issue. The Medicare Contractor advised the issue appealed references both the hospital and the rehabilitation sub-unit, and that DSH and LIP are separate and distinct payments for low-income patients. The Medicare Contractor cited Board Rule 13 which requires group appeals to have a single, common issue. The Medicare Contractor also stated that a jurisdictional impediment exists with Participant No. 2 (Prov. No. 52-0193) as this Provider appealed from an RNPR and no adjustment was made to the DSH Medicaid ratio, nor has the Group provided protested amount detail.

On May 15, 2014, SRG filed a *timely* response to the Medicare Contractor's jurisdictional concerns. SRG argues that the treatment of both the DSH and LIP issues is the same, and the Providers hoped to reduce the administrative burden to the Board and its staff that would result from separate appeals for the DSH and LIP payment issues. SRG states that it felt this approach of including both issues was reasonable and efficient.

On December 8, 2021, SRG notified the Board that this CIRP group is now complete.[2]

On April 4, 2023, the Medicare Contractor filed a Jurisdictional Challenge stating it made no final determination regarding the appealed issue for Participant Nos. 2 and 3. The Provider did not file a response to this Jurisdictional Challenge.

On April 19, 2023, the Board issued the Notice of Hearing and Critical Due Dates ("Critical Due Dates Notice") setting the filing deadlines of the final position papers for June 14, 2023 and July 14, 2023 for the Providers and the Medicare Contractor, respectively. The Critical Due Dates Notice gave the following instruction on the required content for the Providers' final position paper:

> Group's Final Position Paper – The position paper **must state the material facts** that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), **and provide arguments applying the material facts** to the controlling authorities. This filing **must** also **include any exhibits**

[1] Statement of Group Issue (Mar. 21, 2014).
[2] The Providers' Representative filed the Schedule of Providers and Supporting Documents on August 18, 2022.

> **the Group will use to support its position**. *See* Board Rule 27 for more specific content requirements. If the Group misses its due date, the Board will dismiss the cases.[3]

On May 24, 2023, the Providers filed their Final Position Paper in which they continue to "challenge the exclusion of days pertaining to patients with Medicaid coverage and initially identified as Medicare recipients from the calculation of the Provider's Medicaid ratio used in the determination of the Providers Operating Disproportionate Share Hospital, Low Income Payment, and Capital Disproportionate Share Hospital adjustment calculations."

Providers' Preliminary and Final Position Papers

On April 14, 2022, SRG filed the Providers' Preliminary Position Paper consisting of 2 pages of argument with 2 exhibits containing copies of 2 regulatory authorities -- 42 C.F.R. §§ 412.106 and 412.320. The Position Paper describes the issue under appeal as a challenge to the *exclusion* of Medicaid Eligible Medicare Unmatched Days *from the DSH Medicaid Ratio* as used in the calculation of Operating DSH, Capital DSH, and LIP ***and*** that "these days have been incorrectly identified as Medciare days during filng and audit of the hospitals cost report and that are ***not*** *included in the Medicare Fraction* . . . as indicate by CMS."[4] The argument offered in the Providers' Preliminary Position Paper is that "information needed to perform the necessary review of the Calculations is contained in CMS' data sets referred to as 'MedPAR SSI Data Files' and ***had been*** *temporarily unavailable* pending the release of CMS' revised SSI ratios."[5] SRG goes on to state the Providers have requested the MedPAR SSI Data Files and are "performing a review to identify Medicaid days incorrectly omitted from the Medicaid Fraction…[t]he detailed list will be provided forthcoming."[6] However, the Providers do not explain when their request was filed or what the status is or when the MedPar files which "***had been*** temporarily unavailable"[7] became available.

On May 24, 2023, SRG filed the Providers' Final Position Paper which is even shorter than their Preliminary Position Paper and contains the same two regulatory exhibits. The Providers reiterate that they are challenging the ***exclusion*** of days pertaining to patients with Medicaid coverage and initially identified as Medicare recipients ***from*** the calculation of ***their Medicaid ratios*** used to determine their Operating DSH, Capital DSH and LIP adjustment calculations. The Providers again claim these days have been incorrectly identified as Medicare days during filing and audit of the hospital's cost report and that they are ***not*** *included in the Medicare ratio of the DSH and LIP calculations*. The Providers claim that "[t]he information needed to perform the necessary review of the Calculations is contained in CMS' data sets referred to as "MedPAR SSI data Files" and ***had been*** *temporarily unavailable* pending release of CMS' revised SSI ratios" but then recognize that "***[d]uring 2012***, CMS issued revised SSI ratios for FFY 2006-2010 as required by CMS' Ruling 1498R . . . and, ***at the same time***, *the MedPAR SSI Data Files*

[3] (Italics emphasis in original and bold and underline emphasis added.)
[4] Providers' Preliminary Position Paper at 6.
[5] *Id.* (emphasis added).
[6] *Id.*
[7] (Emphasis added.)

became available for review by hospitals' receiving IPPS DSH payments."[8] Significantly, the Providers do not explain in their Final Position Paper whether they received the relevant MedPAR SSI Data Files after they became available in 2012 and, if so, whether they reviewed those files to identify any specific days at issue in this appeal as being ***excluded*** *from* ***both*** *their SSI fraction* ***and*** *Medicaid fraction*.

Finally, neither position paper identifies any specific days being at issue (*i.e*., a day for which a patient had Medicare and was Medicaid eligible but was excluded from both the Medicaid and SSI fractions of the DSH calculation).

Medicare Contractor's Position

The Medicare Contractor argues that the cost issue in dispute – Medicaid Eligible Medicare Unmatched Days – was not adjusted in the Revised NPRs for Participant Nos. 2 (PN 52-0193) and 3 (PN-52-0198). The Medicare Contractor explain that the scope of the Revised NPRs was limited to the DSH SSI fraction, and no final determination was made regarding Medicaid Eligible Medicare Unmatched days. The Medicare Contractor contends the Medicaid Eligible Medicare Unmatched Days are outside the scope of the final determinations under appeal, and that Aurora Baycare Medical Center and Aurora Medical Center should be dismissed pursuant to 42 C.F.R. § 405.1887(d) and 42 C.F.R. § 405.1889.

Additionally, the Medicare Contractor asserts that if Participant Nos. 2 and 3 are dismissed from this CIRP group, there will be only one remaining Participant which violates Board Rule 12.6.1 regarding the minimum number of participants permitted in CIRP group appeals.[9]

Board Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2014), 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. LIP Sub-issue

The regulation at 42 C.F.R. § 405.1853(b)(2) specifies that "[e]ach position paper must set forth relevant facts and arguments regarding the Board's jurisdiction over ***each remaining*** *matter at issue* in the appeal . . ., and the merits of the provider's Medicare payment claims *for* ***each remaining*** *issue*."[10] Consistent with this regulation, Board Rule 25.3 (Nov. 2021) mandates that position papers must be complete, and that "[i]f the provider fails to brief an appealed issue in its position paper, the Board will consider the unbriefed issue abandoned and effectively withdrawn."

[8] Providers' Final Position Paper at 6 (emphasis added).
[9] MAC Jurisdictional Challenge (Apr. 4, 2023).

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

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

Failure to comply with the Board's briefing requirements for a position paper can be found at 42 C.F.R. § 405.1868:

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

The Provider has named the LIP Payment as an issue in its Preliminary and Final Position Papers, but has failed to brief this issue. The Providers did not provide any relevant facts and arguments regarding the Board's jurisdiction or the merits of the specific Medicare payment claims regarding the LIP Payment issue even though it is required under 42 C.F.R. §§ 405.1835(b)(1) and 405.1853(b)(2)-(3) and associated Board Rules. As described more fully below, Board jurisdiction over LIP issues has been contested and litigated and, as such, should have been briefed. For these reasons, the Board considers the LIP issue abandoned and effectively withdrawn from the group appeal. Indeed, it is not even clear whether any of the participants in this case have properly appealed the LIP issue since: (1) the "LIP issue" is unique to IRFs; (2) an

IRF is assigned a separate Medicare provider number; and (3) no such IRF provider numbers are listed in the Schedule of Providers.[10]

Even if the Providers had not abandoned the LIP issue, the Board would have still dismissed it. Under 42 U.S.C. § 1395ww(j)(8)(B), Congress specifically precludes administrative or judicial review of the prospective payment rates under the IRF-PPS. Although providers have attempted to dispute exactly what rate-setting "steps" Congress intended to shield from review under the statute, the D.C. Circuit's decision in *Mercy Hosp., Inc. v. Azar,* 891 F. 3d 1062 (June 8, 2018) ("*Mercy*") answers this question and clarifies what is shielded from review in its analysis of this issue.

In *Mercy*, the Court describes CMS' two-step rate-setting process for Medicare reimbursement for IRFs. The first step takes place prior to the beginning of the fiscal year and involves CMS' establishment of a standardized reimbursement rate, while the second step involves CMS' adjustments (calculated by the Medicare contractor) to "the standardized rates to reflect the particular circumstances of each hospital for that year." One of the ways in which CMS adjusts a hospital's IRF Medicare payment is by taking into account the number of low-income patients ("LIP") served by the hospital, also known as the LIP adjustment. The Court in *Mercy* affirmed the District Court's decision, wherein the District Court concluded that 42 U.S.C. § 1395ww(j)(8) prohibits administrative or judicial review of the Medicare Contractor's determination of the LIP adjustment, because such review amounts to review of the establishment of the hospital's prospective payment rates.[11] The D.C. Circuit concluded that the Statute's plain language prohibits administrative and judicial review of not only the statutory adjustments, but also the "step two rates" utilized by the Medicare Contractor when adjusting the standardized reimbursement rate and then calculating a hospital's final payment.[12]

B. Participant Nos. 2 and 3 – Appeal from RNPRs

The Code of Federal Regulations provides for an opportunity for a reopening of a determination and the issuance of a revised determination at 42 C.F.R. § 405.1885, which provides in relevant part:

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

[10] For example, Participant No. 1 is Aurora Sinai Medical Center and the Medicare provider number assigned to its acute care IPPS operations is 52-0064. In contrast, the Medicare provider number assigned to its IRF is 52-T064. However, the Schedule of Providers for this case does not list both provider numbers, but rather only lists the provider number for its acute care IPPS operations – 52-0064.

Additionally, 42 C.F.R. § 405.1889 explains the effect of revised determination such as an RNPR:

> (a) If a revision is made in a Secretary or contractor determination or a decision by a reviewing entity after the determination or decision is reopened as provided in §405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the provisions of §§ 405.1811, 405.1834, 405.1835, 405.1837, 405.1875, 405.1877 and 405.1885 of this subpart are applicable.
>
> (b)(1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.
>
> (2) Any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision.[13]

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

> (a) *Right to hearing on final contractor determination*. A provider . . . has a right to a Board hearing, as a single provider appeal, with respect to a final contractor or Secretary determination for the provider's cost reporting period, if -
>
> (1) The provider is dissatisfied with the contractor's final determination of the total amount of reimbursement due the provider, as set forth in the contractor's written notice specified under § 405.1803. **Exception**: If a final contractor determination is reopened under § 405.1885, **any review by the Board must be limited solely to those matters that are specifically revised in the contractor's revised final determination** (§§ 405.1887(d), 405.1889(b), and the "Exception" in § 405.1873(c)(2)(i)).
>
> (2) The amount in controversy (as determined in accordance with § 405.1839) must be $10,000 or more.
>
> (3) Unless the provider qualifies for a good cause extension under § 405.1836, the date of receipt by the Board of the provider's hearing request must be no later than 180 days after

> the date of receipt by the provider of the final contractor or Secretary determination.[14]

The Board finds that it does not have jurisdiction over the DSH Medicaid Eligible Medicare Unmatched Days issue in this appeal for Participants Nos. 2 and 3 because the revised NPRs from which they have appealed were issued to update the SSI percentage to the revised SSI percentages issued by CMS. Significantly, the Medicaid fraction was ***not*** revised (*i.e.*, the RNPR did not revise the Medicaid fraction to ***exclude*** any days from the Medicaid fraction) and the Provider's final position paper does not contend that any of the excluded days should have been *included* in the SSI fraction. Thus, pursuant to 42 C.F.R. § 405.1889(b) as referenced in § 405.1835(a)(1), Participant Nos. 2 and 3 do not have the right to appeal a Medicaid Fraction cost item in connection with the Unmatched Medicaid Eligible Days issue under appeal as this matter was not specifically revised in the RNPRs.

C. Position Papers Filed By All Providers, Including Participant No. 1 (Prov. No. 52-0064)

With respect to position papers, the regulations at 42 C.F.R. § 405.1853(b)(2)-(3) state the following:

> (b) *Position Papers*.
>
> ****
>
> (2) …. 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, **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.[11]

Board Rule 27 incorporates the requirements for preliminary position papers as delineated in Board Rule 25. In this regard, it states the following, in pertinent part:

> **Rule 27 Final Position Papers**
>
> ****
>
> **27.2 Content**
>
> The final position paper should address each remaining issue. *The minimum requirements* for the position paper narrative and exhibits

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

are the same as those outlined for preliminary position papers at Rule 25.[12]

Rule 25 Preliminary Position Papers

25.1 Content of Position Paper Narrative

The text of the position papers *must* contain the elements addressed in the following subsections.

25.1.1 Provider's Position Paper

A. Identify any issues that were raised in the appeal but are already resolved (whether by administrative resolution, agreement to reopen, transfer, withdrawal, dismissal, etc.) and require no further documentation to be submitted.

B. For each issue that has not been fully resolved, *state the material facts that support the provider's claim.*

C. *Identify the controlling authority*, (e.g. statutes, regulations, policy or, case law) *supporting the provider's position*.

D. *Provide a conclusion applying the material facts to the controlling authorities*.

25.2 Position Paper Exhibits

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.[13]

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

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

[12] (Italics emphasis added).
[13] (Italics emphasis added).

> appeal to comply with Board rules and orders or for inappropriate conduct during proceedings in the appeal.
>
> (b) If a provider fails to meet a filing deadline or other requirement established by the Board in a rule or order, the Board may-
>
> (1) Dismiss the appeal with prejudice;
>
> (2) Issue an order requiring the provider to show cause why the Board should not dismiss the appeal; or
>
> (3) Take any other remedial action it considers appropriate.

The Providers' *Model Form B – Group Appeal Request* (Mar. 21, 2014) describes the Medicaid Eligible Medicare Unmatched Days issue as a challenge to "the exclusion of days pertaining to patients with Medicaid coverage and initially identified as Medicare recipients from the calculation of the Provider's Medicaid ratio…these days…are ***not*** included in the Medicare fraction (or SSI ratio)… ".[14] Notwithstanding, the group appeal statement goes on to state the providers "request that the necessary files be provided to review the Medicare Fraction and determine if the omitted days were or were not included in the Medicare Fraction."[15] In other words the Providers wanted the listing to identify Medicare patients who were also Medicaid eligible *but were excluded from the SSI fraction* as well as the Medicaid fraction because it is their position that this class of days should be included in the Medicaid fraction.

While the Providers *allege* that there are errors in DSH SSI Ratios, they have failed to submit data regarding the alleged errors for these Providers and fiscal year end in the appeal request or Final Position Paper. Indeed, the Providers' recognize that 42 C.F.R. § 412.106(b)(iii) specifies that "The hospital has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed…". However, the Providers have failed to set forth the merits of their claim, explain why the agency's calculation is wrong, identify missing documents to support their claim, and explain when the documents will be available. To the contrary, the Providers recognize in their final position paper that the MedPAR SSI Data Files became available ***during 2012*** (*well before* this appeal was filed on March 25, 2014). Notwithstanding the availability of this MedPAR data,[16] the Providers fail to explain whether they have obtained those MedPAR data files and, if so, what those findings are. Indeed, even though this case had been pending since March 2014 (over 9 years), the Providers do not give in their Final Position Paper any update or progress on their efforts to identify any days at issue since they filed their Preliminary Position Paper more than a

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[14] (Emphasis added.)
[15] Statement of Group Issue (Mar. 21, 2014).
[16] 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. (Last visited Dec. 1, 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." (Emphasis added.)

year earlier. Accordingly, it is clear that the Provider in this appeal offers ***no*** *material facts or evidence* pertaining to its FYE 12/31/2006 Medicaid Eligible Medicare Unmatched Days alleged errors, either in its appeal request or in its Final Position Paper.

Finally, the Providers final position paper provides no legal basis for why the identified class of days (if there were to be any identified) must be included in the numerator of the Medicaid fraction. Why must the days *identified as Medicare as well as Medicaid eligible and allegedly not included in either the SSI fraction or the numerator of the Medicaid fraction* be included in the numerator of the Medicaid fraction? There are specific statutory and regulatory provisions governing the DSH calculation must be determined. However, the Providers have not provided any legal basis for their position that days for which a patient qualified for Medicare and was Medicaid eligible but was excluded from the SSI fraction and numerator of the Medicaid fraction ***must*** be included in the numerator of the Medicaid fraction (contrary to their exclusion). The merits of the Providers' position must be set forth in the position paper. The fact that it was not demonstrates that the position paper filings were perfunctory and hollow and did not comply with the regulations and rules governing the content of position papers.

Thus, the Board hereby dismisses this group appeal as the Providers have failed to develop their case as required by the regulations and the Board Rules. The Board has determined that the Providers have violated Board Rule 25.2.2 and 42 C.F.R. 405.1853(b)(2) because the Providers' final position paper did not set forth the relevant facts and arguments regarding the merits of this Provider's claims with regards to the Medicaid Eligible Medicare Unmatched Days issue. Indeed, having not identified any specific days at issue (notwithstanding the MedPAR data being available since 2012), the Board must conclude that there are no days in dispute and that the actual amount in controversy is $0. To this end, the Board finds that the Providers have abandoned the Medicaid Eligible Medicare Unmatched Days issue by filing a perfunctory/hollow position paper that did not include any discussion or analysis of the MedPAR data files that have been available to providers since 2012, as admitted by the Providers in their Final Position Paper.[17]

Conclusion

The Board finds that the LIP sub-issue was abandoned by the providers by not briefing this issue, including addressing the Board's jurisdiction over this issue and the merits of the Providers Medicare payment claims pertaining to the issue, in its position papers. Additionally, this issue is precluded from administrative review under 42 U.S.C. § 1395ww(j)(8)(B) and affirmed in *Mercy*. The Board dismisses the LIP payment issue from the appeal.

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[17] This is further reinforced by the fact that a witness list was due to be filed 30 days prior to the currently scheduled December 12, 2023 hearing. However, no such witness list was filed. As a result, if the Board were to hold a hearing, the Providers would have no evidence in the record and no witnesses to present at the hearing. As noted above, per 42 C.F.R. § 412.106(b)(iii), "[t]he hospital has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed…" Similarly, per 42 C.F.R. § 405.1871(a)(3), the provider has *the "burden of production of evidence* ***and*** *burden of proof* by establishing, by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue." (Emphasis added.)

The Board also finds that Participant Nos. 2 and 3 are appealing from RNPRs that did not adjust Medicaid Eligible Unmatched Medicare Days. Therefore, the Board lacks jurisdiction over the issue for Participant Nos. 2 and 3, and these two Participants are dismissed from the appeal.

Lastly, the Board finds that all Participants in this CIRP Group have filed a perfunctory position paper in violation of 42 C.F.R. 405.1853(b)(2) and Board Rule 25 (as applied to final position paper via Board Rule 27.2). As there are no Providers or issues remaining in this CIRP group appeal, the case is now 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:

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

For the Board:

12/1/2023

X Clayton J. Nix

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

Byron Lamprecht
WPS Government Health Administrators
1000 N 90th Street, Suite 302
Omaha, NE 68114-2708

RE: ***Board Decision* – SSI Percentage (Provider Specific) and Medicaid Eligible Days**
Henderson County Community Hospital (Provider Number 44-0008)
FYE: 01/31/2017
Case Number: 20-0479

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. 20-0479*

On May 24, 2019, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end January 31, 2017.

On November 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[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 Quorum 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 Quorum Health groups on June 18, 2020. After an issue withdrawal, the remaining issues in this appeal are Issues 1 and 3.

[1] On June 18, 2020, this issue was transferred to PRRB Case No. 20-1339GC.
[2] This issue was withdrawn on April 30, 2021.
[3] On June 18, 2020, this issue was transferred to PRRB Case No. 20-1340GC.

On July 9, 2020, the Provider filed its preliminary position paper. On October 6, 2020, the Medicare Contractor filed a Jurisdictional Challenge, requesting the dismissal of Issue 1. On October 29, 2020, the Medicare Contractor filed its preliminary position paper. On March 2, 2023, the Medicare Contractor filed a second jurisdictional challenge, requesting the dismissal of Issue 3. The Provider has not replied to either jurisdictional challenge.

A. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 20-1339GC

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 Quorum Health, the Provider transferred its Issue 2 – DSH/SSI Percentage to the CIRP group under 20-1339GC, Quorum Health CY 2017 DSH SSI Percentage CIRP Group, on June 18, 2020. The Group Issue Statement in Case No. 20-1339GC reads, in part:

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

[4] Issue Statement at 1 (Nov. 20, 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.[5]

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

On July 9, 2020, 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 (January 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

[5] Group Issue Statement, Case No. 20-1339GC.

> 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).[6]

MAC's Contentions

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

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

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

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.[8]

Issue 3 – DSH – Medicaid Eligible Days

The MAC argued that the Provider abandoned the DSH – Medicaid Eligible Days issue:

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[6] Provider's Preliminary Position Paper at 8-9 (Jul. 9, 2020).
[7] Jurisdictional Challenge at 6-7 (Oct. 6, 2020).
[8] *Id*. at 4-6.

> The MAC contends that the Providers were in violation of Board Rule 25.3 when they failed to sufficiently develop and set forth the relevant facts and arguments regarding the merits of their claim in the preliminary position papers. Moreover, the Providers 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 their preliminary position paper, the Providers make the broad allegation, "…the Provider contends that the total number of days reflected in its' . . . cost report does not reflect an accurate number of Medicaid eligible days. . ." The Providers have failed to include any evidence to establish the material facts in this case relating to inaccuracies in the Medicaid Percentage calculation at issue. The Provider merely repeats its appeal request.[9]

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

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 either of the Jurisdictional Challenges and the time for doing so has elapsed. Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

Board Analysis and Decision:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (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/SSI Percentage (Provider Specific) issue. The jurisdictional analysis for Issue No. 1 has two relevant aspects to consider:

[9] Jurisdictional Challenge #2 at 4 (March 2, 2023).
[10] Board Rule 44.4.3, v. 2.0 (Aug. 2018).

1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, and 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

1. First Aspect of Issue 1

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH/SSI Percentage issue that was appealed in PRRB Case No. 20-1339GC.

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 issue in group Case No. 20-1339GC 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)(vi)(I). Thus, the Board finds the DSH Payment/SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH/SSI Percentage issue in Case No. 20-1339GC. 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 20-1339GC. 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) as to how the alleged "provider specific" errors can be

[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).

distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 20-1339GC.

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. 20-1339GC, 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." For example, the Provider asserts that "the SSI entitlement of individuals can be ascertained from State records" but fails to explain what that means, what the basis for the alleged fact is,[16] or why that is even relevant to the issue. 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, *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

[16] There are no exhibits or citations to state records or examples of how SSI entitlement can be ascertained from state records.

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 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 20-1339GC 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.

1. Second Aspect of Issue 1

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

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

B. DSH – 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:

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[17] Last accessed December 4, 2023.
[18] 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.[19]

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

The Provider's preliminary position paper indicated that it would be sending the eligibility listing under separate cover.[20]

Board Rule 7.3.1.2 (Nov. 2021) 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 MAC asserts that 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 MAC thus asserts that the Provider has essentially abandoned the issue by failing to properly develop its arguments

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

and to provide supporting documents or to explain why it cannot produce those documents, as required by the regulations and the Board Rules.[21]

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

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. *Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board through a schedule applicable to a specific case or through general instructions*.[22]

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,[23] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[24] 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,* then provide the following information in the position papers:
>
> 1. Identify the missing documents;

[21] *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.
[22] (Emphasis added).
[23] The minimum requirements for Final Position Paper narratives and exhibits is the same as those for Preliminary Position Papers. *See* Board Rule 27.2.
[24] (Emphasis added).

> 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.[25]

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:

> 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"[26] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. 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

[25] (Emphasis added).
[26] (Emphasis added).

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 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 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.[27]

****

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. 20-1339GC and there is no final determination from which the Provider can appeal the SSI realignment portion of the issue. The Board also dismisses the Medicaid eligible days issue as the Provider failed to meet the Board requirements for position papers for this issue. As no issues remain pending, the Board hereby closes Case No. 20-0479 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:

12/4/2023

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

[27] Board Rule 25, of which 25.2.1 and 25.2.2 are a part, is applicable to final position papers via Board Rule 27.2.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Dismissal for Erroneous Filing Pursuant to Board Rules 20 and 20.1***

SRG Presence Post 10/1/2013 DPP Medicare/Medicaid Part C Days CIRP Group
PRRB Case No. 17-0817GC

Dear Mr. Putnam:

The Provider Reimbursement Review Board (the "Board") has reviewed the subject common issue related party ("CIRP") group appeal in response to a November 3, 2023 "Rule 22 Jurisdictional Review" filed by the Medicare Contractor. The Board notes that the CIRP group was filed prior to the implementation of the Office of Hearing Case & Document Management System ("OH CDMS").[1] The electronic record for the CIRP group, which is considered a "Legacy" case, has not yet been populated. A brief history of the facts and the Board's determination are set forth below.

Pertinent Facts:

On November 13, 2020, Strategic Reimbursement Group, LLC ("Strategic"/"Group Representative") designated the CIRP group fully formed. At the time, pursuant to Board Rule 20, within 60 days of the group's full formation, the Group Representative was required to file a hard copy of the full Schedule of Providers with supporting jurisdictional documentation. That submission would have been due on January 12, 2021[2].

On November 1, 2021, the Board issued revised Board Rules which changed certain procedures for group appeals. Specifically, Rule 20 addresses the population of Issues/Providers in the Office of Hearings Case & Document Management System ("OH CDMS"). Rule 20 advises that, "***within (60) sixty days of the full formation of the group***, the group representative must file a statement certifying that the group is fully populated in OH CDMS with the relevant supporting jurisdictional documentation (*i.e.*, all participants in the group are shown under the Issues/Providers Tab for the group in OH CDMS with the relevant supporting jurisdictional documentation."[3]

[1] The group was filed on January 18, 2017.
[2] At the time the deadlines for the subject appeal were suspended pursuant to Alert 19 due to the COVID 19 Pandemic.
[3] (Emphasis added.)

On November 7, 2022, the Board issued Alert 23, which gave notice that effective December 7, 2022, the Board was resuming its normal operations following the COVID- 19 Pandemic. The Alert 23 included a reminder to the Parties regarding the Rule 20 Certification requirement.

On May 12, 2023, the Board issued a Critical Due Dates notification in the subject group case, setting new deadlines for the subject appeal. The Group's preliminary position paper deadline was set for September 22, 2023.

On September 5, 2023, Strategic filed its preliminary position paper.

On November 1, 2023, the Medicare Contractor sent an email to Strategic advising that it had not yet received the Group's "Rule 20" letter.[4] On the same date, a few hours later, Strategic uploaded a Rule 20 Certification in OH CDMS, indicating the group was fully populated.

On November 3, 2023, the Medicare Contractor filed its Rule 22 Jurisdictional Review Response indicating that OH CDMS was not populated as there were no providers listed under the participants tab, nor were there any copies of appeal requests, transfers, etc. The Medicare Contractor advised that, to date, Strategic had not provided the Medicare Contractor with any jurisdictional documentation for it to perform its review.

Significantly, Strategic did ***not*** file any response to the Medicare Contractor's November 3, 2023 filing. As set forth below, Strategic has failed to meet the requirements of Rules 20 and 20.1. Below is a discussion regarding Rule 20 and Rule 20.1 requirements and the information that was required in this case.

Rule 20/20.1 Background:

Rule 20 addresses the population of Issues/Providers in OH CDMS. Pursuant to Board Rule 20:

> If ***all*** the participants in a fully-formed group are ***populated*** under the Issues/Providers Tab in OH CDMS with supporting jurisdictional documentation (*see* Rule 21), then the representative is exempt from filing a ***hard copy*** of the schedule of providers with supporting jurisdictional documentation. In this instance, the Board uses the schedule of providers and supporting jurisdictional documentation that is created in OH CDMS using the information and documents included in each participating provider's request for transfer or direct add to the group.
>
> ***Prior to*** certifying that the group is fully formed or the date on which a group is fully formed, the group representative should review each participating provider's supporting jurisdictional documentation to ensure it is complete and, if not, file any additional documentation in OH CDMS.[5] If *all* of the participants in a fully-formed group are

[4] Although this email was not separately uploaded in OH CDMS, a copy of the email was submitted as an exhibit to the Medicare Contractor's Rule 22 Jurisdictional Review Letter.

[5] If all participants are populated but jurisdictional support is not complete, the Rule 20 Certification must certify that all participants are populated, but should include an identification of the documents that are missing and then ***only*** file

> ***populated*** under the Issues/Providers Tab in OH CDMS, then ***within (60) sixty days of the full formation of the group***, the group representative must file a statement certifying that the group is *fully* populated in OH CDMS with the relevant supporting jurisdictional documentation (*i.e.*, all participants in the group are shown under the Issues/Providers Tab for the group in OH CDMS with the relevant supporting jurisdictional documentation).[6]

Board Rule 20.1 applies to **"Group Cases that Are Not Fully Populated in OH CDMS."** Pursuant to Board Rule 20.1:

> If any participants in a fully-formed group are ***not*** populated under the Issues/Providers Tab in OH CDMS with supporting jurisdictional documentation (*see* Rule 21), then the Representative must prepare a traditional schedule of providers (*i.e.* Model Form G at Appendix G), for *all* participants in the group **following the instructions in this Rule and Rule 21, unless the Board instructs otherwise.** Specifically, *within sixty (60) days of the full formation of the group* (see Rule 19), the group representative must prepare and file a schedule of providers with the supporting jurisdictional documentation for all providers in the group that demonstrates that the Board has jurisdiction over each participant named in the group appeal (*see* Rule 21) . . . .

The Board recognizes that the Critical Due Dates notifications do not include a deadline for filing, as relevant, the Rule 20 Certification or the traditional SoP under Board Rule 20.1. However, making the applicable filing under Board Rules 20 and 20.1 *is **and** remains* a requirement under Board Rules and must be made ***within 60 days of full formation***.

Upon review, we note that in this group case, ***none*** of the providers are populated behind the Participants tab (*i.e.*, none are listed there) and, therefore, Rule 20.1 applies. As such, the Representative was required to separately file a PDF copy of the full SoP with *all relevant supporting jurisdictional documentation* within the 60-day period allotted under Board Rule 20.1.[7]

Board Determination:

Pursuant to 42 C.F.R. § 405.1868:

> (a) The Board has full power and authority to make rules and establish procedures, not inconsistent with the law, regulations, and CMS Rulings, that are necessary or appropriate to carry out the provisions of section 1878 of the Act and of the regulations in this

in OH CDMS those additional missing documents. See, https://www.cms.gov/files/document/oh-cdms-prrb-user-manual-supplement-supplemental-document-uploads-group-appeals.pdf.

[6] (Underline emphasis added.)

[7] Rule 20/20.1 Certifications must be stand-alone filings and never part of another filing *(e.g., never embedded within a preliminary position paper filing, group status response, etc.).*

> subpart. *The Board's powers include the authority to take appropriate actions in response to the **failure of a party** to a Board appeal **to comply with Board*** rules and ***orders*** or for inappropriate conduct during proceedings in the appeal.
>
> (b) *If a provider fails to meet a filing deadline or other requirement established by the Board in a rule or order, the Board may—*
>
> *(1) Dismiss the appeal with prejudice***;**
>
> (2) Issue an order requiring the provider to show cause why the Board should not dismiss the appeal; or
>
> (3) Take any other remedial action it considers appropriate.[1]

Although in Case No. 17-0817GC, the group was designated to be fully formed on November 13, 2020, which was ***prior to the effective date of Alert 23***, and perhaps Strategic may have inferred that the 60 day time frame for filing the Rule 20 Certification was considered to be one of the suspended "Board-set deadlines," the Board re-established the group's deadlines when it issued the May 12, 2023 Critical Due Dates notification. Further, the Medicare Contractor's notifications put Strategic on notice of the deficiencies regarding the Rule 20 submission.

The Board is also cognizant of the fact that, on more than one occasion, it has explained the background and requirements of Board Rule 20 and Rule 20.1 to Strategic. At least three (3) times in April and May 2023, as a courtesy, the Board has extended Strategic additional time to correct such deficiencies. In doing so, the Board provided instruction on when Board Rule 20 versus Board Rule 20.1 applies and admonished Strategic for its failure to comply with these Rules. Finally, the Board notified Strategic that "the Board is ***not*** *inclined to consider further extensions* in future Strategic groups for the Representative *to correct deficient Rule 20 and Rule 20.1 submissions*."[8] Notwithstanding the prior instruction, Strategic continues to miss or make deficient filings related to this Board Rule.[9] Accordingly, regarding the instant case, Case No. 17-0817GC, *the Board **admonishes** Strategic for filing a **false** Rule 20 Certification* in a case which has obviously *not* been populated with all of the participants (*i.e.,* obviously not all of the participants in the case are listed behind the Participants tab in OH CDMS for this case) because there, in fact, no participants listed behind Participants tab in OH CDMS for this case.

Additionally, the Board notes that the Medicare Contractor made Strategic aware of the deficiencies in this group at least twice, via e-mail and in its Rule 22 Jurisdictional Review letter filed in OH CDMS for this case. Notwithstanding the Medicare Contractor notifications (and the Board's prior instruction), Strategic failed to respond to either of those Medicare Contractor notifications, which

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[8] Board Scheduling Order, Case No. 15-2016GC (May 30, 2023) (emphasis added).

[9] Examples of cases in which the Board has provided instruction and directed Strategic to come into compliance include Case Nos. 16-2016GC (Board letter dated May 30, 2023) and 14-4233GC (Board letter dated April 11, 2023). These letters include the following instruction from the Board: "Only when one or more of the participants for a group are ***not*** listed behind the Participants Tab in OH CDMS, does Board Rule 20.1 apply. In that instance (and only for that instance), Rule 20.1 specifies that the Group Representative must file in OH CDMS a PDF copy of the SoP with supporting *jurisdictional* documentation." (Emphasis in original.)

suggests to the Board that Strategic has abandoned its appeal.[10] Consequently, because the full SoP with supporting documentation was not timely filed in the subject group as required under Board Rule 20.1, the Board hereby dismisses Case No. 17-0817GC pursuant to its authority under 42 C.F.R. § 405.1868.

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

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

For the Board:

12/5/2023

X Clayton J. Nix

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

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

[10] Indeed, even if the Board were to accept Strategic's certification as complying with Rule 20, then it would be certifying that ***all*** participants in the CIRP group are listed behind the Participants tab in OH CDMS with all relevant supporting jurisidictional documentation. However, there are not any participants listed behind the Participants tab in OH CDMS for this case. Accordingly, Strategic has effectively abandoned this appeal by effectively certifying that this appeal contains no participants. This abandonment is supported by the instruction the Board has previously given (*see supra* note 9 and accompanying text) and its failure to correct this fatal flaw even after being notified by the Medicare Contractor.

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

RE: ***Board Decision***
Northwest Medical Center – (Prov. No. 03-0085)
FYE 9/30/2014
Case No.: 18-1617

Dear Mr. Summar:

The Provider Reimbursement Review Board ("Board") reviewed the documentation in Case No. 18-1617 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. 18-1617

On February 16, 2018, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end September 30, 2014.

On August 15, 2018, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained six (6) issues:

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

As the Provider is owned by Community Health Systems, Inc. (hereinafter "CHS") and, thereby, 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 CHS groups on March 22, 2019. After the withdrawal of Issue 3 (DSH – Medicaid Eligible Days), the remaining issues in this

[1] This issue was transferred to case PRRB Case No. 18-0109GC on March 22, 2019.
[2] This issue was withdrawn on October 13, 2023.
[3] This issue was transferred to case PRRB Case No. 18-0112GC on March 22, 2019

appeal are Issues 1 (SSI Percentage (Provider Specific) and 4 (DSH –and Uncompensated Care Distribution Pool).

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

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 CHS, the Provider transferred its Issue 2 – DSH/SSI Percentage to the CIRP group under 18-0109GC, QRS CHS 2014 DSH SSI Percentage CIRP Group, on March 22, 2019. The Group Issue Statement in Case No. 18-0109GC reads:

> **Statement of the Issue:**
>
> Whether the Medicare/SSI fraction used in the Medicare Disproportionate Share Hospital and LIP payment calculations accurately and correctly counted the correct number of patient days to be included in the numerator and denominator of the Medicare/SSI fraction calculation per the Medicare Statute at 42 U.S.C. §1395ww(d)(5)(F)(vi)?
>
> **Statement of the Legal Basis:**
>
> The Provider(s) contend(s) that the Lead MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww (d)(5)(F)(vi). The Provider(s) contend(s) that the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") and used by the Lead MAC to settle their Cost Report were incorrectly computed.

[4] Issue Statement at 1 (Aug. 15, 2018).

> The Provider(s) also contend(s) that CMS inconsistently interprets the term "entitled" as it is used in the statute. CMS requires SSI payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the denominator. CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days of care) as Medicare Part A days, yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment.
>
> The Provider(s) further contend(s) that the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") fail to address all the deficiencies as described in Baystate Medical Center v. Michael 0. Leavitt, 545 F. Supp. 2d 20, as amended, 587 F. Supp. 2d 37, 44 (D.D.C. 2008) and incorporate a new methodology inconsistent with the Medicare Statute.
>
> Providers in this case are also seeking resolution of the following additional aspects of the Medicare fraction that were not addressed in the Baystate case:
>
> 1. Availability of MEDPAR and SSA records,
> 2. 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]

On March 27, 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 the Centers for Medicare and Medicaid Services ("CMS") was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation. This is based on certain data from the State of Arizona and the Provider that does not support the SSI percentage issued by CMS.
>
> The Provider has worked with the State of Arizona and has learned that similar to Loma Linda Community Hospital v. Dept of Health

[5] Group Issue Statement, Case No. 18-0109GC.

> and Human Services, No. CV -94-0055 (C.D. Cal. June 2, 1995), the 5Sf entitlement of individuals can be ascertained from State records.
>
> The Provider is seeking the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, HHS/HCFAJOIS, 09-07-009, which was published in the Federal Register on August 18, 2000, from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. See 65 Fed. Reg. 50,548 (2000). The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction.[6]

On October 19, 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 9 all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra (Appellants' reply brief included as Exhibit P-3).[7]

C. Filings Concerning the Jurisdictional Challenge

[6] Provider Preliminary Position Paper at 8-9 (August 20, 2019).
[7] Provider Final Position Paper at 8-9 (October 19, 2023).

1. MAC's Contentions:

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

The MAC filed its jurisdictional challenge on December 11, 2018, and 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 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.[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]

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)."[11]

Provider's Jurisdictional Response:

The Board Rules require that Provider Responses to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[12] The Provider has not ***timely*** filed a response to the Jurisdictional Challenge. 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

[8] The MAC also challenged jurisdiction over the UCC and IPPS Payment issue, however the Provider has since withdrawn those issues.
[9] Jurisdictional Challenge at 6 (December 11, 2018).
[10] *Id*. at 5-6.
[11] Jurisdictional Challenge at 19.
[12] Board Rule 44.4.3, v. 2.0 (Aug. 2018).

information contained in the record." The Provider filed its jurisdictional challenge response on January 15, 2019, which is more than 30 days after the challenge was filed.

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 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. 18-0109GC.

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."[13] The Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[14] The Provider argues 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."[15]

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

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

PRRB Rule 4.6[16], 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 18-01097GC, 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.[17] Provider is misplaced in referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 18-0109GC.

To this end, the Board also reviewed the Provider's Position Papers 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. 18-0109GC, 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.[18]

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

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

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

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

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 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 18-0109GC are the same issue.[21] Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

2. Second Aspect of Issue 1

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

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[19] Last accessed February 24, 2023.
[20] Emphasis added.
[21] 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).

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 dismisses 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. Preclusion of 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).[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

[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).

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

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

[25] 830 F.3d 515, 517.
[26] *Id.* at 519.
[27] *Id.* at 521-22.
[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).

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 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

[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.*
[36] *Id.* at 262-64.
[37] *Id.* at 265.
[38] *Id.* (discussing *Leedom v. Kyne*, 358 U.S. 184, 188 (1958)).

> 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* 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 finds that the same findings are applicable to the Provider's challenge to their FFY 2014 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 2014. 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. 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.

---

[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.
[43] *Id.* at *9.
[44] 139 S. Ct. 1804 (2019).
[45] *Ascension* at *8 (bold italics emphasis added).

Decision

The Board hereby dismisses the DSH Payment/SSI Percentage (Provider Specific) issue from appeal as it is duplicative of the issue that was transferred to PRRB Case No. 18-0109GC. Additionally, 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 pursuant to 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2) which preclude administrative and judicial review of certain aspects of the UCC payment calculation.

As no issues remain, Case No. 18-1617 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
Ratina Kelly, CPA

For the Board:

12/5/2023

X Robert A. Evarts, Esq,

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

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

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

Jody Erdfarb
Wiggin and Dana LLP
281 Tresser Boulevard
Enterprise, AL 36330

RE: ***Board Determination on Request for Reconsideration of Dismissal/Reinstatement***
Yale New Haven Hospital (Prov. No. 07-0022)
Appealed Period: FYE 2023
PRRB Case No.: 23-1069

Dear Mr. Erdfarb:

The Provider Reimbursement Review Board (the "Board") has reviewed the above-captioned appeal in response to **November 9, 2023** correspondence from **Yale New Haven Hospital** ("YNHH"/"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 3, 2023,** YNHH 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 Increase Factor ("AIF") under Case No. 23-1069.

On **March 6, 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 29, 2023 and the Medicare Contractor's preliminary position paper deadline for February 26, 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 31, 2023**, following the expiration of the preliminary position paper deadline, the Board dismissed Case No. 23-1069 because the Provider failed to timely file the preliminary position paper.

On **November 09, 2023**, YNHH filed a request for reconsideration, asking to reinstate its case. In its request, YNHH stated its position that it met the requirements of the appeal request when the preliminary position paper was filed, even though its appeal request was not filed under that category of document (i.e., the document category for position papers). YNHH also maintains that CMS's issuance of the AIF reduction was due to a technical oversight and should be corrected. Last, YNHH explained that it conferred with the Medicare Contractor concerning the Motion, and that "the Provider is authorized to represent that the MAC does ***not*** consent to the motion and believes the matter is solely between the Provider and the Board."[3]

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.

YNHH 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.)
[3] Motion for Reinstatement at 1 (Nov. 9, 2023) (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.[4]

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 because it *incorrectly* thought that the appeal request satisfied the requirements of the preliminary position paper. Further, contrary to Board Rule 44 governing motions, YNHH's motion for reconsideration is deficient because: (1) it failed to attach the missing position paper to its request for reinstatement, and instead, the Provider included its appeal request as an exhibit to the request, and (2) 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.

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."[5] 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*."[6] 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 fulfilled the requirements of the preliminary position paper. 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."[7] The Provider failed to follow the process set forth in

[4] (Emphasis added.)
[5] (Emphasis added.)
[6] (Emphasis added.)
[7] 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 Critical Due Dates Notice and Board Rules. The representative is charged with being familiar 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.[8]

In summary, pursuant to its authority under 42 C.F.R. § 405.1868(a)-(b), the Board denies YNHH's request for reinstatement of Case No. 23-1069. The Board finds that the Provider was at 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 as well as the fact that its request for reinstatement is deficient since it failed, *as a prerequisite for consideration of a reinstatement request*: (1) to attach the missing position paper to its request for reinstatement, and instead, the Provider included its appeal request as an exhibit to the request, and (2) to 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. Therefore, the Board declines to exercise its

---

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."

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

discretion to reinstate Case No. 23-1069 and it thereby remains closed. The Board denial is consistent with numerous cases in which federal courts have upheld the Board's authority to dismiss cases for failure of the provider to timely file position papers or other Board filings.[9] 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:

12/5/2023

X Clayton J. Nix

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

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

[9] *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
7500 Security Boulevard
Mail Stop: B1-01-31
Baltimore, MD 21244
410-786-2671

Via Electronic Delivery

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

RE: ***Board Decision***
Siloam Springs Memorial Hospital (04-0001)
FYE: 03/31/2016
Case Number: 18-1672

Dear Mr. Summar,

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed documentation in Case No. 18-1672 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. 18-1672

On February 28, 2018, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end March 31, 2016. On August 31, 2018, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained five (5) issues:

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

As the Provider is owned by Community Health Systems, Inc. (hereinafter "CHS") and, thereby, subject to the mandatory Common Issue Related Party ("CIRP") group regulation at 42 C.F.R. § 405.1837(b)(1), the Provider transferred Issues 2 and 5 to CHS groups on March 22, 2019. After the withdrawal of Issue, the remaining issues in this appeal are Issues 1 and 4, the DSH –

[1] On 03/22/2019, this issue was transferred to PRRB Case No. 19-1409GC.
[2] On 08/09/2023, the Provider withdrew this issue.
[3] On 03/22/2019, the Provider transferred to PRRB Case No. 19-1410GC.

SSI Percentage (Provider Specific) and Uncompensated Care Distribution Pool issues are still pending in the appeal.

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.[4]

As the Provider is commonly owned by CHS, the Provider transferred its Issue 2 – DSH/SSI Percentage to the CIRP group under 19-1409GC, QRS CHS 2016 DSH SSI Percentage CIRP Group, on March 22, 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 Disproportionate Share Hospital ("DSH")/Supplemental Security Income ("SSI") percentage, and whether CMS should be required to recalculate the SSI percentages using a denominator based solely upon covered and paid for Medicare Part A days, or alternatively, expand the numerator of the SSI percentage to include paid/covered/entitled as well as unpaid/non-covered/eligible SSI days?
>
> **Statement of the Legal Basis**
>
> The Provider(s) contend(s) that the MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute at 42 U.S.C. § 1395ww (d)(5)(F)(vi)(I). The Provider(s) further contend(s) that the SSI

[4] Issue Statement at 1 (August 31, 2018).

> 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.

On April 28, 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 (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 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 – SSI Percentage (Provider Specific)[6]

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 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]

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.[8]

Issue 4 – UCC Distribution Pool

The MAC argues "that the Board does not have jurisdiction over the UCC DSH payment issue because jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2)."[9]

The MAC also contends that this issue is a duplicate of PRRB Case Nos. 15-1175GC and 16-0785GC, and should therefore, be dismissed.[10]

---

[5] Provider's Preliminary Position Paper at 8-9 (April 28, 2018).
[6] The MAC also challenged jurisdiction over the Two Midnight Rule issue, however the Provider has since transferred that issue to a group appeal.
[7] MAC's Jurisdictional Challenge (Feb. 5, 2019).
[8] *Id.*
[9] *Id.*
[10] *Id.*

2. Provider's Jurisdictional Response

Issue 1 – DSH – SSI Percentage (Provider Specific)

The Provider contends each of the appealed SSI issues are separate and distinct issues, and pursuant to Board Rule 8.1 "Some issues may have multiple components". The Provider argues it is entitled to appeal an item with which it is dissatisfied, and the MAC specifically adjusted the Provider's SSI percentage which resulted from its understated SSI percentage. The Provider cites *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) which contemplates whether Baystate's SSI fractions were understated due to the number of days included in the SSI ratio.

Issue 4- DSH- Uncompensated Care

The Provider argues the Statute does not authorize the Secretary to estimate the uninsured patient population percentage and believes it is entitled to a writ of mandamus directing the Secretary to revise her estimates. Additionally, the statute does not preclude challenges to the regulations and policies relied upon by the Secretary in computing estimates for DSH Factors 1-3, even if challenges to the estimates themselves are precluded.

Board Analysis and Decision:

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

A. DSH/SSI Percentage (Provider Specific)

The 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 "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. 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[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, 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] 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 Position Papers 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

[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 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).

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 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

[16] (Emphasis added).
[17] Last accessed February 24, 2023.
[18] Emphasis added.

not provide HHS with the specific codes assigned to individual patients. See 75 Fed. Reg. at 50,276." Here, the Provider does not explain what information it needs or is waiting on or claims that it should have access to.

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.[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 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 dismisses 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).[20]

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).[21]

[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).
[20] The Provider was also a participant in PRRB Case Nos. 15-1134GC (appealing from the Fed. Reg. dated Aug. 22, 2014) and 16-0769GC (appealing from the Fed. Reg. dated Aug. 17, 2015) (Covering service dates through Feb. 28, 2018). Both CIRP Group appeals have been dismissed for a lack of jurisdiction.
[21] 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

(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*"),[22] the U.S. Court of Appeals for the District of Columbia Circuit ("D.C. Circuit") upheld the D.C. District Court's decision[23] 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."[24] 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.[25]

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.[26]

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*").[27] In *DCH v. Azar*, the provider alleged that it was challenging the methodology adopted and employed by the

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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.

[22] 830 F.3d 515 (D.C. Cir. 2016).

[23] 89 F. Supp. 3d 121 (D.D.C. 2015).

[24] 830 F.3d 515, 517.

[25] *Id.* at 519.

[26] *Id.* at 521-22.

[27] 925 F.3d 503 (D.C. Cir. 2019) ("*DCH v. Azar*").

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."[28] 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.[29]

c. Scranton Quincy Hosp. Co. v. Azar

Recently, in *Scranton Quincy Hosp. Co. v. Azar* ("*Scranton*"),[30] 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.[31] 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.[32] 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.[33] Nevertheless, the Secretary used each hospital's shorter cost reporting period in calculating the Factor 3 values for their FY 2015 DSH payments.[34]

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

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

another was also a challenge to a "period selected by the Secretary," which is also barred from review.[35]

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."[36] 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.[37] 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.[38]

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.[39] 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*").[40] 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.[41] 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."[42] The D.C. Circuit further dismissed the

[35] *Id.* at 262-64.
[36] *Id.* at 265.
[37] *Id.* (discussing *Leedom v. Kyne*, 358 U.S. 184, 188 (1958)).
[38] *Id.* at 264 (quoting *DCH v. Azar*, 925 F.3d at 509-510).
[39] *Id.* at 264-6511 (quoting *DCH v. Azar*, 925 F.3d at 509).
[40] Civ. No. 20-139, 2021 WL 3856621 (D.D.C. August 30, 2021).
[41] *Id.* at *4.
[42] *Id.* at *9.

applicability of the Supreme Court's 2019 decision in *Azar v. Allina Health Servs*.[43] 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***."[44]

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 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. Additionally, the Board dismisses the UCC Distribution Pool issue as the Board does not have jurisdiction because 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2) preclude administrative and judicial review of certain aspects of the UCC payment calculation.

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:

12/6/2023

X Robert A. Evarts, Esq.

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

cc: Wilson C. Leong, Esq., Federal Specialized Services
Michael Redmond, Novitas Solutions, Inc.

[43] 139 S. Ct. 1804 (2019).
[44] *Ascension* at *8 (bold italics emphasis added).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Katarina Haskell, Esq.
Honigman Miller Schwartz and Cohn, LLP
660 Woodward Ave.
Detroit, MI 48226

RE: ***Notice of Dismissal***
Honigman Standardized Amount CIRP Group Cases
Case Nos. 23-0695GC, *et al.* (*see* **Appendix A** listing 51 group cases)

Dear Ms. Haskell:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal requests filed by the Providers in the fifty-one (51) above-referenced common issue related party ("CIRP") *and* optional group cases. The Medicare Contractor has filed Jurisdictional Challenges in forty-five (45) of those group cases. The Providers' Representative filed responses to these challenges, and also responded on behalf of six (6) other IPPS Standardized Amount CIRP Groups in which there was no challenge filed, but the issue is identical. As set forth below, the Board has determined that, consistent with 42 U.S.C. § 1395ww(d)(7) and 42 C.F.R. § 405.1840(b), it lacks substantive jurisdiction over the appealed issue and is therefore dismissing all fifty-one (51) CIRP and optional group cases in their entirety.

In summary, the Board finds that it lacks substantive jurisdiction over the issue raised in these appeals. The standardized amounts used for IPPS rates for FFYs 1984 and FFY 1985 are each based on the budget neutrality adjustment made for that FFY and the 1984 and 1985 budget neutrality adjustments are presumably designed to be corrective of the initial base rate that was set *using 1981 data*.[1] Therefore, the *final* FFY 1984 and 1985 standardized amounts are *inextricably intertwined* with those applicable budget neutrality adjustments.[2] Indeed, the standardized amounts were too high for FFYs 1984 and 1985 and the budget neutrality adjustments applied to those years reduced the standardized amounts (reduced by factors of approximately 0.03 for FFY 1984 and 0.05 for FFY 1985) and, thus, these budget neutrality adjustments appear to have already automatically accounted for any such alleged errors in setting the initial base rate (which

[1] The Board has included at **Appendix B** examples of other adjustments to the standardized amounts that have occurred outside of the FFY 1984 and 1985 budget neutrality adjustments. These intervening adjustments for FFYs 1986 and 2018 include both mandatory and discretionary revisions ***to the standardized amounts*** (as well as the Congress' decisions to revise or not revise the "applicable percentage increases" for FFYs 1986 and forward as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i)) and highlight the complexity of the issue before the Board, particularly where such adjustments were made in a budget neutral manner or were based on factoring in certain other estimated impacts

[2] *See infra* note 53 (citing to decisions that discuss similar circumstances involving Medicare provisions found to be inextricably tied to certain other provisions for which Congress precluded administrative and judicial review).

again was based on 1981 data).[3] Because 42 U.S.C. 1395ww(d)(7) prohibits administrative or judicial review of those adjustments and the resulting *final* standardized amounts for those years were carried/flowed forward, the Board may not review the standardized amount used for the FFYs being appealed as they relate to the issue in these appeals, *i.e.*, the alleged inaccuracies in the standardized amounts used for FFY 1984 as carried/flowed forward for all years following FFY 1984 to the FFYs being appealed. In this regard, the Board notes that the Providers may not simply pass through, or over, the budget neutrality adjustments for FFYs 1984 and 1985 because those adjustments are tied to an absolute *external* event (the Secretary's estimate, based on the best available data, of what would have been paid for those years if there were no IPPS) ***and*** were ***fixed*** (no greater *and* no less than what would have been paid had there been no IPPS). To do otherwise, would impact the very integrity of IPPS.

Background:

Honigman, Miller, Schwartz and Cohn, LLP ("Providers' Representative") represents a number of providers in CIRP and optional groups which are challenging the IPPS standardized amount. The Medicare Contractor filed three (3) Jurisdictional Challenges covering forty five (45) group cases.[4] The Providers' Representative filed responses to these challenges, and also responded on behalf of six (6) other IPPS Standardized Amount CIRP Groups in which there was no challenge filed, but the issue is identical.[5] The group issue statements, jurisdictional challenges, and responses thereto for all fifty one (51) cases are materially identical.

The group issue statement presented is:

> Whether the Providers are entitled to an additional payment because inclusion of transfers in the 1981 data used for computing the Medicare Inpatient Prospective Payment System ("IPPS") standardized amount reduced the Providers' IPPS payment for [the applicable] Federal Fiscal Year . . . ?[6]

Procedural Background:

A. Appealed Issue

In the Providers' group issue statements, they explain that the IPPS requires the categorization of different types of discharges (diagnostic related groups, or "DRGs"), and payment rates applicable to each discharge category. Their appeals challenge the latter, arguing that the data used to establish the initial "flat rate" payable per discharge resulted in an understated payment rate. CMS opted to use 1981 as a "base year" to calculate these rates, and thus data was collected from hospitals' 1981 cost reports to determine average costs for each discharge

[3] *See infra* note 41 (discussing how the removal of nurse anesthetists costs were removed from IPPS and how that removal was *automatically* accounted for as part of the 1985 budget neutrality adjustment).
[4] *See* **Appendix A**.
[5] *See id.*
[6] *E.g.*, Case No. 23-0695GC, Description of Issue (Jan. 30, 2023).

category. The data was adjusted for inflation and standardized, but the Providers argue that the initial calculation of this standardized amount continues to serve as the base for all future calculations. Since the Providers allege this initial calculation was understated, they argue that the calculation for each subsequent year has also been understated.[7]

The Providers claim that the data sources used in collecting the 1981 data did not distinguish between patients who were discharged from the hospital, and patients who were transferred to another hospital or facility. They state that CMS views transfers as distinct from discharges, but in calculating the average cost per discharge using the 1981 data, CMS erroneously included transfers in the total number of discharges, thereby inflating the denominator of the cost to discharge ratio. They claim that CMS has acknowledged this error in at least one other context (*i.e.*, during the implementation of the capital PPS), and that this error was the reason for certain DRG weight recalibrations, but that CMS failed to fully correct the flawed Standardized Amount.[8]

In each case, the Providers are challenging the applicable FFY IPPS rates as set forth in the Federal Register.[9] They argue the appeals are not barred by the "predicate facts" provision of 42 C.F.R. § 405.1885(a)(1)(iii) and that there is no impediment to CMS correcting its erroneous data to remediate the flawed Standardized Amount. They claim that the average cost per discharge should not include transfers, that CMS has acknowledged this as well as the fact that certain Standardized Amounts erroneously included transfers, and that this practice violates both the Medicare Act and Administrative Procedure Act. Finally, they argue that the understated Standardized Amounts and their resulting understated Medicare payments produces cost shifting prohibited by 42 U.S.C. § 1395x(v)(1)(A)(i).[10]

In their appeal requests, the Providers characterize the standardized amount as "flawed" and contend that, since the Board is bound to implement the standardized amount, it cannot grant the relief they seek. The issue statements indicate that a request for Expedited Judicial Review would be forthcoming, though none were ever filed consistent with Board Rule 42.[11] As such, this determination does ***not*** consider whether EJR would be appropriate for any of these cases.[12]

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[7] *Id.* at 1-2.
[8] *Id.* at 3-4 (citing 56 Fed. Reg. 43449, 43387 [sic] (Aug. 30, 1991) (related to capital PPS) and 60 Fed. Reg. 45791 (Sept. 1, 1995) (related to recalibration of DRG weights to exclude transfers for FY 1996)).
[9] *E.g.*, Case No. 23-0695GC, Description of Issue at 5 ("The Providers challenge the FFY 2023 IPPS rates as set forth in 87 Fed. Reg. 49429-49430, 49453-49454 (Addendum Tables 1.A. – 1.E. of the FY 2023 IPPS Final Rule) (August 10, 2022) (Filed in the OH CDMS), which is the date of the final determination of the Secretary of HHS. 42 U.S.C. § 1395oo(a). The FFY 2023 IPPS rates are based on the Flawed Standardized Amount.").
[10] Description of Issue at 4-6.
[11] *Id.* at 7.
[12] In considering whether EJR is appropriate, the Board would also need to consider whether there are any factual issues in dispute. The EJR request and any response filed thereto would assist the Board in making that determination since Board Rule 42.3 specifies that an EJR request must include, among other things, "a fully developed narrative . . . that *[d]emonstrates that there are* ***no factual issues*** *in dispute* . . . ." (Emphasis added.)

B. Jurisdictional Challenges

The Medicare Contractor filed challenges in forty-five (45) different group cases, and the Providers filed responses in each case, as well as six (6) cases where the issue is identical but no challenge was filed.[13] The Medicare Contractor argues that the merits of the appealed issue are illegitimate, and that the Board lacks subject matter jurisdiction and need not even address the merits of the issue. It references, and specifically adopts, the same rationale set forth the Board's April 6, 2023 decision dismissing five (5) different CIRP group appeals concerning the same Standardized Amount issue. It argues the Board should apply the same rationale and find that 42 U.S.C. § 1395ww(d)(7)(A) precludes administrative review of the base year standardized amounts because: (1) budget neutrality was fixed to (*i.e.*, no greater and no less than) what would have been payable under the reasonable cost-based reimbursement provisions of the prior law if IPPS had not been implemented; and (2) as a result, the initial base amount became inextricably intertwined with the ***ensuing*** 1984 and 1985 budget neutrality adjustments. In further support, the Medicare Contractor contends that the 1984 and 1985 budget neutrality adjustments accounted for and corrected any potential errors in the original base amount because, through those adjustments, the Secretary reduced the standardized amount based on her finding that the base year (in comparison to the *fixed* reference point) was, in fact, initially set too high (rather than understated as the Providers claim).

The Providers' responses to these challenges reiterated that the group appeal rests on the fact that each appeal's IPPS payments for the applicable FFY is "improperly understated because the Secretary failed to remove or adjust for patient *transfers* that were included in the 1981 base-year data."[14] They claim that the budget-neutral adjustments and any preclusion provisions do not apply to their IPPS challenges. The ask the Board to find it has jurisdiction over these appeals and that expedited judicial review is warranted.

The Providers counter the Medicare Contractor by arguing that budget neutrality adjustments are not applicable to these appeals. The Providers claim they do not seek to challenge the FFY 1984 or 1985 IPPS payments, but rather they "contest the Standardized Amount for [the applicable FFY] and the methodology by which the Standardized Amount was initially calculated in 1983."[15] The further claim that neither 42 U.S.C. §§ 1395ww(d)(7)(A) nor 1395oo(g)(2) restrict challenges to the methodology deriving from the original Standardized Amount based on the 1981 data.[16] They argue that there is a strong presumption in favor of judicial review, and that in this instance there is not clear indication that Congress intended to preclude review of more recent FFY Standardized Amounts or the predicate facts related to the methodology for calculating the FFY 1984 Standardized Amount.[17] Finally, the Providers conclude that expedited judicial review is

[13] *See* **Appendix A** for complete list of challenges and cases impacted where the challenges are all materially identical.
[14] *E.g.*, Case Nos. 23-0270GC, *et al.*, Providers' Response to MACs' Jurisdictional Challenges at 2 (Nov. 14, 2023).
[15] *Id.* at 6.
[16] *Id.* at 7.
[17] *Id.* at 7-8.

appropriate here because the Board is bound to apply the Standardized Amount and, thus, cannot grant the relief sought (*i.e.*, a change to the Standardized Amount).[18]

Board Decision:

As described more fully below, the Board finds that it lacks substantive jurisdiction over each of the 51 groups because the initial 1983 standardized amounts,[19] set for the IPPS, are ***inextricably*** intertwined with the 1984 and 1985 budget neutrality adjustments to the "applicable percentage increases" for IPPS[20] and 42 U.S.C. § 1395ww(d)(7) prohibits administrative or judicial review of those budget neutrality adjustments. The fact that the Secretary's budget neutrality adjustment to the FY 1984 Federal Rates was 0.970[21] demonstrates that, contrary to the Providers' assertions, the initial standardized amount was ***not*** understated but rather was *overstated* by a factor of 0.030 (*i.e.*, 1.000 – 0.970) and, thus, these budget neutrality adjustments appears to have already automatically accounted for any such alleged errors in setting the initial base rate.[22] Indeed, it is only natural that Congress established the 1984 and 1985 budget neutrality adjustments since the initial base rate was initially set *using 1981 data*.

A. Statutory Background on IPPS and the Standardized Amount Used in IPPS Rates

Part A of the Medicare program covers "inpatient hospital services." Since October 1, 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the IPPS.[23] Under IPPS, Medicare pays a prospectively-determined rate per eligible discharge, subject to certain payment adjustments.[24]

In order to implement IPPS, "the statute require[d] that the Secretary determine national and regional adjusted DRG prospective payment rates for each DRG to cover the operating costs of inpatient hospital services."[25] The methodology for arriving at the appropriate rate structure is

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[18] *Id.* at 9-11. Though the Providers make statements in their filings that expedited judicial review is appropriate, they acknowledge that such a request must be filed separately as a standalone request pursuant to Board Rule 42.2. *Id.* at 11, n.4. Indeed, Board Rule 42.2 (2021) explicitly states:

> Because an EJR request is time sensitive, the request for EJR is to be filed separately and clearly labeled. **The request for EJR is not to be included in the text of another filing such as a jurisdictional brief** or position paper and will not be considered filed if so included.

(emphasis added).

[19] The Board notes that, initially, there was not just one standardized amount. Rather there were 20 average standard amounts per discharge according to urban/rural designation in each of the nine census divisions and the nation and each of these 20 rates is further divided into a labor and nonlabor portion. *See* 48 Fed. Reg. 39752, 39763 (Sept. 1, 1983).

[20] 42 U.S.C. § 1395ww(e) is entitled "Proportional adjustments in applicable percentage increases." The 1984 and 1985 budget neutrality adjustments are set forth is § 1395ww(e)(1)(B) which is cross-referenced for 1984 IPPS rates at § 1395ww(d)(2)(F) and for 1985 IPPS rates at § 1395ww(d)(3)(C).

[21] In the final rule published on January 3, 1984, the Secretary revised the Federal budget neutrality adjustment factor to 0.970. 49 Fed. Reg. 234, 334 (Jan. 3, 1984).

[22] *See infra* note 41 (discussing how the removal of nurse anesthetists costs were removed from IPPS and how that removal was *automatically* accounted for as part of the 1985 budget neutrality adjustment).

[23] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.

[24] *Id.*

[25] 48 Fed. Reg. 39752, 39763 (Sept. 1, 1983).

located at 42 U.S.C. § 1395ww(d)(2) and "requires that certain ***base period*** *cost data* be developed and modified in several specified ways (*i.e.*, inflated, standardized, grouped, and adjusted) resulting in 20 average standard amounts per discharge according to urban/rural designation in each of the nine census divisions and the nation."[26] Specifically, § 1395ww(d)(2) (Jan. 1985) stated, in pertinent part:

> (2) The Secretary shall determine a national adjusted DRG prospective payment rate, for each inpatient hospital discharge in fiscal year 1984 involving inpatient hospital services of a subsection (d) hospital in the United States, and shall determine a regional adjusted DRG prospective payment rate for such discharges in each region, for which payment may be made under part A of this subchapter. Each such rate shall be determined for hospitals located in urban or rural areas within the United States or within each such region, respectively, as follows:
>
> (A) DETERMINING ALLOWABLE INDIVIDUAL HOSPITAL COTS FOR BASE PERIOD.—The Secretary shall determine the allowable operating costs per discharge of inpatient hospital services for the hospital for the most recent cost reporting period for which data are available.
>
> (B) UPDATING FOR FISCAL YEAR 1984.—The Secretary shall update each amount determined under subparagraph (A) for fiscal year 1984 by—
>
> (i) updating for fiscal year 1983 by the estimated average rate of change of hospital costs industry-wide between the cost reporting period used under such subparagraph and fiscal year 1983 and the most recent case-mix data available, and
>
> (ii) projecting for fiscal year 1984 by the applicable percentage increase (as defined in subsection (b)(3)(B)) for fiscal year 1984.
>
> (C) STANDARDIZING AMOUNTS.—The Secretary shall standardize the amount updated under subparagraph (B) for each hospital by—
>
> (i) excluding an estimate of indirect medical education costs,[27]

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[26] *Id.* (emphasis added).

[27] Consistent with the concerns raised by the Board in **Appendix B**, the Board notes that Congress has amended this clause (i) numerous times and, as a result, it currently reads:

> (i) excluding an estimate of indirect medical education costs (taking into account, for discharges occurring after September 30, 1986, the amendments made by section 9104(a) of the Medicare and Medicaid Budget Reconciliation Amendments of 1985), except that the Secretary shall not take into account any reduction in the amount of additional payments under paragraph (5)(B)(ii) resulting from the amendment made by section 4621(a)(1) of the Balanced Budget Act of 1997 or any additional payments under such paragraph resulting from the application of section 111 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, of section 302 of the

> (ii) adjusting for variations among hospitals by area in the average hospital wage level, and
>
> (iii) adjusting for variations in case mix among hospitals.[28]

Thus, as quoted above, § 1395ww(d)(2)(A) requires that the Secretary determine a "base period" operating cost per discharge using the most recent cost reporting period for which data are available. Further, consistent with these statutory provisions, the Secretary used Medicare hospital cost reports for reporting periods ending in 1981 and set the 1984 "base period" operating cost per discharge amount using the 1981 operating costs per discharge amount *updated* by an inflationary factor.[29] The Providers dispute how the Secretary determined discharges" and allege that the Secretary improperly treated transfers as discharges for purposes of this calculation.

The Secretary then "standardized" the FFY 1984 base period operating cost per discharge using the process prescribed at 42 U.S.C. § 1395ww(d)(2)(c). The standardization process removed the effects of certain variable costs from the cost data, including (but not limited to) excluding costs associated with indirect medical education costs, adjusting for variations in average hospital wage levels, and adjusting for variations in case mix among hospitals.

The initial standardized amounts have been annually adjusted and/or updated. However, contrary to the characterization in the D.C. Circuit's 2011 decision in *Saint Francis Med. Ctr. v. Azar* ("*Saint Francis*"), the standardized amount is not adjusted each year simply for inflation.[30] Significantly, some of these annual adjustments were required to be *budget neutral* and are not subject to administrative review. In particular, 42 U.S.C. § 1395ww(c)(1)(B) provides the budget neutrality adjustment for "the applicable percentage increases" to the standardized amounts for 1984 and 1985 and states, in pertinent part:

> **(e) Proportional adjustments in *applicable percentage increases***
>
> (1) . . . .
>
> (B) *For discharges occurring in fiscal year 1984 or fiscal year 1985*, *the Secretary shall provide* under subsections (d)(2)(F) and

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Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, or the Medicare Prescription Drug, Improvement, and Modernization Act of 2003,

[28] The Board notes that Congress later added clause (iv) in 1985 and, consistent with the concerns raised by the Board in **Appendix B**, the Board notes that Congress has amended this clause numerous times and, as a result, it currently reads:

> (iv) for discharges occurring on or after October 1, 1986, excluding an estimate of the additional payments to certain hospitals to be made under paragraph (5)(F), except that the Secretary shall not exclude additional payments under such paragraph made as a result of the enactment of section 6003(c) of the Omnibus Budget Reconciliation Act of 1989, the enactment of section 4002(b) of the Omnibus Budget Reconciliation Act of 1990, the enactment of section 303 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, or the enactment of section 402(a)(1) 4 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

[29] *Id*. at 39763-64.

[30] 894 F.3d 290, 291 (D.C. Cir. 2011). *Saint Francis* did not analyze how the standardized amount is updated annually nor did it make specific legal holdings regarding the standardized amount.

> (d)(3)(C) for such equal proportional adjustment *in each of the average standardized amounts* otherwise computed for that fiscal year as may be necessary to assure that—
>
> (i) *the aggregate payment amounts* otherwise provided under subsection (d)(1)(A)(i)(II) and (d)(5) *for that fiscal year* for operating costs of inpatient hospital services of hospitals (excluding payments made under section 1395cc(a)(1)(F) of this title),
>
> *are not greater or less than*—
>
> (ii) the DRG percentage (as defined in subsection (d)(1)(c)) of *the payment amounts which would have been payable for such services* for those same hospitals for that fiscal year under this section *under the law as in effect before April 20, 1983* (excluding payments made under section 1395cc(a)(1)(F) of this title).[31]

The Secretary implemented the above budget neutrality provisions at 42 C.F.R. §§ 412.62(i) and 412.63(v) for the 1984 rate year and 1985 rate year respectively. Specifically, § 412.62(i) provides the following instruction for maintaining budget neutrality for the 1984 Federal IPPS rates:

> (i) *Maintaining budget neutrality.* (1) CMS adjusts each of the **reduced standardized amounts** determined under paragraphs (c) through (h) of this section **as required for fiscal year 1984** so that the estimated amount of aggregate payments made, excluding the hospital-specific portion (that is, the total of the Federal portion of transition payments, plus any adjustments and special treatment of certain classes of hospitals for Federal fiscal year 1984) **is not greater or less than** 25 percent of **the payment amounts that would have been payable** for the inpatient operating costs for those same hospitals for fiscal year 1984 **under the Social Security Act as in effect on April 19, 1983**.
>
> (2) The aggregate payments considered under this paragraph exclude payments for per case review by a utilization and quality control quality improvement organization, as allowed under section 1866(a)(1)(F) of the Act.[32]

Similarly, the regulation at 42 C.F.R. § 412.63(v) provides the following instruction for maintaining budget neutrality for the 1985 Federal rates for IPPS:

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[31] (Bold emphasis in original and italics and underline emphasis added.) The budget neutrality adjustment at 42 U.S.C. § 1395ww(e)(1)(B) is cross-referenced for 1984 at 1395ww(d)(2)(F) and for 1985 at § 1395ww(d)(3)(C).
[32] (Italics emphasis in original and bold and underline emphasis added.)

> (v) *Maintaining budget neutrality for fiscal year 1985.* (1) For fiscal year 1985, CMS will adjust each of **the reduced standardized amounts** determined under paragraph (c) of this section **as required for fiscal year 1985** to ensure that the estimated amount of aggregate payments made, excluding the hospital-specific portion (that is, the total of the Federal portion of transition payments, plus any adjustments and special treatment of certain classes of hospitals for fiscal year 1985) **is <u>not greater or less</u>** than 50 percent of the **payment amounts that would have been payable** for the inpatient operating costs for those same hospitals for fiscal year 1985 **under the law as in effect on April 19, 1983**.
> (2) The aggregate payments considered under this paragraph exclude payments for per case review by a utilization and quality control quality improvement organization, as allowed under section 1866(a)(1)(F) of the Act.[33]

Essentially, Congress mandated that the Secretary/CMS adjust the standardized amounts for both 1984 and 1985 to ensure that the estimated amount of aggregate payments made under IPPS was not *greater than **<u>or</u>** less than* what would have been payable for inpatient operating costs for the same hospitals under the prior reimbursement system (*i.e.*, reasonable costs subject to TEFRA limits). In other words, pursuant to budget neutrality, the size of the pie, expressed as average payment per case, is prescribed by law to be *no more **and** no less* than what would have been paid had IPPS not been implemented. Significantly, the reference points for maintaining budget neutrality for 1984 and 1985 are ***<u>external</u>*** to IPPS and, thus, ***fixed*** (no greater *and* no less) based on the best data available.[34] Since these points are ***fixed,*** it also means that it is capped (*i.e.*,

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

[34] 48 Fed. Reg. 39752, 39887 (Sept. 1, 1983) provides the following discussion supporting the Board's pie concept:

> Section 1886(e)(1) of the Act requires that, for Federal fiscal years 1984 and 1985, prospective payments be adjusted so that aggregate payments for the operating costs of inpatient hospital services are neither more nor less than we estimate would have been paid under prior legislation for the costs of the same services. To implement this provision, we are making actuarially determined adjustments to the average standardized amounts used to determine Federal national and regional payment rates and to the updating factors used to determine the hospital-specific per case amounts incorporated in the blended transition payment rates for fiscal years 1984 and 1985. Section 1886(d)(6) of the Act requires that the annual published notice of the methodology, data and rates include an explanation of any budget neutrality adjustments. This section is intended to fulfill that requirement.
> Although, for methodological reasons, the budget neutrality adjustment is calculated on a per discharge basis, it should be emphasized that the ultimate comparison is between the aggregate payments to be made under the prospective payment system and the aggregate payments that would have been incurred under the prior legislation. Therefore, changes in hospital behavior from that which would have occurred in the absence of the prospective payment system are required to be taken into account in determining the budget neutrality adjustment if they affect aggregate payment. For example, any expectation of increased admissions beyond the level that would have occurred under prior law would have to be considered in the adjustment. To assist in making the budget neutrality adjustment for, and take account of, fiscal year 1985, HCFA will monitor for changes in hospital behavior attributable to the new system.

cannot be increased subsequently outside of the budget neutrality adjustment). Indeed, it is only natural that Congress established this structure for 1984 and 1985 budget neutrality adjustments since the initial base rate for IPPS was initially set ***using 1981 data***.

This conclusion is supported by the fact that the normal annual inflation adjustments to the standardized amount provided for in IPPS apply ***only*** for FY 1986 forward, as set forth in 42 U.S.C. § 1395ww(b)(3)(B)(3)(i) and cross referenced in § 1395ww(d)(3)(A). Specifically, 42 U.S.C. § 1395ww(b)(3)(B)(i) (2018) defines the term "applicable percentage increase" starting with fiscal year 1986 (as opposed to 1984):

> (B)(i) For purposes of subsection (d) and subsection (j) for discharges occurring during a fiscal year, the "applicable percentage increase" shall be—
>
> (I) ***for fiscal year 1986***, 1/2 percent,
>
> (II) for fiscal year ***1987***, 1.15 percent,
>
> (III) for fiscal year ***1988***, 3.0 percent for hospitals located in a rural area, 1.5 percent for hospitals located in a large urban area (as defined in subsection (d)(2)(D)), and 1.0 percent for hospitals located in other urban areas,
>
> (IV) for fiscal year ***1989***, the market basket percentage increase minus 1.5 percentage points for hospitals located in a rural area, the market basket percentage increase minus 2.0 percentage points for hospitals located in a large urban area, and the market basket percentage increase minus 2.5 percentage points for hospitals located in other urban areas,
>
> (V) for fiscal year ***1990***, the market basket percentage increase plus 4.22 percentage points for hospitals located in a rural area, the market basket percentage increase plus 0.12 percentage points for hospitals located in a large urban area, and the market basket percentage increase minus 0.53 percentage points for hospitals located in other urban areas,
>
> (VI) for fiscal year ***1991***, the market basket percentage increase minus 2.0 percentage points for hospitals in a large urban or other urban area, and the market basket percentage increase minus 0.7 percentage point for hospitals located in a rural area,
>
> (VII) for fiscal year ***1992***, the market basket percentage increase minus 1.6 percentage points for hospitals in a large urban or other urban area, and the market basket percentage increase minus 0.6 percentage point for hospitals located in a rural area,
>
> (VIII) for fiscal year ***1993***, the market basket percentage increase minus 1.55 percentage point for hospitals in a large urban or other

> urban area, and the market basket percentage increase minus 0.55 1 for hospitals located in a rural area,
>
> (IX) for fiscal year ***1994***, the market basket percentage increase minus 2.5 percentage points for hospitals located in a large urban or other urban area, and the market basket percentage increase minus 1.0 percentage point for hospitals located in a rural area,
>
> (X) for fiscal year ***1995***, the market basket percentage increase minus 2.5 percentage points for hospitals located in a large urban or other urban area, and such percentage increase for hospitals located in a rural area as will provide for the average standardized amount determined under subsection (d)(3)(A) for hospitals located in a rural area being equal to such average standardized amount for hospitals located in an urban area (other than a large urban area),
>
> (XI) for fiscal year ***1996***, the market basket percentage increase minus 2.0 percentage points for hospitals in all areas,
>
> (XII) for fiscal year ***1997***, the market basket percentage increase minus 0.5 percentage point for hospitals in all areas,
>
> (XIII) for fiscal year ***1998***, 0 percent,
>
> (XIV) for fiscal year ***1999***, the market basket percentage increase minus 1.9 percentage points for hospitals in all areas,
>
> (XV) for fiscal year ***2000***, the market basket percentage increase minus 1.8 percentage points for hospitals in all areas,
>
> (XVI) for fiscal year ***2001***, the market basket percentage increase for hospitals in all areas,
>
> (XVII) for fiscal year ***2002***, the market basket percentage increase minus 0.55 percentage points for hospitals in all areas,
>
> (XVIII) for fiscal year ***2003***, the market basket percentage increase minus 0.55 percentage points for hospitals in all areas,
>
> (XIX) for each of fiscal years ***2004*** through ***2006***, subject to clause (vii), the market basket percentage increase for hospitals in all areas; and
>
> (XX) ***for each subsequent fiscal year***, subject to clauses (viii), (ix), (xi), and (xii), the market basket percentage increase for hospitals in all areas.[35]

The "applicable percentage increase" as defined in § 1395ww(b)(3)(B) is incorporated into § 1395ww(d)(3)(A), as it relates to updating of the standardized amount:

[35] (Emphasis added.)

(B) UPDATING PREVIOUS STANDARDIZED AMOUNTS.—(i) For discharges occurring in a fiscal year beginning ***before*** October 1, 1987, the Secretary shall compute an average standardized amount for hospitals located in an urban area and for hospitals located in a rural area within the United States and for hospitals located in an urban area and for hospitals located in a rural area within each region, *equal to the respective average standardized amount computed for the previous fiscal year under paragraph (2)(D) or under this subparagraph*, ***increased for the fiscal year involved by the applicable percentage increase under subsection (b)(3)(B)***. With respect to discharges occurring on or after October 1, 1987, the Secretary shall compute urban and rural averages on the basis of discharge weighting rather than hospital weighting, making appropriate adjustments to ensure that computation on such basis does not result in total payments under this section that are greater or less than the total payments that would have been made under this section but for this sentence, and making appropriate changes in the manner of determining the reductions under subparagraph (c)(ii).

(ii) For discharges occurring in a fiscal year beginning on or after October 1, 1987, and ending on or before September 30, 1994, the Secretary shall compute an average standardized amount for hospitals located in a large urban area, for hospitals located in a rural area, and for hospitals located in other urban areas, within the United States and within each region, equal to the respective average standardized amount computed for the previous fiscal year under this subparagraph increased by the applicable percentage increase under subsection (b)(3)(B)(i) with respect to hospitals located in the respective areas for the fiscal year involved.

(iii) For discharges occurring in the fiscal year beginning on October 1, 1994, the average standardized amount for hospitals located in a rural area shall be equal to the average standardized amount for hospitals located in an urban area. For discharges occurring on or after October 1, 1994, the Secretary shall adjust the ratio of the labor portion to non-labor portion of each average standardized amount to equal such ratio for the national average of all standardized amounts.

(iv)(I) Subject to subclause (II), for discharges occurring in a fiscal year beginning on or after October 1, 1995, the Secretary shall compute an average standardized amount for hospitals located in a large urban area and for hospitals located in other areas within the United States and within each region equal to the respective average standardized amount computed for the previous fiscal year under

> this subparagraph increased by the applicable percentage increase under subsection (b)(3)(B)(i) with respect to hospitals located in the respective areas for the fiscal year involved.
>
> (II) For discharges occurring in a fiscal year (beginning with fiscal year 2004), the Secretary shall compute a standardized amount for hospitals located in any area within the United States and within each region equal to the standardized amount computed for the previous fiscal year under this subparagraph for hospitals located in a large urban area (or, beginning with fiscal year 2005, for all hospitals in the previous fiscal year) increased by the applicable percentage increase under subsection (b)(3)(B)(i) for the fiscal year involved.

Thus, while 42 U.S.C. § 1395ww(d)(2) provides the methodology for calculating the standardized amount to be used for each year, and that the amount is subject to the "applicable percentage increase" under subsection (b)(3)(B) *for years after 1984*, it remains that it is not always a simple inflationary or market basket adjustment. In particular, the FFY 1984 and 1985 budget neutrality adjustments (as referenced in § 1395ww(d)(2)(F) and in § 1395ww(d)(3)(C)) were the applicable percentage increases for FFYs 1984 and 1985 and, as described below, those adjustments are not administratively reviewable.

B. Jurisdictional Findings -- 42 U.S.C. § 1395ww(d)(7)(A) Precludes Administrative Review of the Base Year Standardized Amounts

The Providers essentially are challenging the standardized amount used in the IPPS rates for several FFYs claiming that the Secretary improperly treated transfers as discharges when using 1981 cost report data to determine the initial FFY 1984 base cost per discharge which, in turn, was standardized to arrive at the FFY 1984 standardized amounts. More specifically, the Providers maintain that, the understatement of the standardized amount in the FFY 1984 IPPS Final Rule caused a corresponding underpayment in IPPS payments in FFY 1984 ***and every FFY thereafter*** *because the standardized amount for all IPPS payments for every FFY are based on CMS's calculation of the FFY 1984 standardized amount*.[36]

The published standardized amount for each FFY in these appeals reflects the prior year's standardized amount plus "the applicable percentage increase" as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i) (as referenced in 42 U.S.C. § 1395ww(d)(3(A)) as well as other potential adjustments. Significantly, the "applicable percentage increase[s]" for 1984 forward are ***not*** always simply a cost inflation adjustment or other similar percentage adjustment. To this point, for the first two (2) years of IPPS, Congress mandated that the budget neutrality adjustments for FFYs 1984 and 1985 serve as the "applicable percentage increase" for those years. As a result, the IPPS rates that the Secretary used *for the very first year of IPPS* and then the second year of

[36] *E.g.*, PRRB Case 23-0270GC *et al.*, Providers' Response to MACs' Jurisdictional Challenges at 10 ("The Secretary's error caused a ripple-effect of incorrectly calculated Standardized Amounts since 1983 because of the erroneous embedded methodology.").

IPPS were adjusted for budget neutrality. For FFYs 1986 and forward, Congress provided for an "applicable percentage increase" in 42 U.S.C. § 1395ww(b)(3)(B)(i) as referenced in 42 U.S.C. § 1395ww(d)(3(A). In addition, there are other *permanent* adjustments (*i.e*., adjustments not for that year only but that also apply on a going-forward basis) to the standardized amount that have occurred in other years outside of the "applicable percentage increase."[37] Thus, the standardized amount for a particular year is an amalgamation that builds upon the prior year's standardized amount and then adds additional adjustments for the current year.

The Providers are, essentially, seeking to peel back the amalgamated standardized amount for each applicable FFY *and, thus, reach back* ***more than 30 years*** to increase the initial 1984 base rate that was used to set the initial 1984 standardized amount***s***. They would then incorporate the alleged increased base rate into the FFY 1984 standardized amount***s*** and then simply carry or flow that *increase forward 35 years*. However, in order to peel the amalgamated standardized amounts for the FFYs at issue (singular[38]) *as used in the IPPS rates for each FFY* back to the initial standardized amount***s*** (plural[39]) used in FFY 1984, and then carry/flow any change forward *to the FFY at issue*, the Providers would have to pass through the FFY 1984 and 1985 budget neutrality adjustments which were the only "applicable percentage increase[s]" for those years. However, they cannot do so because the budget neutrality adjustments had the effect of ***fixing*** the pie for FFYs 1984 and 1985 to (*i.e*., no more ***and*** no less than) the aggregate amounts that would have been paid had IPPS not been implemented.[40] More specifically, the amalgamated standardized payment amount for each FFY at issue reflects the *fixed* FFY 1984 and 1985 budget neutrality adjustments (and not the initial FFY 1984 standardized amounts since the standardized amounts for both FFYs 1984 and 1985 were each adjusted for budget neutrality became *fixed* for purposes of subsequent years as a result of those budget neutrality adjustments). Indeed, it is only natural that Congress established the 1984 and 1985 budget neutrality adjustments in this manner since the initial FFY 1984 standardized amount for IPPS was initially set *using 1981 data*. Thus, in the Board's view, the Providers cannot get back to the FFY 1984 standardized amounts without first passing through the FFY 1984 and 1985 budget neutrality adjustments. Regardless, the Providers would not be able to flow forward any adjustments made to the FFY 1984 standardized amounts because:

(1) They, again, would not be able to get through the FFY 1984 and 1985 budget neutrality adjustments that Congress otherwise ***fixed*** to an external point (no greater and no less); and

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[37] *See* **Appendix B**.
[38] *See supra* note 19 accompanying text.
[39] *See id.*
[40] *See, e.g.,* 48 Fed. Reg. 39752, 39805 (Sept. 1, 1983) (stating: "Hospital Impact—During its first two years, aggregate payments under the prospective payment system will be adjusted, in accordance with Section 1886(e)(1) of the Act, to be "budget neutral"; that is, so that aggregate payments under the prospective payment system, including outlier payments, exceptions, and adjustments, will be neither more nor less than the estimated payment amounts to affected hospitals that would have resulted under the Social Security Act as in effect before April 20,1983.").

(2) The IPPS rates paid for FFYs 1984 and 1985 are based on standardized amounts that were adjusted downwards as a result of the budget neutrality adjustment for FFY 1984 and also for FFY 1985 (*see* discussion below in Sections B.1 and B.2).[41]

Accordingly, the Board finds that the Providers challenge to the standardized amounts at issue are *inextricably* intertwined with the budget neutrality adjustments made for FFY 1984 and 1985.[42]

Furthermore, Congress has precluded Board (and judicial) review of the FFY 1984 and 1985 budget neutrality adjustments. Specifically, 42 U.S.C. § 1395ww(d)(7)(A) precludes administrative and juridical review of the neutrality adjustment at § 1395ww(e)(1):

> (7) There shall be no administrative or judicial review under section 1395oo of this title or otherwise of—
>
> (A) the determination of the requirement, or the proportional amount, of any adjustment effected pursuant to subsection (e)(1) or the determination of the applicable percentage increase under paragraph (12)(A)(ii), . . .[43]

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[41] Indeed, the FY 1986 IPPS Final Rule included an example where the Secretary recognized an adjustment to the budget neutrality adjustments would be impacted by the removal of nurse anesthetists costs and confirmed that the adjustments to the standardized amounts had already taken this removal into account:

> c. Nonphysician anesthetist costs. In the August 31, 1984 final rule, we implemented section 2312 of Pub. L. 98-369, which provided that hospital costs for the services of nonphysician anesthetists will be paid in full as a reasonable cost pass-through for cost reporting periods beginning before October 1, 1987.
>
> We did not directly reduce the FY 1985 Federal rates to exclude the estimated costs of these services, *because any required adjustment would be incorporated in the budget neutrality adjustment factors applied to the national and regional standardized amounts*. (See 49 FR 34794; August 31, 1984). ***Since the FY 1986 standardized amounts are derived from an update of the FY 1985 amounts, which were adjusted for budget neutrality, the rates will automatically include the appropriate adjustment***. We are not making further adjustments to the Federal rates for this factor for either FY 1986 or FY 1987.

50 Fed. Reg. at 35708 (emphasis added). *See also* 52 Fed. Reg. 33034, 33064 (Sept. 1, 1987) (stating: "In the September 3, 1985 final rule, we noted that to the extent an adjustment was warranted to reflect the removal of these costs from the prospective payment rates for FY 1985, *it was incorporated in the overall* ***budget neutrality*** *adjustment* (50 FR 35708). Therefore, because this adjustment has already been built into the FY 1985 base from which the FY 1986, FY 1987, and proposed FY 1988 rates are derived, we did not propose to make further adjustments to the average standardized amounts for FY 1988.").

[42] The Board notes that the D.C. Circuit's decision in *Saint Francis* is not applicable to the 1984 and 1985 budget neutrality adjustments given the statutory provision precluding administrative and judicial review of those adjustments. Further, *Saint Francis* did not analyze how the standardized amount is updated annually nor did it make specific legal holdings regarding the standardized amount.

[43] With regard to implementing this statutory provision, 48 Fed. Reg. 39752, 39785 (Sept. 1, 1983) states:

> Section 1886(d)(7) of the Act precludes administrative and judicial review of the following:
> —A determination of the requirement, or the proportional amount, of any "budget neutrality" adjustment effected under section 1886(e)(1) of the Act; or
> —The establishment of DRGs, of the methodology for the classification of hospital discharges within DRGs, or of the appropriate weighting factors of DRGs under section 1886(d)(4) of the cost. It was the clear intent of Congress that a hospital would not be permitted to argue that the level of the payment that it receives under the prospective payment system is inadequate to cover its costs.

Similarly, the statute governing Board appeals is located at 42 U.S.C. § 1395oo and states in subsection (g)(2):

> The determinations and other decisions described in section 1395ww(d)(7) of this title shall not be reviewed by the Board or by any court pursuant to an action brought under subsection (f) or otherwise.

The Secretary incorporated the exclusion of the 1984 and 1985 budget neutrality provisions into the Board's governing regulations at 42 C.F.R. § 405.1804 which states in pertinent part:

> Neither administrative nor judicial review is available for controversies about the following matters:
>
> (a) The determination of the requirement, or the proportional amount, of the budget neutrality adjustment in the prospective payment rates required under section 1886(e)(1) of the Social Security Act [*i.e.* 42 U.S.C. § 1395ww(e)(1)].[44]

Since the FFY 1984 and 1985 budget neutrality adjustments are based on an ***external, fixed*** reference point (*i.e.*, no greater and no less than the reference point) and are not reviewable, the Board finds that the FFYs 1984 and 1985 budget neutrality adjustments effectively fixed the standardized amounts from that point forward for use in the IPPS system.[45]

Indeed, the Secretary's implementation of the fixed FFY 1984 and 1985 budget neutrality adjustments confirms that the Providers' allegation that the standardized rates for ***each FFY at issue*** are somehow understated due to alleged errors in the FFY 1984 base rate is moot.

> Thus, as discussed above, neither the definition of the different DRGs, their weight in relation to each other, nor the method used to assign discharges to one of the groups is to be reviewable. However, if there is an error in the coding of an individual patient's case, review would be permitted. (See the Report of the Committee on Ways and Means on H.R. 1900, H. Report No. 98-25, (98th Cong., 1st Sess.) 143 (1982).) As noted below, we believe the appropriate review concerning coding errors should be conducted by the entity (i.e., the PSRO/PRO or fiscal intermediary) which made the initial determination.

[44] The Secretary recently clarified 42 C.F.R. § 405.1804(a) and affirmed that 42 U.S.C. § 1395ww (e)(1) "required that, for cost reporting periods beginning in FYs 1984 and 1985, the IPPS result in aggregate program reimbursement equal to 'what would have been payable' under the reasonable cost-based reimbursement provisions of prior law; that was, for FYs 1984 and 1985, the IPPS would be 'budget neutral.'" 78 Fed. Reg. 74825, 75162 (Dec. 10, 2013) (making technical change to the 42 C.F.R. § 405.1804(a)).

[45] *See, e.g.,* 48 Fed. Reg. 39752, 39765 (Sept. 1, 1983) (stating "We point out that aside from being technically desirable, the effect of standardizing nonlabor hospital costs in Alaska and Hawaii is to decrease the reduction for budget neutrality stemming from the requirements in section 1886(e)(1)(B) of the Act.").

1. *The Secretary determined that the initial standardized amounts for FFY 1984 were too high and, therefore, reduced the FFY 1984 standardized amounts through the FFY 1984 budget neutrality adjustment as reflected in the **final** FFY 1984 IPPS rates*.

In the interim final rule published on September 1, 1983, the Secretary issued a FFY 1984 budget neutrality adjustment to the FFY 1984 standardized amounts of 0.969:

> Section 1886(e)(1) of the Act requires that the prospective payment system result in aggregate program reimbursement equal to "what would have been payable" under the reasonable cost provisions of prior law; that is, for fiscal years 1984 and 1985, the prospective payment system should be "budget neutral."
>
> Under the Amendments, the prospective payment rates are a blend of a hospital-specific portion and a Federal portion. Section 1886(e)(1)(A) of the Act requires that aggregate payments for the hospital specific portion should equal the comparable share of estimated reimbursement under prior law. **Similarly, section 1886(e)(1)(B) of the Act requires that aggregate reimbursement for the Federal portion of the prospective payment rates plus any adjustments and special treatment of certain classes of hospitals should equal the corresponding share of estimated outlays prior to the passage of Pub. L. 98-21**. Thus, for fiscal year 1984, 75 percent of total projected reimbursement based on the hospital-specific portion should equal 75 percent of total estimated outlays under law as in effect prior to April 20, 1983. Likewise, total estimated prospective payment system outlays deriving from the 25 percent Federal portion, including adjustments and special payment provisions, should equal 25 percent of projected reimbursement under prior laws.
>
> **The adjustment of the Federal portion was determined as follows**:
>
> - *Step 1*—Estimate total incurred payments for inpatient hospital operating costs for fiscal year 1984 that would have been made on a reasonable cost basis under Medicare prior to Pub. L. 98-21.
> - *Step 2*—Multiply total incurred payments by 25 percent, i.e., the Federal portion of total payment amounts for fiscal year 1984.
> - *Step 3*—Estimate the Federal portion of total payments that would have been made without adjusting for budget neutrality, but with the adjustment for outlier payments.
> - *Step 4*—Add an estimate of total adjustments and payments under special payment provisions to the Federal portion (e.g., outliers, indirect medical education).

> • *Step 5*—The difference between the step 2 and step 4 amounts is divided proportionally among the standardized amounts, resulting in the budget neutrality adjusted (standardized) amounts.
>
> **The resulting adjustment factor for the fiscal year 1984 <u>Federal portion</u> is .969**. Payment amounts of hospitals excluded from the prospective payment system (e.g., psychiatric and children's hospitals) and of hospitals not participating in prospective payment because of their participation in demonstrations and studies were not included in the calculations above.[46]

In the final rule published on January 3, 1984, the Secretary revised the Federal budget neutrality adjustment factor to 0.970 using the same methodology.[47] Significantly, in the January 1984 final rule, the Secretary suggests that, in calculating the budget neutrality adjustment factor, CMS made no attempt to adjust for transfers under IPPS:

> Regarding additional adjustments recommended by commenters, we made no adjustments to either the adjusted standardized amounts or to the budget neutrality estimates for conditions that could not be quantified on the basis of currently available data, even if there were a likelihood that these conditions might exist under prospective payment. For example, no adjustment was made for the likelihood that admissions would increase more rapidly under prospective payment than under the provisions of Pub. L. 97-248, or for costs that might be disallowed as a result of audit or desk review by the intermediaries. *Likewise, we made no attempt to quantify adjustments **for the likelihood of transfers** under prospective payment*, emergency room services, and disallowed costs which are successfully appealed.[48]

Accordingly, while the Providers did not appeal the budget neutrality adjustment, the above excerpt suggests that the Providers' concern about the Secretary's alleged mistreatment of transfers may be misplaced and that the treatment of transfers in the context of the budget neutrality adjustment for FFY 1984 may have more significance.

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[46] 48 Fed. Reg. 39752, 39840-41 (Sept. 1, 1983) (bold, underline emphases added, and italics emphasis in original).
[47] 49 Fed. Reg. 234, 334 (Jan. 3, 1984).
[48] *Id.* at 255 (Emphasis added.) *See also Id.* at 331 (stating as part of the discussion on the budget neutrality adjustments: "The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) established a DRG-adjusted limit on the allowable amount of inpatient operating costs per case and a per case limit on the rate of increase of operating costs of inpatient hospital services. Due to these per case limits, the incentives that influence hospital admission patterns are similar under TEFRA and prospective payment. Accordingly, ***we have assumed that the number of admissions under both prior law and the prospective payment system will be the same***. As a result, the budget neutrality factors can be calculated by comparing reimbursement per discharge for each of the systems, and there is no need to estimate an actual number of hospital admissions." (emphasis added)).

Finally, the Secretary also declined to increase the base standardized amount to reflect the increased costs associated with the shift in costs of hospital-based physician services from Part B to Part A, as suggested in a comment. The Secretary noted that such an increase would simply be offset or neutralized by a corresponding increase in the budget neutrality adjustment for FFY 1984:

> Finally, applying such an adjustment to the average standardized amounts (and, by extension, to the per case budget neutrality estimates of Federal rate payments) would not actually increase the level of payments under budget neutrality. If we were to increase the initial standardized amounts to reflect this shift, the budget neutrality adjustment factor would have to be recalculated, would accordingly be increased, and the net result would be virtually identical. As a result, such an adjustment would have no effect on payment levels during FYs 1984 and 1985, which are subject to budget neutrality.[49]

Regardless, the Secretary's application of a 0.970 budget neutrality adjustment factor to the FFY 1984 standardized amounts for the Federal rates confirms that these standardized rates were too high and were reduced by a factor of 0.030. Thus, the ***final*** IPPS payment rates used for the first year of IPPS (*i.e.*, FFY 1984), as published on January 3, 1984, reflect the Secretary's FFY 1984 budget neutrality adjustment. Moreover, as previously noted, since the FFY 1984 budget neutrality adjustment is based on an ***external, fixed*** reference point (*i.e.*, no greater and no less than the reference point) and is not reviewable, the FFY 1984 budget neutrality adjustment effectively ***fixed*** the standardized amounts for FFY 1984 as used from that point forward (*i.e.*, as used both for the FFY 1984 IPPS payment rates and for subsequent years). Again, it is only natural that Congress established the 1984 and 1985 budget neutrality adjustments in this manner since the initial FFY 1984 standardized amount for IPPS was initially set *using 1981 data*.

2. *The FFY 1985 budget neutrality adjustment also reduced the FFY 1985 standardized amounts, reaffirming that the Secretary's determined that the initial standardized amounts for FFY 1984 were set too high.*

For FFY 1985, the Secretary applied a budget neutrality adjustment of 0.954 to the standardized amounts used for the Federal national rates and 0.950 to the standardized amounts used for the regional rates. The Secretary described these adjustments as follows:

> In accordance with section 1886(e)(1) of the Act, the prospective payment system should result in aggregate program reimbursement equal to "what would have been payable" under the reasonable cost provisions of prior law; that is, for FYs 1984 and 1985, the prospective payment system must be "budget neutral".
>
> During the transition period, the prospective payment rates are a blend of a hospital-specific portion and a Federal portion. ***Further, effective***

[49] *Id.* at 255.

> ***October 1,1984***, *the Federal portion will be a blend of national and regional rates*. As a result, we must determine three budget neutrality adjustments— one each for both the national and regional rates, and one for the hospital-specific portions. The methodology we are using to make these adjustments is explained in detail in section V. of this addendum.
>
> Based on the data available to date, we have computed the following Federal rate budget neutrality adjustment factors:
>
> Regional—.950
> National—.954[50]
>
> ****
>
> [T]he FY 1985 adjusted average standardized amounts (Federal rates) were required by law to be adjusted to achieve budget neutrality; that is, to ensure that aggregate payments for the operating costs of inpatient hospital services would be ***neither more nor less than*** *we estimated would have been paid under prior legislation for the costs of the same services*. (The technical explanation of how this adjustment was made was published in the August 31, 1984 final rule (49 FR 34791).) These budget neutrality-adjusted rates for FY 1985 are then to be used as the basis for the determination of rates for later years.
>
> Our FY 1985 budget neutrality adjustment factors were based on data and assumptions that resulted in standardized amounts that were higher than necessary to achieve budget neutrality. Therefore, we have updated the FY 1985 standardized amounts using a factor that takes into account the overstatement of the FY 1985 amounts to ensure that accuracy of the FY 1986 standardized amounts. To this end, we have identified several factors, discussed in section III.A.3.c., below, that contributed to the overstatement of the FY 1985 standardized amounts. We have determined an appropriate percent value for each of them, and have combined them into a proposed composite correction factor for FY 1986 that equals —7.5 percent.[51]

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[50] 49 Fed. Reg. 34728, 34769 (Aug. 31, 1984).

[51] 50 Fed. Reg. 35646, 35695 (Sept. 3 1985) (emphasis added). *See also* 49 Fed. Reg. at 34767 (stating "We believe the explicit language of section 2310 of Pub. L. 98-369 and section 1886(d)(3)(A) of the Act requires a reduction in the standardized amounts used to compute the Federal rates before adjusting for budget neutrality. . . . Thus, while the Federal rates . . . . have been reduced in this final rule to reflect the inflation factor prescribed by section 2310 of Pub. L. 98-369, we point out that the offset for budget neutrality has also been adjusted. The reduction in the regional and national standardized rates . . . attributable to section 2310 of Pub. L. 98-369 is entirely due to the revised budget neutrality adjustments for 1984 and 1985.").

Thus, like her budget neutrality adjustments made for FFY 1984, the Secretary again confirmed that the standardized amounts were too high and exercised her discretion to adjust down the standardized amounts to be used in the ***final*** FFY 1985 IPPS rates.

* * * * *

In summary, the Providers claim they do not seek to challenge the FFY 1984 or 1985 IPPS payments, but rather they "contest the Standardized Amount for [the applicable FFY] and the methodology by which the Standardized Amount was initially calculated in 1983."[52] They also claim that the Budget Neutrality Preclusion Provisions are not applicable here because they only bar administrative and judicial review of *a* ***narrow*** *category of challenges* to the Secretary's determination of the requirement, or the proportional amount, of any budget neutrality adjustment effected pursuant to 42 U.S.C. § 1395ww(e)(1) in FFYs 1984 and 1985.[53]

The Board disagrees and finds that it lacks substantive jurisdiction over the issue raised in these appeals. The standardized amounts used for IPPS rates for FFYs 1984 and FFY 1985 are each based on the budget neutrality adjustment made for that FFY and the 1984 and 1985 budget neutrality adjustments are presumably designed to be corrective of the initial base rate that was set *using 1981 data*.[54] Therefore, the *final* FFY 1984 and 1985 standardized amounts are *inextricably intertwined* with those applicable budget neutrality adjustments.[55] Indeed, the standardized

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[52] *E.g.*, PRRB Case Nos. 23-0270GC, *et al.*, Providers' Response to MACs' Jurisdictional Challenges at 6.
[53] *Id.* at 9.
[54] The Board has included at **Appendix B** examples of other adjustments to the standardized amounts that have occurred outside of the FFY 1984 and 1985 budget neutrality adjustments. These intervening adjustments for FFYs 1986 and 2018 include both mandatory and discretionary revisions ***to the standardized amounts*** (as well as the Congress' decisions to revise or not revise the "applicable percentage increases" for FFYs 1986 and forward as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i)) and highlight the complexity of the issue before the Board, particularly where such adjustments were made in a budget neutral manner or were based on factoring in certain other estimated impacts
[55] *See DCH Reg'l Med. Ctr. v. Azar*, 925 F.3d 503, 507 (D.C. Cir. 2019) ("We cannot review the Secretary's method of estimation without also reviewing the estimate. And because the two are inextricably intertwined, section 1395ww(r)(3)(A) precludes review of both."); *Mercy Hosp., Inc. v. Azar*, 891 F.3d 1062, 1067 (D.C. Cir. 2018) ("As both a textual and a practical matter, the LIP adjustment is inextricably intertwined with the step-two rate, and so the shield that protects the step-two rate from review protects the LIP adjustment as well."); *Yale New Haven Hosp. v. Becerra*, 56 F.4th 9, 18 (2nd Cir. 2022) ("Thus, we join the D.C. Circuit in "reject[ing] the argument that 'an "estimate" is not the same thing as the "data" on which it is based.'" *DCH Reg'l Med. Ctr. v. Azar* . . . . We also adopt the D.C. Circuit's holding that "[i]n this statutory scheme, a challenge to the [Secretary's choice of what data to include and exclude] for estimating uncompensated care is ... a challenge to the estimates themselves. The statute draws no distinction between the two." *Id*. at 506. Indeed, the statutory text of section 1395ww(r)(2)(C)(i) explicitly and affirmatively defines the statutory term "estimate[ ]" to encompass "the Secretary['s] determin[ation]" of what data is the "be[st] proxy for the costs of [qualifying] hospitals for treating the uninsured" and, ultimately, of what data to "use" or not "use." 42 U.S.C. § 1395ww(r)(2)(C)(i)." (citations partially omitted)). Similarly, the Board notes that the Board erred in finding that it had jurisdiction in *Columbia/HCA 1984-1986 PPS Federal Rate/Malpractice Group v. Blue Cross & Blue Shield Ass'n*, PRRB Dec. 2000-D74 (Aug. 18, 2000). In that decision, the Board found that "the issue in this case, whether the federal portion of the PPS rates should be adjusted because it was based on 1981 hospital cost report data which incorporated an invalid 1979 Malpractice Rule, does not fall into either [of the] limitations on Board jurisdiction [at 42 U.S.C. §§ 1395ww(d)(7) or 1395oo(g)(2)]. The Board finds that it can determine whether the existing statute and regulations concerning the establishment of the federal portion of the PPS rate require or permit retroactive adjustments." *Id.* at 16. The Board further found that "the retroactive adjustment proposed by the Provider would increase the federal portion of the PPS rates ***and therefore require some adjustment to be made to maintain budget***

amounts were too high for FFYs 1984 and 1985 and the budget neutrality adjustments applied to those years reduced the standardized amounts (reduced by factors of approximately 0.03 for FFY 1984 and 0.05 for FFY 1985) and, thus, these budget neutrality adjustments appear to have already automatically accounted for any such alleged errors in setting the initial base rate (which again was based on *1981 data*).[56] Because 42 U.S.C. 1395ww(d)(7) prohibits administrative or judicial review of those adjustments and the resulting *final* standardized amounts for those years were carried/flowed forward, the Board may not review the standardized amount used for the FFYs being appealed as they relate to the issue in these appeals, *i.e.*, the alleged inaccuracies in the standardized amounts used for FFY 1984 as carried/flowed forward for all years following FFY 1984 to the FFYs being appealed. In this regard, the Board notes that the Providers may not simply pass through, or over, the budget neutrality adjustments for FFYs 1984 and 1985 because those adjustments are tied to an absolute *external* event (the Secretary's estimate, based on the best available data, of what would have been paid for those years if there were no IPPS) ***and*** were ***fixed*** (no greater *and* no less than what would have been paid had there been no IPPS). To do otherwise, would impact the very integrity of IPPS.

Accordingly, the Board finds, however, that: (1) the appealed issue is *inextricably* intertwined with the FFY 1984 and 1985 budget neutrality adjustments to the standardized amounts; (2) 42 U.S.C. §§ 1395oo(g)(2) and 1395ww(d)(7) (and related implementing regulations) prohibit administrative and judicial review of those budget neutrality adjustments; and (3) thus, it does not have substantive jurisdiction over the issue in fifty-one (51) CIRP and optional group cases listed in Appendix A. Accordingly, the Board hereby closes these fifty-one (51) group cases and removes them from the Board's docket.

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

Board Members Participating:

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

For the Board:

12/14/2023

X Clayton J. Nix

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

neutrality. 42 U.S.C. § 1395ww(e) and 42 C.F.R. § 412.63(j)" but that "[b]ecause the Board has determined that the adjustments are not required, how those adjustments would be made are moot, and in any event would not be subject to review by the Board. 42 C.F.R. § 405.1804(a)." *Id.* at 18 (Emphasis added.) While the Board's 2000 decision got it right that the FFY 1984 budget neutrality provision is implicated and precluded from administrative review, the above case law demonstrates that the Board erred in finding it could review the FY 1984 standardized amounts. Rather, the case law (as well as the Board's discussion herein) demonstrate that any adjustment to the FFY 1984 standardized amounts would be *inextricably* tied to the ensuing budget neutrality adjustments made for FFYs 1984 and 1985.

[56] *See supra* note 41 (discussing how the removal of nurse anesthetists costs were removed from IPPS and how that removal was *automatically* accounted for as part of the 1985 budget neutrality adjustment).

cc: Byron Lamprecht, WPS Government Health Administrators (J-8)
Cecile Huggins, Palmetto GBA (J-J)
Dana Johnson, Palmetto GBA c/o National Government Services, Inc. (J-M)
Wilson Leong, FSS
Jacqueline Vaughn, CMS OAA

APPENDIX A
Jurisdictional Challenges and Responses; 51 Cases at Issue

On September 9, 2023, the Medicare Contractor filed a challenge to the following thirty (30) cases which all share a common lead Medicare Contractor, WPS Government Health Administrators (J-8):

23-0695GC Henry Ford Health FFY 2023 IPPS Standardized Amount CIRP Group
23-0533GC Bronson Healthcare FFY 2023 IPPS Standardized Amount CIRP Group
23-0433GC Michigan Medicine FFY 2023 IPPS Standardized Amount CIRP Group
23-0333GC Trinity Health FFY 2023 IPPS Standardized Amount CIRP Group
23-0252G Honigman Miller FFY 2023 Medicare IPPS Standardized Amount Group
22-0665GC Michigan Medicine FFY 2022 FFY 2022 Medicare IPPS Standardized Amount
22-0648GC Henry Ford Health FFY 2022 Medicare IPPS Standardized Amount CIRP Group
22-0611G Honigman Miller FFY 2022 Medicare IPPS Standardized Amount Group
22-0460GC Bronson Healthcare FFY 2022 IPPS Standardized Amount CIRP Group
22-0415GC Trinity Health FFY 2022 IPPS Standardized Amount CIRP Group
21-0630GC Trinity Health FFY 2021 IPPS Standardized Amount CIRP Group
21-0586GC Beaumont Health FFY 2021 Medicare IPPS Standardized Amount CIRP Group
21-0563GC Henry Ford Health FFY 2021 Medicare IPPS Standardized Amount CIRP Group
21-0560GC Michigan Medicine FFY 2021 Medicare IPPS Standardized Amount CIRP Group
21-0524GC Bronson Healthcare FFY 2021 IPPS Standardized Amount CIRP Group
21-0478G Honigman Miller FFY 2021 Michigan Hospitals IPPS Standardized Amount
20-1088GC Sparrow Health System FFY 2020 Medicare IPPS Standardized Amount CIRP
20-0935GC Michigan Medicine FFY 2020 Medicare IPPS Standardized Amount CIRP Group
20-0650G Honigman Miller FFY 2020 Michigan Hospitals IPPS Standardized Amount
20-0628GC Henry Ford Health FFY 2020 Medicare IPPS Standardized Amount CIRP Group
20-0624GC Beaumont Health FFY 2020 Medicare IPPS Standardized Amount CIRP Group
20-0579GC Bronson Healthcare FFY 2020 IPPS Standardized Amount CIRP Group
20-0543GC Trinity Health FFY 2020 IPPS Standardized Amount CIRP Group
19-0886GC Sparrow Health System FFY 2019 IPPS Standardized Amount CIRP Group
19-0711GC Henry Ford Health FFY 2019 Medicare IPPS Standardized Amount CIRP Group
19-0602GC Michigan Medicine FFY 2019 Medicare IPPS Standardized Amount CIRP Group
19-0403GC Beaumont Health FFY 20219 Medicare IPPS Standardized Amount CIRP Group
19-0316GC Bronson Healthcare FFY 2019 IPPS Standardized Amount CIRP Group
19-0174GC Trinity Health FFY 2019 IPPS Standardized Amount CIRP Group
19-0142G Honigman Miller FFY 2019 Michigan Hospitals IPPS Standardized Amount Group

On September 15, 2023, the Medicare Contractor filed a challenge to the following eleven (11) cases which all share a common lead Medicare Contractor, Palmetto GBA (J-J):

23-0270GC Baptist Memorial FFY 2023 IPPS Standardized Amount CIRP Group
22-0690GC WellStar Health FFY 2022 FFY 2022 Medicare IPPS Standardized Amount CIRP
22-0172GC Baptist Memorial FFY 2022 BMHCC FY 2022 Medicare IPPS Standardized Amt
21-1114GC WellStar Health FFY 2021 FFY 2021 Medicare IPPS Standardized Amount CIRP

21-0410GC Baptist Memorial FFY 2021 IPPS Standardized Amount CIRP Group
20-1669GC Baptist Memorial FFY 2018 FY 2018 IPPS Standardized Amount CIRP Group
20-1130GC WellStar Health FFY 2020 Medicare FFY 2020 Standardized Amount CIRP
20-0554GC Baptist Memorial FFY 2020 IPPS Standardized Amount CIRP Group
20-0117GC Baptist Memorial CY 2016 IPPS Standardized Amount CIRP Group
19-0520GC Baptist Memorial CYs 2013 & 2015 BMHCC FFY IPPS Standardized Amount CIRP
19-0254GC Baptist Memorial CY 2014 BMHCC FFY IPPS Standardized Amount CIRP

On September 19, 2023, the Medicare Contractor filed a challenge to the following four (4) cases which all share a common lead Medicare Contractor, Palmetto GBA c/o National Government Services, Inc. (J-M):

22-0677GC Atrium Health FFY 2022 Medicare IPPS Standardized Amount CIRP Group
21-1000GC Atrium Health FFY 2021 Medicare IPPS Standardized Amount CIRP Group
20-1052GC Atrium Health FFY 2020 Medicare IPPS Standardized Amount CIRP Group
19-0001GC Atrium Health FFY 2019 Medicare IPPS Standardized Amount CIRP Group

The Providers' Representative filed a number of individual and consolidated responses to these challenges, but generally grouped them by fiscal year instead of the servicing Medicare Contractor. Consolidated Responses were filed for cases with FFYs 2019, 2020, 2021, 2022, and 2023, which captioned all of the challenged cases above. "Out of an abundance of caution," these consolidated responses were also filed on behalf of the following six (6) cases where no challenge was filed, but the appealed issue is identical:

18-1575GC BMHCC FFY 2019 IPPS Standardized Amount CIRP Group
19-0275GC Wellstar Health FY 2019 IPPS Standardized Amount CIRP Group
19-0454GC BayCare Health FFY 2019 Standardized Amount CIRP Group
20-0958GC BayCare Health FFY 2020 Standardized Amount CIRP Group
21-1071GC BayCare Health FFY 2021 Standardized Amount CIRP Group
22-0634GC BayCare Health FFY 2022 Standardized Amount CIRP Group

Finally, four (4) responses were also filed in the following cases (*already listed above*), each of which have a different assigned Medicare Contractor:

19-0520GC Baptist Memorial CYs 2013 & 2015 BMHCC FFY IPPS Standardized Amount
20-0117GC Baptist Memorial CY 2016 IPPS Standardized Amount CIRP Group
20-1669GC BMHCC FFY 2018 IPPS Standardized Amount CIRP Group
21-1000GC Atrium Health FFY 2021 Medicare IPPS Standardized Amount CIRP Group

APPENDIX B

The following are examples of other adjustments to the standardized amounts that have occurred outside of the FFY 1984 and 1985 budget neutrality adjustments and the "applicable percentage increases" for FFYs 1986 and forward as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i):

a. "Restandardization of base year costs per case used in [the] calculation of Federal rates" for both the labor and non-labor portions to reflect the survey-based wage index as discussed in the FY 1986 IPP Final Rule. 50 Fed. Reg. 35646, 35692 (Sept. 3, 1985).

b. Recalibration of DRG weights done in a budget neutral manner pursuant to 42 U.S.C. § 1395ww(d)(4)(C) at least every 4 years beginning with 1986.[57] An example of recalibration can be found in the FY 1986 IPPS Final Rule wherein the Secretary changed its methodology for calculating the DRG relative weights.[58]

c. Budget neutrality adjustments made to the standardized amount designated for urban hospitals and the one designated for rural hospitals when certain urban hospitals were deemed to be

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[57] The Secretary confirmed that, beginning in 1991, these adjustments are to be made in a budget neutral manner:

> Section 1886(d)(4)(C)(iii) of the Act requires that beginning with FY 1991, reclassification and recalibration changes be made in a manner that assures that the aggregate payments are neither greater than nor less than the aggregate payments that would have been made without the changes. Although normalization is intended to achieve this effect, equating the average case weight after recalibration to the average case weight before recalibration does not necessarily achieve budget neutrality with respect to aggregate payments to hospitals because payment to hospitals is affected by factors other than average case weight. Therefore, as discussed in section II.A.4.b. of the Addendum to this final rule, we are making a budget neutrality adjustment to implement the requirement of section 1886(d)(4)(C)(iii) of the Act.

59 Fed. Reg. 45330, 45348 (Sept. 1, 1994).

[58] 50 Fed. Reg. 35646, 35652 (Sept. 3, 1985). As part of this recalibration process, the Secretary responded to a comment on the use of transfers in the recalibration process as follows:

> *Comment:* A commenter was concerned that, by including transfer cases in the calculation of the relative weights, we might be inappropriately reducing the relative weights of DRGs in which there are significant proportions of transfer cases.
>
> *Response:* This commenter assumes that the charges for transfer cases are lower than charges for the average case in a DRG. Our data show that this assumption is not correct for many DRGs. To test the effect of including transfers in the calculation of the relative weights, we computed mean charges for each DRG, both with and without the transfer cases. We then conducted statistical tests to determine whether these two means differed significantly at the .05 confidence level (that is, there is only a .05 probability that the observed difference in the means would occur if the two sets of cases came from the same underlying population). The results indicate that transfers have a statistically significant effect on the mean charges of only 16 DRGs. For 13 of the 16 DRGs, inclusion of transfer cases tends to ***increase*** the mean charges. However, for three DRGs, the mean charges are reduced by the inclusion of the transfer cases.
>
> Since the inclusion of transfer cases raises the mean charges for some DRGs and lowers them for others, and because these effects are limited to such a small number of DRGs, we decided not to revise the method we used to recalibrate the relative weights. During FY 1986, we will be studying the entire issue of transfers and the appropriate payment for these cases. This study may reveal other ways of handling transfer cases in future recalibrations.

Id. at 35655-56.

urban effective with discharges occurring on or after October 1, 1988. 53 Fed. Reg. 38476, 38499-500, 38539 (Sept. 30, 1988) (implementing OBRA 87, Pub. L. 100-203, § 4005).[59]

d. Effective for FFY 1995, eliminating the initial two standardized amounts (one for urban hospital and another for rural hospitals)[60] and replacing them with one single standardized amount as specified at 42 C.F.R. § 1395ww(d)(3)(C)(iii).[61]

e. Budget neutrality provision at 42 U.S.C. § 1395ww(d)(3)(A)(vi) that allows Secretary to adjust standardized amount to eliminate the effect of "changes in coding or classification of discharges that do not reflect real changes in case mix."

f. The discretion of the Secretary in 42 U.S.C. § 1395ww(d)(3)(I)(i) to "provide by regulation for such other exceptions and adjustments to such payments amounts under this subsection as the Secretary deems appropriate."

g. The subsequent amendments that Congress made in 1994[62] and 1997[63] to add subparagraphs (I) and (J) to 42 U.S.C. § 1395ww(d)(5) to recognize and incorporate the concept of transfers into IPPS *in a budget neutral manner*. The Secretary made adjustments to the standardized amounts in order to implement the permanent incorporation of transfers into IPPS.[64]

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[59] *See also* 56 Fed. Reg. 43358, 43373 (Aug. 30, 1991) (stating "Consistent with the prospective payment system for operating costs, the September 1, 1987 capital final rule provided for separate standardized amounts for hospitals located in urban and rural areas. Subsequently, the Omnibus Budget Reconciliation Act of 1987 (Pub. L. 100-203) provided for a higher update factor for hospitals located in large urban areas than in other urban areas and thereby established three standardized amounts under the prospective payment system for operating costs. Large urban areas are defined as those metropolitan statistical areas (MSAs) with a population of more than 1 million (or New England County metropolitan statistical areas (NECMAs) with a population of more than 970,000). Beginning with discharges on or after April 1,1988 and continuing to F Y 1995, the Congress has also established higher update factors for rural hospitals than for urban hospitals. The differential updates have had the effect of substantially reducing the differential between the rural and other urban standardized amounts. Section 4002(c) of Public Law 101-508 provides for the elimination of the separate standardized amounts for rural and other urban hospitals in FY 1995 by equating the rural standardized amount to the other urban standardized amount. The separate standardized amount for large urban hospitals would continue. Currently, the large urban standardized amount under the prospective payment system for operating costs is 1.6 percent higher than the standardized amount for hospitals located in other urban areas.").

[60] *See* 42 U.S.C. §§ 1395ww(d)(2)(D), 1395ww(d)(3)(A); *supra* note 19.

[61] Omnibus Reconciliation Act of 1990, Pub. L. 101-508, § 4002(c), 104 Stat. 1388, 1388-33 – 1388-35 (1990).

[62] Social Security Act Amendments of 1994, § 109, Pub. L. 103-432, 108 Stat. 4398, 4408 (1994) placed the then-existing language of 42 U.S.C. § 1395ww(d)(5)(I) into clause (i) and added the following clause (ii): "(ii) In making adjustments under clause (i) for transfer cases (as defined by the Secretary) in a fiscal year, the Secretary may make adjustments to each of the average standardized amounts determined under paragraph (3) to assure that the aggregate payments made under this subsection for such fiscal year are not greater than or lesser than those that would have otherwise been made in such fiscal year."

[63] Balanced Budget Act of 1997, Pub. L. 105-33, § 4407, 111 Stat. 251, 401 (1997), further revised 42 U.S.C. § 1395ww(d)(5)(I) and added § 1395ww(d)(5)(J).

[64] *See* 60 Fed. Reg. 45778, 45854 (Sept. 1, 1995) ("[W]e are revising our payment methodology for transfer cases, so that we will pay double the per diem amount for the first day of a transfer case, and the per diem amount for each day after the first, up to the full DRG amount. For the data that we analyzed, this would result in additional payments for transfer cases of $159 million. *To implement this change in a budget neutral manner*, we adjusted the standardized amounts by applying a budget neutrality adjustment of 0.997583 in the proposed rule.").

To illustrate the complex nature of these issues, Board points to the Secretary's exercise of her discretion under 42 U.S.C. § 1395ww(d)(3)(I)(i) on making recommendations to Congress on whether to make adjustments to the "applicable percentage increases" or update factor for FFY 1986 as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i). In the September 1985 Final Rule,[65] the Secretary asserted that the FFY 1985 Federal rates were "overstated" and cited to the GAO's 1985 report entitled "Report to the Congress of the United States: Use of Unaudited Hospital Cost Data Resulted in Overstatement of Medicare Prospective Payment System Rates" and, pursuant to 42 U.S.C. § 1395ww(e)(4), made a recommendation to Congress that it not provide any increase to FFY 1985 standardized amounts but rather freeze the FFY 1986 amounts at the FFY 1985 levels (*i.e.*, recommended an update factor of 0 percent for FFY 1986).[66] The following excerpts from that rulemaking describe how the Secretary determined that the FFY 1985 standardized amounts were overstated when reviewing whether to recommend that Congress adjust the update factor for the FFY 1986 standardized amounts:

> Since the standardized amounts for FY 1985 are used as the basis for the determination of rates for later years, the level of the FY 1985 standardized amounts must be corrected for any experience that developed since they were published. *We believe that it is necessary, **each year**, to review the appropriateness of the level of the previous year's prospective payment rates for providing reasonable payment for inpatient hospital services furnished to beneficiaries*. Further, we think this review must include assessment of whether the previous year's prospective payment rates have established adequate incentives for the efficient and effective delivery of needed care.
>
> In addition to this general consideration, *the FY 1985 adjusted average standardized amounts* (***Federal rates***) *were required by law **to be adjusted to achieve budget neutrality***; that is, to ensure that aggregate payments for the operating costs of inpatient hospital services would be *neither more **nor** less than* we estimated would have been paid under prior legislation for the costs of the same services. (The technical explanation of how this adjustment was made was published in the August 31, 1984 final rule (49 FR 34791).) *These budget neutrality-adjusted rates for FY 1985 are then to be used as the basis for the determination of rates for later years*.
>
> *Our FY 1985 budget neutrality adjustment factors were based on data and assumptions that resulted in standardized amounts that were **higher** than necessary to achieve budget neutrality*. Therefore, *we have updated the FY 1985 standardized amounts using a factor that takes into account the **overstatement** of the FY 1985 amounts to*

[65] 50 Fed. Reg. 35646, 35704 (Sept. 3, 1985).
[66] U.S. Gov't Accountability Office, GAO/HRD-85-74, Use of Unaudited Hospital Cost Data Resulted in Overstatement of Medicare's Prospective Payment System Rates (1985).

ensure that accuracy of the FY 1986 standardized amounts. To this end, we have identified several factors, ***discussed in section II.A.3.c.***, below, that contributed to the overstatement of the FY 1985 standardized amounts. *We have determined an appropriate percent value for each of them, and have combined them into* ***a proposed composite correction factor*** *for FY 1986 that equals –7.5 percent*.

In addition, we have developed factors representing productivity, technological advances, and the elimination of ineffective practice patterns, which are necessary to ensure the cost-effective delivery of care. Each of these factors interacts with the others, to some extent, and has an impact on the quality of care. Making conservative assumptions, we have determined an appropriate percent value for each of these factors, taking into consideration their potential effect on quality. **We have combined these values into a composite policy target adjustment factor**, **as discussed in section III.3.e., below**. For FY 1986, this factor equals —1.5 percent.

The Secretary is required under section 1886(e)(4) of the Act to make those adjustments in establishing the update factor that are ". . . necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality." *Establishing FY 1986 prospective payment rates based on FY 1985 rates* ***that have been demonstrated to be overstated****, clearly would not comport with the statutory requirement that the rates represent payment for efficiently delivered care*.

Since the forecasted hospital market basket increase for FY 1986 is +4.27 percent, and the adjustment for Part B costs and FICA taxes is +.31 percent, it is clear that there is a potential justification of a –4.42 percent decrease in the FY 1986 standardized amounts as compared to those for FY 1985 as described below:

	Percent
Forecasted market basket increase..	+4.27
Part B costs and FICA taxes.....	+.31
Composite correction factor.....	–7.5
Composite policy target adjustment factor.....	–1.5

However, for the reasons discussed in section II.A.3.f., below, we have decided that such a decrease is undesirable. Therefore, we are

maintaining the FY 1986 standardized amounts at the same average level as FY 1985, in effect applying a zero percent update factor.[67]

****

(3) *Additional causes for the overstatement of FY 1985 Federal rates.* In addition to the factors above, which we believe we must correct, **other considerations also contributed significantly to the overstatement of the FY 1985 standardized amounts**.

When we set the standardized amounts for FY 1985, we made assumptions on hospital cost per case increases in order to estimate, for purposes of budget neutrality, the payments that would have been made had prior payment rules continued in effect. These assumed rates of increase in cost per case were 10.9 percent for 1983, 9.8 percent for 1984, and 9.8 percent for 1985. These assumptions were significantly higher than the actuarial estimates. The actuarially estimated rates of increase in cost per case (which ignore any effects of the prospective payment system such as shorter lengths of stay) are 9.8 percent for 1983, 8.1 percent for 1984, and 8.5 percent for 1985. After application of the revised market basket, discussed previously, use of these actuarial estimates would reduce the standardized amounts by an additional 1.2 percent.

For FY 1985, we also used 1981 unaudited, as-submitted cost reports (to get recent data as quickly as possible) to set the Federal rates. The hospital specific rates were set using later (1982 or 1983) cost reports that were fully audited. The audits adjusted the total cost for these reports downward by $2.2 billion, of which Medicare realized about $900 million in inpatient recoveries. **Since the cost data used to set the Federal rates do not reflect audit recoveries, it is likely that they are overstated by a similar amount**. We do not know precisely what proportion of this amount applies to capital-related costs and other costs that would not affect the Federal rates. However, approximately 90 percent of hospitals" total inpatient costs are operating costs, and if only 40 percent of the $900 million in audit recoveries is related to Federal payments for inpatient operating costs, there would have been, conservatively estimated, at least a one percent overstatement of allowable costs incorporated into the cost data to determine the FY 1985 standardized amounts.

[67] 50 Fed. Reg. at 35695 (bold, italics, and underline emphasis added).

> In addition, the General Accounting Office (GAO) recently conducted a study to evaluate the adequacy of the Standardized amounts. In its report to Congress dated July 18, 1985 (GAO/HRD-85-74), **GAO reported findings that the standardized amounts, as originally calculated, are overstated by as much as 4.3 percent because they were based on unaudited cost data and include elements of capital costs.** GAO recommended that the rates be adjusted accordingly.
>
> We believe that these causes for the overstatement of the standardized amounts are related to our own procedures and decisions. Thus, they are unlike both the market basket index, which is a technical measure of input prices, and the increases in case-mix, which would not have been passed through beyond the extent to which they affected the estimates of cost per case. Further, as discussed below, even without making these corrections, we could justify a negative update factor for FY 1986, although we are not establishing one. **Since we have decided to set FY 1986 standardized amounts at the same level as those for FY 1985, making corrections now to reflect the cost per case assumptions and the audit data would have no practical effect. Therefore, we have decided <u>at this time not</u> to correct the standardized amounts for these factors.**
>
> We received no comments on this issue.
>
> (4) ***Composite Correction Factor.*** We are adjusting the standardized amounts as follows to take into consideration the overstatement of the prior years, amounts:
>
> | | *Percent* |
> |---|---|
> | Case mix..... ..... | –6.3 |
> | Market basket..... | –1.2 |
> | Composite correction factor..... | –7.5[68] |

Congress did immediately act on the Secretary's September 3, 1985 recommendation because, shortly thereafter on September 30, 1985, it enacted § 5(a) of the Emergency Extension Act of 1985 ("EEA-85") to maintain existing IPPS payment rates for FFY 1986 at the FFY 1985 Rates (*i.e.*, provide a 0 percent update factor) until November 14, 1985 as specified in EEA-85 § 5(c).[69] Congress subsequently modified this freeze on several different occasions as explained in the interim final rule published on May 6, 1986:

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[68] *Id.* at 35703-04 (bold and underline emphasis added).

[69] Pub. L. 99-107, § 5(a), 99 Stat. 479, 479 (1985). In July 1984, Congress had *already* reduced the 1 percent update factor planned for FFY 1986 to ¼ of a percentage point. Deficit Reduction Act of 1984, Pub. L. 98-369, § 2310(a), 98 Stat. 494, 1075 (1984). As part of the Emergency Extension Act of 1985, Congress further reduced the update factor for FFY 1986, presumably in response to the Secretary's recommendation.

> - Pub. L. 99-155, enacted December 14, 1985, extended the [EEA-85] delay through December 14, 1985.
>
> - Pub. L. 99-181, enacted December 13, 1985, extended the [EEA-85] delay through December 18, 1985.
>
> - Pub. L. 99-189, enacted December 18, 1985, extended the [EEA-85] delay through December 19, 1985.
>
> - Pub. L. 99-201 enacted December 23, 1985, extended the [EEA-85] delay through March 14, 1986.[70]

Second, on April 7, 1986, Congress further revised EEA-85 § 5(c) by extending the 0 percent update factor through April 30, 1986 and then specified that, for discharges on or after May 1, 1986, the update factor would be ½ of a percentage point.[71]

The examples highlight concerns about how certain future actions and decisions by the Secretary and Congress build upon prior decisions. Here, the Secretary's recommendation to Congress regard the FFY 1986 update factor were based on its analysis of the FFY 1984 and 1985 standardized amounts that had already been adjusted for budget neutrality. To the extent the 1984 standardized amounts had been *further* adjusted (*as **now** proposed by the Providers*), it could have potentially impacted the Secretary's recommendation to Congress for the FFY 1986 update factor as well as Congress' subsequent revisions to the updated factor. Accordingly, this highlights how revisiting and otherwise adjusting the FY 1984 standardized amounts can have ripple effects with the update factor and other adjustments that were made for subsequent years *based on analysis of the prior year(s) and other information*.

[70] 51 Fed. Reg. 16772, 16772 (May 6, 1986).
[71] *See id.* at 16773. *See also* Medicare and Medicaid Budget Reconciliation Amendments of 1985, Pub. L. 99-272, § 9101(a), 100 Stat. 151, 153 (1986).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Christopher Kenny, Esq.
King & Spalding, LLP
1700 Pennsylvania Ave, NW, Ste. 200
Washington, DC 20006-4706

RE: ***Decision re: Motion for Reinstatement***
23-1796GC Hendrick Health FFY 2024 § 1115 Waiver Days Texas CIRP Group
23-1797GC CHRISTUS Health FFY 2024 § 1115 Waiver Days Texas CIRP Group
23-1798GC CHS FFY 2024 § 1115 Waiver Days Texas CIRP Group
23-1799GC Ardent Health FFY 2024 § 1115 Waiver Days Texas CIRP Group
23-1802GC UHS FFY 2024 § 1115 Waiver Days Texas CIRP Group
23-1803GC HCA FFY 2024 § 1115 Waiver Days Texas CIRP Group
23-1804G King & Spalding FFY 2024 § 1115 Waiver Days Texas Group

Dear Mr. Kenny:

On October 31, 2023, King & Spalding, LLP ("K&S") filed the Motion for Reinstatement and Response to MAC's Jurisdiction Challenge ("Motion for Reinstatement") in the above-captioned seven (7) group cases (1 *optional* group and 6 common issue related party ("CIRP") groups) on behalf of the Providers in these group cases as their designated representative. The Provider Reimbursement Review Board ("Board") has reviewed the Motion for Reinstatement and set forth below is the decision of the Board to deny it.

Background:

On September 29, 2023, K&S filed group appeal requests to establish the six (6) above-referenced CIRP group appeals, and the single *optional* group appeal. Each participant in the groups is a hospital located in Texas and was *directly added* to the relevant group appeal ***based on*** an appeal of the federal fiscal year 2024 inpatient prospective payment system final rule ("FFY 2024 IPPS Final Rule")[1] as it relates to the inclusion of § 1115 waiver days in the Medicaid fraction of the disproportionate share hospital ("DSH") payment calculation[2] for their fiscal year(s) impacted by FFY 2024.[3] Specifically, each of the seven (7) group appeals contains the following issue statement:

[1] 88 Fed. Reg. 58640 (Aug. 28, 2023).
[2] *Id.* at 59012-26 (excerpt from the preamble to the final rule addressing "Counting of Certain Days Associated With Section 1115 Demonstration in the Medicaid Fraction").
[3] FFY 2024 runs from October 1, 2023 through September 30, 2024. Some of the Providers in these seven (7) 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 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

> This appeal challenges **CMS's final determination** set forth in the [IPPS] 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 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).[4]

Significantly, the group appeal request that established of these group appeals does ***not*** *discuss the basis for the Board's jurisdiction* over the group appeal and, similarly, the direct add requests for *each* of the participants in these groups does ***not*** *discuss or explain the Board's jurisdiction or the basis for their right to appeal* the FFY 2024 IPPS Final Rule other than asserting that the final rule serves as a "CMS's final determination" for the above issue.

On the same day as the filing of the appeal requests, K&S filed a Consolidated Petition for Expedited Judicial Review ("EJR Request") for the seven (7) group cases. *Significantly, the EJR request asserts that "[t]he Board has* ***jurisdiction*** *over these appeals pursuant to [42 U.S.C. § 1395oo(a)]" because* ***"[a]ll*** the Providers ***filed their appeals under [§ 1395oo(a)(1)(A)(i)]***."[5] The EJR Request then asserts that "[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 that is appealable to the Board pursuant to section 1878(a)"[6] and that principle is true of the Secretary's codification of the § 1115 waiver days policy as part of the FFY 2024 IPPS Final Rule. They

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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.

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

[5] Providers' EJR Request at 11 (Sept. 29, 2023) (emphasis added). Significantly, the EJR request does *not* reference the right to appeal under 42 U.S.C. § 1395oo(a)(1)***(A)(ii)*** as the Providers ***now*** assert in their Request for Reinstatement.

[6] *Id.* (citing: "*See Washington Hosp. Ctr. v. Bowen*, 795 F.2d at 144-48 (D.C. Cir. 1986); *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)").

explain that, "[b]y 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)."[7]

On October 6, 2023, the Medicare Contractor filed a 5-paragraph response to the EJR Request asserting that both the appeals and the EJR request are premature based on the fact that "because "[the Providers'] 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."[8] The filing was not styled as a "Jurisdictional Challenge" but rather as a "Response to Providers' EJR Request."

On October 25, 2023 (26 days after the EJR request was filed and *19 days after the Medicare Contractor's response was filed*[9]), the Board issued an EJR Determination which denied the EJR Request and dismissed the cases because FFY 2024 IPPS Final Rule "appealed in the instant cases 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."[10]

Providers' Motion for Reinstatement:

In its October 31, 2023 Motion for Reinstatement, K&S argues that, before the Board ruled on the EJR Request and dismissed the case for lack of jurisdiction, the Providers should have been afforded an opportunity both to respond to the Medicare Contractor's "jurisdictional challenge" and to address "certain 'factual gaps' that [the Board] believed prevented it from determining whether it had jurisdiction over the appeals."[11]

K&S notes that all of the Providers are in Texas and asserts that Texas has an approved § 1115 wavier impacted by the regulatory amendments published in the FFY 2024 IPPS Final Rule under appeal.[12] K&S insists that the new regulation is "unquestionably a final payment determination because it ***will reduce*** the amount of Medicare DSH payment the Providers receive in FY 2024"[13] and that "[t]he impact is not hypothetical or speculative" based on the following:

1. "According to the Hospital Cost Report Information System (HCRIS), each Provider has ***historically*** qualified for and received Medicare DSH payments."[14]

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[7] *Id.*
[8] Medicare Contractors' Response to the EJR Request at 1 (Oct. 6, 2023).
[9] *See infra* note 46 and accompanying text.
[10] Board's Dismissal Letter at 14 (Oct. 25, 2023). The Statutory and Regulatory Background related to DSH payments and Section 1115 Waiver Days was set forth in the Board's October 25, 2023 decision.
[11] Motion for Reinstatement at 1, 3.
[12] *Id.* at 1-2.
[13] *Id.* at 2 (emphasis added).
[14] *Id.* (emphasis added). K&S does not provide any of this "historical" data but rather includes as Exhibit P-2 to its Motion for Reinstatement a table that purports to list the empirical DSH payments each provider received over the *past* 10 years. A footer on the exhibit asserts that the source is "Hospital Cost Report Information System [HCRIS], Worksheet E, Part A, Line 34 ("Disproportionate Share Adjustment")." However, the HCRIS is a CMS database

2. All but one Provider in these appeals "is ***projected*** [by the Secretary] to qualify" as a DSH hospital in FY 2024, the year under appeal.[15]

3. The historical HCRIS data "also shows that each Provider has ***historically*** treated uninsured patients who qualified for and received charity discounts under the hospitals' financial assistance policies—the very population of patients covered by the Texas Section 1115 waiver. Exhibit P-4."[16]

4. "The payment impact of the Secretary's new regulation is further corroborated by data from the Texas Department of Health and Human Services indicating that *each of the Providers has* ***historically*** *received* coverage payments from the Section 1115 UC pool authorized by the Texas Section 1115 Waiver for treating uninsured charity patients. Exhibit P-5."[17]

K&S claims that the Board's October 25, 2023 decision was "premature" because the Providers had no opportunity to respond to the Medicare Contractor's "jurisdictional challenge." K&S points out that Board Rule 44.6 addresses the timing of jurisdictional challenges and the timing for responses thereto in group cases. Specifically, the Providers maintain that, under this Rule, the Board should have issued a scheduling order to allow for a response to the Medicare Contractor's October 6, 2023 filing. As a result, K&S requests reinstatement asserting that the Board issuing a decision prior to their response was fundamentally unfair and prejudicial.[18]

K&S references the Board's discussion of certain "factual gaps" and essentially characterizes that discussion as the Board stating that the filling of "the 'factual gaps' in the record [is] necessary for the Board to exercise jurisdiction" (*e.g.*, whether Texas even had an applicable § 1115 waiver program or whether the Providers in these appeals would ultimately be eligible for a DSH payment *for the FY 2024 and 2025 years at issue*). K&S then objects to the Board's dismissal based on those "factual gaps" and contends that dismissal was not an appropriate remedy for these "factual gaps" or deficiencies and implies that the Board could have simply resolved these factual disputes, and that it would have been appropriate to allow the Providers to supplement the record to fill these gaps. Similarly, with respect to the EJR Request, K&S maintains that, if the Board found the request to be incomplete, the Board "must notify the provider that it is incomplete and provide instructions to supplement the request with the missing information or documents" per 42 C.F.R. § 405.1842(e)(3)(ii).[19] Even though the Providers disagree that the Board-identified "factual gaps" are barriers to jurisdiction, K&S submitted with the Motion for Reinstatement five (5) Exhibits "to

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based on uploads by CMS and/or the relevant Medicare contractor and, in connection with a particular hospital for a prior year (dependent on when uploads by the Medicare contractor/CMS occur), HCRIS will contain the as-filed cost report, any amended cost report if one has been accepted, the Notice of Program reimbursement ("NPR") if it has been issued, and any revised NPR if one has been issued. As a result, it is unclear where the information originates from within HCRIS (*e.g.*, as filed cost report vs. amended cost report vs. NPR vs. revised NPR) and whether it reflects the "final determination" of DSH payment as described at 42 C.F.R. § 412.106(i).

[15] *Id.* at 2, n.4.

[16] *Id.* (footnote omitted) (emphasis added).

[17] *Id.* (emphasis added).

[18] *Id.* at 3.

[19] *Id.* at 4.

address the Board's concerns" and "to demonstrate" that no such "factual gaps" exist.[20] These exhibits are described, in part above, and also included at Exhibit P-1 a copy of the CMS approval letter for the Texas § 1115 waiver program that the Providers contend is an uncompensated care pool and that the § 1115 waiver day policy codified in the FY 2024 IPPS Final Rule would otherwise exclude any patient care days covered by that program (in whole or in part) from being counted in the numerator of the Medicaid fraction.

K&S then moves to more substantive arguments as to why the regulatory amendments published in the FFY 2024 IPPS Final Rule qualify as an appealable "final determination of the amount of payment under subsection (d)."[21] More specifically, K&S asserts that the final rule "constitutes a final determination [the Secretary] will make no Medicare DSH payments to Providers attributable to Section 1115 UC pool days" and that, as a result, "[w]aiting for a MAC to settle a future cost report will not alter that result because the MACs are bound by this regulation."[22] Accordingly, K&S argues that any rule or regulation that fixes an aspect of IPPS payments is, as such, a final determination,[23] and that the new regulation fixes the Providers' reimbursement for the § 1115 Waiver days at issue at "zero."[24] K&S claims that the appeals here are distinguishable from those underlying the D.C. District Court's decision in *Memorial Hospital of South Bend v. Becerra* ("*Memorial Hospital*")[25] and the D.C. Circuit's decision in *Washington Hosp. Ctr. v. Bowen* ("*Washington Hospital*").[26] The Providers state that *Memorial Hospital* held jurisdiction is proper over a Secretarial determination when it is ***either*** the only determination on which payment depended ***or*** clearly promulgated as a final rule.[27] They posit that the final determination here was a clearly promulgated final rule, while the determinations in *Memorial Hospital* and *Washington Hospital* were not.[28]

The Providers also attempt to distinguish the current challenge to those made in the recent Board dismissal in *Tampa Gen. Hosp.* related to the FFY 2024 IPPS Final Rule on Part C days.[29] They claim that, "while the policy at issue in [the Part C Days Rule] appeal impacted 'one of many variables' in calculating DSH payments, the same is not true in this case. The Secretary's final

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[20] *Id.* at 2, 4.
[21] *Id.* at 4.
[22] *Id.*
[23] *Id.* at 5 (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)).
[24] *Id.* at 4. K&S runs through an example involving Hendrick Medical Center ("Hendrick") and asserts that Hendrick "has historically qualified for Medicare DSH, Exhibit P-2, is projected by the Secretary to qualify or Medicare DSH in FY 2024, Exhibit P-3, has historically provided hospital services as charity care to uninsured individuals, Exhibit P-4, and has historically received payments from the UC pool authorized by the Texas Section 1115 waiver to cover services rendered to such patients. Exhibit P-5." Accordingly, K&S states that "[Hendrick] ***projects*** *that it will qualify* for Medicare DSH in FY 2024 ***and*** *will treat* uninsured charity patients who qualify for coverage under the Texas UC pool"; and that "[b]ased on data from its most recently filed cost report, [Hendrik] calculated a good faith estimate that the inclusion of Section 1115 UC pool days in its Medicaid fraction would increase its Medicare DSH payment by $205,128 in FY 2024." (Emphasis added.)
[25] No. 20-3461, 2022 WL 888190 (D.D.C. Mar. 25, 2022).
[26] 795 F.2d 139, 148 (D.C. Cir. 1986).
[27] Motion for Reinstatement at 7 (citing *Memorial Hospital*, 2022 WL 888190 at *8).
[28] *Id.* at 7-8.
[29] *Id.* at 8.

rule regarding Section 1115 days fixes the payment rate for Section 1115 days at zero and it 'cannot be revised.'"[30] They also claim that the inability to "forecast" the *actual* or exact amount in controversy does not divest the Board of jurisdiction,[31] as the same issue was present in appeals of the Two-Midnight rate reduction issue and the rural floor budget neutrality adjustment issue, each for which the Board routinely granted EJR.[32]

Medicare Contractor's Response to Motion for Reinstatement:

On November 8, 2023, the Medicare Contractor filed a Response to Providers' Motion for Reinstatement. It argues that its responsive filing to the EJR Request was not a "jurisdictional challenge," but rather a response to the EJR Request. As such, it claims that the rules governing "jurisdictional challenges" and requiring the Board issue a scheduling order for the Providers to respond are not applicable. Instead, the governing rules are those related to EJR Requests and responses thereto, which do not permit the Providers to file a response to the Medicare Contractor.

With regard to the Providers' argument that the Board should have permitted them to supplement the record to cure factual gaps, the Medicare Contractor states the following:

> *The Providers' motion essentially notes that both their appeal and their request for EJR were* ***incomplete*** but claims that the Board was obligated to provide them with opportunities to correct or supplement the record prior to issuing a substantive decision. *Nothing* in the Board rules *requires* that the Providers be given *opportunities to correct* ***incomplete*** *appeals* ***or*** *EJR requests*. Board Rule 4.1 notes that the Board "will dismiss appeals that fail to meet the timely filing requirements and/or jurisdictional requirements" and that "[t]he Board may review jurisdiction on its own motion at any time." Nothing in the Board rules mandates the entry of a scheduling order in response to an "own motion" review of jurisdiction.[33]

Finally, the Medicare Contractor supports the Board's dismissal and denial of EJR by asserting that "nothing in their motion supports reversal of the Board's prior decision." It notes that, even in the Motion for Reinstatement, the Providers recognize that at least one Provider is not projected to qualify for a DSH payment. The Medicare Contractor continues to question the Providers' ability to meet the amount in controversy, especially considering the uncertain nature of many DSH formula variables for a cost reporting period that has not yet concluded. Specifically, "[t]he Provider's *blanket assertion* that it ***will*** *meet* the amount in controversy requirement, set against the backdrop of multiple, unknown variables, falls flat."[34] It concludes that the appeals are premature and an appeal in this instance would be more appropriate after the Providers' cost reports are finalized.

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[30] *Id.* (citing *Abbott-Nw. Hosp. v. Leavitt*, 377 F. Supp. 2d 119, 127 (D.D.C. 2005)).
[31] *Id.* at 5, 8-9 (citing to *Georgetown Univ. Hosp. v. Sullivan*, 934 F.2d 1270, 1284, n.6 (D.C. Cir. 1991)).
[32] *Id.* at 9 (citing *Shands*, 139 F. Supp. at 240 and *Cape Cod*, 6040 F.3d at 205).
[33] Medicare Contractor's Response to Motion for Reinstatement at 2 (Nov. 8, 2023) (emphasis added).
[34] *Id.* (emphasis added).

Decision of the Board:

The Providers filed their Motion for Reconsideration requesting that the Board reconsider its jurisdictional dismissal and reinstate the Provider's appeal under Board Rule 47.1 which reflects the reopening process in 42 C.F.R. §§ 405.1885 and 405.1889. As set forth below, the Board denies the Motion.

A. Board Rules and Regulations Reviewed in Considering the Request:

In considering the request, the Board reviewed the following regulations and Board Rules of which relevant excerpts are included in Appendix A:

1. *42 C.F.R. § 405.1840* addressing "Board jurisdiction."

2. *Board Rule 4.1* addressing the general requirements for Board Jurisdiction and specifies that the Board may review jurisdiction at any time.

3. *Board Rule 16.2* confirming that participants in a group directly added to a group must meet the requirements for filing an individual appeal request under Board Rules 6 to 8 (which implement 42 C.F.R. § 405.1835).

4. *Board Rule 7* addressing the support required for an individual appeal request consistent with 42 C.F.R. § 405.1835(b) or (d) as applicable.

5. *42 C.F.R. § 405.1835(b)* addressing the minimum content requirements that an appeal request meet.

6. *42 C.F.R. §§ 405.1837(c), (e)(2)* confirming the minimum content requirements for a group appeal request and that the Board may make jurisdictional findings **at any time** (regardless of whether requested by the group representative).

7. *Board Rules 8 and 14* confirming that an acknowledgement of an appeal request (individual or group) does not limit the Board's ability to later dismiss an appeal for being jurisdictionally deficient.

8. *Board Rule 20* specifying that, in situations where OH CDMS lists all participants behind the Participants tab, then the group representative must file a statement within 60 days following full formation of the group "certifying" that OH CDMS lists all participants in the group behind the participants tab and includes **all** relevant supporting jurisdictional documentation for each participant in the group.

9. *Board Rule 42* addressing, in part, the content requirements for an EJR request.

10. *42 C.F.R. § 405.1842* governing EJR requests.

11. *Board Rule 44.6* addressing how jurisdictional challenges are handled in a group case when an EJR request is filed concurrent with the Rule 20 certification.

12. *Board Rule 47.1* addressing motions for reinstatement.

B. Board Analysis and Findings:

1. The Board was not required to give the Providers an opportunity to file a reply to the Medicare Contractor's Response to the EJR request prior to dismissing these seven (7) cases.

In the cover letter to its motion for reinstatement, K&S contends that "[r]einstatement is required because, contrary to the governing regulations and Board rules, the Board did not afford the Providers an opportunity to respond to the MAC's jurisdictional challenge" and that "[f]ailing to give Providers the opportunity to respond to the MAC's challenge is fundamentally unfair and prejudicial to Providers who reasonably relied on Rule 44.6 and awaited a Scheduling Order before responding to the MAC's challenge."[35] K&S also contends that the Board determined that the EJR request is incomplete due to "factual gaps" regarding jurisdiction and that, as a result, "the Board ***must*** *notify* the provider that the [EJR] request is incomplete and provide instructions to supplement the request with the missing information or documents" pursuant to 42 C.F.R. § 405.1842(e)(3)(ii).[36]

The Board disagrees with K&S' contentions. In reviewing the Motion for Reconsideration, the Appeal requests for the seven (7) group cases, and the above regulations and Board Rules, the Board makes the following comments on the procedural history of these seven (7) group cases:

a. The Providers' group appeal requests for these seven (7) group cases were all filed on the ***same*** day[37] and did not address the Board's jurisdiction over the cases and the participants therein, *notwithstanding* instruction in Board Rule 7.2 and 42 C.F.R. §§ 405.1835(b)(1) that they do so, *and notwithstanding* the facts that: (a) 42 C.F.R. § 405.1840 specifies that the Board "***must*** determine" its jurisdiction over an appeal "***[a]fter*** a request for a Board hearing [individual or group] is filed"[38]; and (b) 42 C.F.R. § 405.1835(b) specifies that "the Board ***may dismiss*** with prejudice ***the appeal*** or take any other remedial action it considers appropriate" "if the provider submits a hearing request that does not meet the requirements of paragraph (b)(1)."

[35] Motion for Reconsideration at ().
[36] *Id.* at 4 (emphasis added).
[37] All the cases were filed between 2:05 pm and 5:29 pm EDT on September 29, 2023.
[38] (Emphasis added.) The group issue statement for these appeals only contains references to certain Medicare regulatory provisions and certain case law addressing the inclusion of § 1115 waiver days in the DSH adjustment under the IPPS.

b. In ***each*** of these group cases, ***less than*** *4 hours after the group appeal request was filed*, K&S made the following filings: (a) designated the relevant group fully formed; ***and*** (b) filed "Certification that Group is Complete and Fully Populated on OH CDMS" with "the Providers in the [] group appeal certify[ing] that ***all*** *the relevant* ***supporting jurisdictional documentation*** for this group has been fully populated in OH CDMS"[39]

c. 42 C.F.R. § 405.1837(e)(2) specifies that "The Board *may make* ***jurisdictional findings*** *under § 405.1840* ***at any time***, including, but not limited to, following a request by the providers for the jurisdictional findings." Similarly, Board Rule 4.1 confirms that "[t]he Board may review jurisdiction on its own motion ***at any time***."[40] The D.C. District Court recently confirmed this fact in its 2022 decision in *Memorial Hosp. of South Bend v. Becerra*, No. 20-3461, 2022 WL 888190 at *10 (D.D.C. Mar. 25, 2022).[41]

d. Notwithstanding Board Rule 42.3 which requires an EJR Request to contain "a ***fully developed*** narrative" that, among other things, "[d]emonstrates that the Board has jurisdiction."[42] the Providers' EJR Request only *briefly* addresses their alleged right to appeal the codification of the § 1115 waiver day policy in FFY 2024 IPPS Final Rule by asserting that *"*[t]he Board has ***jurisdiction*** over these appeals pursuant to [42 U.S.C. § 1395oo(a)]" *because* "***[a]ll*** the Providers *filed their appeals* ***under [§ 1395oo(a)(1)(A)(i)]***"[43] (as opposed to § 1395oo(a)(1)***(A)(ii)*** which they are now asserting the Motion for Reconsideration). The EJR Request then asserts that "[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 that is appealable to the Board pursuant to

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[39] (Emphasis added.)

[40] (Emphasis added.)

[41] Specifically, the Court in *Memorial Hospital* states the following at 2022 WL 888190 at *10:

> Plaintiffs also contend that the PRRB's delay stymied them from pursuing relief in other ways. The hospitals were no doubt exceedingly frustrated by waiting eleven years for a resolution of their appeal, only to have it *sua sponte* dismissed by the PRRB. The Board could certainly have acted with greater alacrity, but *no matter its pace,* ***the PRRB was still obligated to determine if it had jurisdiction*** *and, if not, to "dismiss[ ] the appeal," as it did here*. See 42 C.F.R. § 405.1840(c)(2); id. at § 405.1840(a)(4). Plaintiffs argue that jurisdictional issues could have been raised earlier—such as when the PRRB acknowledged receipt of the appeal in 2009 . . . —and that they could have been allowed to brief the jurisdictional issue prior to dismissal. . . . They also note that the MAC told the PRRB when the case was initially filed that "no jurisdictional impediments exist for these providers." . . . *While the hospitals may feel sandbagged, the PRRB's rules explicitly state that "[a]n acknowledgement does not limit the Board's authority . . . to dismiss the appeal if it is later found to be jurisdictionally deficient."* CMS, PRRB Rule 9 (Aug. 29, 2018), https://go.cms.gov/3vEW0LW. And the Board's acknowledgement of receipt was purely procedural and did not address the merits of the appeal. ***The Board, moreover, is allowed to "review jurisdiction on its own motion at any time."*** CMS, PRRB Rule 4.1 (Aug. 29, 2018), https://go.cms.gov/3vEW0LW. There was thus nothing improper about its dismissing the hospitals' claims on its own motion, although it admittedly could have done so sooner.

(Underline emphasis in original and bold and italics emphasis added.)

[42] (Emphasis added.)

[43] Providers' EJR Request at 11 (Sept. 29, 2023) (emphasis added). The EJR request does ***not*** reference the right to appeal under 42 U.S.C. § 1395oo(a)(1)(A)(ii) as the Providers are ***now*** asserting in their Request for Reinstatement.

section 1878(a)"[44] and that principle is true of the Secretary's codification of the § 1115 waiver days policy as part of the FFY 2024 IPPS Final Rule. They then conclude that, "[b]y 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)."[45]

e. The Medicare Contractor filed its Response to the EJR Request ("Response") within five (5) business days of the EJR request. The filing was not styled as a "Jurisdictional Challenge" but rather as a "Response to Providers' EJR Request." Similar to the Provider's discussion of jurisdiction in the EJR Request, the Response is brief at 5 paragraphs (barely a page long) and without any specific citations outside of generic citations to the final rule at issue and 42 U.S.C. § 1395oo. There was nothing preventing K&S from filing a reply to the Response in the 19 days (12 business and 7 nonbuisness days) *before* the Board issued its October 26, 2023 Dismissal Determination; however, K&S did not do so.[46]

f. The "Decision" section of the Board's October 26, 2023 Dismissal Determination does ***not*** discuss or rely on the Medicare Contractor's Response to the EJR Request (much less "grant" any request made by the Medicare Contractor therein).[47] Rather, the focus of the "Decision" section is on whether the FFY 2024 IPPS Final Rule is an appealable "final determination" within the context of 42 U.S.C. § 1395oo(a)(1)(A)(ii) and 42 C.F.R. § 405.1835 *as directed by 42 C.F.R. § 405.1840(a)*.

Further, based on its review of the Board's Rules and governing regulations and the above comments, the Board makes the findings set forth below. First, the Board disagrees with the Providers' assertion that the Board violated its own Rules by dismissing these appeals and denying its EJR Request before it had filed a reply to the Medicare Contractor's October 6, 2023 filing. Consistent with 42 C.F.R. §§ 405.1840 and 405.1837(e)(2), Board Rule 4.1 (Nov. 2021) clearly explains that the "Board may review jurisdiction on its own motion at any time." Rule 42.3 (Content of the EJR Request) clearly states that any EJR Request must contain "a ***fully developed***

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[44] *Id.* (citing: "*See Washington Hosp. Ctr. v. Bowen*, 795 F.2d at 144-48 (D.C. Cir. 1986); *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)").

[45] *Id.*

[46] While business days are noted, electronic filings may be made in OH CDMS on any nonbusiness day at any hour unless there is scheduled maintenance (which occurs after normal business hours or on weekends as noted in Board Rule 2.1.1). Accordingly, there were 7 additional nonbusiness days occurring between the Medicare Contractor's filing (3 weekends and 1 holiday) and the Board Dismissal Determination, *resulting in a total of 19 days between the filing of the Response and the Dismissal Determination* (*i.e.,*12 business days + 7 nonbusiness days).

[47] The Board notes that the Medicare Contractor referenced another recent dismissal that the Board made in another case but did not give a citation. The citation is as follows: 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/listprrb-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)).

narrative" that, among other things, "[d]emonstrates that the Board has jurisdiction."[48] If a request for EJR does not clearly demonstrate that the Board has jurisdiction, the request is deficient and it may be denied by the Board.[49] The Board is permitted to review jurisdiction over any appeal *without input from any party* as confirmed by the decision of the D.C. District Court in *Memorial Hospital*.[50] In further support of its position, the Board notes that: (1) under Board Rules and regulations cited above, the Providers had an obligation to demonstrate the Board's jurisdiction over these appeals both in their appeal request ***and*** in their EJR request; and (2) concurrent its filing of the EJR request, K&S filed certification *in each group* that the OH CDMS record contains "***all*** *the relevant* ***supporting jurisdictional documentation*** for this group."[51] However, it failed to do so.

Indeed, the Board's dismissal was made within 27 days of the appeal request (as well as the EJR request) and dismissed the appeal consistent with 42 C.F.R. § 405.1840(a)(1) which specifies "*[a]fter a request for hearing is filed* under § 405.1835 or § 405.1837 of this part, the Board ***must*** *determine* in accordance with paragraph (b) of this section, whether or not it has jurisdiction to grant a hearing on each of the specific matters at issue in the hearing request." The criteria in § 405.1840(b) specifies that "[t]he Board has jurisdiction to grant a hearing over a specific matter at issue in an appeal ***only if*** *the provider has a right to a Board hearing* as a single provider appeal under § 405.1835 of this subpart or as part of a group appeal under § 405.1837 of this subpart, as applicable." Here, the Board determined that, shortly after the appeal request was filed, the Providers did not have the right under 42 U.S.C. § 1395oo(a)(1)(A)(ii) to appeal codification of the § 1115 waiver day policy from the FFY 2024 IPPS Final Rule. Consistent with § 405.1840(a)(1), the Board would have issued the Dismissal Determination for these cases (*irrespective of whether the Providers had filed their EJR request concurrent with their appeal requests*). Unfortunately, the Providers conflated the appeal request with the EJR Request by filing them at the same time. Regardless of whether the Board is correct in finding no procedural deficiency or error, the Providers have had an opportunity to present those additional arguments (plus others) to the Board in its Motion for Reconsideration.

Second, the Providers mischaracterize the Board's discussion on "factual gaps." Contrary to the Providers' assertion, these "factual gaps" did ***not*** "prevent[] [the Board] from determining whether it had jurisdiction over the appeals." The Dismissal Determination discusses four (4) "factual gaps or flaws" that "demonstrate that the final rule was not an appealable final determination" because this information must be determined before any "final determination" of DSH payment can be made. The Providers' attempts to supplement the record to try to fill these gaps/flaws does not and cannot change the fact that, *for purposes of 42 U.S.C. § 1395oo(a)(1)(A)(ii)*, the final rule itself does not address these gaps/flaw and, as such, cannot be a "final determination" of the Providers' eligibility for a DSH payment *for FY 2024 (and FY 2025 as relevant*[52]) and, if so, how much.

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[48] (Emphasis added.)
[49] *See* 42 C.F.R. § 405.1868(b) (permitting dismissal or other remedial action for failure to meet requirements established by the Board); Board Rule 41.2 (permitting dismissal of a case or issue for failure to comply with Board procedures).
[50] *See supra* note 41 and accompanying text.
[51] Moreover, while the Board did not issue a scheduling order, K&S had 12 business days (19 calendar days) between that filing and the Board's Dismissal Determination but did not file anything.
[52] *See supra* note 3.

Indeed, K&S' ***belated*** attempt to supplement the record through its Motion for Reconsideration demonstrates the extent to which the EJR Request was *fatally flawed*, notwithstanding the requirement in Board Rule 42.3 that an EJR Request contain "a ***fully developed*** narrative" that, among other things, "[d]emonstrates that the Board has jurisdiction."[53] Even if the Board were to have jurisdiction (which it does not), the fact that *neither* the FFY 2024 IPPS Final Rule, the appeal request, *nor* the EJR Request identify the *specific* § 1115 waiver program(s) at issue highlights how the Providers failed to develop the record for this case prior to filing the EJR Request. In situations where the Board has jurisdiction in a case and the Board proceeds with processing and ruling on an EJR request, the Board has no obligation to give the provider an opportunity to cure a *fatally flawed* EJR request (such as the one here), but rather may deny the EJR request pursuant to 42 C.F.R. § 405.1842(f)(2)(iii).[54] In this regard, the Board notes that Rule 42.3 also requires that any EJR must "[d]emonstrate[] that there are ***no*** *factual issues* in dispute."[55] As such, even if the Board were to have jurisdiction (which it does not), the "factual gaps" identified by the Board in the EJR Request at issue independently made the EJR Request deficient and were a sufficient basis for the Board to deny the EJR Request itself.[56] Regardless of whether the EJR request itself was fatally flawed, the fact remains that the codification of the § 1115 waver day policy at issue is not a "final determination" under 42 U.S.C. § 1395oo(a)(1)(A)(ii) as confirmed in the October 26, 2023 Dismissal Determination.

2. The Board's October 26, 2023 Dismissal of the seven (7) Cases and Denial of the EJR Request Was Correct.

The Board notes that the alleged "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. As the Board explained in its October 26, 2023 Dismissal Determination, 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

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[53] (Emphasis added.)

[54] In situations where the Board has jurisdiction but denies an EJR request, the provider has an opportunity to refile the EJR request and cure any defects or flaws or missing information. Here, the Board never reaches the sufficiency of the EJR request because it lacks jurisdiction over the appeal requests in the first instance. As such, the Board declines to accept K&S ***belated*** supplementation of the record through the Exhibits attached to its Motion for Reinstatement.

[55] (Emphasis added.)

[56] The factual disputes would need to be addressed and resolved *prior to* Board consideration of an EJR request. For example, if the Board were to find jurisdiction and were to accept the Providers' *belated* supplementation of the record (neither of which it has), the Board would need to make a finding on whether the alleged Texas § 1115 waiver day program identified in Exhibit P-1 is in fact covered by the regulatory provision as alleged by the Providers since this finding is not made in the FFY 2024 IPPS Final Rule that the Providers have appealed. As K&S filed the EJR Request simultaneously with the appeal requests being filed, the parties have not had an opportunity to either confer regarding any factual issues (which could result in stipulations) or file position papers for this case. *See* 42 C.F.R. § 405.1853(a)-(b); Board Rules 23, 25, 35.1.

to the DSH adjustment being calculated "with respect to a [hospital's] cost reporting period."[57] 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.[58]

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***."[59]

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[57] 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.

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

[59] 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 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.
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> *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.
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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 (where final payment is determined and reimbursed through the cost report audit and settlement process) include bad debts,[60] direct graduate medical education ("GME"),[61] and indirect GME.[62] 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 . . . .";[63] 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."[64]

> **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).

[60] 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.).

[61] 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.").

[62] 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)).

[63] 795 F.2d at 143 (emphasis added).

[64] *Id.* at 147 (footnote omitted).

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[65]) "*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 **on the cost report*** for the relevant fiscal year:

> (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:
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> ****
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> (iv) **The hospital has the <u>burden</u> of furnishing data adequate to <u>prove</u> eligibility for <u>each</u> Medicaid patient day <u>claimed</u>** under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.[66]

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[65] 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.

[66] 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' <u>burden</u>** to furnish data adequate **to <u>prove</u> eligibility for <u>each</u> Medicaid patient day it <u>claims</u>** 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 <u>burden of proof</u>** and must verify with the State that a patient was eligible for Medicaid* (for some covered services) *during **<u>each</u** 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**<u>not</u>** be verified by State records* to have fallen within a period wherein the patient was eligible for Medicaid *can**<u>not</u>** be counted*." (emphasis added)); 80 Fed. Reg. 70298, 70559

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 distinguishable from the facts presented in the D.C. Circuit's decision in *Washington Hospital*[67] and *Cape Cod*.

(Nov. 13, 2015) ("We have identified only *one circumstance where a provider may have difficulty obtaining sufficient information to make an appropriate cost report claim within the allotted time* ***for cost report submission***. This circumstance may occur if a hospital experiences difficulty obtaining sufficient information from State agencies *for the purpose of* ***claiming*** *DSH Medicaid-eligible patient days*. Therefore, as explained below in our response to the next comment, we will instruct contractors, in this limited circumstance, that they must accept one amended cost report submitted within a 12-month period after the hospital's cost report due date, solely for the specific purpose of revising a claim for DSH by using updated Medicaid-eligible patient days, after a hospital receives updated Medicaid eligibility information from the State." (emphasis added)).

[67] 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)).

The Board recognizes that, in the 2022 *Memorial Hospital* and 2023 *Battle Creek* decision, the D.C. District Court addressed the Board's jurisdiction over appeals based on the publication of the SSI fractions[68] (another variable used in the DSH calculation) and reached different conclusions. In the instant case, the Board declines to follow D.C. District Court's 2023 decision in *Battle Creek* and instead finds the D.C. District Court's 2022 decision in *Memorial Hospital* to be instructive.[69] While the D.C. District Court's 2022 decision in *Memorial Hospital* also concerns the publication of SSI fractions, the Board finds it instructive based on its thoughtful application of the D.C. Circuit's decision in *Washington Hospital*. 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

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[68] The Board also recognizes that the publication of the SSI ratios was at issue in *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) ("*Allina II*"). However, *Allina II* has no relevance to the ***jurisdictional*** issue being addressed here. First, the *Allina II* 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)*). Further, the Board takes administrative notice that the Complaint filed to establish the *Allina II* litigation makes clear that ***none*** of the nine (9) Plaintiff hospitals based their right to appeal on the publication of the SSI fractions pursuant to 42 U.S.C. § 1395oo***(a)(1)(A)(ii)***. Rather, the Complaint makes clear that each of the nine (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). *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)). 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 the Providers have the right to appeal the policy at issue published in the FFY 2024 IPPS Final Rule pursuant to 42 U.S.C. § 1395oo***(a)(1)(A)(ii)***.

[69] 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. Further, the Board notes that the Secretary's handling of the Part C days policy change announced in the June 9, 2023 final rule (88 Fed. Reg. 37772 (June 9, 2023)) supports the Board's findings here as that final rule only discussed hospital appeal rights from an NPR or RNPR to be issued following the publication of revised SSI fractions. Specifically, in finalizing that the recent Part C days policy adoption in the June 2023 Final Rule, the Secretary announced that "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." 88 Fed. Reg. at 37788 (emphasis added).

determination on which payment depended or clearly promulgated as a final rule."[70] 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*."[71] 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).").[72]

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.[73]

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 FFY 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"[74] 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).[75] More specifically, here, each of the Providers are asserting that certain

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[70] 2022 WL 888190 at *8.
[71] *Id.* at *9 (emphasis added).
[72] *Id.* at *8.
[73] *Id.* at *9. The Board also recognizes that, in their Motion at 6-7, 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 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).
[74] 42 C.F.R. § 412.106(i)(2) (emphasis added).
[75] 2022 WL 888190 at *9 (emphasis added).

unspecified § 1115 waiver days[76] 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. In its October 25, 2023 Dismissal Determination, the Board listed certain factual gaps or flaws *to demonstrate that the promulgation of the policy at issue in the FFY 2024 IPPS Final Rule* was not an appealable reimbursement "determination" which will not occur until a "***final** [DSH] payment* determination"[77] is made consistent with 42 C.F.R. § 412.106(i) as part of the cost report audit/settlement process. K&S subsequent (and belated) attempts in its Motion for Reconsideration to address these gaps/flaws cannot change the fact that the codification of the new § 1115 waiver day policy in the FY 2024 IPPS Final Rule is not an appealable "final determination" for purposes of 42 U.S.C. § 1395oo(a)(1)(A)(ii) or 42 C.F.R. § 405.1835(a).[78]

* * * * *

In summary, the Board is not persuaded by the arguments presented in the Motion for Reconsideration and hereby affirms its October 25, 2023 finding that the FFY 2024 IPPS Final Rule appealed in these seven (7) group cases 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. Based on the foregoing, the Board ***denies*** the Providers' Motion for Reinstatement filed on October 31, 2023.

Board Members Participating:

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

For the Board:

12/14/2023

X Clayton J. Nix

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

cc: Michael Redmond, Novitas Solutions, Inc. (J-H), (J-L)
Byron Lamprecht, WPS Government Health Administrators (J-5)
Wilson Leong, FSS
Jacqueline Vaughn, OAA

[76] *See supra* notes 65 and 66 and accompanying text; Board's October 25, 2023 Dismissal Determination at 13-14 (describing how the class of § 1115 waiver days alleged to be issue in the case are unspecified and undefined *for the fiscal years at issue* not only from the four corners of the FY 2024 IPPS Final Rule being appealed but also from the four corners of the appeal request and EJR request).
[77] 42 C.F.R. § 412.106(i)(2) (emphasis added).
[78] To the extent this information was relevant (which the Board finds it is not), it should have been included with the appeal request or, at a minimum, with the EJR request as discussed *supra*.

APPENDIX A

Excerpts from Relevant Board Rules & Regulations

1. *42 C.F.R. § 405.1840*—This regulation addresses "Board jurisdiction" and states, in pertinent part:

> (a) *General rules*. (1) **After a request for a Board hearing is filed** under § 405.1835 or § 405.1837 of this part, the Board **must determine in accordance with paragraph (b)** of this section, **whether or not it has jurisdiction to grant a hearing** on each of the specific matters at issue in the hearing request. . . .
>
> (b) *Criteria*. Except with respect to the amount in controversy requirement, **the jurisdiction of the Board to grant a hearing** must be determined separately for each specific matter at issue in each contractor or Secretary determination for each cost reporting period under appeal. The Board has **jurisdiction to grant a hearing** over a specific matter at issue in an appeal **only if the provider has a right to a Board hearing** as a single provider appeal under § 405.1835 of this subpart or as part of a group appeal under § 405.1837 of this subpart, as applicable. . . .
>
> (c) *Board's jurisdictional findings and jurisdictional dismissal decisions*. (1) In issuing an EJR decision under § 405.1842 of this subpart or a hearing decision under § 405.1871 of this subpart, as applicable, the Board must make a separate determination of whether it has jurisdiction for each specific matter at issue in each contractor or Secretary determination under appeal. A decision by the Board must include specific findings of fact and conclusions of law as to whether the Board has jurisdiction to grant a hearing on each matter at issue in the appeal.
>
> (2) Except as provided in §§ 405.1836(e)(1) and 405.1842(f)(2)(i), where the Board determines it lacks jurisdiction to grant a hearing for every specific matter at issue in an appeal, it must issue a dismissal decision dismissing the appeal for lack of Board jurisdiction. The decision by the Board must include specific findings of fact and conclusions of law explaining the Board's determination that it lacks jurisdiction to grant a hearing on each matter at issue in the appeal. A copy of the Board's decision must be sent promptly to each party to the appeal (as described in § 405.1843).
>
> (3) A dismissal decision by the Board under paragraph (c)(2) of this section is final and binding on the parties unless the decision is

> reversed, affirmed, modified or remanded by the Administrator under § 405.1875(a)(2)(ii) and § 405.1875(e) or § 405.1875(f) of this subpart, no later than 60 days after the date of receipt by the provider of the Board's decision. **The Board decision is inoperative during the 60-day period for review of the decision by the Administrator**, or in the event the Administrator reverses, affirms, modifies or remands that decision within that period. **A final Board decision under paragraphs (c)(2) and (c)(3) of this section may be reopened and revised by the Board in accordance with §§ 405.1885 through 405.1889 of this subpart**.[79]

2. *Board Rule 4.1*—This Board Rule addresses the general requirements for Board Jurisdiction and specifies that the Board may review jurisdiction *at any time*:

> **4.1 General Requirements**
>
> *See* 42 C.F.R. §§ 405.1835 - 405.1840.
> The Board **will dismiss appeals that fail to meet** the timely filing requirements and/or **jurisdictional requirements**. A jurisdictional challenge (see Rule 44.4) may be raised at any time during the appeal; however, for judicial economy, the Board strongly encourages filing any challenges as soon as possible. **The Board may review jurisdiction on its own motion at any time**. The parties cannot waive jurisdictional requirements.

3. *Board Rule 16.2*—This Board Rule confirms that participants in a group directly added to a group must meet the requirements for filing an individual appeal request under Board Rules 6 to 8 (which implement 42 C.F.R. § 405.1835).

> **16.2 Filing Requirements for Requests to Join a Group Directly from a Final Determination**
>
> *A direct add request must include the same information required for a provider filing an individual appeal* (see Rules 6 through 8), including the determination and issue-specific information addressed in Rule 7, plus a copy of the representative letter associated with the group appeal. *This information must be provided* in order for the Board *to*

[79] (Bold and underline emphasis added.) *See also* 42 C.F.R. § 405.1845(e) (stating "(e) *Hearings*. The Board may conduct **a hearing** and issue a hearing decision (as described in §405.1871 of this subpart) on a specific matter at issue in an appeal, **provided it finds jurisdiction over the matter at issue in accordance with § 405.1840 of this part** and determines it has the legal authority to fully resolve the issue (as described in §405.1867 of this subpart)." (bold emphasis added)); Board Rule 4.1 (stating "*The Board **will dismiss** appeals that fail to meet* the timely filing requirements and/or *jurisdictional requirements*. . . . The Board may review jurisdiction on its own motion at any time." (emphasis added)).

> *confirm that the direct add request meets the requirements for a Board hearing*. See 42 C.F.R. §§ 405.1835(a), 405.1835(c), 405.1840(a).[80]

4. *Board Rule 7*—Board Rule 7 addresses the support required for an individual appeal request consistent with 42 C.F.R. § 405.1835(b) or (d) as applicable:

> **Rule 7 Support for Appealed Final Determination, Availability of Issue-Related Information and Basis for Dissatisfaction**
>
> *The provider must support the determination being appealed and the basis for its dissatisfaction* for each issue under appeal *consistent with 42 C.F.R. § 405.1835(b)* or (d) as applicable. . . .
>
> ****
>
> **7.2 Issue Related Information**
>
> **7.2.1 General Information**
> The following information and supporting documentation *must be submitted for each issue raised in the appeal request*.
>
> • An issue title and a concise issue statement describing:
> o the adjustment, including the adjustment number,
> o the controlling authority,
> o why the adjustment is incorrect,
> o how the payment should be determined differently,
> o the reimbursement effect, and
> o *the basis for jurisdiction before the PRRB*.
>
> • A copy of the applicable audit adjustment report page(s) or a statement addressing why an adjustment report is not applicable or available.
>
> • A calculation or other support for the reimbursement effect noted in the issue statement.
>
> • Support for protested items or claim of dissatisfaction as noted in Rules 7.3 and 7.4.
>
> **7.2.2. Additional Information**
> Providers *must* submit additional information not specifically addressed above *in order to support jurisdiction* or appropriate claim for the appealed issue(s).

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

> Example: Revised NPR workpapers and applicable cost report worksheets to document that the issue under appeal was specifically adjusted.[81]

5. *42 C.F.R. § 405.1835(b)*—This regulation addresses the minimum content requirements that an appeal request meet:

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

[81] (Bold emphasis in original and underline and italics emphasis added.) This Rule is based on 42 C.F.R. § 405.1835(a)-(b) and, in this regard, the Board notes that subsection (b)(1) states that an appeal request ***must*** include "*[a] demonstration that the provider* ***satisfies the requirements*** *for a Board hearing* as specified in paragraph (a) of this section, including a specific identification of the final contractor or Secretary determination under appeal." This necessarily includes whether the Board has substantive jurisdiction over the matter being appealed. *See* 42 C.F.R. § 405.1840(b) (emphasis added).

> for the item, and why the provider self-disallowed the item instead of claiming reimbursement for the item.
>
> (3) **A copy of the final contractor or Secretary determination under appeal and any other documentary evidence the provider considers necessary to satisfy the hearing request requirements of paragraphs (b)(1) and (b)(2) of this section**.[82]

6. *42 C.F.R. §§ 405.1837(c), (e)(2)*—Subsection (c) of this regulation specifies the minimum content requirements for a group appeal request and subsection (e)(2) confirms that the Board may make jurisdictional findings ***at any time*** (regardless of whether requested by the group representative).

> (c) *Contents of request for a group appeal*. The request for a Board hearing as a group appeal must be submitted in writing to the Board, and the request **must include** all of the following:
>
> (1) A demonstration that the request satisfies the requirements for a Board hearing as a group appeal, as specified in paragraph (a) of this section.
>
> (2) An explanation (for each specific item at issue) of each provider's dissatisfaction with the final contractor or Secretary determination under appeal, including an account of—
>
> (i) Why the provider believes Medicare payment is incorrect for each disputed item;
>
> (ii) How and why the provider believes Medicare payment must be determined differently for each disputed item; and
>
> (iii) If the provider self-disallows a specific item (as specified in § 413.24(j) of this chapter), an explanation of the nature and amount of each self-disallowed item, the reimbursement sought for the item, and why the provider self-disallowed the item instead of claiming reimbursement for the item.
>
> (3) A copy of each final contractor or Secretary determination under appeal, and any other documentary evidence the providers consider to satisfy the hearing request requirements of paragraphs (c)(1) and (c)(2) of this section, and a precise description of the one question

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

> of fact or interpretation of law, regulations, or CMS Rulings that is common to the particular matter at issue in the group appeal.
>
> (4) **A statement that**—
>
> (i) The providers believe **they have satisfied <u>all</u> of the requirements for a group appeal hearing request** under paragraph (a) of this section **<u>and</u> requesting the Board to proceed to make jurisdictional findings <u>in accordance with § 405.1840</u>**; or
>
> (ii) The Board is requested to defer making jurisdictional findings until the providers request the findings in accordance with paragraph (e)(2) of this section.[83]
>
> ****
>
> (2) **The Board <u>may make jurisdictional findings</u> under § 405.1840 <u>at any time</u>, including, but not limited to, following a request by the providers for the jurisdictional findings**. The providers may request jurisdictional findings by notifying the Board in writing that the group appeal is fully formed, or that the providers believe they have satisfied all of the requirements for a group appeal hearing request, and the Board may proceed to make jurisdictional findings. The providers must include with the notice any additional information or documentary evidence that is required for group appeal hearing requests. The Board does not dismiss a group appeal hearing request for failure to meet the $50,000 amount in controversy requirement until the Board has determined, in accordance with paragraph (e)(1) of this section, that the group is fully formed.[84]

7. *<u>Board Rules 8 and 14</u>*—These Board Rules confirm that acknowledgement of an appeal request (individual or group) does not limit the Board's ability to later dismiss an appeal for being jurisdictionally deficient:

> **Rule 9 Board Acknowledgement of Appeals**
>
> The Board will send an acknowledgement notice via email to the designated representative confirming receipt of the appeal request and identifying the case number assigned. *Such an acknowledgement notice does <u>not limit the Board's authority</u>* to require more information or *<u>to dismiss the appeal</u>* if it is later found to be jurisdictionally deficient. *If the appeal request does not*

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

> *comply with the filing requirements, the Board may dismiss the appeal or take other remedial action*.
>
> ****
>
> **Rule 14 Acknowledgement of Group Appeal**
>
> The Board will send an Acknowledgement and Critical Due Dates Notice via email to the group representative and the lead Medicare contractor confirming receipt of the group appeal and the case number assigned. *Such an acknowledgement notice does not limit the Board's authority* to require more information or *to dismiss the appeal* if it is later found to be jurisdictionally deficient. *If the provider's appeal does not comply with the filing requirements, the Board may dismiss the appeal or take other remedial action*.[85]

8. *Board Rule 20*—This Board Rule specifies that, in situations where OH CDMS lists all participants behind the Participants tab, then the group representative must file a statement within 60 days following full formation of the group "*certifying*" that OH CDMS lists all participants in the group behind the participants tab and includes ***all*** *relevant supporting jurisdictional documentation* for each participant in the group:

> **Rule 20 Group Schedule of Providers and Supporting Documentation – Procedure**
>
> If ***all*** the participants in a fully-formed group are ***populated*** under the Issues/Providers Tab in OH CDMS with supporting jurisdictional documentation (*see* Rule 21), then the representative is exempt from filing a ***hard copy*** of the schedule of providers with supporting jurisdictional documentation. In this instance, the Board uses the schedule of providers and supporting jurisdictional documentation that is created in OH CDMS using the information and documents included in each participating provider's request for transfer or direct add to the group.
>
> ***Prior to*** *certifying that the group is fully formed or the date on which a group is fully formed*, the group representative should review each participating provider's supporting jurisdictional documentation to ensure it is complete and, if not, file any additional documentation in OH CDMS. If ***all*** of the participants in a fully-formed group are ***populated*** under the Issues/Providers Tab in OH CDMS, then ***within (60) sixty days of the full formation of the group***, the group representative must file a statement certifying that the group is *fully populated* in OH CDMS with the relevant supporting jurisdictional

[85] (Bold emphasis added and italics and underline emphasis added.)

documentation (*i.e*., all participants in the group are shown under the Issues/Providers Tab for the group in OH CDMS with the relevant supporting jurisdictional documentation).[86]

9. *Board Rule 42*—This Rule addresses, in part, the content requirements for an EJR request:

> **Rule 42 Expedited Judicial Review**
>
> **42.1 General**
> A provider or group of providers may bypass the Board's hearing process and obtain expedited judicial review ("EJR") for a final determination of reimbursement that involves a challenge to the validity of a statute, regulation, or CMS ruling. Board jurisdiction must be established prior to granting an EJR request. Similarly, the Board must process and rule on any substantive claim challenges pertaining to the cost report at issue prior to granting an EJR request (*see* Rule 44.5). In an appeal containing multiple issues, EJR may be granted for fewer than all the issues, in which case the Board will conduct a hearing on the remaining issues. The Board will make an EJR determination within 30 days *after it determines whether it has jurisdiction and the request for EJR is complete*. *See* 42 C.F.R. § 405.1842.
>
> **42.2 Requests for EJR**
> Because an EJR request is time sensitive, the request for EJR is to be filed separately and clearly labeled. . . .
>
> **42.3 Content of the EJR Request**
> A provider or a group of providers must file a written request for EJR with a fully developed narrative that:
>
> - Identifies the issue for which EJR is requested;
> - *Demonstrates that there are no factual issues in dispute*;
> - *Demonstrates that the Board has jurisdiction*;
> - Identifies the controlling law, regulation, Federal Register notice, or CMS ruling that is being challenged; and
> - Explains why the Board does not have authority to decide the legal question posted by the appeal.

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

10. *42 C.F.R. § 405.1842*—This regulation governs EJR requests and states, in pertinent part:

> (d) *Provider requests*. A provider (or, in the case of a group appeal, a group of providers) may request a determination by the Board that it lacks the authority to decide a legal question relevant to a specific matter at issue in an appeal. A provider must submit a request in writing to the Board and to each party to the appeal (as described in § 405.1843 of this subpart), and the request must include—
>
> (1) For each specific matter and question included in the request, **an explanation of why the provider believes the Board has jurisdiction under § 405.1840 of this subpart over each matter at issue** and no authority to decide each relevant legal question; and
>
> (2) **Any documentary evidence the provider believes supports the request**.
>
> (e) *Board action on provider requests*. (1) **If the Board makes a finding that it has jurisdiction to conduct a hearing on a specific matter at issue in accordance with § 405.1840(a) of this part**, then (and only then) it must consider whether it lacks the authority to decide a legal question relevant to the matter at issue. The Board is required to make a determination of its authority to decide the legal question raised in a review request under paragraph (d)(1) of this section by issuing an EJR decision no later than 30 days after receiving a complete provider request as defined in paragraph (e)(2) of this section.
>
> (2) Requirements of a complete provider request. A complete provider request for EJR consists of the following:
>
> (i) A request for an EJR decision by the provider(s).
>
> (ii) All of the information and documents found necessary by the Board for issuing a decision in accordance with paragraph (f) of this section.
>
> (3) Board's response to provider requests. After receiving a provider request for an EJR decision, the Board must review the request, along with any responses to the request submitted by other parties to the appeal (as described in § 405.1843 of this subpart). The Board must respond to the provider(s) as follows:

(i) Upon receiving a complete provider request, issue an EJR decision in accordance with paragraph (f) of this section no later than 30 days after receipt of the complete provider request. If the Board does not issue a decision within that 30-day period, the provider has a right to file a complaint in Federal district court in order to obtain EJR over the specific matter(s) at issue.

(ii) If the provider has not submitted a complete request, issue no later than 30 days after receipt of the incomplete request a written notice to the provider describing in detail the further information that the provider must submit in order to complete the request.

(f) *Board's decision on EJR: Criteria for granting EJR*. Subject to paragraph (h)(3) of this section, the Board is required to issue an EJR decision following either the completion of the Board's own motion consideration under paragraph (c) of this section, or a notice issued by the Board in accordance with paragraph (e)(3)(i) of this section.

(1) The Board's decision must grant EJR for a legal question relevant to a specific matter at issue in a Board appeal if the Board determines the following conditions are satisfied:

(i) The Board has jurisdiction to conduct a hearing on the specific matter at issue in accordance with § 405.1840 of this subpart.

(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.

(2) **The Board's decision must deny EJR** for a legal question relevant to a specific matter at issue in a Board appeal **if <u>any</u> of the following conditions are satisfied**:

(i) **The Board determines that it does <u>not have jurisdiction</u> to conduct a hearing** on the specific matter at issue **in accordance with § 405.1840 of this subpart**.

(ii) The Board determines it has the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is neither a challenge to the constitutionality of a provision of a statute, nor a challenge to the substantive or procedural validity of a regulation or CMS Ruling.

> (iii) **The Board does <u>not</u> have sufficient information to determine whether the criteria specified in paragraph (f)(1)(i) or (f)(1)(ii) of this section are met**.

11. <u>*Board Rule 44.6*</u>—This Rule addresses how jurisdictional challenges are handled in a group case when an EJR request is filed concurrent with the Rule 20 certification (*i.e*., certification that OH CDMS contains the final Schedule of Providers with supporting jurisdictional documentation):

> **44.6 Special Rules for Filing Challenges (Jurisdictional or Substantive Claim) in Group Cases When an EJR Request is Filed within 60 Days of the Final Schedule of Providers**
>
> If the final schedule of providers for a group appeal is filed concurrently with an EJR request, or 60 days has not yet transpired between the filing of the final SOP and the EJR request, then the Medicare contractor (or any other moving party) has five (5) business days to either:
>
> 1. File any jurisdictional and/or Substantive Claim Challenge(s) related to the group appeal (or participants therein, as relevant); or
>
> 2. Submit a filing wherein the Medicare contractor certifies that it will, *in fact*, be filing a challenge(s) (whether to a Jurisdictional or Substantive Claim Challenge) related to the group appeal (or participants therein, as relevant) but it has not yet had an opportunity to complete its review of the final schedule of providers and to finalize the filing for the challenge(s).
>
> If the Medicare contractor files the certification described above in No. 2, then the Medicare contractor must file the challenge(s) ***no later than twenty (20) days following the filing of the EJR request***. <u>Following receipt of those challenges</u> (and consistent with 42 C.F.R. §§ 405.1842(e)(3), 405.1873(b)(1), and 405.1873(d)(2) and Board Rule 42.1), <u>the Board will issue a Scheduling Order</u> setting a deadline for the Provider's response and will confirm therein that the 30-day period for the Board to rule on the EJR request has been stayed because the EJR request is incomplete and the Board does not yet have all the information necessary to rule on the EJR request. NOTE: If the Medicare contractor files the certification, then the failure of the Medicare contractor to file any challenges within the 20-day deadline will be grounds for the Board to take remedial action pursuant to 42

> C.F.R. § 405.1868(c)(1), unless the Medicare contractor establishes good cause.[87]

12. *Board Rule 47.1*—This Rule addresses motions for reinstatement:

> **47.1 Motion for Reinstatement**:
> A provider may request reinstatement of an issue(s) or case within three years of the date of the Board' 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.[88]

[87] (Bold and italics emphasis in original and underline emphasis added.)
[88] (Underline and italics emphasis added.) *See also* 42 C.F.R. § 405.1885 (entitled, in pertinent part, "Reopening a . . . reviewing entity decision" and stating in subsection (a) that "a decision by a reviewing entity (as described in § 405.1801(a)) may be reopened, with respect to specific findings on matters at issue in a determination or decision . . . by the reviewing entity that made the decision (as described in paragraph (c) of this section).")

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

Byron Lamprecht
WPS Government Health Administrators
1000 N 90th Street, Suite 302
Omaha, NE 68114

RE: ***Board Decision***
Byrd Regional Hospital (Prov. No. 19-0164)
FYE: 07/31/2017
Case No.: 20-0080

Dear Mr. Summar and Mr. Lamprecht:

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the documentation in Case No. 20-0080 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. 20-0080*

On April 2, 2019, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end July 31, 2017.

On September 30, 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[2]
4. UCC Distribution Pool
5. 2 Midnight Census IPPS Payment Reduction[3]

As the Provider is owned by Community Health Systems, Inc. (hereinafter "CHS") and, thereby, subject to the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1), the Provider transferred Issues 2 and 5 to CHS groups on April 21, 2020. After the withdrawal of Issue 3, the remaining issues in this appeal are Issues 1 and 4.

[1] On April 21, 2020, this issue was transferred to PRRB Case No. 20-0997GC.
[2] This issue was withdrawn on March 2, 2023.
[3] On April 21, 2020, this issue was transferred to PRRB Case No. 20-0997GC.

On May 22, 2020, the Provider submitted its preliminary position paper.

On August 5, 2020, the Medicare Contractor filed a jurisdictional challenge, requesting the dismissal of Issues 1 and 4.

On September 9, 2020, the Medicare Contractor filed its preliminary position paper.

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 April 21, 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 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

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

> 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 $3,000.

On May 22, 2020, the Provider filed its preliminary position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Provider Specific**
>
> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation based on the Provider's Fiscal Year End (July 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

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

> 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]

MAC's Contentions

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

The MAC argues that the Board lacks jurisdiction over the DSH – SSI Percentage (Provider Specific) issue for two reasons. First, the MAC argues that the SSI realignment portion of the issue is premature:

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

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

Issue 4 – UCC Distribution Pool

The MAC argues "that the Board does not have jurisdiction over the UCC DSH payment issue because jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2)."[9]

[6] Provider's Preliminary Position Paper at 8-9 (May 22, 2020).
[7] Jurisdictional Challenge at 6 (Aug. 5, 2020).
[8] *Id*. at 4-5.
[9] *Id*. at 9.

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 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."

Analysis and Recommendation

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2020), 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 dismisses the DSH Payment/SSI Percentage (Provider Specific) issue. The analysis for Issue No. 1 has two relevant aspects to consider: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, and 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

1. *First Aspect of Issue 1*

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

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."[11] 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)."[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]

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

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

In making this finding, the Board further notes that CMS regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, is pursuing that issue as part of the group under Case 20-0997GC. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[14] Provider is misplaced in referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 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.

[14] 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).

> Once the documents become available, promptly forward them to the Board and the opposing party.[15]

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

> https://www.cms.gov/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]

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

2. *Second Aspect of Issue 1*

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

[15] (Emphasis added).
[16] Last accessed February 24, 2023.
[17] Emphasis added.

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 dismisses 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:

> (A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).[18]
>
> (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*"),[19] the U.S. Court of Appeals for the District of Columbia Circuit ("D.C. Circuit") upheld the D.C. District Court's decision[20] 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.

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[18] 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.
[19] 830 F.3d 515 (D.C. Cir. 2016).
[20] 89 F. Supp. 3d 121 (D.D.C. 2015).

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."[21] 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.[22]

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.[23]

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*").[24] 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."[25] 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.[26]

c. Scranton Quincy Hosp. Co. v. Azar

Recently, in *Scranton Quincy Hosp. Co. v. Azar* ("*Scranton*"),[27] 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.[28] For 2015 payments, the Secretary announced she would calculate DSH payments based on Medicaid and

[21] 830 F.3d 515, 517.
[22] *Id.* at 519.
[23] *Id.* at 521-22.
[24] 925 F.3d 503 (D.C. Cir. 2019) ("*DCH v. Azar*").
[25] *Id.* at 506.
[26] *Id.* at 507.
[27] 514 F. Supp. 249 (D.D.C. 2021).
[28] *Id.* at 255-56.

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.[29] 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.[30] Nevertheless, the Secretary used each hospital's shorter cost reporting period in calculating the Factor 3 values for their FY 2015 DSH payments.[31]

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.[32]

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."[33] 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.[34] 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.[35]

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[29] *Id.* (quoting 79 Fed. Reg. 49854, 50018 (Aug. 22, 2014)).
[30] *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.
[31] *Id.*
[32] *Id.* at 262-64.
[33] *Id.* at 265.
[34] *Id.* (discussing *Leedom v. Kyne*, 358 U.S. 184, 188 (1958)).
[35] *Id.* at 264 (quoting *DCH v. Azar*, 925 F.3d at 509-510).

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.[36] 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*").[37] 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.[38] 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."[39] The D.C. Circuit further dismissed the applicability of the Supreme Court's 2019 decision in *Azar v. Allina Health Serv*s.[40] 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***."[41]

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

[36] *Id.* at 264-6511 (quoting *DCH v. Azar*, 925 F.3d at 509).
[37] Civ. No. 20-139, 2021 WL 3856621 (D.D.C. August 30, 2021).
[38] *Id*. at *4.
[39] *Id.* at *9.
[40] 139 S. Ct. 1804 (2019).
[41] *Ascension* at *8 (bold italics emphasis added).

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. 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 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, Appeal No. 20-0080 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
Ratina Kelly, CPA

For the Board:

12/14/2023

X Robert A. Evarts, Esq.

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

cc: Wilson Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Notice of Dismissal***
24-0447GC – LSU Health CY 2013 Treatment of Part C Days Final Rule CIRP Group
24-0446GC – LSU Health CY 2012 Treatment of Part C Days Final Rule CIRP
24-0445GC – LSU Health CY 2011 Treatment of Part C Days Final Rule CIRP Group
24-0444GC – LSU Health CY 2010 Treatment of Part C Days Final Rule CIRP Group
24-0443GC – LSU Health CY 2009 Treatment of Part C Days Final Rule CIRP Group
24-0441GC – LSU Health CY 2008 Treatment of Part C Days Final Rule CIRP Group
24-0440GC – LSU Health CY 2007 Treatment of Part C Days Final Rule CIRP Group

Dear Ms. Goron:

The Provider Reimbursement Review Board ("PRRB") is in receipt of the seven (7) above-referenced common issue related party ("CIRP") group appeals that were filed on December 7, 2023 by the Providers' representative, Healthcare Reimbursement Services, Inc. ("HRS") based on an appeal of the final rule published in the Federal Register on June 9, 2023 ("June 9, 2023 Final Rule") involving Part C days as used in the disproportionate share calculation ("DSH") by the Centers for Medicare and Medicaid Services ("CMS").[1] Set forth below is the Board's decision dismissing these 7 CIRP group cases for failure of the Providers' to timely file their appeals.

Background

On Thursday, December 7, 2023, HRS filed appeal requests in the Office of Hearings Case and Document Management System ("OH CDMS") to establish the seven (7) above-referenced CIRP group cases. The appeal request filed for each of these groups identifies the final determination being appealed as the June 9, 2023 Final Rule and describe the group issue as follows:

> **ISSUE TITLE**
>
> [DSH] – Inclusion of Part C Days in Denominator of the Medicare Fraction- Challenge to Part C Days retroactive final rule.
>
> **STATEMENT OF ISSUE**
>
> The issue is whether Part C days are properly included in the denominator of the Medicare Fraction per a June 9, 2023, retroactive final rule issued by [CMS], which is binding on the [Medicare contractor], or whether such final rule is illegal and cannot be enforced.

[1] 88 Fed. Reg. 37772 (June 9, 2023).

> The Providers appeal the Secretary's determination, which it calls a "final action," embodied in a June 9, 2023, retroactive final rule, that requires Part C Days to be included in the Medicare Fraction of the disproportionate payment percentage for discharges occurring prior to October 1, 2013 ("the Part C Days Final Rule"). The Part C Days Final Rule became effective on August 8, 2023. The Providers challenge the procedural and substantive validity of the Part C Days Final Rule. Specifically, the Providers assert that the Part C Days Final Rule is procedurally invalid the retroactive nature of the rule violates the rulemaking provisions of the Social Security Act and the Administrative Procedure Act, and is contrary to the D.C. Circuit's opinion in *Northeast Hospital v. Sebelius*, and established precedent regarding the applicability of a pre-existing rule when a later rule is vacated (as was the 2004 final rule on Part C days). The Part C Days Final Rule is substantively invalid because it is arbitrary and capricious. Specifically, the Part C Days Final Rule is arbitrary and capricious because CMS did acknowledge that putting Part C Days in the Medicare Fraction was a departure from its policy or practice prior to the vacated 2004 rule. The Part C Days Final Rule also failed to account for hospitals' reliable interest on the pre-2004 final rule practice or policy, and also failed to recognize the enormous adverse financial impact on hospitals due to the change from the pre-2004 final rule practice or policy.
>
> The Providers acknowledge that this issue is pending in an appeal that was remanded to the MAC. However, that remand preceded the Part C Days Final Rule and this appeal is limited to challenging the Part C Days final rule. Moreover, it is not clear whether the Providers will have full appeal rights following any decision upon remand. That is, it is not clear whether the Providers will be afforded the opportunity to challenge the legality of the Part C Days Final rule if, for example: (a) there is no change in the Providers' Disproportionate Payment Percentage (DPP) in the MAC's determination following remand because Part C days were placed in the Medicare Fraction originally; or (b) there is a positive change in the Providers' DPP for other reasons (such as the addition of Medicaid eligible days) but the DPP would have been even greater had Part C days not been included in the Medicare Fraction. For this reason, out of an abundance of caution the Providers bring this challenge to the Part C Days Final Rule at this time.[2]

Each group was filed ***181 days*** after the publication of the June 9, 2023 Final Rule provision that implemented the Final Rule for "Treatment of Medicare Part C Days in the Calculation of a Hospital's Medicare Disproportionate Patient Percentage."[3]

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[2] Providers' Hearing Requests establishing the group appeals.

[3] 88 Fed. Reg. 37772 (June 9, 2023). *See also Wash. Hosp. Ctr. v. Bowen*, 795 F.2d 139, 146 (D.C. Cir. 1986) ("[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") and *Dist. of Columbia Hosp. Ass'n Wage Index Group Appeal*, HCFA Adm'r Dec.,

Decision of the Board

The Board finds that these seven (7) group appeals were not timely filed as required by the Board's enabling statute at 42 U.S.C. § 1395oo(a)(3), which requires an appeal be filed "*within 180 days after notice of the . . . Secretary's final determination.*"[4] These appeals were filed in OH CDMS 181 days after the issuance of the June 9, 2023 Federal Register provision that implemented the Final Rule for "Treatment of Medicare Part C Days in the Calculation of a Hospital's Medicare Disproportionate Patient Percentage."

The Board is bound by all of the provisions of Title XVIII of the Act (the Social Security Act, as amended) and the regulations issued thereunder.[5] The Board cannot apply a regulation or instruction which is contrary to a statute and other regulations that deal specifically with the matter at hand: the date a provider is deemed to have notice of the contents of the Federal Register. In this case, the laws and regulations governing the publication of Federal Register notices specifically define the time of notice as that of publication. These laws and regulations have been incorporated into Title XVIII.

The Secretary[6] has enacted Part 401 of Title 42 of the Code of Federal Regulations which is entitled "General Administrative Requirements." Subpart B, §§ 401.101(a)(1) and (2) of this Part states that "[t]he regulations in this subpart: (1) Implement section 1106(a)[7] of the Social Security Act [relating to disclosure of information] as it applies to [CMS] . . . [and] (2) Relate to the availability to the public, under 5 U.S.C. § 552,[8] of records of CMS." These laws and regulations set out which records are available and how they may be obtained, and they supplement the regulations of CMS relating to the availability of information. Section 401.106 of this subpart, which deals with publication of materials under 5 U.S.C. § 552, requires publication to serve as notice and identifies the Federal Register as the vehicle to be used to give notice. Section 552(a) states in part that:

> (1) Each agency shall separately state and currently publish in the Federal Register for the guidance of the public-
>
> * * * *
>
> (D) substantive rules of general applicability adopted as authorized by law, and statements of general policy or interpretations of general applicability formulated and adopted by the agency; and
>
> (E) each amendment, revision, or repeal of the foregoing.

In order to comply with the statutes and regulations requiring that public notice be given, CMS publishes the schedules of the Prospective Payment System (PPS) rates as well as other PPS

Medicare & Medicaid Guide (CCH) ¶ 41,025 (Jan. 15, 1993) (publication of the wage index in the Federal Register is a final determination which can be appealed to the Board).

[4] (Emphasis added).

[5] *See* 42 C.F.R. § 405.1867.

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

[7] 42 U.S.C. § 1306(a).

[8] 5 U.S.C. § 550 *et seq.* contains the Administrative Procedures Act; 5 U.S.C. § 552 deals with the availability of government information and is known as the Freedom of Information Act ("FOIA").

policies (including the Part C days policy published in the June 9, 2023 Final Rule) in the Federal Register pursuant to the requirements of 42 C.F.R. § 412.8(b)(2). This regulation was created to comply with 5 U.S.C. § 552 of the Freedom of Information Act which requires that agencies publish regulations and notices in the Federal Register.[9]

With regard to the notices published in the Federal Register, 44 U.S.C. § 1507 states in part that:

> A document required. . .to be published in the Federal Register is not valid as against a person who has not had actual knowledge of it until the duplicate originals or certified copies of the document have been filed with the Office of the Federal Register and a copy made available for public inspection as provided by section 1503. . . . *[F]iling of a document, required or authorized to be published [in the Federal Register] by section 1505. . .is sufficient to give notice* of the contents of the document to a person subject to or affected by it.[10]

Reflecting new technology and the ability to transmit information immediately upon publication, the Government Printing Office ("GPO") promulgated 1 C.F.R. § 5.10 which authorizes publication of the Federal Register on the internet at the GPO website.[11] The GPO website containing the Federal Register is updated daily at 6 a.m. Monday through Friday, except holidays.[12] Consequently, the Provider is deemed to have notice of the Part C days policy at issue on the date the Federal Register was published and made available online.

With respect to statutes and regulations dealing with the Federal Register, the Supreme Court has found that:

> Congress has provided that the appearance of rules and regulations in the Federal Register give legal notice of their contents . . . .
>
> . . . Regulations [are] binding on all who sought to come within the [Act], regardless of actual knowledge of what is in the Regulations or of the hardship resulting from innocent ignorance.[13]

The statutes governing the Board (44 U.S.C. § 1507 as applied through the requirements of 42 C.F.R. § 401.101 and the Administrative Procedures Act ("APA")) are clear on their face: the date of publication of the Federal Register is the date the Providers are deemed to have notice of the June 2023 Final Rule. The Board is bound by all of the provisions of Title XVIII which includes, by reference, the provisions of the Administrative Procedures Act and the Public Printing and Documents law which require that CMS publish its notices and regulations in the Federal Register. In publishing materials in the Federal Register, CMS must comply with the statutes and regulations governing the Superintendent of Documents and the Governing Printing Office.

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[9] *See also* 42 C.F.R. Part 401, Subpart B.
[10] (Emphasis added).
[11] *See also* 44 U.S.C. § 4101 (the Superintendent of Documents is to maintain an electronic director and system of online access to the Federal Register).
[12] *See* http://www.gpo.gov/help/index.html#about_federal_register.htm.
[13] *Fed. Crop Ins. Corp. v. Merrill*, 332 U.S. 380, 385 (1947).

Pursuant 42 U.S.C. § 1395oo(a)(3), the Board's enabling statute, providers have 180 days "after *notice* of the Secretary's final determination" to file an appeal. To this end, Board Rule 4.3.2 confirms that the appeal period for a final rule published in the Federal Register appeal ends 180 days from the date of publication:

> The date of receipt of a Federal Register Notice is the date the Federal Register is published. The appeal period begins on the date of publication and ends 180 days from that date.

In this case, the notice of the Secretary's determination is, by law, the date the Federal Register is issued by the Superintendent of Documents, or June 9, 2023. Here, the 180th day for appealing was Wednesday December 6, 2023. The seven (7) group appeals were not filed with the Board until Thursday, December 7, 2023, and thus were not timely filed.

Consequently, the Board concludes that it does not have jurisdiction over these seven (7) untimely-filed group appeals and hereby dismisses them. Case Nos. 24-0447GC, 24-0446GC, 24-0445GC, 24-0444GC, 24-0443GC, 24-0441GC, and 24-0440GC are closed and removed from the Board's docket.[14] Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f)(1) 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:

12/14/2023

X Ratina Kelly

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

cc: Wilson Leong, Federal Specialized Services
Michael Redmond, Novitas Solutions, Inc.

[14] Regardless, even if the Board did not dismiss these appeals as being untimely, the Board would find that the Providers appeals were premature as they failed to appeal from a "final determination" consistent with the jurisdictional dismissal decisions issued in: (1) Case Nos. 23-1796GC, *et al*. on Oct. 25, 2023 (available at: https://www.cms.gov/files/document/prrb-jurisdictional-decisions-10-1-2023-through-10-31-2023.pdf (last accessed 12/12/2023)); and (2) Case No. 23-1498 on Aug. 8, 2023 (available at: https://www.cms.gov/files/document/prrb-jurisdictional-decisions-8-1-2023-through-8-31-2023.pdf (last accessed 12/12/2023)). Moreover, even if it were a final determination, the Board would also need to conduct further review to confirm whether the Providers have established (consistent with 42 C.F.R. §§ 405.1835(b)(1) and 405.1837(c)(1), (3)) that the June 9, 2023 Final Rule is, in fact, applicable to them (*i.e*., confirm for the fiscal years at issue that either: (a) no NPR has been issued; or (b) they had a Board appeal of the Part C issue that was subsequently remanded per CMS Ruling 1739-R).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

Wilson Leong
Federal Specialized Services
1701 S. Racine Avenue
Chicago, IL 60608-4058

RE: **Notice of Dismissal**
Baylor Medical Center at Irving (Prov. No. 45-0079, FYE 06/30/2007)
Case No. 16-2099

Dear Mr. Ravindran and Mr. Leong,

The Provider Reimbursement Review Board ("Board or PRRB") is in receipt of the Medicare Contractor's May 7, 2018 and October 4, 2023 Jurisdictional Challenges and the Provider's November 2, 2023 Jurisdictional Response. The Board's decision is set forth below.

Pertinent Facts

On **July 27, 2016**, Baylor Medical Center at Irving ("Baylor"), Provider No. 45-0079, FYE 6/30/07, filed a timely Individual Appeal Request from a Revised Notice of Program Reimbursement ("RNPR") dated January 26, 2016, appealing the following issues:

Issue 1: Disproportionate Share Hospital ("DSH") Payment/Supplemental Security Income ("SSI") Percentage- Provider Specific
Issue 2: DSH SSI Percentage[1]
Issue 3: DSH- SSI Fraction/Medicare Managed Care Part C Days[2]
Issue 4: DSH-SSI Fraction/Dual Eligible Days (Exhausted Part A benefit days, Medicare Secondary Payor ("MSP") Days, and No-Pay Part A Days)[3]
Issue 5: DSH-Medicaid Fraction/Medicare Managed Care Part C Days[4]
Issue 6: DSH-Medicaid Fraction/Dual Eligible Days (Exhausted Part A benefit days, MSP days, & No-Pay Part A days)[5]
Issue 7: DSH-Medicaid Eligible Days
Issue 8: DSH-Medicare Managed Care Part C Days[6]
Issue 9: DSH-Dual Eligible Days (Exhausted Part A Benefit days, MSP Days, & No-Pay Part A Days)[7]

[1] Transferred to CN 13-3926GC on 03/08/17.
[2] Transferred to CN 13-3929GC on 03/08/17.
[3] Transferred to CN 13-3938GC on 03/08/17.
[4] Transferred to Cn 13-3918GC on 03/08/17.
[5] Transferred to CN 13-3896GC on 03/08/17.
[6] Transferred to CN 13-3918GC on 03/08/17.
[7] Transferred to CN 13-3896GC on 03/08/17.

Pursuant to 42 C.F.R. 405.1835(e), the Provider had until Tuesday, September 27, 2016 to add additional issues to its appeal; however, the Provider did not request the addition of any issues.

As the Provider is commonly-owned by Baylor Scott & White Health and is thereby subject to the regulation at 42 C.F.R. § 405.1837(b)(1), the Provider transferred Issues 2, 3, 4, 5, 6, 8, and 9 to CIRP groups for Baylor Scott & White Health. After all of the transfers, only 2 issues remained in the case: Issue 1 (the DSH SSI Percentage (Provider Specific) issue) *and* Issue 7 (the DSH Medicaid Eligible Days issue remained in the appeal).

On **March 22, 2017**, the Provider filed its preliminary position paper (providing a complete copy to the Medicare Contractor but filing only the cover page with the Board consistent with Board Rules[8]). Similarly, on **August 1, 2017**, the Medicare Contractor filed its preliminary position paper.

On **May 7, 2018**, the Medicare Contractor filed a Jurisdictional Challenge over Issue 1, the DSH SSI Percentage (Provider Specific) issue and Issue 7, the DSH Medicaid Eligible Days issue, amongst other issues.[9] Pursuant to Board Rule 44.4 (Jul. 2015), any response to the jurisdictional challenge was due within 30 days (*i.e.*, no later than Wednesday, Jun 6, 2018). However, on June 11, 2018, the Provider filed its response and it was ***not*** *timely*.

On **September 16, 2021**, the Board notified the parties that the record for this case had been fully populated in OH CDMS and that "[f]rom this point forward, the Board will rely on the documents in OH CDMS to adjudicate your case" and advised the parties to review the record for any discrepancies." At that point, OH CDMS only listed 2 issues as being present in this case – Issue 1 entitled "DSH – SSI Percentage" and Issue 7 entitled "DSH – Medicaid Eligible Days."

On **December 12, 2022**, the Board issued a Notice of Hearing and specified that final position papers must be filed on July 18, 2023 and August 17, 2023 by the Provider and Medicare Contractor, respectively. Significantly, the Notice included the following instruction regarding the Provider's final position paper:

> Provider's Final Position Paper – For each remaining issue, the position paper must state the material facts that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), and provide arguments applying the material facts to the controlling authorities. This filing must also include any exhibits the Provider will use to support its position. *See* Board Rule 27 for more specific content requirements. If the Provider misses its due date, the Board will dismiss the cases.[10]

On **July 14, 2023**, the Provider timely filed its final position paper. On **August 3, 2023**, the Medicare Contractor timely filed its final position paper.

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[8] Effective for cases filed on or after August 29, 2019, providers are required to file the complete preliminary position paper (including any exhibits).
[9] The Medicare Contractor also filed a jurisdictional challenge over issues, 5, 6, 8, 9, although these issues were transferred to group appeals on 3/8/17.
[10] (Footnote omitted and italics emphasis in original.)

On **October 4, 2023**, the Medicare Contractor filed a second Jurisdictional Challenge *over* ***Issue 7****, DSH Medicaid Eligible Days*, challenging Section 1115 Waiver Days (as untimely added to the appeal). Significantly, on **October 31, 2023**, the Provider ***withdrew*** *Issue 7*, DSH Medicaid Eligible Days, from the appeal ***without qualification*** *and****,*** *in particular, without requesting bifurcation of the alleged 1115 waiver days sub-issue*. As a result of this dismissal, OH CDMS ***only*** list a single issue remaining in this appeal, namely Issue 1.

Notwithstanding the unqualified withdrawal of Issue 7 (and the fact that OH CDMS ***only*** shows Issue 1 remaining in this appeal), two days later, on **November 2, 2023**, the Provider submitted a response to the Medicare Contractor's second Jurisdictional Challenge over the identified "sub-issue" Section 1115 Waiver Days. The Provider asserted that the 1115 waiver days issue was part of Issue 7 as a sub-issue: "FSS's description of section 1115 waiver days as a "sub-issue" is tantamount to an admission that section 1115 waiver days is included within the issue of Medicaid eligible days." Significantly, the Response does not discuss or even acknowledge the withdrawal of Issue 7 which was made 2 days earlier.

On **November 9, 2023**, the Provider requested *a 180-day postponement* of the December 18, 2023, hearing date because it "has submitted an additional day's listing to the MAC but due to an impending jurisdictional challenge the audit process has not moved forward."

Medicare Contractor's Contentions

Issue 1 – DSH – SSI Percentage (Provider Specific)

The Medicare Contractor contends that Issue 1 should be dismissed because it is a duplicate of Issue 2, DSH SSI Percentage. The Medicare Contractor maintains in Issue 1, Baylor contends that the Medicare Contractor used the incorrect SSI percentage in processing its DSH payment. In Issue 2, Baylor also contends that the Secretary improperly calculated its SSI percentage. The Medicare Contractor asserts Baylor is making the same argument as it is required to use the same SSI ratio provided by CMS. The SSI ratio is the underlying dispute in both Issues 1 and 2. The Medicare Contractor argues under Board Rules, Baylor is barred from filing a duplicate SSI percentage issue appeal. Thus, the Board should find that the SSI percentage is one issue for appeal purposes and dismiss Issue 1.[11]

The Medicare Contractor also maintains Issue 1 includes Baylor's subsidiary appeal over SSI realignment. The Medicare Contractor contends there was no final determination over SSI realignment. The Medicare Contractor asserts 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 to receive a realigned SSI percentage. The Medicare Contractor contends Baylor's appeal is premature as Baylor has not exhausted all available remedies.[12]

[11] Medicare Contractor's May 7, 2018 Jurisdictional Challenge at 2-3.
[12] *Id*. at 3.

Issue 7- DSH- Medicaid Eligible Days, Section 1115 Waiver Days

The Medicare Contractor contends in the Issue Statement of its Appeal Request, Baylor asserts the issue as "[w]hether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ('DSH') calculation." Its issue description provides "[t]he 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." The Medicare Contractor maintains Baylor filed its Preliminary Position Paper. The Preliminary Position Paper mentions only Medicaid eligible days and makes no reference to Section 1115 Waiver days and excludes any type of day listing.

The Medicare Contractor contends on July 14, 2023, Baylor filed its Final Position Paper and for the first-time referenced Section 1115 Waiver Days.[13] The Medicare Contractor argues by referencing the list of Section 1115 Waiver Days for the first time in its Final Position Paper, Baylor is now attempting to untimely add an issue to the appeal.[14] The Medicare Contractor maintains the Section 1115 Waiver Days issue is a separate issue. It is one component of the DSH issue.[15] The Medicare Contractor asserts Board Rules support the argument that the Section 1115 Waiver Days issue is a component of DSH different from the generic Medicaid eligible days issue and must be separately identified and appealed.

The Medicare Contractor maintains Baylor is attempting to untimely add the issue of Section 1115 waiver days by including the waiver days as part of its list of additional eligible days. The Medicare Contractor asserts added issues must be added within 60 days of the expiration of the appeal filing deadline. The Medicare Contractor contends in this case, that would be 240 days from the date of the original NPR. The original NPR was issued on January 26, 2016. Thus, the period to add issues was on or about August 28, 2016.

The Medicare Contractor asserts in addition Baylor failed to brief this issue in its Preliminary Position Paper.[16] The Medicare Contractor maintains Baylor's Final Position Paper references Section 1115 Waiver Days and includes a listing of 2,802 days at Exhibit 1. The Final Position Paper estimated impact uses the same estimated 250 additional days in the numerator of the Medicaid proxy for a next impact of $112,932, which is the same impact as estimated in the Appeal Request and the Preliminary Position Paper.

The Medicare Contractor asserts the Provider's Final Position Paper has expanded its estimated days by a factor of 10. This dramatic increase is the estimated impact. The Medicare Contractor argues the inclusion of references to Section 1115 Waiver Days for the first time clearly shows Baylor is adding an issue and not merely modifying its estimated impact.[17] The Medicare Contractor argues the issue Baylor is now trying to address was not timely added. Submitting a list of Section 1115 Waiver days along with the list of eligible days in the Final Position Paper does not constitute the proper adding of an issue. The Medicare Contractor contends Baylor is nearly seven

[13] Medicare Contractor's October 4, 2023 Jurisdictional Challenge at 2.
[14] *Id*. at 3.
[15] *Id*. at 5.
[16] *Id*. at 6.
[17] *Id*. at 7.

years past the 240-day deadline to add an issue. Baylor did not formally add the disputed issue to the Appeal Request via a Model Form C. The Medicare Contractor argues the Section 1115 Waiver Days is a separate and distinct issue from the Medicaid Eligible Days issue that was originally appealed and should not be considered a part of this appeal. The Medicare Contractor asserts as Baylor has failed to timely add the Section 1115 Waiver Days as an issue to the appeal consistent with 42 C.F.R. § 405.1853(b)(e) and Board Rule 25, it requests this issue be dismissed.[18]

Provider's Contentions

Issue 1 – DSH – SSI Percentage (Provider Specific)

Baylor contends each of the appealed SSI issues are separate and distinct issues. Baylor maintains Issues 1 and 2 represent different components of the SSI issue, which was specifically adjusted during the audit. Baylor asserts since these specific appeal issues represent different components of the SSI issue, the Board should find jurisdiction over both the SSI (Systemic) and SSI (Provider Specific/Realignment issues).[19]

Baylor contends it is not addressing the errors which resulted from CMS' improper data matching process, but it is addressing the various errors and omission and commission that do not fit into the systemic errors category. Thus, the Board should find jurisdiction over the SSI (Provider Specific) issue in the instant appeal. Baylor argues this is an appealable item because the Medicare Contractor specifically adjusted its SSI percentage, and it is dissatisfied with the amount of DSH payments that it received for fiscal year 2007 resulting from its understated SSI percentage due to errors of omission and commission.[20] Baylor asserts its SSI percentage was adjusted on its cost report. As such, the Board should find that it has jurisdiction over the SSI (Provider Specific) issue.[21]

Issue 4- DSH- Medicaid Eligible Days, Section 1115 Waiver Days

Baylor maintains the Medicare Contractor's description of Section 1115 Waiver days as a "sub-issue" of Issue 7 is tantamount to an admission that Section 1115 waiver days is included within Issue 7 for Medicaid Eligible days. Baylor contends the definition of Medicaid Eligible days in 42 C.F.R. § 412.106(b)(4)(i) specifically includes Section 1115 Waiver Days. Baylor asserts its appeal statement provided "all Medicaid eligible days, including but not limited to Medicaid paid days . . . ." Thus, it appealed the failure to include any and all types of Medicaid eligible days. The Medicare Contractor was put on notice of this. Baylor maintains the Board Rules in effect governing the filing of Preliminary and Final Position Papers is the July 1, 2015 version. Consistent with the regulatory meaning of "issue" and with Rule 7.1, the Final Position Paper was not required to delve into subparts of an issue or specific arguments relating to the issue.

Baylor asserts the Final Position Paper was required only to identify the issue and its reimbursement impact. The Medicare Contractor asserts Rule 27.2 speaks to what a provider

[18] *Id*. at 8.
[19] Provider's June 11, 2018 Jurisdictional Response at 1-2.
[20] *Id*. at 2.
[21] *Id*. at 2-3.

should do with respect to the content of the Final and Preliminary Position Papers, not what it must do. Baylor contends the detail required under the 2018 version of the Board's Rules for Preliminary and Final Position papers is applicable only for appeals filed after the effective date of the 2018 version. Baylor asserts for appeals filed prior to the effective date of the 2018 version of the Board's Rules, the existing rules for Final Position Papers state that only the failure to timely file the Final Position Paper is grounds for dismissal.[22]

Decision of the Board:

A. SSI Provider Specific

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2014), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

The jurisdictional analysis for Issue 1 has two relevant aspects to consider: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, and 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

1. First Aspect of Issue 1

The first aspect of Issue 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—has been consolidated into Issue 2, DSH-SSI Percentage. Issue 2 was transferred into Group Case No. 13-3926GC, QRS BHCS 2007 DSH SSI Percentage CIRP Group.

Issue 1, DSH SSI Percentage (Provider Specific) issue in the present appeal concerns:

> [T]he MAC did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. §1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations.[23]

The Provider contends that its SSI percentage published by the Centers for Medicare and Medicaid Services ("CMS") was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.[24]

In the SSI percentage issue in group Case No. 13-3926GC, which includes the provider in this case, and the same fiscal year, the Providers assert that:

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[22] *Id*. at 2.
[23] Provider's July 27, 2016 Individual Appeal Request, Issue Statement, Issue 1, Case No. 16-2099.
[24] *Id*.

> The Providers contend that the Lead MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww(d)(5)(F)(i). The Providers further contend that the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") and used by the Lead MAC to settle their Cost Report does not address all the deficiencies as described in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20, as amended, 587 F. Supp. 2d 37, 44 (D.D.C. 2008) and incorporates a new methodology inconsistent with the Medicare statute.
>
> The Providers challenge their SSI percentages based on the following reasons:
>
> 1. Availability of MEDPAR and SSA Records,
> 2. Paid days vs. Eligible days,
> 3. Not in agreement with provider's records,
> 4. Fundamental problems in the SSI percentage calculation,
> 5. Covered days vs. Total days,
> 6. Non-covered days, ie. Exhausted Benefit ("EB"), Medicare Secondary Payor ("MSP") Days and Medicare Advantage, Medicare Managed Care, Medicare+Choice and/or Part C Days (Collectively "MA") Days;
> 7. CMS Ruling 1498-R and
> 8. Failure to adhere to required notice and comment rulemaking procedures in adopting policy on EB, MSP and MA days.[25]

The Board finds that the first aspect of Issue 1, DSH/SSI (Provider Specific) issue, in this appeal is duplicative of the DSH/SSI (Systemic Errors) issue that was directly filed into Case No. 13-3926GC. The first aspect of Issue 1 in the present appeal concerns "[w]hether the Medicare Administrative Contractor ("MAC") used the correct Supplemental Security Income ("SSI") percentage in the Disproportionate Share Hospital ("DSH") Calculation."[26] 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)."[27] Similarly, the Provider argues that "its' SSI percentage published by the Centers for Medicare and Medicaid Services ("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."[28] The DSH systemic issues filed into Case No. 13-3926GC, 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)(vi)(I).

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[25] Providers' September 27, 2023 Group Appeal Request, Group Issue Statement, Case No. 13-3926GC
[26] Provider's July 27, 2016 Individual Appeal Request, Issue Statement, Issue 1, Case No. 16-2099.
[27] *Id.*
[28] *Id.*

Thus, the Board finds that the first aspect of Issue 1 in this appeal is duplicative of the group issue in Case No. 13-3926GC, for this same provider and fiscal year. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (July 1, 2015), the Board dismisses this aspect of the DSH/SSI (Provider Specific) issue.

In making this finding, the Board further notes that CMS regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, is pursuing that issue as part of the group under Case 13-3926GC. 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.[29] 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. 13-3926GC.

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 20-1332GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. 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.[30] Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with the Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" in its Preliminary Position Paper and include *all* exhibits.

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

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

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[29] 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).

[30] 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.

> 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.[31]
> 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."[32]

In its final position paper, the Provider again states that it "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" and again cites to the 2000 Federal Register (65 Fed. Reg. 50548 (2000)). However, the Provider again fails to explain what data it does not have access to in compliance with Board Ruel 25.2.2.[33] It cites to a Brief filed in a court case but fails to specifically explain how or why it is relevant. To the extent it is, the Board notes that it would be a common issue subject to the CIRP group rules to which this Provider is subject (as

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[31] Last accessed February 24, 2023.
[32] Emphasis added.
[33] The Board notes that 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."

discussed above). Indeed, Issue 2 (SSI Systemic) which was transferred to the CIRP group under Case No. 13-3926GC included this very issue "Availability of MEDPAR and SSA Records." This only reinforces the Board findings that Issue 1 is a prohibited duplicate of Issue 2 which was transferred to Case No. 13-3926GC.

Accordingly, *based on the record before it*, the Board finds that Issue 1 and the group issue in Group Case 13-3926GC, 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.

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

As such, Issue 1, the DSH SSI – (Provider Specific) issue, is dismissed.

B. Medicaid Eligible Days, Section 1115 Waiver Days

The requirements of the content of a request for a Board hearing are outlined in 42 C.F.R. § 405.1835(b) (effective January 1, 2016), which reads:

> (b) *Contents of request for a Board hearing on final contractor determination*. The provider's request for a Board hearing under paragraph (a) of this section must be submitted in writing to the Board, and the request must include the elements described in paragraphs (b)(1) through (b)(4) of this section. If the provider submits a hearing request that does not meet the requirements of paragraph (b)(1), (b)(2), or (b)(3) of this section, the Board may dismiss with prejudice the appeal or take any other remedial action it considers appropriate.
>
> (1) A demonstration that the provider satisfies the requirements for a Board hearing as specified in paragraph (a) of this section, including a specific identification of the final contractor or Secretary determination under appeal.
>
> (2) **For <u>each</u> specific item under appeal**, **a separate explanation of why, and a description of how, the provider is dissatisfied** with the specific aspect of the final contractor or Secretary determination under appeal l, including an account of all of the following:

> (i) **Why the provider believes Medicare payment is incorrect for <u>each</u> disputed item** (or, where applicable, why the provider is unable to determine whether Medicare payment is correct because it does not have access to underlying information concerning the calculation of its payment).
>
> (ii) How and why the provider believes Medicare payment must be determined differently for each disputed item.
>
> (iii) If the provider self-disallows a specific item (as specified in §413.24(j) of this chapter), an explanation of the nature and amount of each self-disallowed item, the reimbursement sought for the item, and why the provider self-disallowed the item instead of claiming reimbursement for the item.[34]

Consistent with the requirement in 42 C.F.R. § 405.1835, Board Rule 8 (Jul. 2015) specifies that where a particular payment issue involves multiple components, the provider must appeal each component separately and describe it as narrowly as possible:

> **Rule 8 – Framing Issues for Adjustments Involving Multiple Components**
>
> **Rules 8.1**
>
> **8 – Framing Issues for Adjustments Involving Multiple Components**
>
> **8.1-General**
>
> Some issues may have multiple components. To comply with the regulatory requirement [at 42 C.F.R. § 405.1835] to specifically identify the items in dispute, each contested component must be appealed as a separate issue and described as narrowly as possible using the applicable format outlined in Rule 7. See common examples below.
>
> **8.2- Disproportionate Share Cases**
> (e.g., dual eligible, general assistance, charity care, HMO days, etc.)
>
> **8.3-Bad Debts Cases**
> (e.g., crossover, use of collection agency, 120-day presumption, indigence determination, etc.)
>
> **8.4-Graduate Medical Education/Indirect Medical Education**
> (e.g., managed care days, resident count, outside entity rotations, etc.)
>
> **8.5-Wage Index**
> (e.g. wage vs. wage-related, rural floor, data corrections, etc.)

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

42 C.F.R. § 405.1853(b)(2)-(3) includes the following requirements for the content of position papers and confirms that the Board has the authority to set deadlines for the submission of exhibits/supporting documentation:

> 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*.[35]

Consistent with this regulation, Board Rule 25 (Jul. 2015) specified in pertinent part the following content requirements in effect when the Provider filed its preliminary position paper:

> **Rule 25- Preliminary Position Papers**
>
> **COMMENTARY:** . . . . Unlike the prior practice, preliminary position papers now are expected to present fully developed positions of the parties and, therefore, require analysis well in advance of the filing deadline. . . .
>
> **25.1 Content: The text of the Preliminary Position Paper must include the following:**
>
> **A. Provider's Preliminary Position Paper**
>
> 1. For <u>each</u> issue, state the material facts that support your claim.
>
> 2. Identify the controlling authority (e.g. statutes, regulations, policy or case law) supporting your position.
>
> 3. Provide a conclusion applying the material facts to the controlling authorities.
>
> ****

[35] (Emphasis added).

25.2 – Preliminary Documents:

A. General: With the preliminary position papers, the parties must exchange all available documentation as preliminary exhibits to fully support your position. The Intermediary must also give the Provider all evidence the Intermediary considered in making the determination (see 42 C.F.R. § 405.1853(a)(3)) and identify any documentary evidence that the Intermediary believes is necessary for resolution which has not been submitted by the Provider.

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

C. Preliminary Documentation List: Parties must attach a list of the exhibits exchanged with the preliminary position paper.

The following Commentary included at Board Rule 23.3 (Jul. 2015)[36] provides additional instruction on the required content of preliminary position papers as well as exhibits to be included with the position paper:

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

Board Rule 41 (Nov. 2021) address Board closure or dismissal of an issue due to abandonment or failure to comply with Board Rules:

[36] (Bold emphasis in the original and underline and italics emphasis added.) Note the Caution statement reference to potential exclusion is a reference to Board Rule 35.2 which governs exclusion of documentary evidence submitted late outside the position paper process.

Rule 41 Dismissal or Closure

41.2 Own Motion (effective November 1, 2021)

The Board may dismiss a case or an issue on its own motion:

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

The Board notes OH CDMS is the official record for this case and QRS withdrew Issue 7 in its entirety ***without any qualification***. As a result, only Issue 1 remains in this case. There is no 1115 waiver days case listed or remaining in this case. Accordingly, the Board hereby affirms that QRS effectively withdrew or abandoned that issue when it withdrew Issue 7 from the case in OH CDMS. This is reflected in the record for OH CDMS.[37]

Indeed, the Board notes that the Provider is arguing in its Response that § 1115 Waiver Days is part of Issue 7 (Medicaid eligible days) as it purports to do in its November 2, 2023 Response when it alleges "Baylor maintains the Medicare Contractor's description of Section 1115 Waiver days as a sub-issue is tantamount to an admission that Section 1115 waiver days is included within the issue of Medicaid Eligible days."[38] Similarly, in its Response, QRS argues 1115 waiver days is part of Issue 7: "Consistent with the regulatory meaning of "issue" and with Rule 7.1, discussed above, the final position paper was not required to delve into "subparts" of an issue or specific arguments relating to the issue." Moreover, the Board notes that QRS did not brief § 1115 waiver days as a separate issue in its final position paper but rather discussed them as part of the Issue 7, Medicaid Eligible Days, discussion and to this end included as Exhibit P-1 to its final position paper entitled "1115 Waiver and Additional ME Days Consolidated." Similarly, in looking at the preliminary position paper (as attached to the Jurisdictional Challenge as Exhibit C-2), QRS did not mention 1115 waiver days at all but rather filed a perfunctory terse 5-sentence argument. Accordingly, the Board finds QRS intended to withdraw Issue 7 in its entirety on October 31, 2023 without qualification.

In the alternative, to the extent that the Provider could argue that the Section 1115 Waiver Days was presented as a separate issue (separate and apart from Medicaid Eligible Days) and that its withdrawal of Issue 7 without qualification did not otherwise include Medicaid eligible days (notwithstanding the fact that the official record in OH CDMS does not list 1115 waiver days as a separate issue pending in this case), the Board would find that the 1115 waiver days issue: (1)

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[37] To the extent the Provider wished to preserve the 1115 wavier days as a separate issue distinct and separate from Medicaid eligible days and not have it withdrawn as part of Issue 7, the proper procedure would be for QRS to request bifurcation of Issue 7 ***prior to*** withdrawing Issue 7. Instead, QRS withdrew Issue 7 in its entirety from OH CDMS and, as a result, only Issue 1 is listed as pending in OH CDMS for this case.

[38] Provider's June 11, 2018 Jurisdictional Response at 2.

was ***not*** properly included in the appeal request; (2) was ***not*** timely added to the appeal; and (3) was ***not*** properly briefed in either the preliminary position paper or even the final position paper. Any of these 3 reasons would be sufficient separate and independent bases to dismiss the 1115 waiver days issue. In this regard, the Board finds the Section 1115 Waiver Days issue is a separate issue that should have been appealed separately and briefed separately because it is a component of DSH different from the *generic* Medicaid eligible days issue and, thus, must be separately identified and appealed pursuant to Board Rule 8.1.

In this regard, the Board notes that § 1115 Waiver days are not traditional Medicaid eligible days. Indeed, it was only effective January 20, 2000, that the Secretary incorporated certain specific types of § 1115 Waiver days were incorporated into the DSH calculation *at her discretion* (*i.e*., it is the Secretary's position that no statute requires that § 1115 waiver days be included).[39] Rather, they relate to Medicaid expansion program(s) and are only includable in the DSH adjustment calculation if they meet the requirements in 42 C.F.R. § 412.106(b)(4) relating to § 1115 Waiver days. Indeed, not every state Medicaid program has a qualifying § 1115 expansion program ***and*** not every inpatient day associated with beneficiary enrolled in a § 1115 waiver program necessarily qualifies to be included in the Medicaid fraction.[20] In contrast, every state has a Medicaid state plan and every state Medicaid plan includes inpatient hospital benefits and, by statute at 42 U.S.C. § 1395ww(5)(F)(vi)(II), the numerator of the DSH Medicaid fraction must include§ inpatient days of patients "who . . . were eligible for medical assistance under a State plan approved under subchapter XIX" but who were not entitled to Medicare Part A.

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

> (2) *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

[39] 65 FR 47054, 47087 (Aug. 1, 2000). The Secretary's discussion in the preambles to the final rules revising 42 C.F.R. § 412.106(b)(4) to address 1115 waiver days demonstrates this as well as subsequent cases disputing the meaning of those revisions. Further, the Board has found that when a class of days (e.g., 1115 waiver days) is excluded due to choice, error, and/or advertence from the as-filed cost report, then that class of days is an unclaimed cost for which the Board would lack jurisdiction under 42 U.S.C. § 1395oo(a). *See, e.g.,* PRRB Jurisdictional Decision, Case Nos. 06-1851, 061852 (Nov. 17, 2017) (dismissing the class of adolescent psychiatric days from the appeal because no days were claimed with the as-filed cost report due to choice, error and/or inadvertence and, as such, the practical impediment standard or futility concept in the *Norwalk* and *Danbury* Board decisions is not applicable) (available at: https://www.cms.gov/regulations-and-guidance/review-boards/prrbreview/downloads/jd-2017-11.pdf (last accessed Dec. 15, 2023)).

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

The appeal request only references Medicaid eligible days notwithstanding the fact that 1115 waiver days are treated very differently from regular Medicaid eligibility. The documentation verifying eligibility is different and the standard for determining eligibility is different. Further, it was not a given that all 1115 waiver days are necessarily days that would qualify under 412.106(b)(4) as demonstrated by Board decisions and case law.[40] Here, 42 C.F.R. § 405.1835(b) and Board Rule 8 required each separate issue to be identified. The Provider failed to do so. The Board recognizes that the appeal statement states that "The MAC, contrary to the regulation, failed to include all Medicaid eligible days, *including but not limited to* Medicaid paid days, unpaid eligible days eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation." However, the "including but not limited to" phrase only pertained to traditional Medicaid eligible days and reasons why they may not have been included in the fraction. It did not expand to include other classes of days such as general assistance, State-only days or 1115 waiver days. A generic catchall phrase cannot be used to essentially shoehorn in the later addition of issue on ***untimely*** basis in contravention to Board Rules and regulations.

In practice, new issues had to be added to this case no later than 240 days after receipt of the contractor's determination. However, there is no evidence in the record to indicate the Provider added the § 1115 Waiver days to the case properly or timely prior to the Tuesday, September 27, 2016.

Because the Provider did not either appeal the § 1115 Waiver days or add it to the appeal prior to the deadline to add issues, and it is a distinct issue, the Board finds that the issue was not properly or timely appealed (indeed the final position paper is the first time 1115 waiver days is mentioned for the first time *nearly 7* ***years after*** *the deadline to add issues to the appeal*). The DSH Medicaid Eligible Days issue as stated in the original appeal request cannot be construed to include § 1115 Waiver days. Additionally, there is no indication that any § 1115 waiver days

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[40] *See, e.g., CCT&B 2005-2006 Hurricane Katrina § 1115 Waiver UCP Days Group v. Novitas Solutions, Inc.*, PRRB Dec. No. 2016-D18 (Sept. 16, 2016); *QRS 1993-2007 DSH/Iowa Indigent Patient/Charity Care (GA) Group v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (Jan. 15, 2013), *affirming* PRRB Dec. No. 2013-D02 (Nov. 21, 2012); *Singing River Health Sys. v. Novitas Solutions, Inc.*, PRRB Dec. 2016-D19 (Sept. 20, 2016); *Adventist Health Sys. v. Sebelius*, 715 F.3d 157 (6th Cir. 2013).

were included with the as-filed cost report which, if true, would make them an unclaimed cost and provide an independent basis for dismissal.

Regardless, the Provider failed to brief the issue in its preliminary position paper as 1115 waiver days are ***not*** identified or discussed notwithstanding the content requirements in 42 C.F.R. § 405.1853(b)(2) and Board Rule 25. Indeed, there were no listing of days at issue (whether Medicaid eligible or 1115 waiver days) provided with the position paper notwithstanding the requirement in Board Rule 25 that all exhibits be included and the clear burden of proof the provider has 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1871(a)(3).[41] Rather, the Provider promised that it was being sent under separate cover, yet never did so.

Finally, the Board finds in its Final Position Paper Baylor asserts for the first time, again *nearly **7 years after** the deadline to add issues to the appeal*:

> [t]he adjustment amount for the remaining issues of $171,032 is largely attributable to the MAC's exclusion of Medicaid eligible days, including Section 1115 Waiver Days, and SSI days from the Provider's disproportionate patient percentage.[42]

Baylor continues:

> [u]nder section 1886(d)(5)(F)(vi)(ii), and 42 C.F.R. § 412.106(b)(4)(1), Medicaid eligible days (including section 1115 waiver days, which are paid under waiver authority of section 1115 of the Social Security Act and regarded as and treated as Medicaid eligible days] are to be included in the numerator of the Provider's Medicaid Fraction of the disproportionate patient percentage. The issue is whether the Medicare Administrative Contractor (MAC) included in the Provider's Medicaid Fraction of the disproportionate patient percentage all Medicaid eligible days (including section 1115 waiver days).[43]
>
> Based on the listing of Medicaid Eligible days, including Section 1115 waiver days, which was sent to the MAC (a redacted copy is being provided with this Final Position Paper), the Provider contends that the total number of days reflected in its 2007 cost report does not reflect an accurate number of Medicaid eligible days, as required by HCFA Ruling 97-2 and the pertinent Federal Court decisions.[44]

However, even in the Final Position Paper, the Provider fails to identify what § 1115 waiver program(s) are involved and whether or not the § 1115 waive days at issue would qualify under 42 C.F.R. § 412.106(b)(i)-(ii) as "days attributable to populations eligible for Title XIX matching

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[41] 42 C.F.R. § 405.1871(a)(3) makes clear the Provider has the "burden of production of evidence and burden of proof [to] establish[], by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue."
[42] Provider's July 14, 2023 Final Position Paper at 2.
[43] *Id*. at 9-10.
[44] *Id* at 10.

payments through a waiver approved under section 1115 of the Social Security Act" and the patients underlying those days are "deemed eligible for Medicaid" based on "the patient [being] eligible for inpatient hospital services . . . under a waiver authorized under section 1115(a)(2) . . . on that day, regardless of whether particular items or services were covered." The Board finds submitting a list of Section 1115 Waiver days along with the list of eligible days in the Final Position Paper[45] does not constitute the proper adding of an issue. Rather, the final position paper is perfunctory in that it only makes perfunctory conclusions[46] and fails to comply with its obligations under 42 C.F.R. §§ 405.1853(b)(2)-(3), 412.106(b)(4)(iii), and 405.1871(a)(3) and Board Rules 25 and 27.2 (in effect when the final position paper was filed[47]).

Based on the above, the Board finds that QRS withdrew Issue 7 in its entirety (including the 1115 waiver days issue) and, in the alternative that, even if QRS had not withdrawn it, the Board would have dismissed due to the fact that the appeal did not include § 1115 waiver days, nor was it either properly added or even briefed in the position paper filings consistent with 42 C.F.R. §§ 405.1853(b)(2)-(3), 412.106(b)(4)(iii), and 405.1871(a)(3) and Board Rules 25 and 27.2.[48]

* * * * *

In summary the Board finds that the first aspect of Issue 1, DSH SSI Percentage (Provider Specific), in this appeal is duplicative of the group issue in Case No. 13-3926GC, for this same provider and fiscal year. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (July 1, 2015), the Board dismisses this aspect of the DSH/SSI (Provider Specific) issue. The second aspect of the DSH SSI Percentage (Provider Specific) issue—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—is also dismissed by the Board for lack of jurisdiction.

Finally, the Board finds that the Provider withdrew issue 7 from the appeal in its entirety and without qualification and, as such, it is not pending in the appeal. Regardless, the Section 1115 Waiver days issue, was not timely appealed to the appeal (as a sub-issue of Issue#7) nor was it properly added or briefed in the position paper filings consistent with 42 C.F.R. §§ 405.1853(b)(2)-(3), 412.106(b)(4)(iii), and 405.1871(a)(3) and Board Rules 25 and 27.2.

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[45] *See* Provider's July 14, 2023 Final Position Paper Ex. P-1.

[46] For example, QRS cites to *Forrest General Hosp.*, 926 F.3d 221 (5th Cir. 2019) for the proposition that "the plain language of the statute and regulations require inclusion in the Medicaid Fraction of the days belong to individual who are included in a section 1115 demonstration project that provides benefits through an uncompensated care pool." However, QRS fails to explain why this sweeping statement is relevant to the § 1115 waiver days at issue. Is QRS asserting that the § 1115 waiver days at issue relate to an uncompensated care pool? Is that pool similar to that in *Forrest General Hosp.*? QRS fails to brief the merits of its claims and fails to establish the Board's jurisdiction over the § 1115 waiver day issue as required by 42 C.F.R. § 405.1853(b)(2). Indeed, the quoted sentence is the only time the final position paper references "uncompensated care pool."

[47] Contrary to QRS' assertion, the Provider's final position paper was subject to the Board Rules then in effect that had been issued November 2021 (more than 1½ years prior to the July 14, 2023 filing date of that position paper). This version reinforces the fact that position papers (whether preliminary or final) must be fully developed for each issue and all exhibits must be included.

[48] If 1115 waiver days were found to be part of the appeal request and had been properly briefed, the Board would still need to address an additional jurisdictional issue – review whether it had jurisdiction over the 1115 waiver days

Accordingly, to the extent it could be considered pending in the appeal, the Board would dismiss the 1115 waiver days issue.

As no issues remain in the appeal, the Board hereby closes Case No. 16-2099 and removes it from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

12/15/2023

X Clayton J. Nix

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

cc: Michael Redmond, Novitas Solutions, Inc.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

Lorraine Frewert
Noridian Healthcare Solutions
c/o Cahaba Safeguard Administrators (J-E)
P.O. Box 6782
Fargo, ND 58108-6782

RE: ***Board Determination on Request for Reinstatement***
Case No. 18-1005GC – UC 2010 Exclusion of Dual Elig. Part C Days from Medicaid Ratio CIRP
Case No. 18-1008GC – UC 2010 Inclusion of Medicare Part C Days in the SSI Ratio CIRP

Dear Mr. Chinea and Ms. Frewert:

The Provider Reimbursement Review Board (the "Board") has reviewed the December 9, 2022 request for reinstatement of the subject common issue related party ("CIRP") group appeals. The pertinent facts regarding these CIRP groups and the Board's determination are set forth below.

Pertinent Facts:

On **February 26, 2018**, Toyon Associates, Inc. ("Toyon"/ "Representative") filed the subject Medicaid and SSI Fraction Part C Days CIRP groups:[1]

- The "UC 2010 Exclusion of Dual Eligible Part C Days from the Medicaid Ratio CIRP Group" *("Medicaid Fraction Part C Days CIRP")* was filed under Case No. 18-1005GC and included one provider: University of California Davis Medical Center (05-0599), which transferred the DSH Payments - Dual Eligible Part C Days - Medicaid Ratio issue from Case No. 17-1817.
- The "UC 2010 Inclusion of Medicare Part C Days in the SSI Ratio CIRP Group" ("*SSI Fraction Part C Days")* Group was filed under Case No. 18-1008GC and included three providers:
  - University of California Davis Medical Center (05-0599), which transferred the "DSH-Inclusion of Part C Days in the SSI Ratio" issue from Case No. 17-1817;
  - University of Santa Monica (05-0112) which was initially transferred to an optional "Medicare Fraction Medicare Advantage Days" Group, Case No. 15-1683G, from which it was transferred to the CIRP group; and

[1] The group cases are considered to be "Legacy" cases as they were filed prior to the Office of Hearings Case & Document Management System ("OH CDMS") being mandatory. Both groups were populated in OH CDMS on March 3, 2022.

- University of California, Irvine Medical Center (05-0348) which transferred the "DSH Incl. of Medicare Pt C Days in SSI Ratio Issued 3/16/12" issue from Case No. 18-1368.[2]

On **September 25, 2020**, Toyon filed the "Univ of California CY 2010 DSH Medicare Part C - SSI Ratio/DE Part C - Medicaid Ratio CIRP Group" ("*Combined Fraction CIRP*") under Case No. 20-2138GC for the same calendar year. Case No. 20-2138GC was formed with a single participant, UCSF Medical Center (05-0454), that transferred to the group from its individual appeal, Case No. 20-1140.

On **September 30, 2020**, the Board closed the *Combined Fraction CIRP* group, Case No. 20-2138GC, with the originating participant, UCSF Medical Center, when it issued a remand pursuant to CMS Ruling 1739-R.

On **September 30, 2022,** the Board dismissed the *Medicaid and SSI Fraction Part C Days* Groups Case Nos. 18-1005GC & 18-1008GC because the issue in the groups were found to be duplicative of the issue that had been remanded in the *Combined Fraction CIRP* group under Case No. 20-2138GC. The Board found that the University of California Health System's pursuit of the Part C CIRP issue in Case No. 20-2138GC was in violation of 42 C.F.R. § 405.1837(b)(1)(i) and Board Rules 12.3.1 and 4.6. Additionally, the Board found that Toyon made false certifications in its pursuit of the duplicate group. Consequently, the Board determined that, by filing the new *Combined Fraction CIRP* group, Toyon effectively abandoned the earlier CIRP groups under Case Nos. 18-1005GC and 18-1008GC.

On **December 9, 2022**, Toyon requested the reinstatement of Case Nos. 18-1005GC & 18-1008GC. In its request for reinstatement, Toyon explained that in 2018, when it filed the separate Medicaid and SSI Fraction Dual Eligible Days groups, the Board considered each fraction of the Part C issue to be separate issues. However, in 2020, when Case No. 20-2138GC was filed, the Board had reversed its position and considered both fractions of the Part C issue to be a single issue. Toyon argued that, because the sole provider in Case No. 20-2138GC, UCSF Medical Center, had appealed the Part C Days issue as a single issue in the individual case from which it was transferring, it could not have transferred the single issue to the two separate Medicaid and SSI Fraction Part C Days groups, that had already been established respectively, under Case Nos. 18-1005GC and 18-1008GC. In addition, Toyon argued that the three University of California providers participating in Case Nos.18-1005GC[3] and 18-1008GC were not duplicative of the sole provider included in Case No. 20-2138GC.

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.

[2] UC, Irvine Med. Ctr. (05-0348) also requested the transfer of an issue titled "Inclusion of Medicare Part A Unpaid Days in SSI Ratio" from Case No. 18-1368 to the "Univ of California CY 2010 SSI/Medicaid DE Days CIRP Group," Case No. 20-2018GC.
[3] Case No. 18-1005GC included only 1 of the 3 participants also in Case No. 18-1008GC – UC Davis Med. Ctr. (05-0599).

Having reviewed the facts in all three Univ. of Calif. CY 2010 Part C Days Groups, Case Nos. 20-2138GC, 18-1005GC and 18-1008GC, the Board ***denies*** Toyon's request for reinstatement of Case Nos. 18-1005GC and 18-1008GC.

Pursuant to 42 C.F.R. § 405.1837(b) and Board Rule 12.3.1

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

When a group is filed, Board Rule 12.10 requires that the Group Representative certify the group submission by confirming that ". . . the group issue filed in this appeal is not pending in any other appeal for the same period for the same providers, nor has it been adjudicated, withdrawn, or dismissed from any other PRRB appeal."

Toyon infers that the reason it filed the (*duplicate*) combined fraction Part C Days CIRP under Case No. 20-2138GC was due to the Board's changing position on whether the SSI and Medicaid Fraction Part C Days issues were considered one or two issues. However, rather than forming a new University of California 2010 Part C Days CIRP group, in violation of 42 C.F.R. § 405.1837(b)(1)(i) and Board Rules 4.6, 12.3.1 and 12.10, it is the Board's position that Toyon should have either:

1. Requested the bifurcation of the combined fraction Part C Days issue into separate SSI and Medicaid Fraction Part C Days issues in the Provider's individual appeal, Case No. 20-1140, prior to requesting the transfer(s); or

2. Requested the consolidation of the two split fraction Part C Days groups, Case Nos. 18-1005GC and 18-1008GC, into a combined fraction group, prior to requesting the transfer from the Provider's individual appeal.

Regardless, at no point *prior to the reinstatement request* did Toyon assert it had informed the Board of its alleged inferences or seek Board guidance and there is no record of that occurring in Case Nos. 18-1005GC or 18-1008GC. Indeed, if that were the case, it should not have certified in its appeal request for Case No. 20-2138GC that there were no other appeals of the same issue pending and, similarly, it should not have made a similar false certification in the individual appeal for the sole provider that was transferred into Case No. 20-2138GC on September 25, 2020. This appears to be a mismanagement issue.[4] By pursuing the UC CIRP issue as part of a

[4] The Board notes that this is not the first instance of mismanagement and duplicate appeal issues involving Toyon. The Board takes administrative notice that, on February 3, 2021, in connection with 109 group cases involving dual eligible ("DE") days (Case No. 18-1724GC, e*t al.*), the Board stated: "***[t]he Board is very displeased with Toyon mismanagement of its appeals of the DE Days issue and admonishes Toyon for causing the Board to needlessly waste resources*** *processing incomplete, improper, and/or inaccurate filings.* ***The Board reminds you*** *that, consistent with basic rules for professional conduct and the duties owed to clients,* ***your*** *responsibilities as a representative for providers and hospital chains include: (a) Both managing and maintaining an accurate inventory of your clients' appeals and any related filings and Board correspondence; (b) Confirming whether your client is*

new *duplicate* appeal under Case No. 20-2138GC (in violation of 42 C.F.R. § 405.1837(b)(1)(i) and Board Rules 12.3.1 and 4.6) and making the false certifications in pursuit thereof, the Board appropriately found that Toyon abandoned the earlier cases under Case Nos. 18-1005GC and 18-1008GC.[5] In this regard, *it has been **more than 2 years** since the Board remanded Case No. 20-2138GC* Toyon still has never filed any objection or request for reinstatement of Case No. 20-2138GC. Accordingly, the Board's basis and reasoning for dismissal of Case Nos. 18-1005GC and 18-1008GC remains valid and appropriate.

Indeed, it would be in appropriate for the Board to reinstate 18-1005GC and 18-1008GC as requested by Toyon since: (1) UC may only pursue a common issue for a particular year in one CIRP group; (2) Case No. 20-2138GC adjudicated for the Part C issue for 2010 which is the same issue and year as that in Case Nos. 18-1005GC and 18-1008GC; and (3) Toyon has not requested reinstatement of Case No. 20-2138GC. With respect to the Part C Days issue, as the Board advised in its initial dismissal of Case Nos. 18-1005GC and 18-1008GC, based on the 2014 holding in *Allina Health Servs. v. Sebelius*, the DSH statute at 42 U.S.C. § 1395ww(d)(5)(F)(vi) "unambiguously requires" that Part C days be included in either the SSI fraction or Medicaid fraction. Under *Allina*, the SSI and Medicaid Fractions of the Part C Days issue are considered a single issue because the disposition of the Part C days in the SSI Fraction issue dictates the disposition of the Part C Days in the Medicaid Fraction (and vice versa).

Therefore, the Board finds that the Part C Days issue in the remanded "Univ of California CY 2010 DSH Medicare Part C - SSI Ratio/DE Part C - Medicaid Ratio CIRP Group" under Case No. 20-2138GC has already been adjudicated for the Univ of California organization. Consequently, the Board declines to exercise its discretion to reopen and reconsider its dismissal of Case Nos.18-1005GC and 18-1008GC.

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

For the Board:

12/15/2023

X Clayton J. Nix

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

cc: Wilson C. Leong, Federal Specialized Services

subject to the CIRP group requirements in 42 C.F.R. § 405.1837(b)(1)(i) and the Board Rules; (c) If so, ensuring that your client complies with those requirements (e.g., joining the relevant existing open CIRP group, establishing a new CIRP group if one had not been previously established, and ensuring no duplicate CIRP groups are filed); and (d) Providing periodic updates to your client regarding their appeals, including the inventory of their cases pending before the Board." and, among other things, "***directs Toyon to review its current inventory of all group cases pending with the Board to identify and remove any duplicate group cases (whether through requests for consolidation or withdrawal).***" (Emphasis in original and footnote omitted.)

[5] The last actions taking in Case Nos. 18-1005GC and 18-1008GC were taken ***prior to*** Toyon establishing the prohibited duplicate appeal under Case No. 20-2138GC on September 25, 2020.

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

Isaac Blumberg
Blumberg Ribner, Inc.
11400 W. Olympic Blvd., Ste. 700
Los Angeles, CA 90064

Lorraine Frewert
Noridian Healthcare Solutions
P.O. Box 6782
Fargo, ND 58108

RE: ***Request to Reinstate & Bifurcate Group Appeal Regarding DSH Part C Days Issue***
Corona Regional Medical Center (Prov. No. 05-0329, FYE 12/31/2002)
Case No. 06-2085

Dear Mr. Blumberg and Ms. Frewert:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Providers' June 7, 2016 request for Rescission of Remand and Bifurcation of Group Appeal regarding DSH Part C Days for Provider Corona Regional Medical Center. As set forth below, the Board denies this request because the Provider is seeking bifurcation of Part C Days but the request for remand, final position paper, nor appeal request specifically raised the Part C Days issue.

Background:

On **August 7, 2006**, the Board received the Provider's initial appeal request. The initial appeal included two issues: Medicare SSI Percentage and Medicare/Medicaid Dual Eligible Patient Days. The description for the Medicare/Medicaid Dual Eligible Patient Days issue reads:

> **Medicare/Medicaid Dual Eligible Patient Days** – The Provider contends that the Disproportionate Share (DSH) adjustment has not been calculated in accordance with Medicare regulations and Manual provisions as described in 42 CFR Section 412.106. Further, the Provider contends that the Medicare/Medicaid dual eligible patient days have not been properly included in the DSH calculation. Estimated Impact: $123,000[1]

On **May 2, 2007**, the Provider filed a Final Position Paper with the following complete issue statement for dual eligible days:

> Facts
>
> During the Medicare audit, the Intermediary calculated the Medicare Disproportionate Share (DSH) Adjustment in accordance with Medicare Statute, Regulations and Manual Provisions. The

[1] Request for Medicare Appeal at 2 (Aug. 7, 2006).

> two variables used in determining the DSH adjustment are (A) the SSI percentage and (B) the Medicaid utilization percentage.
>
> Provider's Position
>
> The Provider agrees in principle with the methodology used by the Intermediary to determine the adjustment. However, the Medicare/ Medicaid dual eligible patient days have not been properly included in the DSH calculation. The estimated impact of the Medicare/ Medicaid Dual Eligible Patient Days is calculated in Exhibit P-2.
>
> Conclusion
>
> The Provider requests the Intermediary to revise the DSH calculation to incorporate the latest and most accurate data available.

Significantly, the Final Position Paper does not discuss Part C days, *much less reference the controlling authority relative to that issue, namely the August 11, 2004 IPPS Final Rule for FFY 2005 published at 69 Fed. Reg. 48916, 49099 (Aug. 11, 2004).*

On **April 3, 2014**, Blumberg Ribner requested a remand under the Standard Procedure of 1498-R without requesting bifurcation of the Part C days issue:

> In accordance with the PRRB's recently issued ALERT 7, the Provider hereby identifies the Dual Eligible Days issue as governed by CMS-1498-R. The Provider hereby requests the Dual Eligible Days issue be remanded under the Standard Procedure. Finally, the Provider reserves the right to challenge both the CMS Ruling and any remand order at the appropriate time.

On **May 29, 2014**, the Board remanded the issue and closed the appeal, as dual eligible days was the last issue pending.

Provider's Request for Rescission of Remand and Bifurcation of Group Appeal Regarding DSH Part C Days Issue:

On **June 7, 2016**, the Board received the request for rescission of the remand and bifurcation of the Part C issue. The Providers argues that the references to dual eligible patient days were intended to refer to persons eligible for Part A and Part C.[2]

The Providers argue that:

> The Board should find that it possessed authority over the dual eligible days issue. The Board's finding that it lacked jurisdiction

[2] Bifurcation Request Letter at 1 (May 27, 2016).

> over, and the [1498-R] remand of, the dual eligible days issue was inappropriate because it was the intent of the Providers to appeal the Medicare Part C days issue.

The Providers refer to a decision in Case No. 08-2624GC in which the Board granted bifurcation of dual eligible Part A and Part C days in Sutter Health 1998 DSH Dual Eligible Days CIRP Group. In that December 30, 2015 letter, the Board stated:

> [T]he Board acknowledges that *at the time that Sutter Health's individual and group appeals were filed, the issue of whether a Medicaid patient that was "dually eligible" for Medicare was not necessarily subdivided by Medicare Part A or HMO/Part C days.* Federal courts later ruled differently on the "dual eligibility" related to Part A and Part C days therefore necessitating the Board to bifurcate these issues. In this case, the Board finds that the *providers' individual appeals and the original optional group appeal added the dual eligible days issue using a broad issue statement that encompassed both dual eligible Part A non-covered days and HMO days.* (Emphasis in original).[3]

The Providers next argue that the Board has the authority to reopen its remand decision and should do so. They reference 42 C.F.R. § 405.1885(b)(3), "A Secretary or contractor determination or decision by the reviewing entity may be reopened and revised at any time if it is established that the determination or decision was procured by fraud or similar fault of any party to the determination or decision." They conclude that that the MAC was at fault in accepting the dual eligible days remand, and the Board should reopen the remand decision.

Last, the Providers argue that they filed their *individual* appeals between March 1, 2002 and August 21, 200**9** in accordance with Board Instructions in effect during that time. The Board Instructions effective March 1, 2002 stated:

> Your hearing request must include an identification and statement of the issue(S) you are disputing. You must identify the specific issues, findings of fact and conclusions of law . . . **You must precisely identify the component of the DSH issue that is in dispute.**

The Providers argue that these Instructions did not require that they state the issue as "finely" as would be required under later rules. The Providers conclude that they were required to precisely define the DSH component at issue, which they did.

However, contrary to their assertion, the March 1, 2002 Board Instructions were ***not*** in effect *until* August 21, 200***9***. Rather, they were superseded by Board Rules issued *one year earlier* effective August 21, 200***8*** because the Board issued the August 21, 2008 revised Board Rules to

[3] *Id.* at 2.

implement changes to the Board's governing regulations *that were similarly effective August 21, 200**8*** and included material and significant clarifications on the minimum content for individual appeal requests (42 C.F.R. § 405.1835(b) (2009)) as well as group appeal requests (42 C.F.R. § 405.1837(c) (2009)).[4]

Decision of the Board:

Board Rule 46.1 (July 1, 2015), in effect at the time the request was filed, addresses how the Board handles a 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 . . . 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."

> **46.1 – 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. These requirements also apply to Rules 46.2 and 46.3 below.[5]

As discussed above, on April 3, 2014, Blumberg Ribner clearly and explicitly identified the issue statement as subject to CMS Ruling 1498-R and ***specifically*** *requested* that the Board issue a standard remand under CMS Ruling 1498-R. Significantly, the remand request was ***unqualified*** and it did not identify any other issues that would remain pending in the Provider's individual appeal or request bifurcation of the dual eligible days issue.[6] Indeed, Blumberg Ribner did not file its request for reinstatement ***until more than 2 years later*** and failed to mention or discuss the fact that it specifically requested that the Board remand the dual eligible days issue without request bifurcation of the Part C days issue.

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[4] *See* 73 Fed. Reg. 30190 (May 23, 2008).
[5] (Emphasis added.)
[6] The request for reinstatement is not a "challenge" to the Ruling or remand order and, if it were, the Board would find that it lacks jurisdiction to consider one since the Ruling removed the Board's jurisdiction for the dual eligible days issue upon remand. Again, Blumberg Ribner requested the Board to remand the dual eligible days issue.

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

Notably, Ruling 1498-R ***does not*** address the Part C days issue. Had the Provider intended to pursue the Part C days issue, it should have notified the Board when it submitted its letter requesting remand, ***if not sooner***. Accordingly, to the extent the alleged Part C issue was ever part of Case No. 06-2085, the Provider abandoned it by failing to properly notify the Board the alleged Part C days issue *prior to requesting remand of the last issue in the appeal*, which would result in the close of the appeal. Accordingly, the Board declines to exercise discretion to reinstate this case since it is clear that Blumberg Ribner has failed to establish good cause for doing so.

There is a separate and independent basis for the Board to deny the reinstatement request. The Board also notes that neither the issue statement of the in the Provider's appeal request nor the issue statement in its Position Paper contemplates the Part C days issue. As pointed out in the rescission and bifurcation request, regulations and Board rules require specificity with regards to each item under appeal. 42 C.F.R. § 405.1835(b)(2) (2009) reads, in part:

> (2) An explanation (for each specific item at issue . . .) of the provider's dissatisfaction with the intermediary's or Secretary's determination under appeal, including an account of the following:
>
> (i) Why the provider believes Medicare payment is incorrect *for each disputed item* . . .[7]
>
> (ii) How and why the provider believes Medicare payment must be determined differently *for each disputed item*.[8]

Board Rules have also long required that providers include identification of the issues in dispute with specificity:

> Your hearing request must include an identification and statement of the issue(s) you are disputing. You must identify the specific issues, findings of fact and conclusions of law with which the affected parties disagree; and you must specify the basis for contending the findings and conclusions are incorrect . . . You must clearly and specifically identify your position in regard to the

[7] (Emphasis added.)
[8] 42 C.F.R § 405.1835(b)(1)-(2) (emphasis added.)

> issues in dispute. For instance, if you are appealing an aspect of the disproportionate share (DSH) adjustment factor or calculation, do not definite the issue as "DSH". You must precisely identify the component of the DSH issue that is in dispute.[9]

The Provider's final position paper was governed by the Board Rules, Part II, Section B.IV (2002), in pertinent part:

> IV. ACCEPTABLE FINAL POSITON PAPERS
>
> If your position paper does not explain the facts or make any arguments about an issue in accordance with the following guidelines, the Board may find that the position paper submitted for this issue is unacceptable. *In this case, it **will dismiss** the issue from the appeal. If you fail to address an issue, the Board **will dismiss** it from your appeal*.
>
> ****
>
> b. Content Standards
>
> The Board expects the position papers to state the relevant facts and present arguments setting forth the parties' positions *for **each** issue*. Specifically, the description of an issue must include a summary of *the pertinent facts and circumstances and **cite the relevant** statutory provisions, **regulations***, CMS Rulings, ***and other controlling authorities***. You must identify the monetary amount, and explain its computation, *for **each** item in dispute*. . . . In addition, the Board expects the papers to contain all documentary evidence and corroboration for the positions taken, as well as other items or statements that would assist the Board in its deliberations. Jurisdiction and other motions must not be embedded in the position papers but must be addressed in a separate document.

The Board finds that the issue statement and preliminary position paper do not properly meet the specificity requirements as set forth in the regulation and Board rules to have appealed the dual eligible Part C days issue. Regardless, the Provider filed a final position paper that did not identify the Part C days issue notwithstanding the directive in Board Rules, Part II, Section B.IV (2002). *Here the final position paper did not even mention or reference the Part C days issue, **much less reference the controlling authority for the Part C days issue** – the August 11, 2004 IPPS Final Rule for FFY 2005 published at 69 Fed. Reg. 48916, 49099 (Aug. 11, 2004)*.

The Board's finding that neither the appeal request nor final position paper met the Board Rules content requirements is consistent with the recent ruling by the U.S. District Court for the

[9] Provider Reimbursement Review Board, Part I, B, II. (March 1, 2002).

District of Columbia in *Evangelical Community Hospital, et al. v. Becerra*.[10] In that case, the provider's issue was tied to improper calculation to DSH payment and read in part, "[t]he intermediary erred by incorrectly calculating the SSI percentage for inclusion in the 'Medicare Fraction' for purposes of the calculation of the provider's [disproportionate share] payment . . ."[11] The Court found that "[t]his description does not specify which portion of the calculation was incorrect nor how the fraction should have been calculated differently."[12] The Court found that this was a description of the issue was a violation of Board rules and a proper basis on which for the Board to dismiss the appeal.[13] Here, the Board makes the same finding based on similarly *overly generalized language*.

For the reasons set forth above, the Board **declines** to exercise its discretion to reopen and reinstate Case No. 06-2085 and, thus, **denies** the request for reinstatement and rescission of remand in order to reinstate the Part C Days issue. Accordingly, Case No. 06-2085 remains closed.

Board Members Participating:

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

For the Board:

12/15/2023

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services

[10] 21-cv-01368 (APM) (D.D.C. Sep. 30, 2022).
[11] *Id*. at 11.
[12] *Id.*
[13] *Id.*

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

Isaac Blumberg
Blumberg Ribner, Inc.
11400 W. Olympic Blvd. Suite 700
Los Angeles, CA 90064

Danelle Decker
Mail point INA102-AF42
P.O. Box 6474
Indianapolis, IN 46206

RE: ***Request for Rescission of Remand and Bifurcation of Group Appeal Regarding DSH Part C Days Issue***
Nyack Hospital (Prov. No. 33-0104, 12/31/2004)
Case No. 07-2519

Dear Mr. Blumberg and Ms. Decker:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Providers' June 7, 2016 request for Rescission of Remand and Bifurcation of Group Appeal regarding DSH Part C Days for Provider Corona Regional Medical Center. As set forth below, the Board denies this request because the Provider is seeking bifurcation of Part C Days but the request for remand, final position paper, nor appeal request specifically raised the Part C Days issue.

Background:

On **July 20, 2007**, the Board received the Provider's initial appeal request to establish the instant individual provider case. The initial appeal included two issues: Medicare SSI Percentage and Medicare/Medicaid Dual Eligible Patient Days. The description for the Medicare/Medicaid Dual Eligible Patient Days issue reads:

> **Medicare/Medicaid Dual Eligible Patient Days** – The Provider contends that the Disproportionate Share (DSH) adjustment has not been calculated in accordance with Medicare regulations and Manual provisions as described in 42 CFR Section 412.106. Further, the Provider contends that the Medicare/Medicaid dual eligible patient days have not been properly included in the DSH calculation. Estimated Impact: $72,000[1]

On **March 27, 2008**, the Provider filed a Final Position Paper with the following complete issue statement for dual eligible days:

[1] Request for Appeal at 2 (July 30, 2007).

Facts

During the Medicare audit, the Intermediary calculated the Medicare Disproportionate Share (DSH) Adjustment in accordance with Medicare Statute, Regulations and Manual Provisions. The two variables used in determining the DSH adjustment are (A) the SSI percentage and (B) the Medicaid utilization percentage.

Provider's Position

The Provider agrees in principle with the methodology used by the Intermediary to determine the adjustment. However, the Medicare/Medicaid dual eligible patient days have not been properly included in the DSH calculation. The estimated impact of the Medicare/Medicaid Dual Eligible Patient Days is calculated in Exhibit P-2.

Conclusion

The Provider requests the Intermediary to revise the DSH calculation to incorporate the latest and most accurate data available.

On **September 11, 2014**, the Board remanded the dual eligible days issue. The appeal remained open and was scheduled for hearing.

On **September 24, 2014**, Robert Wilkin of Blumberg Ribner emailed the Board Advisor requesting closure of the appeal:

> There is no need for the forthcoming Hearing. ***All*** *of the issues have been transferred, withdrawn, remanded or dismissed*.[2]

Therefore, in response to the Provider's assertion that ***all*** *of the issues had been either withdrawn, remanded, or dismissed*, the Board closed the appeal.

Provider's Request for Rescission of Remand and Bifurcation of Group Appeal Regarding DSH Part C Days Issue:

On **June 7, 2016**, the Board received the request for rescission of the remand and bifurcation of the Part C issue. The Providers argues that the references to dual eligible patient days were intended to refer to persons eligible for Part A and Part C.[3]

The Providers argue that:

[2] (Emphasis added.)
[3] Bifurcation Request Letter at 1 (May 27, 2016).

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

The Providers refer to a decision in Case No. 08-2624GC in which the Board granted bifurcation of dual eligible Part A and Part C days in Sutter Health 1998 DSH Dual Eligible Days CIRP Group. In that December 30, 2015 letter, the Board stated:

> [T]he Board acknowledges that *at the time that Sutter Health's individual and group appeals were filed, the issue of whether a Medicaid patient that was "dually eligible" for Medicare was not necessarily subdivided by Medicare Part A or HMO/Part C days.* Federal courts later ruled differently on the "dual eligibility" related to Part A and Part C days therefore necessitating the Board to bifurcate these issues. In this case, the Board finds that the *providers' individual appeals and the original optional group appeal added the dual eligible days issue using a broad issue statement that encompassed both dual eligible Part A non-covered days and HMO days.* (Emphasis in original).[4]

Last, the Providers argue that they filed their *individual* appeals between March 1, 2002 and August 21, 200**9** in accordance with Board Instructions in effect during that time. The Board Instructions effective March 1, 2002 stated:

> Your hearing request must include an identification and statement of the issue(s) you are disputing. You must identify the specific issues, findings of fact and conclusions of law . . . **You must precisely identify the component of the DSH issue that is in dispute.**

The Providers argue that these Instructions did not require that they state the issue as "finely" as would be required under later rules. The Providers conclude that they were required to precisely define the DSH component at issue, which they did.

However, contrary to their assertion, the March 1, 2002 Board Instructions were ***not*** in effect *until* August 21, 200***9***. Rather, they were superseded by Board Rules issued *one year earlier* effective August 21, 200***8*** because the Board issued the August 21, 2008 revised Board Rules to implement changes to the Board's governing regulations *that were similarly effective August 21, 200**8*** and included material and significant clarifications on the minimum content for individual

[4] *Id.* at 2.

appeal requests (42 C.F.R. § 405.1835(b) (2009)) as well as group appeal requests (42 C.F.R. § 405.1837(c) (2009)).[5]

Decision of the Board

Board Rule 46.1 (July 1, 2015), in effect at the time the request was filed, addresses how the Board handles a 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 . . . 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."

> **46.1 – 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. These requirements also apply to Rules 46.2 and 46.3 below.[6]

As discussed above, the case remained open after the Board remanded the dual eligible days issue pursuant to Ruling 1498-R. The Board did not close the case until Blumberg Ribner requested that the Board do so. Specifically, on September 24, 2014 Blumberg Ribner clearly and explicitly stated, "There is no need for the forthcoming Hearing. ***All of the issues*** have been transferred, withdrawn, remanded or dismissed."[7] Even if the Provider had intended to pursue the Part C days issue in this individual appeal, Blumberg Ribner abandoned that issue when it very clearly stated ***without <u>any</u> qualification*** that every issue had been resolved as of September 2014. Notwithstanding, Blumberg Ribner's request for reinstatement was not filed ***until more than 1½ years after the Board closed the case,*** and yet it failed discuss or acknowledge that the Board closed this case consistent with its request. Accordingly, upon this basis along, the Board declines to exercise its discretion to reinstate this individual provider appeal as Blumberg Ribner has failed to establish good cause to do so.

---

[5] *See* 73 Fed. Reg. 30190 (May 23, 2008).
[6] (Emphasis added.)
[7] (Emphasis added.)

There is another separate and independent basis to deny the request for reconsideration. As pointed out in the rescission and bifurcation request, regulations and Board rules require specificity with regards to each item under appeal. 42 C.F.R. § 405.1835(b)(2) (2009) reads, in part:

> (2) An explanation (for each specific item at issue . . .) of the provider's dissatisfaction with the intermediary's or Secretary's determination under appeal, including an account of the following:
>
> (i) Why the provider believes Medicare payment is incorrect *for each disputed item* . . .[8]
>
> (ii) How and why the provider believes Medicare payment must be determined differently *for each disputed item*.[9]

Board Rules have also long required that providers include identification of the issues in dispute with specificity:

> Your hearing request must include an identification and statement of the issue(s) you are disputing. You must identify the specific issues, findings of fact and conclusions of law with which the affected parties disagree; and you must specify the basis for contending the findings and conclusions are incorrect . . . You must clearly and specifically identify your position in regard to the issues in dispute. For instance, if you are appealing an aspect of the disproportionate share (DSH) adjustment factor or calculation, do not definite the issue as "DSH". *You must precisely identify the component of the DSH issue that is in dispute*.[10]

The Board finds that the issue statement for the dual eligible days issue statement can only be read to encompass the dual eligible Part A days issue. The appeal language does not meet the specificity requirements as set forth in the regulation and Board rules to have appealed the dual eligible Part C days issue.

Regardless, the Provider filed a final position paper that did not identify the Part C days issue notwithstanding the directive in Board Rules, Part II, Section B.IV (2002), in pertinent part:

---

[8] (Emphasis added.)
[9] 42 C.F.R § 405.1835(b)(1)-(2) (emphasis added.)
[10] Provider Reimbursement Review Board, Part I, B, II. (March 1, 2002) (emphasis added).

> IV. ACCEPTABLE FINAL POSITON PAPERS
>
> If your position paper does not explain the facts or make any arguments about an issue in accordance with the following guidelines, the Board may find that the position paper submitted for this issue is unacceptable. *In this case, it **will dismiss** the issue from the appeal. If you fail to address an issue, the Board **will dismiss** it from your appeal*.
>
> ****
>
> b. Content Standards
>
> The Board expects the position papers to state the relevant facts and present arguments setting forth the parties' positions *for **each** issue*. Specifically, the description of an issue must include a summary of *the pertinent facts and circumstances and **cite the relevant** statutory provisions, **regulations***, CMS Rulings, ***and other controlling authorities***. You must identify the monetary amount, and explain its computation, *for **each** item in dispute*. . . . In addition, the Board expects the papers to contain all documentary evidence and corroboration for the positions taken, as well as other items or statements that would assist the Board in its deliberations. Jurisdiction and other motions must not be embedded in the position papers but must be addressed in a separate document.

*Here the final position paper did not even mention or reference the Part C days issue, **much less reference the controlling authority for the Part C days issue** – the August 11, 2004 IPPS Final Rule for FFY 2005 published at 69 Fed. Reg. 48916, 49099 (Aug. 11, 2004)*.

The Board's finding that neither the appeal request nor final position paper met the Board Rules content requirements is consistent with the recent ruling by the U.S. District Court for the District of Columbia in *Evangelical Community Hospital, et al. v. Becerra*.[11] In that case, the provider's issue was tied to improper calculation to DSH payment and read in part, "[t]he intermediary erred by incorrectly calculating the SSI percentage for inclusion in the 'Medicare Fraction' for purposes of the calculation of the provider's [disproportionate share] payment . . ."[12] The Court found that "[t]his description does not specify which portion of the calculation was incorrect nor how the fraction should have been calculated differently."[13] The Court found that this was a description of the issue was a violation of Board rules and a proper basis on which for the Board to dismiss the appeal.[14] Here, the Board makes the same finding based on similarly *overly generalized language*.

[11] 21-cv-01368 (APM) (D.D.C. Sep. 30, 2022).
[12] *Id*. at 11.
[13] *Id.*
[14] *Id.*

For the reasons set forth above, the Board **declines** to exercise its discretion to reopen and reinstate Case No. 07-2519 and, thus, **denies** the request for reinstatement and rescission of remand. Accordingly, Case No. 07-2519 remains closed.

Board Members Participating:

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

For the Board:

12/15/2023

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Isaac Blumberg
Blumberg Ribner, Inc.
11400 W. Olympic Blvd. Ste. 700
Los Angeles, CA 90064

Danelle Decker
National Government Services, Inc.
Mail point INA102-AF42 P.O. Box 6474
Indianapolis, IN 46206

RE: ***Request for Rule 41.1 Reinstatement and Bifurcation of Group Appeal Regarding DSH Part C Days Issue***
NYU Healthcare System 2000-9/30/2004 Dual Eligible Days CIRP Group
Case No. 09-0926GC

Dear Mr. Blumberg and Ms. Decker:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Providers' May 6, 2016 request for Rule 41.1 Reinstatement and Bifurcation of Group Appeal regarding DSH Part C Days for the NYU Healthcare System 2000-9/30/2004 Dual Eligible Days CIRP Group. As set forth below, the Board denies this request because the Providers are seeking bifurcation of Part C Days but the instant appeal did not include Part C Days.

Background:

On **February 12, 2009**, the Board received the group appeal request. The entire description for the Medicare/Medicaid Dual Eligible Patient Days issue reads:

> Dual Eligible Days Issue – Dual Eligible Days are patient days associated with those patients who were not included in the SSI denominator by CMS' design as they were not directly billed to Medicare and did not flow through the MEDPAR system via Fee For Service Medicare Part-A. Moreover, these days were disallowed from the Medicaid numerator as well. Hence, neither the Medicaid fraction nor the Medicare fraction captured the days associated with the undisputed indigent population. As the days represent patient who were Medicaid Eligible but not Medicare Entitled, the Provider contends that these days should be included in the Medicaid fraction.
>
> Dual Eligible Days were excluded from the Medicaid fraction for a variety of reasons. By way of example, certain Dual Eligible Days are days associated with patients who are eligible for Medicaid but have exhausted their Medicare Part A benefits ("Exhausted Days"). In Edgewater Medical Center (Chicago, IL.) v. Blue Cross and Blue

> Shield Association/ Blue Cross and Blue Shield of Illinois, PRRB Hearing Dec. No. 2000-D44 (April 7, 2000), the Board held
>
> > The Board continues to maintain that the DSH numerator should include days of dually eligible patients whose Medicare Part A benefits were exhausted and who were eligible for reimbursement under the State's Medicaid plan. *See Jersey Shore Medical Center v. Blue Cross and Blue Shield of New Jersey*, PRRB Case No. 99-D4, Medicare and Medicaid Guide (CCH) ¶80,083, October 30, 1998, *vacated and remanded*, HCFA Administrator, January 4, 1999, Medicare and Medicaid Guide (CCH) ¶80,153 ("*Jersey*").
>
> Thus, in accordance with the Board's holding in the Edgewater, the Provider's Medicaid fraction should include all "Exhausted Days".

The group appeal request was initially formed for FYEs 1986 – 2005. On **August 30, 2012**, the Board sent a letter to Blumberg Ribner stating:

> It is noted that the issue in dispute in the subject appeal is partially governed by CMS Ruling 1498-R. CMS Ruling 1498-R governs the dual eligible day issue for discharges prior to 10/01/2004. The subject group involves fiscal periods after 9/30/2004.
>
> ***Please note that pursuant to Board Rule 13, the matter at issue must involve a <u>single</u> common issue of fact or interpretation of law.*** A group appeal is inappropriate if the Board could make different findings for the various Providers in a group. As the regulations for Dual Eligible days in the DSH ("Disproportionate Share Hospital") fraction was revised for discharges after 10/1/2004, periods before and after that date cannot be comingled as they involve separate interpretations of law.
>
> Therefore, you are to determine and identify which providers and FYEs are to remain in the subject group appeal and which providers and FYEs need to be restructured into a separate CIRP group for FYEs with patient discharges on or after 10/01/2004.[1]

[1] Emphasis added.

On **October 16, 2012**, Blumberg Ribner responded to the Board's request with a list of the providers and described whether they should remain in the group – the Provider with the FYE not subject to remand was no longer in the group. It also requested that the Board clarify whether the Provider with the 12/31/2004 FYE should remain or not. Significantly, Blumberg did not notify the Board that there were any other issues in the case not subject to the 1498-R Remand, notwithstanding the fact that a CIRP group can only contain one issue (42 C.F.R. § 405.1837(a)(2)) and no issues may be added to a group after the appeal request is filed (42 C.F.R. § 405.1837(f)(1)).

On **December 31, 2012**, the Board notified Blumberg Ribner that it had established a new group appeal for FYEs that occur after 10/1/2004 (Case No. 13-0143GC) in order to create separate groups for those periods governed by CMS Ruling 1498-R and those not. The periods governed by CMS Ruling 1498-R remained in the instant group.

On **June 19, 2015**, the Board requested the final Schedule of Providers with supporting jurisdictional documentation from Blumberg Ribner and specified that the SoP must be filed within 30 days. The request noted that the group is subject to CMS 1498-R remand.

On **July 16, 2015**, Blumberg Ribner filed the requested SoP. Significantly, in the filing of the SoP, BRI did ***not*** object to the planned 1498-R Remand, ***nor*** did it notify the Board that there were any other issues in the case not subject to the 1498-R Remand, notwithstanding the fact that a CIRP group can only contain one issue (42 C.F.R. § 405.1837(a)(2)) and no issues may be added to a group after the appeal request is filed (42 C.F.R. § 405.1837(f)(1)).

On **September 17, 2015**, the Board issued a jurisdiction decision dismissing 2 providers and also remanded the group appeal pursuant to CMS Ruling 1498-R and closed the appeal.

Rule 41.1 Reinstatement and Bifurcation of Group Appeal regarding DSH Part C Days Issue

On May 6, 2016, the Board received a letter from Blumberg Ribner requesting Rule 41.1 Reinstatement and Bifurcation of Group Appeal regarding DSH Part C Days issue. The Providers argues that the references to dual eligible patient days were intended to refer to persons eligible for Part A and Part C.[2]

The Providers refer to a decision in Case No. 08-2624GC in which the Board granted bifurcation of dual eligible Part A and Part C days in Sutter Health 1998 DSH Dual Eligible Days CIRP Group. In that December 30, 2015 letter, the Board stated:

> [T]he Board acknowledges that *at the time that Sutter Health's individual and group appeals were filed, the issue of whether a Medicaid patient that was "dually eligible" for Medicare was not necessarily subdivided by Medicare Part A or HMO/Part C days.*

[2] Bifurcation Request Letter at 1 (May 6, 2016).

> Federal courts later ruled differently on the "dual eligibility" related to Part A and Part C days therefore necessitating the Board to bifurcate these issues. In this case, the Board finds that the *providers' individual appeals and the original optional group appeal added the dual eligible days issue using a broad issue statement that encompassed both dual eligible Part A non-covered days and HMO days.* (Emphasis in original).[3]

The Providers next reference an Affidavit of Isaac Blumberg, the Representative of the Providers to support the contention that "the Providers' use of the term 'dual eligible days' was ***intended***" to refer to Medicare Part A Days and Medicare Part C Days." However, the referenced affidavit was ***not*** executed for this case but rather for Case No. 09-1708GC entitled "QRS Providence Health 2004 Medicare Part C Days CIRP Group." As a result, this affidavit does ***not pertain*** to this case as it was executed for a different unrelated case and appears to have a different group issue statement.

Last, the Providers argue that they filed their *individual* appeals between March 1, 2002 and August 21, 200**9** in accordance with Board Instructions in effect during that time. The Board Instructions effective March 1, 2002 stated:

> Your hearing request must include an identification and statement of the issue(S) you are disputing. You must identify the specific issues, findings of fact and conclusions of law . . . **You must precisely identify the component of the DSH issue that is in dispute.**

The Providers argue that these Instructions did not require that they state the issue as "finely" as would be required under later rules. The Providers conclude that they were required to precisely define the DSH component at issue, which they did.

However, contrary to their assertion, the March 1, 2002 Board Instructions were ***not*** in effect *until* August 21, 200***9***. Rather, they were superseded by Board Rules issued *one year earlier* effective August 21, 200***8*** because the Board issued the August 21, 2008 revised Board Rules to implement changes to the Board's governing regulations *that were similarly effective August 21, 200**8*** and included material and significant clarifications on the minimum content for individual appeal requests (42 C.F.R. § 405.1835(b) (2009)) as well as group appeal requests (42 C.F.R. § 405.1837(c) (2009)).[4] As such, the March 1, 2002 Board Instructions were only applicable to one the remaining 4 participants as listed on the Schedule of Providers attached to the Board's June 5, 2015 Remand Order.[5]

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[3] *Id.* at 2.
[4] *See* 73 Fed. Reg. 30190 (May 23, 2008).
[5] The following are a list of the remaining 4 participants with their appeal request: (1) St. Luke's Roosevelt Hosp. Ctr. appealing FY 1997 based on an appeal request filed on Mar. 11, 2004 with an add issue request filed on Aug. 16, 2006; (2) Beth Israel Med. Ctr. appealing FY 1997 based on an appeal request filed on Jul. 8, 2009; (3) St. Luke's Roosevelt Med. Ctr. appealing FY 1998 based on an appeal request filed on Oct. 14, 2009; and (4) Beth Israel Med. Ctr. appealing FY 1998 based on an appeal request filed on Aug. 24, 2009.

Decision of the Board

Board Rule 46.1 (July 1, 2015), in effect at the time the request was filed, addresses how the Board handles a 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 . . . 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."

> **46.1 – 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. These requirements also apply to Rules 46.2 and 46.3 below.[6]

As discussed above, on October 16, 2012, Blumberg Ribner corresponded with the Board regarding what FYEs were subject to CMS Ruling 1498-R remand and should be included in the group appeal. Significantly, Blumberg did not notify the Board that there were any other issues in the case not subject to the 1498-R Remand, notwithstanding the fact that the Board specifically reminded Blumberg Ribner that a CIRP group can only contain one issue (42 C.F.R. § 405.1837(a)(2)) and that no issues may be added to a group after the appeal request is filed (42 C.F.R. § 405.1837(f)(1)). Similarly, Blumberg failed to notify the Board of any alleged Part C issue in this group, when the Board asked for the SoP in order to process this case for 1498-R remand.

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

[6] (Emphasis added.)

Notably, Ruling 1498-R ***does not*** address the Part C days issue. Had the Providers intended to pursue the Part C days issue, they should have notified the Board when it submitted correspondence surrounding 1498-R remand, ***if not sooner***. Accordingly, to the extent the alleged Part C issue was ever part of Case No. 09-0926GC, the Providers abandoned it by failing to properly notify the Board the alleged Part C days issue when it failed to mention the issue in either their October 16, 2012 correspondence or their July 16, 2015 correspondence. Accordingly, the Board declines to exercise its discretion to reopen and reinstate Case No. 09-0926GC because it is clear that the Providers have not established good cause to reinstate/reopen Case No. 09-0926GC.

The Board also notes that the issue statement of the group appeal defines the days at issue in as "Fee For Service Medicare Part-A" days which is clearly the dual eligible days Part A issue, and does *not* contemplate alleged Medicare+Choice Managed Care/Part C days issue since "Fee For Service Medicare Part-A" does not encompass Part C. Moreover, the Board notes that the Affidavit attached to the Reinstatement Request is ***not*** relevant to this case or any of the underlying individual group cases but was rather executed in connection with an unrelated case (Case No. 09-1708GC) and, as such, *only* pertains to that case. Indeed, the Affidavit itself related to the intent of the individual provider appeal requests for the participants in that group and not the group appeal request itself. As such, the Board declines to give it any weight. Accordingly, a second and independent basis upon which to deny reinstatement/reopening is that the alleged Part C Days issue was ***never*** *part of the* ***group appeal*** *issue statement*[7] and, as such, it is clear that the proposed reinstatement for purposes of bifurcation has no merit.

As pointed out in the rescission and bifurcation request, regulations and Board rules require specificity with regards to each item under appeal. 42 C.F.R. § 405.1835(b)(2) (2009) reads, in part:

> (2) An explanation (for each specific item at issue . . .) of the provider's dissatisfaction with the intermediary's or Secretary's determination under appeal, including an account of the following:
>
> (i) Why the provider believes Medicare payment is incorrect *for each disputed item* . . .[8]
>
> (ii) How and why the provider believes Medicare payment must be determined differently *for each disputed item*.[9]

Board Rules have also long required that providers include identification of the issues in dispute with specificity:

> Your hearing request must include an identification and statement of the issue(s) you are disputing. You must identify the specific

[7] The group appeal was filed well after the May 23, 2008 changes to the Board's governing regulations which required greater specificity in issue statements, including group issue statements.
[8] (Emphasis added.)
[9] 42 C.F.R § 405.1835(b)(1)-(2) (emphasis added.)

> issues, findings of fact and conclusions of law with which the affected parties disagree; and you must specify the basis for contending the findings and conclusions are incorrect . . . You must clearly and specifically identify your position in regard to the issues in dispute. For instance, if you are appealing an aspect of the disproportionate share (DSH) adjustment factor or calculation, do not definite the issue as "DSH". You must precisely identify the component of the DSH issue that is in dispute.[10]

The Board finds that the issue statement for the group appeal can only be read to encompass the dual eligible Part A days issue. The group appeal issue language does not meet the specificity requirements as set forth in the regulation and Board rules to have appealed the dual eligible Part C days issue.

This finding is consistent with the recent ruling by the U.S. District Court for the District of Columbia in *Evangelical Community Hospital, et al. v. Becerra*.[11] In that case, the provider's issue was tied to improper calculation to DSH payment and read in part, "[t]he intermediary erred by incorrectly calculating the SSI percentage for inclusion in the 'Medicare Fraction' for purposes of the calculation of the provider's [disproportionate share] payment . . ."[12] The Court found that "[t]his description does not specify which portion of the calculation was incorrect nor how the fraction should have been calculated differently."[13] The Court found that this was a description of the issue was a violation of Board rules and a proper basis on which for the Board to dismiss the appeal.[14] Here, the Board makes the same finding based on similarly overly generalized language.

For the reasons set forth above, the Board **declines** to exercise its discretion to reopen and reinstate Case No. 09-0926GC and, thus, **denies** the request for reinstatement and rescission of remand in order to bifurcate a single participant from the group appeal regarding the Part C Days issue. Accordingly, Case No. 09-0926GC remains closed.

Board Members Participating:

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

For the Board:

12/15/2023

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services

[10] Provider Reimbursement Review Board, Part I, B, II. (March 1, 2002).
[11] 21-cv-01368 (APM) (D.D.C. Sep. 30, 2022).
[12] *Id*. at 11.
[13] *Id.*
[14] *Id.*

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

Isaac Blumberg
Blumberg Ribner, Inc.
11400 W. Olympic Blvd., Ste. 700
Los Angeles, CA 90064

RE: ***Request to Reinstate & Bifurcate Group Appeal Regarding DSH Part C Days Issue***
East Texas Healthcare pre-10/1/2004 Dual Eligible Days CIRP Group
Case No. 09-1326GC

Dear Mr. Blumberg:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the request for Rule 41.1 Reinstatement and Bifurcation of Group Appeal regarding DSH Part C Days that the Providers' representative, Blumberg Ribner, Inc. (Blumberg Ribner or "Representative") filed with the Board on May 23, 2016 in the above referenced appeal entitled "East Texas Healthcare pre 10/1/2004 Dual Eligible Days CIRP Group." As set forth below, the Board **denies** Blumberg Ribner's request to reinstate/reopen this appeal.

Background

On March 17, 2009, the Board received the group appeal request. The entire description for the Medicare/Medicaid Dual Eligible Patient Days issue reads, in part:

> *Dual Eligible Days* are patient days associated with those patients who were not included in the SSI denominator by CMS' design ***as they*** were not directly billed to Medicare and *did not flow through the MEDPAR system via* ***Fee For Service Medicare Part-A***. Moreover, ***these days*** were disallowed from the Medicaid numerator as well. Hence, neither the Medicaid fraction nor the Medicare fraction captured the days associated with the undisputed indigent population. As the days represent patient who were Medicaid Eligible but not Medicare Entitled, the Provider contends that ***these days*** should be included in the Medicaid fraction.
>
> *Dual Eligible Days* were excluded from the Medicaid fraction for a variety of reasons. By way of example, certain Dual Eligible Days are days associated with patients who are eligible for Medicaid but have exhausted their Medicare Part A benefits ("Exhausted Days"). In Edgewater Medical Center (Chicago, IL.) v. Blue Cross and Blue

> Shield Association/ Blue Cross and Blue Shield of Illinois, PRRB Hearing Dec. No. 2000-D44 (April 7, 2000), the Board held
>
> > The Board continues to maintain that the DSH numerator should include days of dually eligible patients whose Medicare Part A benefits were exhausted and who were eligible for reimbursement under the State's Medicaid plan. *See Jersey Shore Medical Center v. Blue Cross and Blue Shield of New Jersey*, PRRB Case No. 99-D4, Medicare and Medicaid Guide (CCH) ¶80,083, October 30, 1998, *vacated and remanded*, HCFA Administrator, January 4, 1999, Medicare and Medicaid Guide (CCH) ¶80,153 ("*Jersey*").[1]
>
> Thus, in accordance with the Board's holding in the Edgewater, the Provider's Medicaid fraction should include all "Exhausted Days".

The appeal request was originally submitted for **FYEs 1994 – 2005**.

On April 13, 2015, the Board, *on its own motion*, notified the Representative that the Board determined the group was CIRP was subject to remand pursuant to CMS Ruling 1498-R:

> The [Board] has begun review of the above-captioned appeal which includes a challenge to the exclusion of Medicare dual eligible days (where the patient was entitled to Part A benefits but the inpatient hospital stay was not covered under Part A or the patient's Part A hospital benefits were exhausted) from the calculation of the [DSH] percentage. This issue, for patient discharges before October 1, 2004, is subject to the [CMS] Ruling 1498-R.

The Board then determined that the group included a provider was appealing 2 FYEs that were *not* entirely subject to CMS Ruling 1498-R (ETMC – Tyler for 10/31/2005 and the partial period from 10/1/2004 – 10/31/2004). Accordingly, the Board transferred that provider and those periods "to a new bifurcated CIRP group, case no. 15-2026GC" and urged the Representative to "[p]lease be sure to add any ETMC providers appealing the post 10/1/2004 Dual Eligible Days issue to the newly bifurcated group, case no. 15-2026GC." Further, the Board required the Representative to submit the final Schedule of Providers ("SoP") and supporting jurisdictional documentation within 45 days so that the Board could apply CMS Ruling 1498-R.

[1] (All emphasis added except for the italics included in the case citation which was in original.)

On May 15, 2015, Blumberg Ribner submitted the final SoP with supporting jurisdictional documentation. Significantly, in the filing of the SOP, Blumberg Ribner did *not* object to the Board's transfer of the Providers not subject to remand, *nor* did it notify the Board that there were any other issues in the case not subject to the CMS Ruling 1498-R remand notwithstanding the fact that a CIRP group can only contain one issue (42 C.F.R. § 405.1837(a)(2)) and no issues may be added to a group after the appeal request is filed (42 C.F.R. § 405.1837(f)(1)).

On June 2, 2015, the Board issued a standard remand in Case No. 09-1326GC and remanded the dual eligible Part A days issue to the Medicare Contractor, pursuant to the Centers for Medicare & Medicaid Services (CMS) Ruling 1498-R.[2] Accordingly, concurrent with the remand, the Board closed the case.

Rule 41.1 Reinstatement and Bifurcation of Group Appeal regarding DSH Part C Days Issue

On May 23, 2016 (*almost a year* after the Board had remanded and closed this case on June 2, 2015), the Board received a letter from Blumberg Ribner requesting Rule 41.1 Reinstatement and Bifurcation of Group Appeal regarding DSH Part C Days issue. The Providers argues that the references to dual eligible patient days were intended to refer to persons eligible for Part A and Part C.[3]

The Providers refer to a decision in Case No. 08-2624GC in which the Board granted bifurcation of dual eligible Part A and Part C days in Sutter Health 1998 DSH Dual Eligible Days CIRP Group. In tat December 30, 2015 letter, the Board stated:

> [T]he Board acknowledges that *at the time that Sutter Health's individual and group appeals were filed, the issue of whether a Medicaid patient that was "dually eligible" for Medicare was not necessarily subdivided by Medicare Part A or HMO/Part C days.* Federal courts later ruled differently on the "dual eligibility" related to Part A and Part C days therefore necessitating the Board to bifurcate these issues. In this case, the Board finds that the *providers' individual appeals and the original optional group appeal added the dual eligible days issue using a broad issue statement that encompassed both dual eligible Part A non-covered days and HMO days.* (Emphasis in original).[4]

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

[3] Bifurcation Request Letter at 1 (May 23, 2016).

[4] *Id.* at 2.

The Providers next reference an Affidavit of Isaac Blumberg, the Representative of the Providers to support the contention that "the Providers' use of the term 'dual eligible days' was ***intended***" to refer to Medicare Part A Days and Medicare Part C Days." However, the referenced affidavit was not executed for this case but rather for Case No. 09-1708GC entitled "QRS Providence Health 2004 Medicare Part C Days CIRP Group." As a result, this affidavit does ***not pertain*** to this case as it was executed for a different unrelated case and appears to have a different group issue statement.

Last, the Providers argue that they filed their *individual* appeals between March 1, 2002 and August 21, 200**9** in accordance with Board Instructions in effect during that time. The Board Instructions effective March 1, 2002 stated:

> Your hearing request must include an identification and statement of the issue(S) you are disputing. You must identify the specific issues, findings of fact and conclusions of law . . . **You must precisely identify the component of the DSH issue that is in dispute.**

The Providers argue that these Instructions did not require that they state the issue as "finely" as would be required under later rules. The Providers conclude that they were required to precisely define the DSH component at issue, which they did.

However, contrary to their assertion, the March 1, 2002 Board Instructions were ***not*** in effect *until* August 21, 200***9***. Rather, they were superseded by Board Rules issued *one year earlier* effective August 21, 200***8*** because the Board issued the August 21, 2008 revised Board Rules to implement changes to the Board's governing regulations *that were similarly effective August 21, 200**8*** and included material and significant clarifications on the minimum content for individual appeal requests (42 C.F.R. § 405.1835(b) (2009)) as well as group appeal requests (42 C.F.R. § 405.1837(c) (2009)).[5]

Board Regulations and Rules:

At the time the group appeal request for this CIRP group case was filed on May 6, 2016, 42 C.F.R. § 405.1837(c) included the following requirements, in pertinent part, for a group appeal request:

> (c) *Contents of request for a group appeal*. The request for a Board hearing as a group appeal must be submitted in writing to the Board, and the request must include all of the following:

[5] *See* 73 Fed. Reg. 30190 (May 23, 2008).

> (1) A demonstration that the request satisfies the requirements for a Board hearing as a group appeal, as specified in paragraph (a) of this section.
>
> (2) An explanation (for each specific item at issue; see §405.1835(a)(1)) of each provider's dissatisfaction with its intermediary 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, **a description of the nature and amount of each self-disallowed item and the reimbursement sought for each item**.
>
> (3) A copy of each intermediary or Secretary determination under appeal, and any other documentary evidence the providers consider necessary to satisfy the hearing request requirements of paragraphs (c)(1) and (c)(2) of this section, and a precise description of the one question of fact or interpretation of law, regulations, or CMS Rulings that is common to the particular matters at issue in the group appeal; . . . .[6]

Further, 42 C.F.R. § 405.1837(a) specifies, in pertinent part, that there may be only one issue for a group:

> (a) *Right to Board hearing as part of a group appeal; criteria*. A provider . . . has a right to a Board hearing, as part of a group appeal with other providers, for specific items claimed for a cost reporting period covered by an intermediary . . . determination for the period, **only if**—
>
> ****
>
> (2) The matter at issue in the group appeal involves **a single question of** fact or **interpretation of law**, **regulations**, or CMS Rulings that is common to each provider in the group; . . . .[7]

To that end, 42 C.F.R. § 405.1837(f)(1) specifies that no issues may be added to a group appeal after the group appeal request is filed:

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

> After the date of receipt by the Board of a group appeal hearing request under paragraph (c) of this section, a provider *may **not** add other questions of fact or law* to the appeal, regardless of whether the question is common to other members of the appeal (as described in §405.1837(a)(2) and (g) of this subpart).[8]

Finally, 42 C.F.R. § 405.1837(b)(1) specifies, in pertinent part, that providers commonly owned by an entity must bring common issues occurring during a year as part of a group for that entity:

> (b) *Usage and filing of group appeals*— (1) *Mandatory use of group appeals*. (i) Two or more providers under common ownership or control that wish to appeal to the Board a specific matter at issue that involves a question of fact or interpretation of law, regulations, or CMS Rulings that is common to the providers, and that arises in cost reporting periods that end in the same calendar year, and for which the amount in controversy is $50,000 or more in the aggregate, **must bring the appeal as a group appeal**.
>
> ****
>
> (iii) A group appeal involving two or more providers under common ownership or control must consist entirely of providers under common (to all) ownership or control.[9]

Board Rule 13 (July 2009) provides guidance on the issue statement for group appeal requests:

> **Rule 13 - Common Group Issue**
>
> The matter at issue must involve a single common question of fact or interpretation of law, regulation or CMS policy or ruling. A group case is not appropriate if facts that must be proved are unique to the respective Providers or if the undisputed controlling facts are not common to all group members. Likewise, a group appeal is inappropriate if the Board could make different findings for the various Providers in the group. However, for illustration purposes in a brief or hearing, facts relating to a specific Provider(s) may be presented as representative of all group members. Refer to Rules 7 and 8 for guidance.

Board Rules 7 and 8 (July 2009) stated in pertinent part:

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[8] (Emphasis added.)
[9] (Bold and underline emphasis added and italics emphasis in original.)

Rule 7 - Issue Statement and Claim of Dissatisfaction

For each issue under appeal, give a brief summary of the determination being appealed and the basis for dissatisfaction. (See Rule 8 for special instructions regarding multi-component disputes.)

6 7.1 - NPR or Revised NPR Adjustments

A. Identification of Issue: Give a concise issue statement describing

• the adjustment, including the adjustment number,
• why the adjustment is incorrect, and
• how the payment should be determined differently.

B. No Access to Data: 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.

7.2 - Self-Disallowed Items

A. Authority Requires Disallowance

If you claim that the item you are appealing was not claimed on the cost report because a regulation, manual, ruling, or some other legal authority predetermined that the item would not be allowed,

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

B. No Access to Data

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

****

> **Rule 8 - Framing Issues for Adjustments Involving Multiple Components**
>
> **8.1 - General**
>
> Some issues may have multiple components. To comply with the regulatory requirement to specifically identify the items in dispute, each contested component must be appealed as a separate issue and *described as narrowly as possible* using the applicable format outlined in Rule 7. See common examples below.
>
> **8.2 - Disproportionate Share Cases** (e.g., dual eligible, general assistance, charity care, HMO days, etc.)
>
> **8.3 - Bad Debts Cases** (e.g., crossover, use of collection agency, 120-day presumption, indigence determination, etc.)
>
> **8.4 - Graduate Medical Education/Indirect Medical Education** (e.g., managed care days, resident count, outside entity rotations, etc.)
>
> **8.5 - Wage Index** (e.g., wage vs. wage-related, rural floor, data corrections, etc.)

Decision of the Board:

Board Rule 46.1 (July 1, 2015), in effect at the time the request was filed, addresses how the Board handles a 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 . . . 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."

> **46.1 – 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. These requirements also apply to Rules 46.2 and 46.3 below.[10]

As discussed above, on April 13, 2015, the Board specifically notified the Providers that the case was subject to CMS Ruling 1498-R and that it had bifurcated from this case the period from 10/1/2004 – 12/31/2004 into a new CIRP group (15-2026GC) for the provider, ETMC – Tyler, that had periods ***not*** subject to 1498-R Remand (i.e. ETMC-Tyler's FYE 10/31/2005 and the partial period from 10/1/2004 – 10/31/2004). To that end, the Board requested the Representative to file the final SoP with supporting jurisdictional documentation so the Board could complete the jurisdictional review and remand this case per CMS Ruling 1498-R. On May 15, 2015, Blumberg Ribner submitted the final SoP with supporting jurisdictional documentation. Significantly, in the filing of the SOP, Blumberg Ribner did *not* object to the Board's transfer of the Providers not subject to remand, *nor* did it notify the Board that there were any other issues in the case not subject to the CMS Ruling 1498-R remand notwithstanding the fact that a CIRP group can only contain one issue (42 C.F.R. § 405.1837(a)(2)) and no issues may be added to a group after the appeal request is filed (42 C.F.R. § 405.1837(f)(1)).

Accordingly, following Blumberg Ribner's filing of the final SOP for Case No. 09-1326GC, the Board reviewed the SOP, remanded Case No. 09-1326GC, and then closed that case. Neither the Providers nor the group representative raised *any* issue to the Board that the appeal should not be bifurcated between those fiscal periods because the Part C days issue was also pending in the appeal. Had the Providers intended to pursue the Part C days issue, they should have notified the Board at that time, if not sooner. Accordingly, an independent basis to deny reinstatement/reopening request is that, to the extent the alleged Part C issue was ever part of Case No. 09-1326GC, the Providers abandoned it by failing to properly notify the Board the alleged Part C days issue when the Board notified the Providers appealing the post-10/1/2004 period that were bifurcated and transferred to a new group and that the group (following that bifurcation) was subject to remand under 1498-R.[11] Indeed, the representative's reinstatement request was filed ***almost a year*** after the case had been remanded and closed and more than a year after the Board had notified the representative that the case was subject to 1498-R Remand. Accordingly, the Board declines to exercise its discretion to reopen and reinstate Case No. 09-1326GC because it is clear that the Providers have not established good cause to reinstate/reopen Case No. 09-1326GC.

There is an alternative independent basis for the Board's denial to exercise its discretion to reinstate this case. The Board notes that the issue statement of the group appeal defines the days at issue in as "Fee For Service Medicare Part-A" days which is clearly the dual eligible days Part A issue, and does *not* contemplate alleged Medicare+Choice Managed Care/Part C days issue

[10] (Emphasis added.)
[11] The Board takes administrative notice that many providers have appealed the Part C days issue from revised NPRs that were issued following a 1498-R remand. It is not clear to the Board whether any of the participants in this CIRP group later appealed the Part C issue for the year(s) at issue based on the revised NPR issued as a result of the 1498-R Remand. If so, it would render the bifurcation request moot.

since "Fee For Service Medicare Part-A" does not encompass Part C.[12] Moreover, the Board notes that the Affidavit attached to the Reinstatement Request is ***not*** relevant to this case or any of the underlying individual group cases but was rather executed in connection with an unrelated case (Case No. 09-1708GC) and, as such, *only* pertains to that case. Indeed, the Affidavit itself related to the intent of the individual provider appeal requests for the participants in that group and not the group appeal request itself. As such, the Board declines to give it any weight. Accordingly, a second and independent basis upon which to deny reinstatement/reopening is that the alleged Part C Days issue was never part of the group appeal issue statement and, as such, it is clear that the proposed reinstatement for purposes of bifurcation has no merit.

As pointed out in the rescission and bifurcation request, regulations and Board rules require specificity with regards to each item under appeal. 42 C.F.R. § 405.1835(b)(2) (2009) reads, in part:

> (2) An explanation (for each specific item at issue . . .) of the provider's dissatisfaction with the intermediary's or Secretary's determination under appeal, including an account of the following:
>
> (i) Why the provider believes Medicare payment is incorrect *for each disputed item* . . .[13]
>
> (ii) How and why the provider believes Medicare payment must be determined differently *for each disputed item*.[14]

Board Rules have also long required that providers include identification of the issues in dispute with specificity:

> Your hearing request must include an identification and statement of the issue(s) you are disputing. You must identify the specific issues, findings of fact and conclusions of law with which the affected parties disagree; and you must specify the basis for contending the findings and conclusions are incorrect . . . You must clearly and specifically identify your position in regard to the issues in dispute. For instance, if you are appealing an aspect of the disproportionate share (DSH) adjustment factor or calculation, do not definite the issue as "DSH". You must precisely identify the component of the DSH issue that is in dispute.[15]

---

[12] In the regard, the Board notes that the Affidavit attached to the Reinstatement Request is ***not*** relevant to this case or any of the underlying individual group cases but was rather executed in connection with an unrelated case (Case No. 09-1708GC) and, as such, *only* pertains to that case. Indeed, the Affidavit itself related to the intent of the individual provider appeal requests for the participants in that group and not the group appeal request itself. As such, the Board declines to give it any weight.

[13] (Emphasis added.)

[14] 42 C.F.R § 405.1835(b)(1)-(2) (emphasis added.)

[15] Provider Reimbursement Review Board, Part I, B, II. (March 1, 2002).

The Board finds that the issue statement for the group appeal can only be read to encompass the dual eligible Part A days issue. The group appeal issue language does not meet the specificity requirements as set forth in the regulation and Board rules to have appealed the dual eligible Part C days issue.[16]

This finding is consistent with the recent ruling by the U.S. District Court for the District of Columbia in *Evangelical Community Hospital, et al. v. Becerra*.[17] In that case, the provider's issue was tied to improper calculation to DSH payment and read in part, "[t]he intermediary erred by incorrectly calculating the SSI percentage for inclusion in the 'Medicare Fraction' for purposes of the calculation of the provider's [disproportionate share] payment . . ."[18] The Court found that "[t]his description does not specify which portion of the calculation was incorrect nor how the fraction should have been calculated differently."[19] The Court found that this was a description of the issue was a violation of Board rules and a proper basis on which for the Board to dismiss the appeal.[20] Here, the Board makes the same finding based on similarly *overly generalized* language.

For the reasons set forth above, the Board **declines** to exercise its discretion to reopen and reinstate Case No. 09-1326GC and, thus, **denies** the request for reinstatement and rescission of remand in order to bifurcate a single participant from the group appeal regarding the Part C Days issue. Accordingly, Case No. 09-1326GC remains closed.

Board Members Participating:

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

For the Board:

12/15/2023

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services
Bruce Snyder, Novitas Solutions, Inc.

[16] Again, the fact that representative's reinstatement request was filed ***almost a year*** after the case had been remanded and closed (and more than a year after the Board had notified the representative that the case was subject to 1498-R Remand) either failed to properly manage its case or was improperly attempting to expand the group appeal to include more than one issue, notwithstanding the 42 C.F.R. § 405.1837(a)(2) requirement that a group appeal can only contain one issue.
[17] 21-cv-01368, 2022WL4598546 (D.D.C. Sep. 30, 2022). *See also Franciscan St. Margaret Health v. Azar*, 407 F. Supp. 3d 28 (D.D.C. 2019).
[18] *Id*. at 11.
[19] *Id.*
[20] *Id.*

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

Isaac Blumberg
Chief Operating Officer
Blumberg Ribner, Inc.
11400 W. Olympic Blvd. Suite 700
Los Angeles, CA 90064

Danelle Decker
Lead Auditor
National Government Services, Inc.
Mail point INA102-AF42 P.O. Box 6474
Indianapolis, IN 46206

RE: ***Request to Reinstate & Bifurcate Group Appeal Regarding DSH Part C Days Issue***
Blumberg Ribner Independent Hosps Pre-10/1/2004 Dual Eligible Days Group II
Case No. 09-1496G

Dear Mr. Blumberg and Ms. Decker:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Providers' June 2, 2016 request for Rule 41.1 Reinstatement and Bifurcation of Group Appeal regarding DSH Part C Days for the Blumberg Ribner Independent Hosps Pre-10/1/2004 Group II. As set forth below, the Board denies this request because the Providers are seeking bifurcation of Part C Days but the instant appeal did not include Part C Days.

Background:

On **July 22, 2008**, the Board received the group appeal request. The entire description for the Medicare/Medicaid Dual Eligible Patient Days issue reads:

> Dual Eligible Days Issue – Dual Eligible Days are patient days associated with those patients who were not included in the SSI denominator by CMS' design as they were not directly billed to Medicare and did not flow through the MEDPAR system via Fee For Service Medicare Part-A. Moreover, these days were disallowed from the Medicaid numerator as well. Hence, neither the Medicaid fraction nor the Medicare fraction captured the days associated with the undisputed indigent population. As the days represent patient who were Medicaid Eligible but not Medicare Entitled, the Provider contends that these days should be included in the Medicaid fraction.
>
> Dual Eligible Days were excluded from the Medicaid fraction for a variety of reasons. By way of example, certain Dual Eligible Days are days associated with patients who are eligible for Medicaid but have exhausted their Medicare Part A benefits ("Exhausted Days"). In Edgewater Medical Center (Chicago, IL.) v. Blue Cross and Blue Shield Association/ Blue Cross and Blue Shield of Illinois, PRRB Hearing Dec. No. 2000-D44 (April 7, 2000), the Board held

> The Board continues to maintain that the DSH numerator should include days of dually eligible patients whose Medicare Part A benefits were exhausted and who were eligible for reimbursement under the State's Medicaid plan. *See Jersey Shore Medical Center v. Blue Cross and Blue Shield of New Jersey*, PRRB Case No. 99-D4, Medicare and Medicaid Guide (CCH) ¶80,083, October 30, 1998, *vacated and remanded*, HCFA Administrator, January 4, 1999, Medicare and Medicaid Guide (CCH) ¶80,153 ("*Jersey*").

Thus, in accordance with the Board's holding in the Edgewater, the Provider's Medicaid fraction should include all "Exhausted Days".

On **June 28, 2010**, Blumberg Ribner filed the final Schedule of Providers ("SoP") with supporting documentation and identified this case as subject to remand under CMS Ruling 1498-R. As a result, Blumberg Ribner notified the Board it would ***not*** submit its Preliminary Position Paper by the July 1, 2010 filing deadline and ***specifically*** *requested* that the Board issue a standard remand under CMS Ruling 1498-R. Significantly, the remand request was ***unqualified*** and it did not identify any other issues being present in the group appeal, notwithstanding the fact that a CIRP group can only contain one issue (42 C.F.R. § 405.1837(a)(2)) and no issues may be added to a group after the appeal request is filed (42 C.F.R. § 405.1837(f)(1)).

On **November 13, 2015**, the Board, on its own motion, notified Blumberg Ribner that the Board was bifurcating the period from 10/1/2004-12/31/2004 and establishing a new group appeal for that period (16-0206G) since the 10/1/2004-12/31/2004 period was not subject to *requested* 1498-R Remand. The period prior to 10/1/2004 remained in the appeal.

Subsequently, on **December 30, 2015**, (consistent with Blumberg's June 28, 2010 request and the Board's November 13 2015 notice) the Board remanded the group appeal of DSH dual eligible days based on CMS Ruling 1498-R, and the appeal was closed.

Rule 41.1 Reinstatement and Bifurcation of Group Appeal regarding DSH Part C Days Issue

On May 27, 2016, the Board received a letter from Blumberg Ribner requesting Rule 41.1 Reinstatement and Bifurcation of Group Appeal regarding DSH Part C Days issue. The Providers argues that the references to dual eligible patient days were intended to refer to persons eligible for Part A and Part C.[1]

The Providers argue that:

> The Board should find that it possessed authority over the dual eligible days. The Board's finding that it lacked jurisdiction over,

[1] Bifurcation Request Letter at 1 (May 27, 2016).

> and the [1498-R] remand of, the dual eligible days issue was inappropriate because it was the intent of the Providers to appeal the Medicare Part C days issue.

The Providers refer to a decision in Case No. 08-2624GC in which the Board granted bifurcation of dual eligible Part A and Part C days in Sutter Health 1998 DSH Dual Eligible Days CIRP Group. In that December 30, 2015 letter, the Board stated:

> [T]he Board acknowledges that *at the time that Sutter Health's individual and group appeals were filed, the issue of whether a Medicaid patient that was "dually eligible" for Medicare was not necessarily subdivided by Medicare Part A or HMO/Part C days.* Federal courts later ruled differently on the "dual eligibility" related to Part A and Part C days therefore necessitating the Board to bifurcate these issues. In this case, the Board finds that the *providers' individual appeals and the original optional group appeal added the dual eligible days issue using a broad issue statement that encompassed both dual eligible Part A non-covered days and HMO days.* (Emphasis in original).[2]

The Providers next argue that the Board has the authority to reopen its remand decision and should do so. They reference 42 C.F.R. § 405.1885(b)(3), "A Secretary or contractor determination or decision by the reviewing entity may be reopened and revised at any time if it is established that the determination or decision was procured by fraud or similar fault of any party to the determination or decision." They conclude that the MAC was at fault in accepting the dual eligible days remand, and the Board should reopen the remand decision.

The Providers next reference an Affidavit of Isaac Blumberg, the Representative of the Providers to support the contention that "the Providers' use of the term 'dual eligible days' was ***intended***" to refer to Medicare Part A Days and Medicare Part C Days." However, the referenced affidavit was not executed for this case but rather for Case No. 09-1708GC entitled "QRS Providence Health 2004 Medicare Part C Days CIRP Group." As a result, this affidavit does ***not pertain*** to this case as it was executed for a different unrelated case and appears to have a different group issue statement.

Last, the Providers argue that they filed their *individual* appeals between March 1, 2002 and August 21, 200**9** in accordance with Board Instructions in effect during that time. The Board Instructions effective March 1, 2002 stated:

> Your hearing request must include an identification and statement of the issue(S) you are disputing. You must identify the specific issues, findings of fact and conclusions of law . . . **You must**

[2] *Id.* at 2.

> **precisely identify the component of the DSH issue that is in dispute.**

The Providers argue that these Instructions did not require that they state the issue as "finely" as would be required under later rules. The Providers conclude that they were required to precisely define the DSH component at issue, which they did.

However, contrary to their assertion, the March 1, 2002 Board Instructions were ***not*** in effect *until* August 21, 200***9***. Rather, they were superseded by Board Rules issued *one year earlier* effective August 21, 200***8*** because the Board issued the August 21, 2008 revised Board Rules to implement changes to the Board's governing regulations *that were similarly effective August 21, 200**8*** and included material and significant clarifications on the minimum content for individual appeal requests (42 C.F.R. § 405.1835(b) (2009)) as well as group appeal requests (42 C.F.R. § 405.1837(c) (2009)).[3]

Decision of the Board

Board Rule 46.1 (July 1, 2015), in effect at the time the request was filed, addresses how the Board handles a 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 . . . 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."

> **46.1 – 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. These requirements also apply to Rules 46.2 and 46.3 below.[4]

[3] *See* 73 Fed. Reg. 30190 (May 23, 2008).
[4] (Emphasis added.)

As discussed above, on June 24, 2010, Blumberg Ribner clearly and explicitly identified the group issue statement as subject to CMS Ruling 1498-R and ***specifically*** *requested* that the Board issue a standard remand under CMS Ruling 1498-R. Significantly, the remand request was ***unqualified*** and it did not identify any other issues being present in the group appeal, notwithstanding the fact that a CIRP group can only contain one issue (42 C.F.R. § 405.1837(a)(2)) and no issues may be added to a group after the appeal request is filed (42 C.F.R. § 405.1837(f)(1)).

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

Notably, Ruling 1498-R ***does not*** address the Part C days issue. Had the Providers intended to pursue the Part C days issue, they should have notified the Board when it submitted its letter explaining that the group issue was subject to remand, ***if not sooner***. Accordingly, to the extent the alleged Part C issue was ever part of Case No. 09-1496G, the Providers abandoned it by failing to properly notify the Board the alleged Part C days issue when it specifically requested that the group be remanded. Accordingly, it is clear that the Providers have not established good cause to reinstate/reopen Case No. 09-1496G.

The Board also notes that the issue statement of the group appeal defines the days at issue in as "Fee For Service Medicare Part-A" days which is clearly the dual eligible days Part A issue, and does *not* contemplate alleged Medicare+Choice Managed Care/Part C days issue since "Fee For Service Medicare Part-A" does not encompass Part C. Moreover, the Board notes that the Affidavit attached to the Reinstatement Request is ***not*** relevant to this case or any of the underlying individual group cases but was rather executed in connection with an unrelated case (Case No. 09-1708GC) and, as such, *only* pertains to that case. Indeed, the Affidavit itself related to the intent of the individual provider appeal requests for the participants in that group and not the group appeal request itself. As such, the Board declines to give it any weight. Accordingly, a second and independent basis upon which to deny reinstatement/reopening is that the alleged Part C Days issue was never part of the group appeal issue statement and, as such, it is clear that the proposed reinstatement for purposes of bifurcation has no merit.

As pointed out in the rescission and bifurcation request, regulations and Board rules require specificity with regards to each item under appeal. 42 C.F.R. § 405.1835(b)(2) (2009) reads, in part:

> (2) An explanation (for each specific item at issue . . .) of the provider's dissatisfaction with the intermediary's or Secretary's determination under appeal, including an account of the following:

> (i) Why the provider believes Medicare payment is incorrect *for each disputed item* . . .[5]
>
> (ii) How and why the provider believes Medicare payment must be determined differently *for each disputed item*.[6]

Board Rules have also long required that providers include identification of the issues in dispute with specificity:

> Your hearing request must include an identification and statement of the issue(s) you are disputing. You must identify the specific issues, findings of fact and conclusions of law with which the affected parties disagree; and you must specify the basis for contending the findings and conclusions are incorrect . . . You must clearly and specifically identify your position in regard to the issues in dispute. For instance, if you are appealing an aspect of the disproportionate share (DSH) adjustment factor or calculation, do not definite the issue as "DSH". You must precisely identify the component of the DSH issue that is in dispute.[7]

The Board finds that the issue statement for the group appeal can only be read to encompass the dual eligible Part A days issue. The group appeal issue language does not meet the specificity requirements as set forth in the regulation and Board rules to have appealed the dual eligible Part C days issue.

This finding is consistent with the recent ruling by the U.S. District Court for the District of Columbia in *Evangelical Community Hospital, et al. v. Becerra*.[8] In that case, the provider's issue was tied to improper calculation to DSH payment and read in part, "[t]he intermediary erred by incorrectly calculating the SSI percentage for inclusion in the 'Medicare Fraction' for purposes of the calculation of the provider's [disproportionate share] payment . . ."[9] The Court found that "[t]his description does not specify which portion of the calculation was incorrect nor how the fraction should have been calculated differently."[10] The Court found that this was a description of the issue was a violation of Board rules and a proper basis on which for the Board to dismiss the appeal.[11] Here, the Board makes the same finding based on similarly overly generalized language.

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[5] (Emphasis added.)
[6] 42 C.F.R § 405.1835(b)(1)-(2) (emphasis added.)
[7] Provider Reimbursement Review Board, Part I, B, II. (March 1, 2002).
[8] 21-cv-01368 (APM) (D.D.C. Sep. 30, 2022).
[9] *Id*. at 11.
[10] *Id.*
[11] *Id.*

For the reasons set forth above, the Board **declines** to exercise its discretion to reopen and reinstate Case No. 09-1496G and, thus, **denies** the request for reinstatement and rescission of remand in order to bifurcate a single participant from the group appeal regarding the Part C Days issue. Accordingly, Case No. 09-1496G remains closed.

Board Members Participating:

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

For the Board:

12/15/2023

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Isaac Blumberg
Blumberg Ribner, Inc.
11400 W. Olympic Blvd. Suite 700
Los Angeles, CA 90064

Danelle Decker
National Government Services, Inc.
Mail point INA102-AF42 P.O. Box 6474
Indianapolis, IN 46206

RE: ***Request to Reinstate & Bifurcate Group Appeal Regarding DSH Part C Days***
Catholic Health Services of Long Island 1998-2004 Dual Eligible Days Group
Case No. 09-1523GC

Dear Mr. Blumberg and Ms. Decker:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Providers' May 12, 2016 request for Rule 41.1 Reinstatement and Bifurcation of Group Appeal regarding DSH Part C Days for the Catholic Health Services of Long Island 1998-2004 Dual Eligible Days group. As set forth below, the Board denies this request because the Providers are seeking bifurcation of Part C Days but the case was withdrawn and there is no cause to reinstate.

Background:

On **April 15, 2009**, the Board received the group appeal request. The description for the Medicare/Medicaid Dual Eligible Patient Days issue reads:

> Dual Eligible Days – Dual Eligible Days are patient days associated with those patients who were not included in the SSI denominator by CMS' design as they were not directly billed to Medicare and did not flow through the MEDPAR system via Fee for Service Medicare Part-A. Moreover, these days were disallowed from the Medicaid numerator as well. Hence, neither the Medicaid fraction nor the Medicare fraction captured the days associated with the undisputed indigent population. As the days represent patient who were Medicaid Eligible but not Medicare Entitled, the Provider contends that these days should be included in the Medicaid fraction.
>
> Dual Eligible Days were excluded from the Medicaid fraction for a variety of reasons. By way of example, certain Dual Eligible Days are days associated with patients who are eligible for Medicaid but have exhausted their Medicare Part A benefits ("Exhausted Days"). In Edgewater Medical Center (Chicago, IL.) v. Blue Cross and Blue Shield Association/ Blue Cross and Blue Shield of Illinois, PRRB Hearing Dec. No. 2000-D44 (April 7, 2000), the Board held

> The Board continues to maintain that the DSH numerator should include days of dually eligible patients whose Medicare Part A benefits were exhausted and who were eligible for reimbursement under the State's Medicaid plan. *See Jersey Shore Medical Center v. Blue Cross and Blue Shield of New Jersey*, PRRB Case No. 99-D4, Medicare and Medicaid Guide (CCH) ¶80,083, October 30, 1998, *vacated and remanded*, HCFA Administrator, January 4, 1999, Medicare and Medicaid Guide (CCH) ¶80,153 ("*Jersey*").

Thus, in accordance with the Board's holding in the Edgewater, the Provider's Medicaid fraction should include all "Exhausted Days."[1]

On **July 8, 2015**, the Board remanded the participants in the group appeal with fiscal year ends ("FYE") prior to 10/01/2004 of DSH dual eligible days based on CMS Ruling 1498-R. The appeal remained open for Providers and FYEs that were *not* subject to CMS Ruling 1498-R.

On **December 18, 2015**, Blumberg Ribner withdrew all remaining participants with FYEs 10/1/2004-12/31/2004, and the appeal was closed.

Rule 41.1 Reinstatement and Bifurcation of Group Appeal regarding DSH Part C Days Issue

On **May 12, 2016**, the Board received a letter from Blumberg Ribner requesting Rule 41.1 Reinstatement and Bifurcation of Group Appeal regarding DSH Part C Days issue. The Providers argues that the references to dual eligible patient days were intended to refer to persons eligible for Part A and Part C.[2]

The Providers refer to a decision in Case No. 08-2624GC in which the Board granted bifurcation of dual eligible Part A and Part C days in Sutter Health 1998 DSH Dual Eligible Days CIRP Group. In that December 30, 2015 letter, the Board stated:

> [T]he Board acknowledges that *at the time that Sutter Health's individual and group appeals were filed, the issue of whether a Medicaid patient that was "dually eligible" for Medicare was not necessarily subdivided by Medicare Part A or HMO/Part C days.* Federal courts later ruled differently on the "dual eligibility" related to Part A and Part C days therefore necessitating the Board to bifurcate these issues. In this case, the Board finds that the

[1] Request for Catholic Health Services of Long Island 1998-2004 Dual Eligible Days Group Appeal, Tab 2 (Aug. 15, 2009).
[2] Bifurcation Request Letter at 1 (May 12, 2016).

> *providers' individual appeals and the original optional group appeal added the dual eligible days issue using a broad issue statement that encompassed both dual eligible Part A non-covered days and HMO days.* (Emphasis in original).[3]

The Providers next reference an Affidavit of Isaac Blumberg, the Representative of the Providers to support the contention that "the Providers' use of the term 'dual eligible days' was ***intended***" to refer to Medicare Part A Days and Medicare Part C Days." However, the referenced affidavit was not executed for this case but rather for Case No. 09-1708GC entitled "QRS Providence Health 2004 Medicare Part C Days CIRP Group." As a result, this affidavit does ***not pertain*** to this case as it was executed for a different unrelated case and appears to have a different group issue statement.

Last, the Providers argue that they filed their *individual* appeals between March 1, 2002 and August 21, 200**9** in accordance with Board Instructions in effect during that time. The Board Instructions effective March 1, 2002 stated:

> Your hearing request must include an identification and statement of the issue(S) you are disputing. You must identify the specific issues, findings of fact and conclusions of law . . . **You must precisely identify the component of the DSH issue that is in dispute.**

The Providers argue that these Instructions did not require that they state the issue as "finely" as would be required under later rules. The Providers conclude that they were required to precisely define the DSH component at issue, which they did.

However, contrary to their assertion, the March 1, 2002 Board Instructions were ***not*** in effect *until* August 21, 200***9***. Rather, they were superseded by Board Rules issued *one year earlier* effective August 21, 200***8*** because the Board issued the August 21, 2008 revised Board Rules to implement changes to the Board's governing regulations *that were similarly effective August 21, 200**8*** and included material and significant clarifications on the minimum content for individual appeal requests (42 C.F.R. § 405.1835(b) (2009)) as well as group appeal requests (42 C.F.R. § 405.1837(c) (2009)).[4]

Decision of the Board

Board Rule 46.1 (July 1, 2015), in effect at the time the request was filed, addresses how the Board handles a 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 . . . 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."

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[3] *Id.* at 2.
[4] *See* 73 Fed. Reg. 30190 (May 23, 2008).

> **46.1 – 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. These requirements also apply to Rules 46.2 and 46.3 below.[5]

The Providers voluntarily *withdrew* the instant appeal in 2015 ***without qualification*** and the Provider remaining the appeal were those FYEs or periods not subject to remand under CMS Ruling 1498-R. In their Reinstatement Request, the Providers did not address the prior *unqualified* withdrawal (filed more than 5 months) or why there is now good cause to reinstate notwithstanding that *unqualified* withdrawal. Accordingly, it is clear that the Providers have not established good cause to reinstate/reopen Case No. 09-1523GC.

For the reason set forth above, the Board **declines** to exercise its discretion to reopen and reinstate Case No. 09-1523GC and, thus, **denies** the request for reinstatement and rescission of remand. Accordingly, Case No. 09-1523GC remains closed.

Board Members Participating:

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

For the Board:

12/15/2023

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services

[5] (Emphasis added.)

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

Isaac Blumberg
Blumberg Ribner, Inc.
11400 W. Olympic Blvd. Suite 700
Los Angeles, CA 90064

Danelle Decker
National Government Solutions, Inc.
Mail point INA02-AF42 P.O. Box 6474
Indianapolis, IN 46206

RE: ***Request to Reinstate & Bifurcate Group Appeal Regarding DSH Part C Days Issue***
Blumberg Ribner Independent Hospitals 2002 Dual Eligible Days 2nd Group
Case No. 09-1915G

Dear Mr. Blumberg and Ms. Decker:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Providers' May 23, 2016 request for Rule 41.1 Reinstatement and Bifurcation of Group Appeal regarding DSH Part C Days for the Blumberg Ribner Independent Hospitals 2002 2nd Group. As set forth below, the Board denies this request because the Providers are seeking bifurcation of Part C Days but the instant appeal did not include Part C Days.

Background:

On **June 19, 2009**, the Board received the group appeal request. The entire description for the Medicare/Medicaid Dual Eligible Patient Days issue reads:

> Dual Eligible Days Issue – Dual Eligible Days are patient days associated with those patients who were not included in the SSI denominator by CMS' design as they were not directly billed to Medicare and did not flow through the MEDPAR system via Fee For Service Medicare Part-A. Moreover, these days were disallowed from the Medicaid numerator as well. Hence, neither the Medicaid fraction nor the Medicare fraction captured the days associated with the undisputed indigent population. As the days represent patient who were Medicaid Eligible but not Medicare Entitled, the Provider contends that these days should be included in the Medicaid fraction.
>
> Dual Eligible Days were excluded from the Medicaid fraction for a variety of reasons. By way of example, certain Dual Eligible Days are days associated with patients who are eligible for Medicaid but have exhausted their Medicare Part A benefits ("Exhausted Days"). In Edgewater Medical Center (Chicago, IL.) v. Blue Cross and Blue

> Shield Association/ Blue Cross and Blue Shield of Illinois, PRRB Hearing Dec. No. 2000-D44 (April 7, 2000), the Board held
>
> > The Board continues to maintain that the DSH numerator should include days of dually eligible patients whose Medicare Part A benefits were exhausted and who were eligible for reimbursement under the State's Medicaid plan. *See Jersey Shore Medical Center v. Blue Cross and Blue Shield of New Jersey*, PRRB Case No. 99-D4, Medicare and Medicaid Guide (CCH) ¶80,083, October 30, 1998, *vacated and remanded*, HCFA Administrator, January 4, 1999, Medicare and Medicaid Guide (CCH) ¶80,153 ("*Jersey*").
>
> Thus, in accordance with the Board's holding in the Edgewater, the Provider's Medicaid fraction should include all "Exhausted Days".

On **August 31, 2010**, Blumberg Ribner submitted a letter to the Board stating that it would not be submitting a Preliminary Position Paper because the appeal issue is subject to remand under CMS Ruling 1498-R. They stated:

> In accordance with the PRRB's recently issued Alert 7, Blumberg Ribner (BRI) herby identifies the subject of the group appeal, dual eligible days, ***as governed by CMS – 1498-R***. Accordingly, BRI will not be submitting a Preliminary Position Paper (PPP) by the May 1, 2011 deadline. Please notify us should the Board determine that a PPP is necessary. *BRI hereby requests that the group appeal be remanded under the Standard Procedure*. Finally, we reserve the right to challenge both the CMS Ruling and any remand order at the appropriate time.[1]

Significantly, Blumberg Ribner's request for remand was unqualified and it did not identify any other issues being present in the group appeal, notwithstanding the fact that a CIRP group can only contain one issue (42 C.F.R. § 405.1837(a)(2)) and no issues may be added to a group after the appeal request is filed (42 C.F.R. § 405.1837(f)(1)).

Between **November 2010 and January 2011**, Blumberg Ribner withdrew 5 participants.

On **September 1, 2011**, the Medicare Contractor filed a Jurisdictional Challenge.

On **September 29, 2011**, Blumberg Ribner filed its response to the Jurisdictional Challenge.

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[1] (Emphasis added.)

On **June 27, 2014**, the Board issued a jurisdictional decision dismissing a Provider, and a 1498-R remand for the remaining providers, and the appeal was closed.

Rule 41.1 Reinstatement and Bifurcation of Group Appeal regarding DSH Part C Days Issue

On May 23, 2016, the Board received a letter from Blumberg Ribner requesting Rule 41.1 Reinstatement and Bifurcation of Group Appeal regarding DSH Part C Days issue. The Providers argues that the references to dual eligible patient days were intended to refer to persons eligible for Part A and Part C.[2]

The Providers refer to a decision in Case No. 08-2624GC in which the Board granted bifurcation of dual eligible Part A and Part C days in Sutter Health 1998 DSH Dual Eligible Days CIRP Group. In that December 30, 2015 letter, the Board stated:

> [T]he Board acknowledges that *at the time that Sutter Health's individual and group appeals were filed, the issue of whether a Medicaid patient that was "dually eligible" for Medicare was not necessarily subdivided by Medicare Part A or HMO/Part C days.* Federal courts later ruled differently on the "dual eligibility" related to Part A and Part C days therefore necessitating the Board to bifurcate these issues. In this case, the Board finds that the *providers' individual appeals and the original optional group appeal added the dual eligible days issue using a broad issue statement that encompassed both dual eligible Part A non-covered days and HMO days.* (Emphasis in original).[3]

The Providers next reference an Affidavit of Isaac Blumberg, the Representative of the Providers to support the contention that "the Providers' use of the term 'dual eligible days' was ***intended***" to refer to Medicare Part A Days and Medicare Part C Days." However, the referenced affidavit was not executed for this case but rather for Case No. 09-1708GC entitled "QRS Providence Health 2004 Medicare Part C Days CIRP Group." As a result, this affidavit does ***not pertain*** to this case as it was executed for a different unrelated case and appears to have a different group issue statement.

Last, the Providers argue that they filed their *individual* appeals between March 1, 2002 and August 21, 200**9** in accordance with Board Instructions in effect during that time. The Board Instructions effective March 1, 2002 stated:

> Your hearing request must include an identification and statement of the issue(S) you are disputing. You must identify the specific issues, findings of fact and conclusions of law . . . **You must**

[2] Bifurcation Request Letter at 1 (May 23, 2016).
[3] *Id.* at 2.

> **precisely identify the component of the DSH issue that is in dispute.**

The Providers argue that these Instructions did not require that they state the issue as "finely" as would be required under later rules. The Providers conclude that they were required to precisely define the DSH component at issue, which they did.

However, contrary to their assertion, the March 1, 2002 Board Instructions were ***not*** in effect *until* August 21, 200***9***. Rather, they were superseded by Board Rules issued *one year earlier* effective August 21, 200***8*** because the Board issued the August 21, 2008 revised Board Rules to implement changes to the Board's governing regulations *that were similarly effective August 21, 200**8*** and included material and significant clarifications on the minimum content for individual appeal requests (42 C.F.R. § 405.1835(b) (2009)) as well as group appeal requests (42 C.F.R. § 405.1837(c) (2009)).[4]

Decision of the Board

Board Rule 46.1 (July 1, 2015), in effect at the time the request was filed, addresses how the Board handles a 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 . . . 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."

> **46.1 – 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. These requirements also apply to Rules 46.2 and 46.3 below.[5]

[4] *See* 73 Fed. Reg. 30190 (May 23, 2008).
[5] (Emphasis added.)

As discussed above, on August 31, 2010, Blumberg Ribner clearly and explicitly identified the group issue statement as subject to CMS Ruling 1498-R.

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

Notably, Ruling 1498-R ***does not*** address the Part C days issue. Had the Providers intended to pursue the Part C days issue, they should have notified the Board (*if not sooner*) when it submitted this letter explaining specifically requesting that the group issue be remanded pursuant to CMS Ruling 1498-R. Significantly, Blumberg Ribner's request for remand was unqualified and it did not identify any other issues being present in the group appeal, notwithstanding the fact that a CIRP group can only contain one issue (42 C.F.R. § 405.1837(a)(2)) and no issues may be added to a group after the appeal request is filed (42 C.F.R. § 405.1837(f)(1)). Indeed, they waived briefing of any other issues by notifying the Board they that would not be filing a Preliminary Position Paper. Accordingly, to the extent the alleged Part C issue was ever part of Case No. 09-1915G, the Providers abandoned it by failing to properly notify the Board the alleged Part C days issue when it specifically requested that the group be remanded. In this regard, the Board notes that it was not until ***almost 2 years later*** that Blumberg Ribner belatedly filed its reinstatement request. Accordingly, the Board declines to exercise its discretion to reopen and reinstate Case No. 09-1915G because it is clear that the Providers have not established good cause to reinstate/reopen Case No. 09-1915G.

The Board also notes that the issue statement of the group appeal defines the days at issue in as "Fee For Service Medicare Part-A" days which is clearly the dual eligible days Part A issue, and does *not* contemplate alleged Medicare+Choice Managed Care/Part C days issue since "Fee For Service Medicare Part-A" does not encompass Part C. Moreover, the Board notes that the Affidavit attached to the Reinstatement Request is ***not*** relevant to this case or any of the underlying individual group cases but was rather executed in connection with an unrelated case (Case No. 09-1708GC) and, as such, *only* pertains to that case. Indeed, the Affidavit itself related to the intent of the individual provider appeal requests for the participants in that group and not the group appeal request itself. As such, the Board declines to give it any weight. Accordingly, a second and independent basis upon which to deny reinstatement/reopening is that the alleged Part C Days issue was never part of the group appeal issue statement and, as such, it is clear that the proposed reinstatement for purposes of bifurcation has no merit.

As pointed out in the rescission and bifurcation request, regulations and Board rules require specificity with regards to each item under appeal. 42 C.F.R. § 405.1835(b)(2) (2009) reads, in part:

> (2) An explanation (for each specific item at issue . . .) of the provider's dissatisfaction with the intermediary's or Secretary's determination under appeal, including an account of the following:
>
> (i) Why the provider believes Medicare payment is incorrect *for each disputed item* . . .[6]
>
> (ii) How and why the provider believes Medicare payment must be determined differently *for each disputed item*.[7]

Board Rules have also long required that providers include identification of the issues in dispute with specificity:

> Your hearing request must include an identification and statement of the issue(s) you are disputing. You must identify the specific issues, findings of fact and conclusions of law with which the affected parties disagree; and you must specify the basis for contending the findings and conclusions are incorrect . . . You must clearly and specifically identify your position in regard to the issues in dispute. For instance, if you are appealing an aspect of the disproportionate share (DSH) adjustment factor or calculation, do not definite the issue as "DSH". You must precisely identify the component of the DSH issue that is in dispute.[8]

The Board finds that the issue statement for the group appeal can only be read to encompass the dual eligible Part A days issue. The group appeal issue language does not meet the specificity requirements as set forth in the regulation and Board rules to have appealed the dual eligible Part C days issue.

This finding is consistent with the recent ruling by the U.S. District Court for the District of Columbia in *Evangelical Community Hospital, et al. v. Becerra*.[9] In that case, the provider's issue was tied to improper calculation to DSH payment and read in part, "[t]he intermediary erred by incorrectly calculating the SSI percentage for inclusion in the 'Medicare Fraction' for purposes of the calculation of the provider's [disproportionate share] payment . . ."[10] The Court found that "[t]his description does not specify which portion of the calculation was incorrect nor how the fraction should have been calculated differently."[11] The Court found that this was a description of the issue was a violation of Board rules and a proper basis on which for the Board

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[6] (Emphasis added.)
[7] 42 C.F.R § 405.1835(b)(1)-(2) (emphasis added.)
[8] Provider Reimbursement Review Board, Part I, B, II. (March 1, 2002).
[9] 21-cv-01368 (APM) (D.D.C. Sep. 30, 2022).
[10] *Id*. at 11.
[11] *Id.*

to dismiss the appeal.[12] Here, the Board makes the same finding based on similarly overly generalized language.

For the reasons set forth above, the Board **declines** to exercise its discretion to reopen and reinstate Case No. 09-1915G and, thus, **denies** the request for reinstatement and rescission of remand in order to bifurcate a single participant from the group appeal regarding the Part C Days issue. Accordingly, Case No. 09-1915G remains closed.

Board Members Participating:

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

For the Board:

12/15/2023

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services

[12] *Id.*

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

Isaac Blumberg
Blumberg Ribner, Inc.
11400 W. Olympic Blvd., Ste. 700
Los Angeles, CA 90064

RE: ***Request to Reinstate & Bifurcate Group Appeal Regarding DSH Part C Days Issue***
Continuum Health Partners 1997-1998 Dual Eligible Days
Case No. 09-2118GC

Dear Mr. Blumberg:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the May 6, 2016 reinstatement request filed by Blumberg Ribner, Inc. ("BRI") on behalf of the Providers in the above common issue related party ("CIRP") group. Specifically, on May 6, 2016, BRI filed a Rule 41.1 Reinstatement and Bifurcation of Group Appeal regarding DSH Part C Days for the Continuum Health Partners 1997-1998 Dual Eligible Days CIRP Group. As set forth below, the Board denies BRI's reinstatement request because the Providers are seeking bifurcation of Part C Days but the group appeal request in the instant appeal did not include Part C Days and, any such arguments to the contrary are moot, since the procedural history of this case demonstrates the Providers abandoned that the Part C Days issue prior to the Board's remand and closure of this CIRP group.

Background

On August 12, 2009, the Board received the CIRP group appeal request. The entire description for the Medicare/Medicaid Dual Eligible Patient Days issue reads, in part:

> Dual Eligible Days Issue – Dual Eligible Days are patient days associated with those patients who were not included in the SSI denominator by CMS' design as they were not directly billed to Medicare and did not flow through the MEDPAR system via Fee For Service Medicare Part-A. Moreover, these days were disallowed from the Medicaid numerator as well. Hence, neither the Medicaid fraction nor the Medicare fraction captured the days associated with the undisputed indigent population. As the days represent patient who were Medicaid Eligible but not Medicare Entitled, the Provider contends that these days should be included in the Medicaid fraction.
>
> Dual Eligible Days were excluded from the Medicaid fraction for a variety of reasons. By way of example, certain Dual Eligible Days are days associated with patients who are eligible for Medicaid but have exhausted their Medicare Part A benefits ("Exhausted Days"). In

> Edgewater Medical Center (Chicago, IL.) v. Blue Cross and Blue Shield Association/ Blue Cross and Blue Shield of Illinois, PRRB Hearing Dec. No. 2000-D44 (April 7, 2000), the Board held
>
> > The Board continues to maintain that the DSH numerator should include days of dually eligible patients whose Medicare Part A benefits were exhausted and who were eligible for reimbursement under the State's Medicaid plan. *See Jersey Shore Medical Center v. Blue Cross and Blue Shield of New Jersey*, PRRB Case No. 99-D4, Medicare and Medicaid Guide (CCH) ¶80,083, October 30, 1998, *vacated and remanded*, HCFA Administrator, January 4, 1999, Medicare and Medicaid Guide (CCH) ¶80,153 ("*Jersey*").
>
> Thus, in accordance with the Board's holding in the Edgewater, the Provider's Medicaid fraction should include all "Exhausted Days".[1]

On October 15, 2014, the Board, *on its own motion*, notified BRI that the CIRP group was subject to remand under the Centers for Medicare & Medicaid Services ("CMS") Ruling 1498-R and required BRI to file the final Schedule of Providers ("SoP") with supporting jurisdictional documentation within 45 days in order to process that remand under the standard procedure. However, BRT failed to comply with this filing deadline.

On April 7, 2015, the Board emailed BRI stating that "On October 15, 2014, the [Board] notified you that *the above referenced appeal was subject to Remand under CMS Ruling 1498-R* and that you were to supply a Schedule of Providers with the associated jurisdictional documentation . . . . You were given 45 days to supply the documentation . . . . [and] [a]s of today's date, the documentation has not yet been submitted." The Board then gave BRI an additional 30 days to submit that required documentation or if not, "it will be presumed you are no longer pursuing the appeal and the case will be dismissed."[2]

On May 5, 2015, BRI submitted the final SoP with supporting jurisdictional documentation. Significantly, in the filing of the SoP, BRI did ***not*** object to the planned 1498-R Remand, ***nor*** did it notify the Board that there were any other issues in the case not subject to the 1498-R Remand, notwithstanding the fact that a CIRP group can only contain one issue (42 C.F.R. § 405.1837(a)(2)) and no issues may be added to a group after the appeal request is filed (42 C.F.R. § 405.1837(f)(1)).

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[1] Request for Continuum Health Partners FYs 1995-1998 Dual Eligible Days Group Appeal, Tab 2 (Aug. 12, 2009).
[2] (Emphasis added.)

On June 5, 2015, the Board issued a standard remand in Case No. 09-2118GC and remanded the dual eligible Part A days issue to the Medicare Contractor, pursuant to CMS Ruling 1498-R.[3] Accordingly, concurrent with the remand, the Board closed the case.

Providers' Request for Bifurcation

On May 6, 2016, (*nearly a year after* the Board had already remanded and closed the case) the Board received a letter from BRI requesting Rule 41.1 Reinstatement and Bifurcation of Group Appeal regarding DSH Part C Days issue. BRI contends that the Providers' appeal of DSH dual eligible days . . . included two issues. First, it included the issue addressed by Ruling 1498-R. Second, it was intended to refer to persons eligible for Medicare Parts A and C."[4] Accordingly, BRI argues that the references in the group appeal request to "dual eligible days" were intended to refer to persons eligible for Parts A and C.[5]

The Providers refer to a decision in Case No. 08-2624GC in which the Board granted bifurcation of dual eligible Part A and Part C days in Sutter Health 1998 DSH Dual Eligible Days CIRP Group. In that December 30, 2015 letter, the Board stated:

> [T]he Board acknowledges that *at the time that Sutter Health's individual and group appeals were filed, the issue of whether a Medicaid patient that was "dually eligible" for Medicare was not necessarily subdivided by Medicare Part A or HMO/Part C days.* Federal courts later ruled differently on the "dual eligibility" related to Part A and Part C days therefore necessitating the Board to bifurcate these issues. In this case, the Board finds that the *providers' individual appeals and the original optional group appeal added the dual eligible days issue using a broad issue statement that encompassed both dual eligible Part A non-covered days and HMO days.* (Emphasis in original).[6]

The Providers next reference an Affidavit of Isaac Blumberg, the Representative of the Providers to support the contention that "the Providers' use of the term 'dual eligible days' was ***intended***" to refer to Medicare Part A Days and Medicare Part C Days." However, the referenced affidavit was ***not*** executed for this case but rather for Case No. 09-1708GC entitled "QRS Providence Health 2004 Medicare Part C Days CIRP Group." As a result, this affidavit does ***not pertain*** to this case as it was executed for a different unrelated case and appears to have a different group issue statement.

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

[4] Reinstatement Request at 1.

[5] Bifurcation Request Letter at 1 (May 23, 2016).

[6] *Id.* at 2.

Last, the Providers argue that they filed their *individual* appeals between March 1, 2002 and August 21, 200**9** in accordance with Board Instructions in effect during that time. The Board Instructions effective March 1, 2002 stated:

> Your hearing request must include an identification and statement of the issue(s) you are disputing. You must identify the specific issues, findings of fact and conclusions of law . . . **You must precisely identify the component of the DSH issue that is in dispute.**[7]

The Providers argue that these Instructions did not require that they state the issue as "finely" as would be required under later rules. The Providers conclude that they were required to precisely define the DSH component at issue, which they did.

However, contrary to their assertion, the March 1, 2002 Board Instructions were ***not*** in effect *until* August 21, 200***9***. Rather, they were superseded by Board Rules issued *one year earlier* effective August 21, 200***8*** because the Board issued the August 21, 2008 revised Board Rules to implement changes to the Board's governing regulations *that were similarly effective August 21, 200**8*** and included material and significant clarifications on the minimum content for individual appeal requests (42 C.F.R. § 405.1835(b) (2009)) as well as group appeal requests (42 C.F.R. § 405.1837(c) (2009)).[8] As such, the March 1, 2002 Board Instructions were only applicable to one the remaining 4 participants as listed on the Schedule of Providers attached to the Board's June 5, 2015 Remand Order.[9]

Decision of the Board

Board Rule 46.1 (July 1, 2015), in effect at the time the request was filed, addresses how the Board handles a 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 . . . 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."

> **46.1 – 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

[7] Reinstatement Request at 3 (quoting Board Instructions, Part 1, at Section B.II.a (Issued May 5, 2002) (emphasis added) (superseded by Board Rules issued Aug. 21, 2008)).
[8] *See* 73 Fed. Reg. 30190 (May 23, 2008).
[9] The following are a list of the remaining 4 participants with their appeal request: (1) St. Luke's Roosevelt Hosp. Ctr. appealing FY 1997 based on an appeal request filed on Mar. 11, 2004 with an add issue request filed on Aug. 16, 2006; (2) Beth Israel Med. Ctr. appealing FY 1997 based on an appeal request filed on Jul. 8, 2009; (3) St. Luke's Roosevelt Med. Ctr. appealing FY 1998 based on an appeal request filed on Oct. 14, 2009; and (4) Beth Israel Med. Ctr. appealing FY 1998 based on an appeal request filed on Aug. 24, 2009.

> 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. These requirements also apply to Rules 46.2 and 46.3 below.[10]

As discussed above, on 2 separate occasions, the Board specifically notified the Providers that the case was subject to CMS Ruling 1498-R. To that end, the Board requested the Representative to file the final SoP with supporting jurisdictional documentation so the Board could complete the jurisdictional review and remand this case per CMS Ruling 1498-R. On May 5, 2015, BRI submitted the final SoP with supporting jurisdictional documentation. Significantly, in the filing of the SoP, BRI did ***not*** object to the planned 1498-R Remand, ***nor*** did it notify the Board that there were any other issues in the case not subject to the 1498-R Remand, notwithstanding the fact that a CIRP group can only contain one issue (42 C.F.R. § 405.1837(a)(2)) and no issues may be added to a group after the appeal request is filed (42 C.F.R. § 405.1837(f)(1)).

Accordingly, following Blumberg Ribner's filing of the final SOP for Case No. 09-2118GC, the Board reviewed the SOP, remanded Case No. 09-2118GC, and then closed that case. Neither the Providers nor the group representative raised *any* issue to the Board that the appeal should not be bifurcated between those fiscal periods because the Part C days issue was also pending in the appeal. Had the Providers intended to pursue the Part C days issue, they should have notified the Board at that time, if not sooner. Accordingly, an independent basis to deny reinstatement/reopening request is that, to the extent the alleged Part C issue was ever part of Case No. 09-2118GC, the Providers abandoned it by failing to properly notify the Board the alleged Part C days issue when the Board notified the Providers that the appeal was subject to remand under 1498-R and asked for the SoP to allow the Board to complete that remand.[11] Indeed, the representative's reinstatement request was filed ***almost a year*** after the case had been remanded and closed and more than a year after the Board had notified the representative that the case was subject to 1498-R Remand. Accordingly, the Board declines to exercise its discretion to reopen and reinstate Case No. 09-2118GC because it is clear that the Providers have not established good cause to reinstate/reopen Case No. 09-2118GC.

There is an alternative independent basis for the Board's denial to exercise its discretion to reinstate this case. The initial starting point is the group appeal request which was filed on August 12, 2009. The regulation at 42 C.F.R. § 405.1837(c) (2008) specifies the minimum "content" for group appeal requests:

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[10] (Emphasis added.)

[11] The Board takes administrative notice that many providers have appealed the Part C days issue from revised NPRs that were issued following a 1498-R remand. It is not clear to the Board whether any of the participants in this CIRP group later appealed the Part C issue for the year(s) at issue based on the revised NPR issued as a result of the 1498-R Remand. If so, it would render the bifurcation request moot.

> (c) *Contents of request for a group appeal*. The request for a Board hearing as a group appeal must be submitted in writing to the Board, and the request must include all of the following:
>
> (1) A demonstration that the request satisfies the requirements for a Board hearing as a group appeal, as specified in paragraph (a) of this section.
>
> (2) An explanation (for each specific item at issue; see §405.1835(a)(1)) of each provider's dissatisfaction with its intermediary 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, a description of the nature and amount of each self-disallowed item and the reimbursement sought for each item.
>
> (3) A copy of each intermediary or Secretary determination under appeal, and any other documentary evidence the providers consider necessary to satisfy the hearing request requirements of paragraphs (c)(1) and (c)(2) of this section, and a precise description of the one question of fact or interpretation of law, regulations, or CMS Rulings that is common to the particular matters at issue in the group appeal; and
>
> (4) A statement that—
>
> > (i) The providers believe they have satisfied all of the requirements for a group appeal hearing request under paragraph (a) of this section and requesting the Board to proceed to make jurisdictional findings in accordance with §405.1840; or
> >
> > (ii) The Board is requested to defer making jurisdictional findings until the providers request the findings in accordance with paragraph (e)(2) of this section.

The issue statement of the group appeal defines the "Dual Eligible Days" at issue as relating to "Fee For Service Medicare Part-A":

> Dual Eligible Days are patient days associated with those patients who were not included in the SSI denominator by CMS' design as they were not directly billed to Medicare and did not flow through the MEDPAR system *via* ***Fee For Service*** *Medicare Part-A*. Moreover, ***these*** *days* were disallowed from the Medicaid numerator as well. Hence, neither the Medicaid fraction nor the Medicare fraction captured the days associated *with the undisputed indigent population*.[12]

Accordingly, it is clear that the term "Dual Eligible Days" as used ***in the group appeal request*** did not relate to or contemplate Medicare+Choice Managed Care Part C days since Medicare+Choice Managed Care Part C days clearly are not "Fee For Service Medicare Part-A." Moreover, the Board notes that the Affidavit attached to the Reinstatement Request is ***not*** relevant to this case or any of the underlying individual group cases but was rather executed in connection with an unrelated case (Case No. 09-1708GC) and, as such, *only* pertains to that case. Indeed, the Affidavit itself related to the intent of the individual provider appeal requests for the participants in that group and not the group appeal request itself. As such, the Board declines to give it any weight. Accordingly, the Board denies the reinstatement/reopening because the alleged Part C Days issue was ***never*** *part of the* ***group appeal*** *issue statement* and, as such, it is clear that the proposed reinstatement for purposes of bifurcation has no merit.

As pointed out in the rescission and bifurcation request, regulations and Board Rules require specificity with regards to each item under appeal. 42 C.F.R. § 405.1835(b)(2) (2009) reads, in part:

> (2) An explanation (for each specific item at issue . . .) of the provider's dissatisfaction with the intermediary's or Secretary's determination under appeal, including an account of the following:
>
> (i) Why the provider believes Medicare payment is incorrect *for each disputed item* . . .[13]
>
> (ii) How and why the provider believes Medicare payment must be determined differently *for each disputed item*.[14]

Board Rules have also long required that providers include identification of the issues in dispute with specificity:

> Your hearing request must include an identification and statement of the issue(s) you are disputing. You must identify the specific issues, findings of fact and conclusions of law with which the affected parties disagree; and you must specify the basis for

[12] (Emphasis added.)
[13] (Emphasis added.)
[14] 42 C.F.R § 405.1835(b)(1)-(2) (emphasis added.)

> contending the findings and conclusions are incorrect . . . You must clearly and specifically identify your position in regard to the issues in dispute. For instance, if you are appealing an aspect of the disproportionate share (DSH) adjustment factor or calculation, do not definite the issue as "DSH". You must precisely identify the component of the DSH issue that is in dispute.[15]

The Board finds that the issue statement for the group appeal can only be read to encompass the dual eligible Part A days issue. The group appeal issue language does not meet the specificity requirements as set forth in the regulation and Board rules to have appealed the dual eligible Part C days issue.

This finding is consistent with the recent ruling by the U.S. District Court for the District of Columbia in *Evangelical Community Hospital, et al. v. Becerra*.[16] In that case, the provider's issue was tied to improper calculation to DSH payment and read in part, "[t]he intermediary erred by incorrectly calculating the SSI percentage for inclusion in the 'Medicare Fraction' for purposes of the calculation of the provider's [disproportionate share] payment . . ."[17] The Court found that "[t]his description does not specify which portion of the calculation was incorrect nor how the fraction should have been calculated differently."[18] The Court found that this was a description of the issue was a violation of Board rules and a proper basis on which for the Board to dismiss the appeal.[19] Here, the Board makes the same finding based on similarly overly generalized language.

For the reasons set forth above, the Board **declines** to exercise its discretion to reopen and reinstate Case No. 09-2118GC and, thus, **denies** the request for reinstatement and rescission of remand in order to bifurcate a single participant from the group appeal regarding the Part C Days issue. Accordingly, Case No. 09-2118GC remains closed.

Board Members Participating:

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

For the Board:

12/15/2023

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services
Danelle Decker, National Government Services, Inc.

[15] Provider Reimbursement Review Board, Part I, B, II. (March 1, 2002).
[16] 21-cv-01368 (APM) (D.D.C. Sep. 30, 2022).
[17] *Id*. at 11.
[18] *Id.*
[19] *Id.*

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

Isaac Blumberg
Blumberg Ribner, Inc.
11400 W. Olympic Blvd., Ste 700
Los Angeles, CA 90064

RE: ***Request to Reinstate & Bifurcate Group Appeal Regarding DSH Part C Days Issue***
MHS 1996 – 2003 DSH Dual Eligibles CIRP Group
Case No. 09-2176GC

Dear Mr. Blumberg:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Providers' May 23, 2016 request for Rule 41.1 Reinstatement and Bifurcation of Group Appeal regarding DSH Part C Days for the MemorialCare Health System 1996 – 2003 Dual Eligible Days CIRP Group. As set forth below, the Board **denies** the request for rescission of the remand and bifurcation of the dual eligible Part A non-covered and Part C days issues. The decision of the Board is set forth below.

Background:

On August 26, 2009, the Board received the group appeal request. The entire description for the Medicare/Medicaid Dual Eligible Patient Days issue reads:

> Dual Eligible Days are patient days associated with those patients who were not included in the SSI denominator by CMS' design as they were not directly billed to Medicare and did not flow through the MEDPAR system via Fee For Service Medicare Part-A. Moreover, these days were disallowed from the Medicaid numerator as well. Hence, neither the Medicaid fraction nor the Medicare fraction captured the days associated with the undisputed indigent population. As the days represent patient who were Medicaid Eligible but not Medicare Entitled, the Provider contends that these days should be included in the Medicaid fraction.
>
> Dual Eligible Days were excluded from the Medicaid fraction for a variety of reasons. By way of example, certain Dual Eligible Days are days associated with patients who are eligible for Medicaid but have exhausted their Medicare Part A benefits ("Exhausted Days"). In Edgewater Medical Center (Chicago, IL.) v. Blue Cross and Blue

> Shield Association/ Blue Cross and Blue Shield of Illinois, PRRB Hearing Dec. No. 2000-D44 (April 7, 2000), the Board held
>
> > The Board continues to maintain that the DSH numerator should include days of dually eligible patients whose Medicare Part A benefits were exhausted and who were eligible for reimbursement under the State's Medicaid plan. *See Jersey Shore Medical Center v. Blue Cross and Blue Shield of New Jersey*, PRRB Case No. 99-D4, Medicare and Medicaid Guide (CCH) ¶80,083, October 30, 1998, *vacated and remanded*, HCFA Administrator, January 4, 1999, Medicare and Medicaid Guide (CCH) ¶80,153 ("*Jersey*").
>
> Thus, in accordance with the Board's holding in the Edgewater, the Provider's Medicaid fraction should include all "Exhausted Days".

On January 22, 2013, the Board, *on its own motion*, notified the Representative that the Board determined the group was CIRP was subject to remand pursuant to CMS Ruling 1498-R and required the Representative to submit the final Schedule of Providers ("SoP") and supporting jurisdictional documentation within 60 days so that the Board could apply CMS Ruling 1498-R.

On March 19, 2013, the Board emailed the Representative confirming that the Board had received the Representative's March 12, 203 request for a 60-day extension to submit the SoP. The Board granted the 60-day extension.

On May 16, 2013, the Representative submitted the final SoP with supporting jurisdictional documentation. Significantly, in the filing of the SoP, the Representative did ***not*** object to the planned 1498-R Remand, ***nor*** did it notify the Board that there were any other issues in the case not subject to the 1498-R Remand, notwithstanding the fact that a CIRP group can only contain one issue (42 C.F.R. § 405.1837(a)(2)) and no issues may be added to a group after the appeal request is filed (42 C.F.R. § 405.1837(f)(1)).

On April 25, 2014, following its review of the SoP and supporting jurisdictional documentation, the Board dismissed one of the participants from the appeal.

On May 8, 2014, the Board issued a standard remand in Case No. 09-2176GC and remanded the dual eligible Part A days issue to the Medicare Contractor, pursuant to the Centers for Medicare & Medicaid Services (CMS) Ruling 1498-R.[1] Accordingly, concurrent with the remand, the Board closed the case.

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[1] Ruling 1498-R was issued on April 28, 2010, by the CMS Administrator to address three specific issues regarding the calculation of the Medicare disproportionate share hospital (DSH) payment adjustment: (1) the Medicare SSI fraction data matching process issue and the method for recalculating the hospital's Medicare SSI fraction, (2) the

Rule 41.1 Reinstatement and Bifurcation of Group Appeal regarding DSH Part C Days Issue

On May 23, 2016, the Board received a letter from Blumberg Ribner requesting Rule 41.1 Reinstatement and Bifurcation of Group Appeal regarding DSH Part C Days issue. The Providers argues that the references to dual eligible patient days were intended to refer to persons eligible for Part A and Part C.[2]

The Providers refer to a decision in Case No. 08-2624GC in which the Board granted bifurcation of dual eligible Part A and Part C days in Sutter Health 1998 DSH Dual Eligible Days CIRP Group. In that December 30, 2015 letter, the Board stated:

> [T]he Board acknowledges that *at the time that Sutter Health's individual and group appeals were filed, the issue of whether a Medicaid patient that was "dually eligible" for Medicare was not necessarily subdivided by Medicare Part A or HMO/Part C days.* Federal courts later ruled differently on the "dual eligibility" related to Part A and Part C days therefore necessitating the Board to bifurcate these issues. In this case, the Board finds that the *providers' individual appeals and the original optional group appeal added the dual eligible days issue using a broad issue statement that encompassed both dual eligible Part A non-covered days and HMO days.* (Emphasis in original).[3]

The Providers next reference an Affidavit of Isaac Blumberg, the Representative of the Providers to support the contention that "the Providers' use of the term 'dual eligible days' was ***intended***" to refer to Medicare Part A Days and Medicare Part C Days." However, the referenced affidavit was not executed for this case but rather for Case No. 09-1708GC entitled "QRS Providence Health 2004 Medicare Part C Days CIRP Group." As a result, this affidavit does ***not pertain*** to this case as it was executed for a different unrelated case and appears to have a different group issue statement.

Last, the Providers argue that they filed their *individual* appeals between March 1, 2002 and August 21, 200**9** in accordance with Board Instructions in effect during that time. The Board Instructions effective March 1, 2002 stated:

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exclusion from the DSH calculation of non-covered patient hospital days for patients entitled to Medicare Part A including days for which the patient's Part A inpatient hospital benefits were exhausted for cost reporting periods before October 1, 2004, and (3) the exclusion from the DSH calculation of the labor/delivery room (LDR) inpatient days.

[2] Bifurcation Request Letter at 1 (May 23, 2016).

[3] *Id.* at 2.

> Your hearing request must include an identification and statement of the issue(S) you are disputing. You must identify the specific issues, findings of fact and conclusions of law . . . **You must precisely identify the component of the DSH issue that is in dispute.**

The Providers argue that these Instructions did not require that they state the issue as "finely" as would be required under later rules. The Providers conclude that they were required to precisely define the DSH component at issue, which they did.

However, contrary to their assertion, the March 1, 2002 Board Instructions were ***not*** in effect *until* August 21, 200***9***. Rather, they were superseded by Board Rules issued *one year earlier* effective August 21, 200***8*** because the Board issued the August 21, 2008 revised Board Rules to implement changes to the Board's governing regulations *that were similarly effective August 21, 200**8*** and included material and significant clarifications on the minimum content for individual appeal requests (42 C.F.R. § 405.1835(b) (2009)) as well as group appeal requests (42 C.F.R. § 405.1837(c) (2009)).[4]

Decision of the Board:

Board Rule 46.1 (July 1, 2015), in effect at the time the request was filed, addresses how the Board handles a 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 . . . 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."

> **46.1 – 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

[4] *See* 73 Fed. Reg. 30190 (May 23, 2008).

> had in its initial appeal. These requirements also apply to Rules 46.2 and 46.3 below.[5]

As discussed above, on January 22, 2015, the Board specifically notified the Providers that the case was subject to CMS Ruling 1498-R. To that end, the Board requested the Representative to file the final SoP with supporting jurisdictional documentation so the Board could complete the jurisdictional review and remand this case per CMS Ruling 1498-R. On May 16, 2013, Blumberg Ribner submitted the final SoP with supporting jurisdictional documentation. Significantly, in the filing of the SOP, Blumberg Ribner did *not* object to the Board's planned 1498-R remand, *nor* did it notify the Board that there were any other issues in the case not subject to the CMS Ruling 1498-R remand notwithstanding the fact that a CIRP group can only contain one issue (42 C.F.R. § 405.1837(a)(2)) and no issues may be added to a group after the appeal request is filed (42 C.F.R. § 405.1837(f)(1)).

Accordingly, following Blumberg Ribner's filing of the final SOP for Case No. 09-2176GC, the Board reviewed the SOP, remanded Case No. 09-2176GC, and then closed that case. Neither the Providers nor the group representative raised *any* issue to the Board that the appeal should not be bifurcated between those fiscal periods because the Part C days issue was also pending in the appeal. Had the Providers intended to pursue the Part C days issue, they should have notified the Board at that time, if not sooner. Accordingly, an independent basis to deny reinstatement/reopening request is that, to the extent the alleged Part C issue was ever part of Case No. 09-2176GC, the Providers abandoned it by failing to properly notify the Board the alleged Part C days issue when the Board notified the Providers it was going to remand the appeal.[6] Indeed, the representative's reinstatement request was filed ***almost a year*** after the case had been remanded and closed and more than a year after the Board had notified the representative that the case was subject to 1498-R Remand. Accordingly, the Board declines to exercise its discretion to reopen and reinstate Case No. 09-2176GC because it is clear that the Providers have not established good cause to reinstate/reopen Case No. 09-2176GC.

There is an alternative independent basis for the Board's denial to exercise its discretion to reinstate this case. The Board finds that the issue statement of the group appeal defines the days at issue in as "Fee For Service Medicare Part-A" days which is clearly the dual eligible days Part A issue, and does *not* contemplate alleged Medicare+Choice Managed Care/Part C days issue since "Fee For Service Medicare Part-A" does not encompass Part C. Moreover, the Board notes that the Affidavit attached to the Reinstatement Request is ***not*** relevant to this case or any of the underlying individual group cases but was rather executed in connection with an unrelated case (Case No. 09-1708GC) and, as such, *only* pertains to that case. Indeed, the Affidavit itself related to the intent of the individual provider appeal requests for the participants in that group and not the group appeal request itself. As such, the Board declines to give it any weight.

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[5] (Emphasis added.)

[6] The Board takes administrative notice that many providers have appealed the Part C days issue from revised NPRs that were issued following a 1498-R remand. It is not clear to the Board whether any of the participants in this CIRP group later appealed the Part C issue for the year(s) at issue based on the revised NPR issued as a result of the 1498-R Remand. If so, it would render the bifurcation request moot.

Accordingly, the Board denies reinstatement/reopening because the alleged Part C Days issue was never part of the group appeal issue statement and, as such, it is clear that the proposed reinstatement for purposes of bifurcation has no merit.

As pointed out in the rescission and bifurcation request, regulations and Board rules require specificity with regards to each item under appeal. 42 C.F.R. § 405.1835(b)(2) (2009) reads, in part:

> (2) An explanation (for each specific item at issue . . .) of the provider's dissatisfaction with the intermediary's or Secretary's determination under appeal, including an account of the following:
>
> (i) Why the provider believes Medicare payment is incorrect *for each disputed item* . . .[7]
>
> (ii) How and why the provider believes Medicare payment must be determined differently *for each disputed item*.[8]

Board Rules have also long required that providers include identification of the issues in dispute with specificity:

> Your hearing request must include an identification and statement of the issue(s) you are disputing. You must identify the specific issues, findings of fact and conclusions of law with which the affected parties disagree; and you must specify the basis for contending the findings and conclusions are incorrect . . . You must clearly and specifically identify your position in regard to the issues in dispute. For instance, if you are appealing an aspect of the disproportionate share (DSH) adjustment factor or calculation, do not definite the issue as "DSH". You must precisely identify the component of the DSH issue that is in dispute.[9]

The Board finds that the issue statement for the group appeal can only be read to encompass the dual eligible Part A days issue. The group appeal issue language does not meet the specificity requirements as set forth in the regulation and Board rules to have appealed the dual eligible Part C days issue.

This finding is consistent with the recent ruling by the U.S. District Court for the District of Columbia in *Evangelical Community Hospital, et al. v. Becerra*.[10] In that case, the provider's issue was tied to improper calculation to DSH payment and read in part, "[t]he intermediary erred by incorrectly calculating the SSI percentage for inclusion in the 'Medicare Fraction' for

[7] (Emphasis added.)
[8] 42 C.F.R § 405.1835(b)(1)-(2) (emphasis added.)
[9] Provider Reimbursement Review Board, Part I, B, II. (March 1, 2002).
[10] 21-cv-01368 (APM) (D.D.C. Sep. 30, 2022).

purposes of the calculation of the provider's [disproportionate share] payment . . ."[11] The Court found that "[t]his description does not specify which portion of the calculation was incorrect nor how the fraction should have been calculated differently."[12] The Court found that this was a description of the issue was a violation of Board rules and a proper basis on which for the Board to dismiss the appeal.[13] Here, the Board makes the same finding based on similarly overly generalized language.

For the reasons set forth above, the Board **declines** to exercise its discretion to reopen and reinstate Case No. 09-2176GC and, thus, **denies** the request for reinstatement and rescission of remand in order to bifurcate a single participant from the group appeal regarding the Part C Days issue. Accordingly, Case No. 09-2176GC remains closed.

Board Members Participating:

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

For the Board:

12/15/2023

X Clayton J. Nix

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

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

[11] *Id*. at 11.
[12] *Id.*
[13] *Id.*

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

Isaac Blumberg
Chief Operating Officer
Blumberg Ribner, Inc.
11400 W. Olympic Blvd. Suite 700
Los Angeles, CA 90064

Byron Lamprecht
WPS Government Health Administrators
1000 N 90th Street, Suite 302
Omaha, NE 68114

RE: ***Request for Rule 41.1 Reinstatement and Bifurcation of Group Appeal Regarding DSH Part C Days Issue***
SSM Health Care 2001, 2002 Dual Eligible Days
Case No. 09-2186GC

Dear Mr. Blumberg and Mr. Lamprecht:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Providers' June 2, 2016 request for Rule 41.1 Reinstatement and Bifurcation of Group Appeal regarding DSH Part C Days for the SSM Health System 2001, 2002 Dual Eligible Days CIRP Group. As set forth below, the Board denies this request because the Provider is seeking bifurcation of Part C Days but the instant appeal did not include Part C Days.

Background:

On August 28, 2009, the Board received the group appeal request. The entire description for the Medicare/Medicaid Dual Eligible Patient Days issue reads:

> Dual Eligible Days Issue – Dual Eligible Days are patient days associated with those patients who were not included in the SSI denominator by CMS' design as they were not directly billed to Medicare and did not flow through the MEDPAR system via Fee For Service Medicare Part-A. Moreover, these days were disallowed from the Medicaid numerator as well. Hence, neither the Medicaid fraction nor the Medicare fraction captured the days associated with the undisputed indigent population. As the days represent patient who were Medicaid Eligible but not Medicare Entitled, the Provider contends that these days should be included in the Medicaid fraction.
>
> Dual Eligible Days were excluded from the Medicaid fraction for a variety of reasons. By way of example, certain Dual Eligible Days are days associated with patients who are eligible for Medicaid but have exhausted their Medicare Part A benefits ("Exhausted Days"). In Edgewater Medical Center (Chicago, IL.) v. Blue Cross and Blue Shield Association/ Blue Cross and Blue Shield of Illinois, PRRB Hearing Dec. No. 2000-D44 (April 7, 2000), the Board held

> The Board continues to maintain that the DSH numerator should include days of dually eligible patients whose Medicare Part A benefits were exhausted and who were eligible for reimbursement under the State's Medicaid plan. *See Jersey Shore Medical Center v. Blue Cross and Blue Shield of New Jersey*, PRRB Case No. 99-D4, Medicare and Medicaid Guide (CCH) ¶80,083, October 30, 1998, *vacated and remanded*, HCFA Administrator, January 4, 1999, Medicare and Medicaid Guide (CCH) ¶80,153 ("*Jersey*").

Thus, in accordance with the Board's holding in the Edgewater, the Provider's Medicaid fraction should include all "Exhausted Days."

On December 12, 2014, he Board, *on its own motion*, notified the Representative that the Board determined the group was CIRP was subject to remand pursuant to CMS Ruling 1498-R[1] and required the Representative to submit the final Schedule of Providers ("SoP") and supporting jurisdictional documentation within 30 days so that the Board could apply CMS Ruling 1498-R.

On January 9, 2015, Blumberg Ribner filed the final SoP with supporting jurisdictional documentation. Significantly, in the filing of the SoP, the Representative did not object to the planned 1498-R Remand, ***nor*** did it notify the Board that there were any other issues in the case not subject to the 1498-R Remand, notwithstanding the fact that a CIRP group can only contain one issue (42 C.F.R. § 405.1837(a)(2)) and no issues may be added to a group after the appeal request is filed (42 C.F.R. § 405.1837(f)(1)).

The Board reviewed the SOP and **on April 30, 2015**, the Board issued a standard remand in Case No. 09-2186GC and remanded the dual eligible Part A days issue to the Medicare Contractor. Accordingly, concurrent with the remand, the Board closed the case.

Providers' Request for Rescission of Remand and Bifurcation of Group Appeal Regarding DSH Part C Days Issue:

On June 2, 2016, the Board received a letter from Blumberg Ribner requesting Rule 41.1 Reinstatement and Bifurcation of Group Appeal regarding DSH Part C Days issue. The Providers argues that the references to dual eligible patient days were intended to refer to persons eligible for Part A and Part C.[2]

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

[2] Bifurcation Request Letter at 1 (May 27, 2016).

The Providers argue that:

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

The Providers refer to a decision in Case No. 08-2624GC in which the Board granted bifurcation of dual eligible Part A and Part C days in Sutter Health 1998 DSH Dual Eligible Days CIRP Group. In that December 30, 2015 letter, the Board stated:

> [T]he Board acknowledges that *at the time that Sutter Health's individual and group appeals were filed, the issue of whether a Medicaid patient that was "dually eligible" for Medicare was not necessarily subdivided by Medicare Part A or HMO/Part C days.* Federal courts later ruled differently on the "dual eligibility" related to Part A and Part C days therefore necessitating the Board to bifurcate these issues. In this case, the Board finds that the *providers' individual appeals and the original optional group appeal added the dual eligible days issue using a broad issue statement that encompassed both dual eligible Part A non-covered days and HMO days.* (Emphasis in original).[3]

The Providers next argue that the Board has the authority to reopen its remand decision and should do so. They reference 42 C.F.R. § 405.1885(b)(3), "A Secretary or contractor determination or decision by the reviewing entity may be reopened and revised at any time if it is established that the determination or decision was procured by fraud or similar fault of any party to the determination or decision." They conclude that that the MAC was at fault in accepting the dual eligible days remand, and the Board should reopen the remand decision.

The Providers next reference an Affidavit of Isaac Blumberg, the Representative of the Providers to support the contention that "the Providers' use of the term 'dual eligible days' was ***intended***" to refer to Medicare Part A Days and Medicare Part C Days." However, the referenced affidavit was not executed for this case but rather for Case No. 09-1708GC entitled "QRS Providence Health 2004 Medicare Part C Days CIRP Group." As a result, this affidavit does ***not pertain*** to this case as it was executed for a different unrelated case and appears to have a different group issue statement.

Last, the Providers argue that they filed their *individual* appeals between March 1, 2002 and August 21, 200**9** in accordance with Board Instructions in effect during that time. The Board Instructions effective March 1, 2002 stated:

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[3] *Id.* at 2.

> Your hearing request must include an identification and statement of the issue(s) you are disputing. You must identify the specific issues, findings of fact and conclusions of law . . . **You must precisely identify the component of the DSH issue that is in dispute.**

The Providers argue that these Instructions did not require that they state the issue as "finely" as would be required under later rules. The Providers conclude that they were required to precisely define the DSH component at issue, which they did.

However, contrary to their assertion, the March 1, 2002 Board Instructions were ***not*** in effect *until* August 21, 200***9***. Rather, they were superseded by Board Rules issued *one year earlier* effective August 21, 200***8*** because the Board issued the August 21, 2008 revised Board Rules to implement changes to the Board's governing regulations *that were similarly effective August 21, 200**8*** and included material and significant clarifications on the minimum content for individual appeal requests (42 C.F.R. § 405.1835(b) (2009)) as well as group appeal requests (42 C.F.R. § 405.1837(c) (2009)).[4]

Decision of the Board

Board Rule 46.1 (July 1, 2015), in effect at the time the request was filed, addresses how the Board handles a 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 . . . 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."

> **46.1 – 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

[4] *See* 73 Fed. Reg. 30190 (May 23, 2008).

> had in its initial appeal. These requirements also apply to Rules 46.2 and 46.3 below.[5]

As discussed above, on December 12, 2014, the Board specifically notified the Providers that it was going to remand the appeal. To that end, the Board requested the Representative to file the final SoP with supporting jurisdictional documentation so the Board could complete the jurisdictional review and remand this case per CMS Ruling 1498-R. On January 9, 2015, Blumberg Ribner submitted the final SoP with supporting jurisdictional documentation. Significantly, in the filing of the SOP, Blumberg Ribner did *not* object to the Board's planned 1498-R remand, *nor* did it notify the Board that there were any other issues in the case not subject to the CMS Ruling 1498-R remand notwithstanding the fact that a CIRP group can only contain one issue (42 C.F.R. § 405.1837(a)(2)) and no issues may be added to a group after the appeal request is filed (42 C.F.R. § 405.1837(f)(1)).

Accordingly, following Blumberg Ribner's filing of the final SOP for Case No. 09-2186GC, the Board reviewed the SOP, remanded Case No. 09-2186GC, and then closed that case. Neither the Providers nor the group representative raised *any* issue to the Board that the appeal should not be bifurcated between those fiscal periods because the Part C days issue was also pending in the appeal. Had the Providers intended to pursue the Part C days issue, they should have notified the Board at that time, if not sooner. Accordingly, an independent basis to deny reinstatement/reopening request is that, to the extent the alleged Part C issue was ever part of Case No. 09-2186GC, the Providers abandoned it by failing to properly notify the Board the alleged Part C days issue when the Board notified the Providers it was going to remand the appeal.[6] Indeed, the representative's reinstatement request was filed ***almost a year*** after the case had been remanded and closed and more than a year after the Board had notified the representative that the case was subject to 1498-R Remand. Accordingly, the Board declines to exercise its discretion to reopen and reinstate Case No. 09-2186GC because it is clear that it is clear that the Providers have not established good cause to reinstate/reopen Case No. 09-2186GC.

There is an alternative independent basis for the Board's denial to exercise its discretion to reinstate this case. The Board also notes that the issue statement of the group appeal defines the days at issue in as "Fee For Service Medicare Part-A" days which is clearly the dual eligible days Part A issue, and does *not* contemplate alleged Medicare+Choice Managed Care/Part C days issue since "Fee For Service Medicare Part-A" does not encompass Part C. Moreover, the Board notes that the Affidavit attached to the Reinstatement Request is ***not*** relevant to this case or any of the underlying individual group cases but was rather executed in connection with an unrelated case (Case No. 09-1708GC) and, as such, *only* pertains to that case. Indeed, the Affidavit itself related to the intent of the individual provider appeal requests for the participants

[5] (Emphasis added.)
[6] The Board takes administrative notice that many providers have appealed the Part C days issue from revised NPRs that were issued following a 1498-R remand. It is not clear to the Board whether any of the participants in this CIRP group later appealed the Part C issue for the year(s) at issue based on the revised NPR issued as a result of the 1498-R Remand. If so, it would render the bifurcation request moot.

in that group and not the group appeal request itself. As such, the Board declines to give it any weight. Accordingly, a second and independent basis upon which to deny reinstatement/reopening is that the alleged Part C Days issue was never part of the group appeal issue statement and, as such, it is clear that the proposed reinstatement for purposes of bifurcation has no merit.

As pointed out in the rescission and bifurcation request, regulations and Board rules require specificity with regards to each item under appeal. 42 C.F.R. § 405.1835(b)(2) (2009) reads, in part:

> (2) An explanation (for each specific item at issue . . .) of the provider's dissatisfaction with the intermediary's or Secretary's determination under appeal, including an account of the following:
>
> (i) Why the provider believes Medicare payment is incorrect *for each disputed item* . . .[7]
>
> (ii) How and why the provider believes Medicare payment must be determined differently *for each disputed item*.[8]

Board Rules have also long required that providers include identification of the issues in dispute with specificity:

> Your hearing request must include an identification and statement of the issue(s) you are disputing. You must identify the specific issues, findings of fact and conclusions of law with which the affected parties disagree; and you must specify the basis for contending the findings and conclusions are incorrect . . . You must clearly and specifically identify your position in regard to the issues in dispute. For instance, if you are appealing an aspect of the disproportionate share (DSH) adjustment factor or calculation, do not definite the issue as "DSH". You must precisely identify the component of the DSH issue that is in dispute.[9]

The Board finds that the issue statement for the group appeal can only be read to encompass the dual eligible Part A days issue. The group appeal issue language does not meet the specificity requirements as set forth in the regulation and Board rules to have appealed the dual eligible Part C days issue.

This finding is consistent with the recent ruling by the U.S. District Court for the District of Columbia in *Evangelical Community Hospital, et al. v. Becerra*.[10] In that case, the provider's

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[7] (Emphasis added.)
[8] 42 C.F.R § 405.1835(b)(1)-(2) (emphasis added.)
[9] Provider Reimbursement Review Board, Part I, B, II. (March 1, 2002).
[10] 21-cv-01368 (APM) (D.D.C. Sep. 30, 2022).

issue was tied to improper calculation to DSH payment and read in part, "[t]he intermediary erred by incorrectly calculating the SSI percentage for inclusion in the 'Medicare Fraction' for purposes of the calculation of the provider's [disproportionate share] payment . . ."[11] The Court found that "[t]his description does not specify which portion of the calculation was incorrect nor how the fraction should have been calculated differently."[12] The Court found that this was a description of the issue was a violation of Board rules and a proper basis on which for the Board to dismiss the appeal.[13] Here, the Board makes the same finding based on similarly overly generalized language.

For the reasons set forth above, the Board **declines** to exercise its discretion to reopen and reinstate Case No. 09-2186GC and, thus, **denies** the request for reinstatement and rescission of remand in order to bifurcate a single participant from the group appeal regarding the Part C Days issue. Accordingly, Case No. 09-2186GC remains closed.

Board Members Participating:

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

For the Board:

12/15/2023

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services

[11] *Id*. at 11.
[12] *Id.*
[13] *Id.*

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

Isaac Blumberg
Chief Operating Officer
Blumberg Ribner, Inc.
11400 W. Olympic Blvd. Suite 700
Los Angeles, CA 90064

Danelle Decker
National Government Services, Inc.
Mail point INA102-AF42
P.O. Box 6474
Indianapolis, IN 46206

RE: ***Request to Reinstate & Bifurcate Group Appeal Regarding DSH Part C Days Issue***
Continuum Health Partners 1999-2000 Dual Eligible Days CIRP Group
Case No. 10-0705GC

Dear Mr. Blumberg and Ms. Decker:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Providers' May 23, 2016 request for Rule 41.1 Reinstatement and Bifurcation of Group Appeal regarding DSH Part C Days for the Continuum Health Partners 1999-2000 Dual Eligible Days CIRP Group. As set forth below, the Board denies this request because the Provider is seeking bifurcation of Part C Days but the instant appeal did not include Part C Days.

Background:

On February 24, 2010, the Board received the group appeal request. The entire description for the Medicare/Medicaid Dual Eligible Patient Days issue reads:

> Dual Eligible Days Issue – Dual Eligible Days are patient days associated with those patients who were not included in the SSI denominator by CMS' design as they were not directly billed to Medicare and did not flow through the MEDPAR system via Fee For Service Medicare Part-A. Moreover, these days were disallowed from the Medicaid numerator as well. Hence, neither the Medicaid fraction nor the Medicare fraction captured the days associated with the undisputed indigent population. As the days represent patient who were Medicaid Eligible but not Medicare Entitled, the Provider contends that these days should be included in the Medicaid fraction.
>
> Dual Eligible Days were excluded from the Medicaid fraction for a variety of reasons. By way of example, certain Dual Eligible Days are days associated with patients who are eligible for Medicaid but have exhausted their Medicare Part A benefits ("Exhausted Days"). In Edgewater Medical Center (Chicago, IL.) v. Blue Cross and Blue

Shield Association/ Blue Cross and Blue Shield of Illinois, PRRB Hearing Dec. No. 2000-D44 (April 7, 2000), the Board held

> The Board continues to maintain that the DSH numerator should include days of dually eligible patients whose Medicare Part A benefits were exhausted and who were eligible for reimbursement under the State's Medicaid plan. *See Jersey Shore Medical Center v. Blue Cross and Blue Shield of New Jersey*, PRRB Case No. 99-D4, Medicare and Medicaid Guide (CCH) ¶80,083, October 30, 1998, *vacated and remanded*, HCFA Administrator, January 4, 1999, Medicare and Medicaid Guide (CCH) ¶80,153 ("*Jersey*").

Thus, in accordance with the Board's holding in the Edgewater, the Provider's Medicaid fraction should include all "Exhausted Days".

Also, the Board in the recent *National DSH Dual Eligible Group Appeal vs. Blue Cross and Blue Shield Association*, PRRB Case Number 2009-D26 (June 23, 2009), held that, "dual eligible days for Medicare Part A exhausted benefit days, Medicare secondary payer days and denied days for lack of medical necessity or custodial care should be included in the Medicaid percentage that is used to calculate the DSH adjustment payment." The Providers request that the record of *National DSH Dual Eligible Group Appeal vs. Blue Cross and Blue Shield Association* be incorporated herein. The Board in its decision in *Allina Health Systems FYs 1995 – 2003 DSH Dual Eligible Days vs. Blue Cross Blue Shield /Noridian Administrative Services*, PRRB Case Number 2009-D35 (July 30, 2009), reached the same conclusion when it held that "the Providers' dual eligible patient days not entitled to benefits under Part A should be in included in the Providers' Medicaid percentage used to calculate the DSH adjustment payment." The Providers also request that the record of *Allina Health Systems FYs 1995 – 2003 DSH Dual Eligible Days vs. Blue Cross Blue Shield /Noridian Administrative Services* be incorporated herein.

On January 20, 2015, the Board, *on its own motion*, notified the Providers that it was going to remand the Providers in the appeal pursuant to Centers for Medicare & Medicaid Services ("CMS") Ruling 1498-R,[1] but that before it could do so, Blumberg Ribner needed to submit a

[1] Ruling 1498-R was issued on April 28, 2010, by the CMS Administrator to address three specific issues regarding the calculation of the Medicare disproportionate share hospital (DSH) payment adjustment: (1) the Medicare SSI fraction data matching process issue and the method for recalculating the hospital's Medicare SSI fraction, (2) the exclusion from the DSH calculation of non-covered patient hospital days for patients entitled to Medicare Part A

final Schedule of Providers ("SoP") for review within 30 days so the Board could apply CMS Ruling 1498-R.

On February 12, 2015, Blumberg Ribner submitted the final SoP with supporting jurisdictional documentation. Significantly, in the filing of the SoP, BRI did ***not*** object to the planned 1498-R Remand, ***nor*** did it notify the Board that there were any other issues in the case not subject to the 1498-R Remand, notwithstanding the fact that a CIRP group can only contain one issue (42 C.F.R. § 405.1837(a)(2)) and no issues may be added to a group after the appeal request is filed (42 C.F.R. § 405.1837(f)(1)).

The Board reviewed the SOP and **on April 30, 2015**, the Board issued a standard remand in Case No. 10-0705GC and remanded the dual eligible Part A days issue to the Medicare Contractor. Accordingly, concurrent with the remand, the Board closed the case.

Rule 41.1 Reinstatement and Bifurcation of Group Appeal regarding DSH Part C Days Issue

On May 23, 2016, the Board received a letter from Blumberg Ribner requesting Rule 41.1 Reinstatement and Bifurcation of Group Appeal regarding DSH Part C Days issue. The Providers argues that the references to dual eligible patient days were intended to refer to persons eligible for Part A and Part C.[2]

The Providers refer to a decision in Case No. 08-2624GC in which the Board granted bifurcation of dual eligible Part A and Part C days in Sutter Health 1998 DSH Dual Eligible Days CIRP Group. In that December 30, 2015 letter, the Board stated:

> [T]he Board acknowledges that *at the time that Sutter Health's individual and group appeals were filed, the issue of whether a Medicaid patient that was "dually eligible" for Medicare was not necessarily subdivided by Medicare Part A or HMO/Part C days.* Federal courts later ruled differently on the "dual eligibility" related to Part A and Part C days therefore necessitating the Board to bifurcate these issues. In this case, the Board finds that the *providers' individual appeals and the original optional group appeal added the dual eligible days issue using a broad issue statement that encompassed both dual eligible Part A non-covered days and HMO days.* (Emphasis in original).[3]

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including days for which the patient's Part A inpatient hospital benefits were exhausted for cost reporting periods before October 1, 2004, and (3) the exclusion from the DSH calculation of the labor/delivery room (LDR) inpatient days.

[2] Bifurcation Request Letter at 1 (May 23, 2016).

[3] *Id.* at 2.

The Providers next reference an Affidavit of Isaac Blumberg, the Representative of the Providers to support the contention that "the Providers' use of the term 'dual eligible days' was ***intended***" to refer to Medicare Part A Days and Medicare Part C Days." However, the referenced affidavit was not executed for this case but rather for Case No. 09-1708GC entitled "QRS Providence Health 2004 Medicare Part C Days CIRP Group." As a result, this affidavit does ***not pertain*** to this case as it was executed for a different unrelated case and appears to have a different group issue statement.

Last, the Providers argue that they filed their *individual* appeals between March 1, 2002 and August 21, 200**9** in accordance with Board Instructions in effect during that time. The Board Instructions effective March 1, 2002 stated:

> Your hearing request must include an identification and statement of the issue(S) you are disputing. You must identify the specific issues, findings of fact and conclusions of law . . . **You must precisely identify the component of the DSH issue that is in dispute.**

The Providers argue that these Instructions did not require that they state the issue as "finely" as would be required under later rules. The Providers conclude that they were required to precisely define the DSH component at issue, which they did.

However, contrary to their assertion, the March 1, 2002 Board Instructions were ***not*** in effect *until* August 21, 200***9***. Rather, they were superseded by Board Rules issued *one year earlier* effective August 21, 200***8*** because the Board issued the August 21, 2008 revised Board Rules to implement changes to the Board's governing regulations *that were similarly effective August 21, 200**8*** and included material and significant clarifications on the minimum content for individual appeal requests (42 C.F.R. § 405.1835(b) (2009)) as well as group appeal requests (42 C.F.R. § 405.1837(c) (2009)).[4]

Decision of the Board

Board Rule 46.1 (July 1, 2015), in effect at the time the request was filed, addresses how the Board handles a 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 . . . 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."

> **46.1 – 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

[4] *See* 73 Fed. Reg. 30190 (May 23, 2008).

> 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. These requirements also apply to Rules 46.2 and 46.3 below.[5]

As discussed above, on January 20, 2015, the Board specifically notified the Providers that it was going to remand the appeal. To that end, the Board requested the Representative to file the final SoP with supporting jurisdictional documentation so the Board could complete the jurisdictional review and remand this case per CMS Ruling 1498-R. On February 12, 2015, Blumberg Ribner submitted the final SoP with supporting jurisdictional documentation. Significantly, in the filing of the SOP, Blumberg Ribner did *not* object to the Board's planned 1498-R remand, *nor* did it notify the Board that there were any other issues in the case not subject to the CMS Ruling 1498-R remand notwithstanding the fact that a CIRP group can only contain one issue (42 C.F.R. § 405.1837(a)(2)) and no issues may be added to a group after the appeal request is filed (42 C.F.R. § 405.1837(f)(1)).

Accordingly, following Blumberg Ribner's filing of the final SOP for Case No. 10-0705GC, the Board reviewed the SOP, remanded Case No. 10-0705GC, and then closed that case. Had the Providers intended to pursue the Part C days issue, they should have notified the Board at that time, if not sooner. Accordingly, to the extent the alleged Part C issue was ever part of Case No. 10-0705GC, the Providers abandoned it by failing to properly notify the Board the alleged Part C days issue when the Board notified the Providers it was going to remand the appeal. Accordingly, an independent basis to deny reinstatement/reopening request is that, to the extent the alleged Part C issue was ever part of Case No. 10-0705GC, the Providers abandoned it by failing to properly notify the Board the alleged Part C days issue when the Board notified the Providers it was going to remand the appeal.[6] Indeed, the representative's reinstatement request was filed ***almost a year*** after the case had been remanded and closed and more than a year after the Board had notified the representative that the case was subject to 1498-R Remand. Accordingly, the Board declines to exercise its discretion to reopen and reinstate Case No. 10-0705GC because it is clear that the Providers have not established good cause to reinstate/reopen Case No. 10-0705GC.

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[5] (Emphasis added.)

[6] The Board takes administrative notice that many providers have appealed the Part C days issue from revised NPRs that were issued following a 1498-R remand. It is not clear to the Board whether any of the participants in this CIRP group later appealed the Part C issue for the year(s) at issue based on the revised NPR issued as a result of the 1498-R Remand. If so, it would render the bifurcation request moot.

There is an alternative independent basis for the Board's denial to exercise its discretion to reinstate this case. The Board also notes that the issue statement of the group appeal defines the days at issue in as "Fee For Service Medicare Part-A" days which is clearly the dual eligible days Part A issue, and does *not* contemplate alleged Medicare+Choice Managed Care/Part C days issue since "Fee For Service Medicare Part-A" does not encompass Part C. Moreover, the Board notes that the Affidavit attached to the Reinstatement Request is ***not*** relevant to this case or any of the underlying individual group cases but was rather executed in connection with an unrelated case (Case No. 09-1708GC) and, as such, *only* pertains to that case. Indeed, the Affidavit itself related to the intent of the individual provider appeal requests for the participants in that group and not the group appeal request itself. As such, the Board declines to give it any weight. Accordingly, a second and independent basis upon which to deny reinstatement/reopening is that the alleged Part C Days issue was never part of the group appeal issue statement and, as such, it is clear that the proposed reinstatement for purposes of bifurcation has no merit.

As pointed out in the rescission and bifurcation request, regulations and Board rules require specificity with regards to each item under appeal. 42 C.F.R. § 405.1835(b)(2) (2009) reads, in part:

> (2) An explanation (for each specific item at issue . . .) of the provider's dissatisfaction with the intermediary's or Secretary's determination under appeal, including an account of the following:
>
> (i) Why the provider believes Medicare payment is incorrect *for each disputed item* . . .[7]
>
> (ii) How and why the provider believes Medicare payment must be determined differently *for each disputed item*.[8]

Board Rules have also long required that providers include identification of the issues in dispute with specificity:

> Your hearing request must include an identification and statement of the issue(s) you are disputing. You must identify the specific issues, findings of fact and conclusions of law with which the affected parties disagree; and you must specify the basis for contending the findings and conclusions are incorrect . . . You must clearly and specifically identify your position in regard to the issues in dispute. For instance, if you are appealing an aspect of the disproportionate share (DSH) adjustment factor or calculation, do

[7] (Emphasis added.)
[8] 42 C.F.R § 405.1835(b)(1)-(2) (emphasis added.)

> not definite the issue as "DSH". You must precisely identify the component of the DSH issue that is in dispute.[9]

The Board finds that the issue statement for the group appeal can only be read to encompass the dual eligible Part A days issue. The group appeal issue language does not meet the specificity requirements as set forth in the regulation and Board rules to have appealed the dual eligible Part C days issue.

This finding is consistent with the recent ruling by the U.S. District Court for the District of Columbia in *Evangelical Community Hospital, et al. v. Becerra*.[10] In that case, the provider's issue was tied to improper calculation to DSH payment and read in part, "[t]he intermediary erred by incorrectly calculating the SSI percentage for inclusion in the 'Medicare Fraction' for purposes of the calculation of the provider's [disproportionate share] payment . . ."[11] The Court found that "[t]his description does not specify which portion of the calculation was incorrect nor how the fraction should have been calculated differently."[12] The Court found that this was a description of the issue was a violation of Board rules and a proper basis on which for the Board to dismiss the appeal.[13] Here, the Board makes the same finding based on similarly overly generalized language.

For the reasons set forth above, the Board **declines** to exercise its discretion to reopen and reinstate Case No. 10-0705GC and, thus, **denies** the request for reinstatement and rescission of remand in order to bifurcate a single participant from the group appeal regarding the Part C Days issue. Accordingly, Case No. 10-0705GC remains closed.

Board Members Participating:

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

For the Board:

12/15/2023

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services

[9] Provider Reimbursement Review Board, Part I, B, II. (March 1, 2002).
[10] 21-cv-01368 (APM) (D.D.C. Sep. 30, 2022).
[11] *Id*. at 11.
[12] *Id.*
[13] *Id.*

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Andrew Ruskin, Esq.
K&L Gates LLP
1601 K Street, NW
Washington, D.C. 20006-1600

RE: ***Expedited Judicial Review Determination***
Trinity Health 2015 IME Calculation – Labor & Delivery Beds CIRP Group
Case No. 17-1196GC

Dear Mr. Ruskin:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' request for expedited judicial review (EJR) filed on December 6, 2023 in the above-referenced common issue related party ("CIRP") 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 (Dec. 6, 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.

#

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 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.*

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 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,

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[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.
[13] *Id.*

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 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

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

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) implementing the FFY 2013 regulatory change to now 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]

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.[25]

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.[26] 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.[27] 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.[28] However, CMS does not explain how it arrived at that conclusion. The Providers

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[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 3.
[26] *Id.*
[27] *Id.* at 8.
[28] *Id.*

assert that the statute requires the IRB Ratio bed count to be based on the methodology that CMS used to count beds in 1983.[29] 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.[30] 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.[31]

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.[32]

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.[33]

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 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.[34]

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.[35]

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[29] *Id.*
[30] *Id.*
[31] *Id.*
[32] *Id.* at 9.
[33] *Id.*
[34] *Id.* at 10.
[35] *Id.*

Medicare Contractor's Response:

On December 12, 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 acknowledging that EJR is appropriate.

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*").[36] 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.[37]

On August 21, 2008, new regulations governing the Board were effective.[38] 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*").[39] 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.[40]

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[36] 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.).
[37] *Bethesda*, 108 S. Ct. at 1258-59.
[38] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[39] 201 F. Supp. 3d 131 (D.D.C. 2016).
[40] *Id.* at 142.

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 all involve cost report periods which began *prior to* January 1, 2016, and therefore, this case 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 appeal was 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 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 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 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 year 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:

12/18/2023

X Clayton J. Nix

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

Enclosure: Schedule of Providers

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Andrew Ruskin, Esq.
K&L Gates LLP
1601 K Street, NW
Washington, D.C. 20006-1600

RE: ***Expedited Judicial Review Determination***
Trinity Health 2016 IME Calculation – Labor & Delivery Beds CIRP Group
Case No. 18-1301GC

Dear Mr. Ruskin:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' request for expedited judicial review (EJR) filed on December 5, 2023 in the above-referenced common issue related party ("CIRP") 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 (Dec. 5, 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 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.*

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 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,

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[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.
[13] *Id.*

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 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

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

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) implementing the FFY 2013 regulatory change to now 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]

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.[25]

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.[26] 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.[27] 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.[28] However, CMS does not explain how it arrived at that conclusion. The Providers

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[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 3.
[26] *Id.*
[27] *Id.* at 8.
[28] *Id.*

assert that the statute requires the IRB Ratio bed count to be based on the methodology that CMS used to count beds in 1983.[29] 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.[30] 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.[31]

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.[32]

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.[33]

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 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.[34]

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.[35]

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[34] *Id.* at 10.
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Medicare Contractor's Response:

On December 12, 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 acknowledging that EJR is appropriate.

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*").[36] 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.[37]

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[37] *Bethesda*, 108 S. Ct. at 1258-59.
[38] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[39] 201 F. Supp. 3d 131 (D.D.C. 2016).
[40] *Id.* at 142.

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 all involve cost report periods which began ***prior to*** January 1, 2016, and therefore, this case 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 appeal was 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 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 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 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. Accordingly, the Board hereby grants the Providers' request for EJR for the issue and year 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:

12/18/2023

X Clayton J. Nix

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

Enclosure: Schedule of Providers

cc: Byron Lamprecht, WPS Government Health Administrators (J-8)
Wilson C. Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Board Decision***
Lower Keys Medical Center (Provider Number 10-0150)
FYE: 09/30/2017
Case Number: 21-0264

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the documentation in Case No. 21-0264 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. 21-0264

On March 30, 2020, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end September 30, 2017.

On September 18, 2020, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained eight (8) issues:

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

[1] On April 27, 2021, this issue was transferred to PRRB Case No. 20-1332GC.
[2] On April 27, 2021, this issue was transferred to PRRB Case No. 19-2620GC.
[3] On April 27, 2021, this issue was transferred to PRRB Case No. 20-1383GC.
[4] On January 13, 2023, the Provider withdrew this issue.
[5] On April 27, 2021, this issue was transferred to PRRB Case No. 19-2620GC.
[6] On April 27, 2021, this issue was transferred to PRRB Case No. 20-1383GC.

8. 2 Midnight Census IPPS Payment Reduction[7]

As the Provider is owned by Community Health Systems, Inc. (hereinafter "CHS") and, thereby, subject to the mandatory Common Issue Related Party ("CIRP") group regulation at 42 C.F.R. § 405.1837(b)(1), the Provider transferred Issues 2-4, and 6-7 to CHS groups on April 27, 2021. After the withdrawal of Issues 5 and 8, the remaining issue in this appeal is Issue 1.

On May 10, 2021, the Provider submitted its preliminary position paper.

On July 29, 2021, the Medicare Contractor filed a jurisdictional challenge, requesting the dismissal of Issue 1.[8]

On August 13, 2021, the Medicare Contractor filed its preliminary position paper.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 20-1332GC and 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.[9]

As the Provider is commonly owned by Community Health, the Provider transferred its Issue 2 – DSH/SSI Percentage to the CIRP group under 20-1332GC, CHS CY 2017 HMA DSH SSI Percentage CIRP Group, on April 27, 2021. Case No. 20-1332GC was consolidated into a duplicate appeal, Case No. 20-0997GC, in which this Provider is a participant. The Group Issue Statement in Case No. 20-0997GC reads, in part:

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[7] On February 17, 2021, the Provider withdrew this issue.
[8] On November 14, 2022, the Medicare Contractor filed a jurisdictional challenge over the Medicaid Eligible Days issue. CHS responded to this challenge on December 14, 2022, and then subsequently withdrew the Medicaid Eligible Days issue on January 13, 2023.
[9] Issue Statement at 1 (Sept. 18, 2020).

Statement of the Issue:

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

Statement of the Legal Basis

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

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

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

On May 10, 2021, 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 the Provider's DSH calculation. This is based on certain data from the State of Florida and the Provider that does not support the SSI percentage issued by CMS.

The Provider has worked with the State of Florida and has learned that similar to *Loma Linda Community Hospital v. Dept of Health*

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

> *and Human Services*, No. CV-94-0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records.
>
> The Provider is seeking the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000 from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. *See* 65 Fed. Reg. 50,548 (2000). The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction.[11]

MAC's Contentions

Issue 1 – DSH – SSI Percentage (Provider Specific)

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

Provider's Jurisdictional Response

The Board Rules require that Provider Responses to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[12] The Provider has not filed a response to the Jurisdictional Challenge of the SSI Provider Specific issue, 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."

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

[11] Provider's Preliminary Position Paper at 8-9.
[12] Board Rule 44.4.3, v. 2.0 (Aug. 2018).

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*

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."[13] The Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[14] The Provider argues 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."[15]

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[16], 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

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

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.[17] The Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors 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.[18]

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

[17] 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).
[18] (Emphasis added).

payments. *We will make the information available for either the Federal fiscal year or, if the hospital's fiscal year differs from the Federal fiscal year, for the* ***months included in the 2 Federal fiscal years that encompass the hospital's cost reporting period***. Under this provision, *the hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year*. The data set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year." Further highlighting the perfunctory nature of the briefing is the fact that providers *can* obtain certain data used to calculate their DSH SSI ratios directly from the Centers for Medicare and Medicaid Services ("CMS") and in some cases on a self-service basis as explained on the following webpage:

> https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH.[19]

This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows: "DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[20]

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 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 20-0997GC are the same issue.[21] 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

[19] Last accessed December 18, 2023.
[20] Emphasis added.
[21] 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).

Medicare Contractor has made a final determination regarding DSH SSI Percentage realignment. Further, the Provider's cost reporting period ends on 9/30, and is thus congruent with the federal fiscal year. As such, realignment of the SSI Percentage would have no effect on reimbursement. Therefore, the Board dismisses this aspect of the appeal.

****

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

Case No. 21-0264 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
Ratina Kelly, CPA

For the Board:

12/18/2023

X Kevin D. Smith, CPA

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Expedited Judicial Review Determination***
Univ. of Chicago MC FFY 2023 Area Wage Index Standardized Amount Reduct. CIRP Grp.
Case No. 23-0679GC

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 above-referenced common issue related party ("CIRP") group appeal, which also included six other group appeals that were decided under separate cover.[1] The Board's decision on jurisdiction and EJR for the above-referenced group appeal is 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.[2]

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[3] known as the inpatient prospective payment system ("IPPS"). Under IPPS, Medicare payments

[1] *See* EJR Determination Letter issued on November 24, 2023 (and Clarification Letter issued on December 1, 2023) in the following six group appeals:
23-0686GC Care New England FFY 2023 Area Wage Index Standardized Amount Reduction CIRP
23-0644GC Emory Healthcare FFY 2023 Area Wage Index Standardized Amount Reduction CIRP
23-0645GC Yale-New Haven FFY 2023 Area Wage Index Standardized Amount Reduction CIRP
23-0646GC UNC Health FFY 2023 Area Wage Index Standardized Amount Reduction CIRP Group
23-0647GC HCA FFY 2023 Area Wage Index Standardized Amount Reduction CIRP Group
23-0682G Hooper Lundy & Bookman FFY 2023 Area Wage Index Standardized Amount Reduction

[2] Providers' EJR Request at 2.

[3] 84 Fed. Reg. 42044, 42052 (Aug. 16, 2019).

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 base payment rate is comprised of a standardized amount[4] for all subsection (d) hospitals located in an "urban" or "rural" area.[5]

As part of the methodology for determining prospective payments to hospitals, 42 U.S.C. § 1395ww(d)(3)(E) requires that the Secretary[6] 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).[7]

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.[8]

A. Changes to the Wage Index Calculation

In the FFY 2019 IPPS proposed rule,[9] 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

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[4] 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). Section 1395ww(d)(3)(E) of the Act 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).

[5] 42 U.S.C. § 1395ww(d)(2)(A)-(D).

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

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

[8] *Id.*

[9] 83 Fed. Reg. 20164 (May 7, 2018).

the FFY 2020 IPPS proposed rule.[10] Therein, the Secretary noted that many respondents expressed: (1) "a common concern that the current wage index system perpetuates 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."[11] 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 . . . ."[12]

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.[13]

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."[14] 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

[10] 84 Fed Reg 19158, 19393-94 (May 3, 2019).
[11] *Id.*
[12] *Id.*
[13] 84 Fed. Reg. at 42326 (citations omitted).
[14] *Id.* at 42328.

method of determining low wage index and high wage index hospitals for purposes of our proposals . . . addressing wage index disparities."[15]

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.[16] When the FFY 2020 IPPS final rule was published the 25th percentile wage index value across all hospitals for FFY 2020 was 0.8457.[17]

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.[18] 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.[19]

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.[20] 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.[21]

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.[22] Based on the data for this final rule, for FY 2022, the 25th percentile wage index value across all hospitals was 0.8437.[23]

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

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

manner by applying an adjustment to the standardized amounts.[24] Based on the data for this final rule, for FY 2023, the 25th percentile wage index value across all hospitals was 0.8427.[25]

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."[26] 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."[27]

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."[28] 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.[29] 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."[30]

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.[31]

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[24] 87 Fed. Reg. 48780, 49006 (Aug. 10, 2022).
[25] *Id.*
[26] 84 Fed. Reg. at 42329.
[27] *Id.* at 42328-9.
[28] *Id.* at 42331.
[29] *Id*.
[30] *Id*.
[31] 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.[32] 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."[33]

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 his 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).

[32] 42 U.S.C. § 1395ww(d)(3)(E).
[33] *Id.*

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 contend EJR is appropriate because: (1) they are dissatisfied with the final payment determination of the Secretary; (2) the Board has jurisdiction over the appeals but lacks authority to decide the question at issue and grant the relief sought; and (3) pursuant to 42 C.F.R. § 405.1867, the Board must comply with all regulations of Title XVIII of the Social Security Act and, thereby, is bound to apply the 0.1854 percent reduction issued in the FFY 2023 IPPS Final Rule.

Decision of the Board:

The participants that comprise the group appeal 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 appealed from the FFY 2023 IPPS Final Rule.[34] The Board has determined that: (1) the participants' documentation shows that the estimated amount

[34] The CMS Administrator has determined that a Federal Register notice is a final determination from which a provider may appeal to the Board. *See District of Columbia Hosp. Ass'n Wage Index Grp. Appeal*, HCFA Adm'r Dec. (Jan. 15, 1993*)*, CCH Medicare & Medicaid Guide ¶ 41,025, *rev'g*, PRRB Juris. Dec. (Case No. 92-1200G, Nov. 18, 1992). *See also* 80 Fed. Reg. 70298, 70569-70 (Nov. 13, 2015).

in controversy exceeds $50,000, as required for a group appeal;[35] (2) the appeal was timely filed; and (3) Board review of the matter in these appeals is not precluded by statute or regulation. In finding that the group meets 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 the group more than clears the minimum $50,000 AiC hurdle. Based on the above, the Board finds that it has jurisdiction for the above-captioned appeal and the underlying Providers. The estimated AiC is subject to recalculation by the Medicare contractors for the actual final amounts in this case.

B. Application of 42 C.F.R. §§ 405.1873 and 413.24(j)

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—

[35] *See* 42 C.F.R. § 405.1837.

> (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
>
> (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.[36]

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

[36] (Bold and underline emphasis added.)

> specific item, **must be included in such EJR decision** along with the other matters prescribed by 405.1842(f)(1). . . .
>
> (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**.[37]

These regulations are applicable to the cost reporting periods in this group case.

2. Appropriate Cost Report Claims: Findings of Fact and Conclusions of Law

i. Background

As explained above, at issue in this appeal are cost reports beginning after January 1, 2016. The Medicare Contractor filed a substantive claim challenge to four providers' cost reports that are partially applicable to this case. Specifically, the four cost reports are those with FYE 12/31/2022, where the period from 10/1/22 to 12/31/22 is applicable to this case, for the following four providers:

> (1) Adventist La Grange Memorial Hospital (14-0065),
> (2) UChicago Medicine Adventhealth Hinsdale (14-0122),
> (3) UChicago Medicine Adventhealth Glenoaks (14-0292), and
> (4) UChicago Medicine Adventhealth Bolingbrook (14-0304).

These cost reports, as well as all of the other cost reports at issue, which have not yet been filed, are during a period which is subject to the regulations on the "substantive reimbursement requirement" for an appropriate cost report claim.[38] 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))"[39] 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.

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[37] (Bold and underline emphasis added.)
[38] 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").
[39] (Emphasis added.)

§ 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"[40] 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.[41]

ii. Cost Reports Not Yet Filed and Applicable to This Case

The Board notes that, when the participants in a group have not filed their cost report, as most of the cost reports in the instant case have not been filed,[42] 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.[43] Section 405.1873(b) sets forth the procedures for Board review of Substantive Claim Challenges:

> 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. U*pon 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

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[40] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."
[41] *See* 42 C.F.R. § 405.1873(a),
[42] The cost reports not yet filed include cost reports with FYEs of 12/31/2022 (the period from 10/1/22 to 12/31/22 being at issue), 6/30/2023 (the period from 10/1/22 to 6/30/23 being at issue), 12/31/23 (the period from 1/1/23 to 9/30/23 being at issue), and 6/30/24 (the period from 7/1/23 to 9/30/23 being at issue).
[43] The preamble to the final rule that adopted the substantive claim regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 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 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.

Claim Challenge would be premature and the Board declines to stay these proceedings until the Providers in this case file the referenced cost reports.

iii. Four Cost Reports That Have Been Filed by Providers with FYE 12/31/22

That said, *if subsequent to the Federal Register appeal being filed*, one or more participants files its cost report, as occurred for four of the providers in this case for cost reports with FYE 12/31/2022, as described above, then any party may raise a Substantive Claim Challenge regarding those participants and submit argument and evidence supporting their position. Here, *for those four cost reports*, the Medicare Contractor has asserted that four of the participants in this Federal Register appeal later filed their cost reports and failed to properly make a cost report substantive claim for the matter at issue in those cost reports in compliance with 42 C.F.R. § 413.24(j).

In response, the Group Representative acknowledges that the Medicare Contractor is correct that these four providers did not explicitly repeat their protest of the AWI Payment Reduction Issue on their identified as-filed Medicare cost reports. Nevertheless, the Group Representative contends that the four Providers' cost report claims for full payment of IPPS satisfies the requirements of § 413.24(j) and, therefore, they ***have*** complied with the regulatory substantive claim requirements. These arguments are further described below.

The Providers/Group Representative have asserted that the four providers ***have*** satisfied the § 413.24(j) requirement under the particular circumstances of this appeal. The Group Representative asserts that filing the Group Appeal in the instant case serves as notice that all of the Hospitals in the Group Appeal protested their IPPS payments based on the Group Issue for all portions of their applicable Medicare cost reporting periods governed by the FFY 2023 IPPS Final Rule, and thus satisfied any substantive claim requirement. Moreover, the Group Representative contends that the Hospitals met the substantive claim requirement because the cost report claims sought reimbursement for all amounts due under law and the AWI Payment Reduction Issue seeks payment amounts of only amounts that would have been paid if the law was allegedly "properly applied." The Group Representative notes that the four providers submitted claims for their aggregate operating IPPS payments on their FYE 12/31/2022 as-filed cost reports, per the requirements of CMS's Hospital 2552-10 cost report form. Specifically, the Group Representative asserts as follows:

> The MAC has not disputed that the four Hospitals (1) submitted claims for all operating IPPS payments on their FYE 12/31/2022 cost reports, (2) were dissatisfied with their total FFY 2023 IPPS payments due to the AWI Payment Reduction Issue, and (3) timely challenged the AWI Payment Reduction Issue to the Board in this Group Appeal, in accordance with 42 U.S.C. § 1395oo(a), and met all jurisdictional requirements. In addition, the four Hospitals' cost report submissions effectively complied with 42 C.F.R. § 413.24(j), because their claims for operating IPPS payments were for all amounts due under law.
>
> Thus, the four Hospitals took every non-futile action necessary to avail themselves of administrative and judicial review under 42

> U.S.C. § 1395oo. Accordingly, the four Hospitals should be found to have properly presented to the MAC, the Board, and CMS claims for additional amounts they are owed if the AWI Payment Reduction Issue were decided in their favor and the standardized amounts were increased to what it should have been absent the unlawful AWI policy.

Further, the Group Representative argues that § 413.24(j) is "futile," referring to the court's finding in *Bethesda*,[44] because it requires hospitals to present a claim for relief to the Medicare Contractor even though the Medicare Contractor cannot provide the relief sought. In this way, the Providers assert that the substantive claim requirement in § 413.24(j) is invalid. Further, the Providers argue that § 413.24(j) conflicts with the statutory right to administrative review, conflicts with the Medicare Act in other ways, such as the Medicare Act's express grant in 42 U.S.C. § 1395oo(a)(1)(A)(ii) to hospitals of the right to appeal Federal Register determinations, and is contrary to *Bethesda*.

The Group Representative notes that in the case of Federal Register appeals, as here, it is factually impossible for the Hospitals to have protested the AWI Payment Reduction Issue on their cost reports with fiscal years ending December 31, 2022 before filing the Group Appeal, since, for example in this case, the due date for filing the appeal was early February of 2023, and the first hospital cost-reporting periods that potentially would include services provided during FFY 2023 would be those ending on October 31, 2022 (covering the first month of FFY 2023), which ordinarily would not be due until the end of March 2023, citing 42 C.F.R. § 412.34(f)(2). The Group Representative contends that filing a Board appeal of a Federal Register determination *ipso facto* puts the Secretary and the Medicare Contractor on notice that the hospital is protesting its payments based on the challenged payment policy, including notice of the amount in controversy on the challenged issue. By filing the Group Appeal with the Board and setting forth the amount in controversy at issue, the Group Representative contends that all group members explicitly protested their FFY 2023 IPPS payments based on the AWI Payment Reduction Issue. Thus, all of the Hospitals should be found to have satisfied any "substantive claim" requirement by the Hospitals filing this Group Appeal.

The Group Representative emphasizes that the AWI Payment Reduction Issue does not turn on any cost report information, and instead, depends solely on the payment parameters the Secretary determined in the FFY 2023 IPPS Final Rule. Thus, the Board should determine that the substantive claim regulations do not apply to appeals from the Federal Register determination, including this Group Appeal. The Group Representative asserts that the rulemaking preamble for the Final Rule establishing the substantive claim requirements left open the substantive claim requirements would not apply to all IPPS payment determination. The Providers acknowledge that the Board does not have the authority to invalidate a regulation but that it can interpret a regulation so as to save it from unlawful statutory conflict.

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[44] 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.)

Lastly, the Group Representative argues that § 413.24(j) cannot be applied to the AWI Payment Reduction Issue because it is not a "specific item of reimbursement," it is a standardized amount. It is a challenge to each and every IPPS payment. Moreover, the purpose of § 413.24(j) is to make sure CMS and the Medicare Contractor are given notice of the claim at issue, and the Secretary has long been aware of the AWI Payment Reduction Issue because it was presented more than two years ago in the *Bridgeport* and *Kaweah Delta* Board appeals and federal court litigation and in subsequent Board appeals every year since. Thus, the Group Representative contends that it is unreasonable to require gratuitous cost-reporting protests on the well-known AWI Payment Reduction Issue.

The Providers are contesting whether they complied with § 413.24(j), and consequently, there is a factual dispute regarding the four Providers' compliance with 42 C.F.R. § 413.24(j) under the particular circumstances of this case. The Board disagrees with the Providers assertions that they have complied with § 413.24(j) as it is prescriptive on how providers comply and only gives 2 compliance options, namely claim it or protest it on the cost report. Here, the Providers concede that they did not specifically claim or protest the AWI payment reduction on the cost report and, instead, assert that there are equivalents that should be accepted. However, the regulations does not allow for exceptions or equivalents (*e.g.*, advance notice through the filing of a Federal Register appeal with the Board prior to filing the cost report). Moreover, the Provider conflate appeal rights under 42 C.F.R. § 405.1835 with the obligation to claim or protest on the cost report the reimbursement your seeking in the first instance consistent with 42 C.F.R. § 413.24(j). In this regard, the Providers are misplaced in referencing the Supreme Court's decision is *Bethesda* as this case concerned appeal rights since the Supreme Court make clear that the decision did not concern "providers who bypass a clearly prescribed exhaustion requirement or who fail to request from the intermediary reimbursement for all costs to which they are entitled under applicable rules."[45]

Since a party to the appeal has questioned, pursuant to § 405.1873(a), whether an appropriate claim was made,[46] the Board finds that there is a regulatory obligation for the Board to affirmatively, on its own, review the appeal documents to determine whether an appropriate claim was made by the four Providers whose cost reports are at issue. While the four Providers have conceded that the Medicare Contractor is correct that these four providers did not explicitly repeat their protest of the AWI Payment Reduction Issue on their identified as-filed Medicare cost reports, they nevertheless contend that they have complied with § 413.24(j). As a result of this factual dispute, pursuant to 42 U.S.C. § 1395oo(f)(1), the Board is not able to reach the Providers' legal challenge to the validity of 42 C.F.R. § 413.24(j) in this case. Based on the above analysis and findings, the Board disagrees with the Providers' contentions and finds that they did not comply with 42 C.F.R. § 413.24(j). Therefore, pursuant to 42 C.F.R. § 405.1873(d)(2), the Board finds in its specific findings of facts and conclusions of law that the four Providers failed to make a substantive claim pursuant to 42 C.F.R. § 413.24(j)(1)-(2), for the four cost reports with FYE 12/31/2022.

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[45] 485 U.S. at 404-05.

[46] The Board notes that Board Rule 10.2 states: "If the Medicare contractor opposes a provider's expedited judicial review request, . . . its response must be timely filed in accordance with Rules 42, 43, and 44."

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 made through notice and comment in the form of an uncodified regulation.[47] 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 . . . .";[48] 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

[47] *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."
[48] *Id.* at 42326.

> 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 that the increase in the wage index for low wage index hospitals, as finalized in this rule, is implemented in a budget neutral manner.[49]

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."[50]

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.[51] The proposed rule did not propose any changes to this policy.[52] 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.[53] 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 this case.

D. Board's Decision Regarding the EJR Request

The Board finds that:

1) It has jurisdiction over the AWI Payment Reduction Issue for the subject year and that the Providers are entitled to a hearing before the Board based on their appeal of a payment determination published in a Federal Register final rule;

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[49] 84 Fed. Reg. at 42331.
[50] 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 . . . ."
[51] 87 Fed. Reg. at 49006 (Aug. 10, 2022).
[52] *Id.* at 49006-08.
[53] *Id.* at 49007-08.

2) Subsequent to the appeal request being filed, the following four Providers filed cost reports for FYE 12/31/2022 that are partially at issue in this case, and the Board finds that, pursuant to 42 C.F.R. § 405.1873(b), they each failed to include in those cost reports "an appropriate claim for the specific item" that is the subject of the group appeal, as required under 42 C.F.R. § 413.24(j):

   (a) Adventist La Grange Memorial Hospital (14-0065) FYE 12/31/2022,
   (b) UChicago Medicine Adventhealth Hinsdale (14-0122) FYE 12/31/2022,
   (c) UChicago Medicine Adventhealth Glenoaks (14-0292) FYE 12/31/2022, and
   (d) UChicago Medicine Adventhealth Bolingbrook (14-0304) FYE 12/31/2022;

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 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:

12/19/2023

X Clayton J. Nix

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

Enclosure: Schedule of Providers

cc: Pamela VanArsdale, National Government Services, Inc. (J-6)
Jacqueline Vaughn, CMS OAA

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

Byron Lamprecht
WPS Government Health Administrators
1000 N. 90th Street, Suite 302
Omaha, NE 68114-2708

RE: ***Board Dismissal of SSI Percentage (Provider Specific)***
Lake Granbury Medical Center (Provider Number 45-0596)
FYE: 11/30/2017
Case Number: 21-0171

Dear Mr. Ravindran and Mr. Lamprecht,

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the documentation in Case Number 21-0171 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. 21-0171*

On February 18, 2020, the Provider, Lake Granbury Medical Center, was issued a Notice of Program Reimbursement ("NPR") for fiscal year end November 30, 2017.

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

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

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 Issue 2 to a CHS group on March 23, 2021. The Provider withdrew Issues 3 and 4 on January 13, 2023, and March 17, 2021, respectively.

The only remaining issue in this appeal is Issue 1, DSH – SSI Percentage (Provider Specific).

[1] On March 23, 2021, this issue was transferred to PRRB Case No. 20-0997GC.
[2] On January 13, 2023, the Provider withdrew this issue from the appeal.
[3] On March 17, 2021, the Provider withdrew this issue from the appeal.

On March 29, 2021, the Provider filed its preliminary position paper.

On July 8, 2021, the Medicare Contractor filed its preliminary position paper.

On June 25, 2021, the Medicare Contractor filed a jurisdictional challenge with the Board over Issue 1. This decision only addresses the challenge to the SSI Provider Specific issue, as that is the only issue remaining and all other issues have been transferred or withdrawn. The Provider did not file a jurisdictional 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/SSI – Provider Specific issue as follows:

> The Provider contends that its' [sic] SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation[.]
>
> . . .
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395 (d)(5)(F)(i).[4]

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

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

[4] Provider's Individual Appeal Request at 17.

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.[5]

On March 29, 2021, the Board received the Provider's preliminary position paper in Case No. 21-0171. 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 (November 30).

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

Similar to *Loma Linda Community Hospital v. Dept. of Health and Human Services,* No CV-94-0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from [s]tate records. However, at this time, the Provider has been unable to analyze the Medicare Part A data because it has not yet received the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR"),

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

> 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]

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 duplicative:

> In Issue 1, the "Provider contends that the MAC did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations.[7]

The Medicare Contractor then cites the Provider's issue statement for Issue 2, DSH – SSI Percentage (Systemic Errors), from the Provider's initial appeal, now transferred to Case No. 20-0997GC[8]:

> The Provider also contends that CMS inconsistently interprets the term "entitled" as it is used in the statute. CMS requires SSI payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the denominator. CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days of care) as Medicare Part A days, yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment.[9]

The Medicare Contractor points out that the Issue statement from the Provider's individual appeal is the same as in Case No. 20-0997GC, to which Issue 2 is now transferred, stating "[t]his

[6] Provider's Preliminary Position Paper at 8-9 (Mar. 29, 2021).
[7] Jurisdictional Challenge at 4 (Jun. 25, 2021).
[8] On March 23, 2021, Issue 2 was transferred to PRRB Group Case No. 20-0997GC.
[9] Jurisdictional Challenge at 5 (Jun. 25, 2021), citing Provider's Initial Appeal, Issue Statement at 18 (Aug. 7, 2020).

component of Issue 1 is repeated by the Provider, word-for-word, within Issue 2."[10] The Contractor continues:

> The MAC contends that the Provider raises the same disputes in Issue 2. The Provider describes Issue 2 as follows:
>
> > The Provider contends that the Lead MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww(d)(5)(F)(vi). The Provider contends that the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") and used by the Lead MAC to settle their Cost Report were incorrectly computed.
> >
> > The Provider also contends that CMS inconsistently interprets the term "entitled" as it is used in the statute. CMS requires SSI payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the denominator. CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days of care) as Medicare Part A days, yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment.[11]

Secondly, the Medicare Contractor argues that the Board lacks jurisdiction over SSI realignment:

> SSI realignment is still active in this appeal. Within its preliminary position paper, the Provider states:
>
> > 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 <u>based on the Provider's Fiscal Year End (November 30</u>.) (Emphasis Added)
>
> The decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election. It is not a final determination. A

[10] Jurisdictional Challenge at 4 (Jun. 25, 2021).
[11] *Id.* at 4-5.

> 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.[12]

Provider's Jurisdictional Response

The Board Rules require that Provider Responses to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[13] The Provider has not filed a response to the Jurisdictional Challenge and the time for doing so has elapsed. Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. 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. 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. 20-0997GC.

The DSH – SSI Percentage (Provider Specific) issue in the present appeal concerns "whether the Medicare Administrative Contractor ("MAC") used the correct Supplemental Security Income ("SSI") percentage in the Disproportionate Share Hospital ("DSH") calculation."[14] Per the appeal

[12] *Id.* at 6.
[13] Board Rule 44.4.3, v. 2.0 (Aug. 2018).
[14] Issue Statement at 1.

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

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 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 DSH Payment/SSI Percentage (Provider Specific) issue in Case No. 21-0171 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[17], 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.[18] The Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors are specific to this provider.

To this end, the Board has also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1 and finds that the Provider's Preliminary 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:

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

> **25.2.2 Unavailable and Omitted Documents (Aug. 29, 2018)**
>
> If documents necessary to support your position are still unavailable, identify the missing documents, explain why the documents remain unavailable, state the efforts made to obtain the documents, and explain when the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.

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

> https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH.[19]

This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows: "DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[20]

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 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. 21-0171 and the group issue from Group Case 20-0997GC are the same issue.

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[19] Last accessed December 18, 2023.
[20] Emphasis added.

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.

1. Second Aspect of Issue 1

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

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

****

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

As no issues remain pending, the Board hereby closes Case No. 21-0171 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:

12/19/2023

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Lisa.ogiVia Electronic Delivery

Monique Hunter
Wild Rose Hospice, LLC.
10101 Harwin Drive, Suite 315
Houston, Texas 77036

RE: ***Board Decision***
Wild Rose Hospice, LLC. (Prov. No. 97-1559)
FYE 09/30/2021
Case No. 23-0121

Dear Ms. Hunter:

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

Background

On October 26, 2022, Wild Rose Hospice filed a request for hearing from a Notice of Effect of Inpatient Day Limitation and Hospice Cap Amount dated April 29, 2022. The hearing request included one issue, Hospice Cap Calculation. The Provider's cover letter included a statement which reads:

> Dear Sir/Madam, after conducting an internal review of the enclosed Cap Letter we received dated April 29, 2022(enclosed), I found discrepancies. When I ran our 2021 total beneficiary count for 2021 it reported 10.2143. This is a 1.6 jump from 8.6274 reported on run date 4/12/22 noted in letter sent to us. Therefore, 10.2143 x $30,472.42 = $311,254.44. This should reduce our overpayment to ($142,166) instead of ($190,522), a difference of ($48,356.91) on the FY2021 CAP year.
>
> Please review our findings and adjust our overpayment and our extended repayment schedule accordingly.

On March 21, 2023, the Board issued a Noice of Case Acknowledgement and Critical Due Dates ("Critical Due Dates Notice"). Significantly, the Critical Due Dates notice set the deadline for the Provider's preliminary position paper as June 23, 2023 and included the following instruction on that filing:

> Provider's Preliminary Position Paper – *For **each** issue*, the position paper ***must** state* the material facts that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), and provide arguments applying the material facts to the controlling authorities. *This filing **must include** any exhibits the Provider will use* to support its position and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. See Board Rule 25.[1]

On June 23, 2023, the Provider filed its Preliminary Position Paper which was solely the above-mentioned issue statement along with two calculation support documents as exhibits. On September 14, 2023, the Medicare Contractor filed its Preliminary Position Paper.

On October 23, 2023, the Medicare Contractor filed a Jurisdictional Challenge over Issue 1-Hospice Cap Calculation. On November 16, 2023, the Provider timely filed its response.

Medicare Contractor's Contentions

The Medicare Contractor argues the Provider failed to file a complete preliminary position paper including all supporting exhibits to document the merits of its argument in accordance with 42 C.F.R. § 405.1853(b)(2) and Board Rule 25. The Medicare Contractor requests that the Board consider this issue as withdrawn and dismiss the appeal in its entirety.

Provider's Jurisdictional Response

The Provider filed a response to the Medicare Contractor's Jurisdictional Challenge on November 16, 2023. The Provider's Jurisdictional Response, in its entirety, essentially re-states the issue statement from its appeal request and preliminary position paper:

> We are appealing our 2021 CAP based on the current beneficiary count of 10.2143. That is a 1.6 jump from 8.6274 from the report run date of 4/12/2022 that was used.
>
> 10.2143 times $30,472 =$ 311,254.44. This reduces our 2021 CAP year requirement to ($142,166) instead of ($190,522), a savings of &48,365.91 on the FY 21 CAP year.[2]

Board Analysis and Decision:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2018), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in

[1] (Emphasis added.)
[2] The Provider's Jurisdictional Response was filed November 16, 2023 however the document is dated June 23, 2023 (the same date/document as its preliminary position paper).

controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

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

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

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

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

> **Rule 25 Preliminary Position Papers**
>
> **25.1 Content of Position Paper Narrative**
>
> The text of the position papers must include the elements addressed in the applicable subsection.
>
> **25.1.1 Provider's Position Paper**
>
> The provider's preliminary position paper must:
>
> A. Identify any issues that were raised in the appeal but are already resolved (whether by administrative resolution, agreement to reopen, transfer, withdrawal, dismissal, etc.) and require no further documentation to be submitted.
>
> B. For each issue that has not been fully resolved, provide a fully developed narrative that:

[3] (Bold emphasis added.)

- States the material facts that support the provider's claim.

- Identifies the controlling authority, (e.g., statutes, regulations, policy, or case law) supporting the provider's position.

- Provides a conclusion applying the material facts to the controlling authorities.

C. Comply with Rule 25.2 addressing Exhibits.

Rule 25.2 Position Paper Exhibits

25.2.1 General

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

25.2.2 Unavailable and Omitted documents

If documents necessary to support your position are still unavailable, then provide the following information in the position papers:

1. Identify the missing documents;

2. Explain why the documents remain unavailable;

3. State the efforts made to obtain the documents; and

4. Explain when the documents will be available.

Once the documents become available, promptly forward them to the Board and the opposing party.

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

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

According to its Appeal Request filed on October 26, 2022, the Provider asserts that the "total beneficiary count for 2021 it reported 10.2143. This is a 1.6 jump form 8.6274 reported on run date 4/12/22"[4] The determination appealed specified that the beneficiary cap was 8.6274 based the "patient by patient proportional methodology" pursuant to 42 CFR 418.309(d)(2) which states; "For cap years ending October 31, 2012, and all subsequent cap years, a hospice's aggregate is calculated using the patient-by-patient proportional methodology described in paragraph (c) of this section . . . ." unless an exception applies.

On June 23, 2023, the Provider filed it Preliminary Position Paper. The Preliminary Position Paper asserts that the beneficiary cap should be 10.2143 and, in support includes a 2-page Provider Statistical and Reimbursement (PS&R) Report. However, the attached 2-page PS&R report does not include any cap information or beneficiary count. The Provider's Preliminary Position Paper does not explain how, why or upon what basis the Provider is asserting the cap should be increased from 8.6274 to 10.2143. The Board finds the Provider's Preliminary Position Paper failed to develop the merits of its case rather simply refiled a portion of its appeal request. Additionally, the Provider failed to include a proper good faith certification as required by Board Rule 25.3 and the Notice of Critical Due Dates.

The Medicare Contractor's Preliminary Position suggests that the Provider is improperly using a streamlined methodology to arrive at the 10.2143 beneficiary count; however, if true, the Provider's Preliminary Position Paper clearly does not state this or explain why the streamlined methodology must be used with citations to the relevant authorities supporting that explanation. The Medicare Contractor's Jurisdictional Challenge asserts "the Provider cites no explanation or authority describing why the MAC's calculations or methodologies were improper or why the Provider's calculations are appropriate."[5] The Board concurs with the Medicare Contractor that the Provider is required to identify and provide documentation to prove its Hospice Cap Amount consistent with 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rule 25.

Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. § 412.106(b)(iii) and 405.1853(b)(2)-(3) and Board Rules 25.2.1 and 25.2.2 (as also reflected in the Critical Due Dates Notice) related to the submission of documentary evidence required to

[4] Provider's Cover Letter Statement, October 13, 2022.
[5] Medicare Contractor Jurisdictional Challenge at 4.

support its claims or describe why said evidence is unavailable as well as failed to fully develop the merits of its Hospice Cap Calculation. Accordingly, the Board hereby dismisses the Hospice Cap Calculation issue.

Decision

The Board hereby dismisses the appeal in its entirety as the Provider failed to meet the Board requirements for position papers for this issue in compliance with 42 C.F.R. §§ 405.1853(b)(2)-(3) and Board Rule 25. As no issues remain pending, the Board hereby closes Case No. 23-0121 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:

12/20/2023

X Clayton J. Nix

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Denial of Improper Request for Expedited Judicial Review***
Univ. of Washington 2007 SSI Covered vs. Total Days CIRP Group
Case No. 10-1325GC

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the document filed in the above captioned ***closed case*** on November 22, 2023 titled "Motion for Reinstatement, Request for Reconsideration of October 25, 2023 Board Dismissal and Denial of EJR, and Notice of Filing Renewed Request for EJR" ("Request for Reconsideration"). The Board is issuing this notice to dismiss/deny any "renewed" request for EJR as improper and void in the first instance.

On September 29, 2023, the group's designated representative, Mr. Ravindran at Quality Reimbursement Services ("QRS"), filed a request for Expedited Judicial Review ("EJR"). On October 25, 2023, the Board issued a decision denying EJR and dismissing the case in its entirety, thereby closing the case.

On November 22, 2023 QRS filed a Request for Reconsideration, wherein they "ask the Board to reinstate the appeal and grant the Hospitals' EJR request, **which the Hospitals formally renew below**."[1] Indeed, QRS makes other affirmative statements about requesting EJR, explicitly stating that "The Hospitals also ***renew*** their request for EJR"[2] and "the Hospitals respectfully ask the Board to reinstate this appeal ***and*** grant the Hospital's *renewed* EJR request."[3]

The Board dismisses/denies the "renewed" request for EJR as void and improper in the first instance. First, the case is ***closed*** and there is no live controversy or pending proceedings before the Board in which to consider any request for EJR.[4] Second, the alleged "renewed" "formal[]" request

[1] Request for Reconsideration at 1 (emphasis added).
[2] *Id.* at 11 (emphasis added).
[3] *Id.* at 12 (emphasis added).
[4] *See* 42 C.F.R. §§ 405.1842(b)(2), (e)(2)(ii) and (e)(3)(ii). *See also Saint Francis v. Becerra*, No. 22-cv-1960, 2023 WL 6294168 (D.D.C. Sept. 27, 2023) (for example stating at *5: "The first sentence of § 405.1842(e)(1) fixes when the thirty-date period for determining authority defined in the second sentence becomes operative, specifically, after the Board determines it has jurisdiction." (citation omitted)).

for EJR is fatally flawed as it cannot be combined with any other filing or request but rather must be a *separate* filing.[5] Board Rule 42.2 explicitly states:

> Because an EJR request is time sensitive, the request for EJR is to be filed *separately* and clearly labeled. The request for EJR is ***not*** to be included in the text of another filing such as a jurisdictional brief or position paper and will not be considered filed if so included.[6]

The Board will address, under separate cover, the request to reinstate Case No. 10-1325GC, ***which remains closed*** unless and until the Board rules otherwise.

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:

12/20/2023

X Clayton J. Nix

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

cc: John Bloom, Noridian Healthcare Solutions (J-F)
Wilson Leong, FSS

[5] Moreover, the original EJR request that QRS is seeking to "renew" was itself fatally flawed as explained in the Board's October 25, 2023 determination and QRS has not otherwise corrected that original fatally flawed filing. Regardless, this case is in a closed status rendering any EJR request improper and void in the first instance.
[6] (Emphasis added.)

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

Isaac Blumberg
Blumberg Ribner, Inc.
11400 W. Olympic Blvd. Suite 700
Los Angeles, CA 90064

Lorraine Frewert, JE Prov. Audit
Noridian Healthcare Solutions
P.O. Box 6782
Fargo, ND 58108-6782

RE: ***Request to Reinstate & Bifurcate Group Appeal Regarding DSH Part C Days Issue***
Blumberg Ribner 2000/2002 Dual Eligibles 2nd Group
Case No. 07-0420G

Dear Mr. Blumberg and Ms. Frewert:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Providers' May 16, 2016 request for Rule 41.1 Reinstatement and Bifurcation of Group Appeal regarding DSH Part C Days for the Blumberg Ribner 2000/2002 Dual Eligibles 2nd Group. As set forth below, the Board denies this request because the Providers are seeking bifurcation of Part C Days but the instant appeal did not include Part C Days.

Background:

On **November 11, 2006**, the Board received the group appeal request. The issue statement in the group appeal request reads:

> [DSH] Adjustment – The Provider contend that their respective DSH adjustments are understated due to the exclusion from the Medicaid proxy calculation of certain days relating to patients dually eligible for both Medicaid and Medicare. Further, the Providers assert that the HCFA Administrator's decision pertaining to said days in *Edgewater Medical Center v. Blue Cross and Blue Shield of Illinois* (June 19, 2000) is inconsistent with applicable Medicare Regulations.

On **June 9, 2008**, the Providers submitted a Position Paper, which included a very brief statement of the issue. Per 42 C.F.R. § 405.1853(b)(2) and Board Rule 25, the Providers were required to brief the relevant facts and merits for each remaining issue and include any supporting documentation.

On **April 30, 2014**, the Board issued a jurisdictional decision. On **May 8, 2014**, the appeal was remanded pursuant to CMS Ruling 1498-R and the appeal was closed.

Rule 41.1 Reinstatement and Bifurcation of Group Appeal regarding DSH Part C Days Issue

On **May 16, 2016**, the Board received a letter from Blumberg Ribner requesting Rule 41.1 Reinstatement and Bifurcation of Group Appeal regarding DSH Part C Days issue. The Providers argues that the references to dual eligible patient days were intended to refer to persons eligible for Part A and Part C.[1]

The Providers refer to a decision in Case No. 08-2624GC in which the Board granted bifurcation of dual eligible Part A and Part C days in Sutter Health 1998 DSH Dual Eligible Days CIRP Group. In that December 30, 2015 letter, the Board stated:

> [T]he Board acknowledges that *at the time that Sutter Health's individual and group appeals were filed, the issue of whether a Medicaid patient that was "dually eligible" for Medicare was not necessarily subdivided by Medicare Part A or HMO/Part C days.* Federal courts later ruled differently on the "dual eligibility" related to Part A and Part C days therefore necessitating the Board to bifurcate these issues. In this case, the Board finds that the *providers' individual appeals and the original optional group appeal added the dual eligible days issue using a broad issue statement that encompassed both dual eligible Part A non-covered days and HMO days.* (Emphasis in original).[2]

The Providers next reference an Affidavit of Isaac Blumberg, the Representative of the Providers to support the contention that "the Providers' use of the term 'dual eligible days' was ***intended***" to refer to Medicare Part A Days and Medicare Part C Days." However, the referenced affidavit was not executed for this case but rather for Case No. 09-1708GC entitled "QRS Providence Health 2004 Medicare Part C Days CIRP Group." As a result, this affidavit does ***not pertain*** to this case as it was executed for a different unrelated case and appears to have a different group issue statement.

Last, the Providers argue that their appeals were filed in accordance with Board Instructions in effect at the time the Providers filed their appeals. The Instructions stated:

> Your hearing request must include an identification and statement of the issue(S) you are disputing. You must identify the specific issues, findings of fact and conclusions of law . . . **You must precisely identify the component of the DSH issue that is in dispute.**

The Providers argue that these Instructions did not require that they state the issue as "finely" as would be required under later rules. The Providers conclude that they were required to precisely define the DSH component at issue, which they did.

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[1] Bifurcation Request Letter at 1 (May 16, 2016).
[2] *Id.* at 2.

However, contrary to their assertion, the March 1, 2002 Board Instructions were ***not*** in effect *until* August 21, 200***9***. Rather, they were superseded by Board Rules issued *one year earlier* effective August 21, 200***8*** because the Board issued the August 21, 2008 revised Board Rules to implement changes to the Board's governing regulations *that were similarly effective August 21, 200**8*** and included material and significant clarifications on the minimum content for individual appeal requests (42 C.F.R. § 405.1835(b) (2009)) as well as group appeal requests (42 C.F.R. § 405.1837(c) (2009)).[3]

Decision of the Board

Board Rule 46.1 (July 1, 2015), in effect at the time the request was filed, addresses how the Board handles a 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 . . . 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."

> **46.1 – 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. These requirements also apply to Rules 46.2 and 46.3 below.[4]

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

[3] *See* 73 Fed. Reg. 30190 (May 23, 2008).
[4] (Emphasis added.)

Notably, Ruling 1498-R ***does not*** address the Part C days issue. Had the Providers intended to pursue the Part C days issue, they should have notified the Board when it submitted its Position Paper, ***if not sooner***. Accordingly, to the extent the alleged Part C issue was ever part of Case No. 07-0420G, the Providers abandoned it by failing to properly notify the Board the alleged Part C days issue when it submitted its Position Paper. Accordingly, it is clear that the Providers have not established good cause to reinstate/reopen Case No. 07-0420G.

Board Rule Part II.B.IV.b (March 1, 2002), in effect at the time of group appeal request, addresses the Content Standards for Position Papers:

> *The Board expects the position papers to state the relevant facts and present arguments setting forth the parties' positions* ***for <u>each</u> issue***. Specifically, the description of an issue must include a summary of the pertinent facts and circumstances and cite the relevant statutory provisions, regulations, CMS Rulings, and other controlling authorities. *You must identify the monetary amounts, and explain its computation, for* ***each*** *item in dispute*. . . . In addition, the Board expects the papers to contain ***<u>all</u> documentary evidence*** *and corroboration for the positions taken*, as well as other items or statements that would assist the Board in its deliberations. Jurisdiction and other motions must not be embedded in the position papers but must be addressed in a separate document.

The Board finds that the Group Representative filed its position paper, and that position paper failed to include the Part C days issue. Indeed, it fails to even mention the controlling authority at issue, namely 69 Fed. Reg. 48916, 49099 (Aug. 11, 2004) in the Section IV.L.4 of the preambel. Per Board Rule Part II.B.IV.b (2002), the Position Paper must brief each issue with the relevant fact, arguments and supporting documentation. Thus, to the extent it was ever part of this appeal, the Providers abandoned that issue by failing to properly brief the issue in their position paper, particularly since a group may contain only a single issue.

For the reason set forth above, the Board **declines** to exercise its discretion to reopen and reinstate Case No. 07-0420G and, thus, **denies** the request for reinstatement and rescission of remand. Accordingly, Case No. 07-0420G remains closed.

<u>Board Members Participating</u>:

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

For the Board:

12/20/2023

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Isaac Blumberg
Blumberg Ribner, Inc.
11400 W. Olympic Blvd. Suite 700
Los Angeles, CA 90064

Danelle Decker
National Government Services, Inc.
Mail point INA102-AF42 P.O. Box 6474
Indianapolis, IN 46206

RE: ***Request for Rescission of Remand and Bifurcation Regarding DSH Part C Days Issue***
Saint Vincent Catholic Medical Center 00-01 Dual Eligible Days CIRP
Case No. 08-2292GC

Dear Mr. Blumberg and Ms. Decker:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Providers' May 12, 2016 request for Rescission of Remand and Bifurcation regarding DSH Part C Days for the Blumberg Ribner 2004 Dual Eligible Days group. As set forth below, the Board denies this request because the Providers are seeking bifurcation of Part C Days but the Provider's representative had opportunity to bifurcate prior to the remand.

Background:

On **July 11, 2008**, the Board received the group appeal request. The entire description for the Medicare/Medicaid Dual Eligible Patient Days issue reads:

> [DSH] Adjustment – The Providers contend that their respective DSH adjustments are understated due to the exclusion from the Medicaid proxy calculation of certain days relating to patients dually eligible for both Medicaid and Medicare. Further, the Providers assert that the HCFA Administrator's decision pertaining to said days in *Edgewater Medical Center v. Blue Cross and Blue Shield of Illinois* (June 19, 2000) is inconsistent with applicable Medicare Regulations.

On **January 28, 2010**, the Providers filed their preliminary position paper.

On **April 20, 2014**, the Board requested that Blumberg Ribner send in the final Schedule of Providers ("SoP") with supporting jurisdictional documentation as so that the Board could process this case for remand pursuant to CMS Ruling 1498-R.

On **May 14, 2014**, Blumberg Ribner filed the requested SoP. However, the filing did not notify the Board of Blumberg Ribner's allegation that the group contained another issue (the Part C

Days issue) notwithstanding the fact that a group can only contain one issue per 42 C.F.R. § 405.1837(a)(2) and the Board notified Blumberg Ribner of its intention to remand the case per 1498-R.

On **August 28, 2014**, the Board issued a jurisdictional decision, and also remanded the appeal pursuant to CMS Ruling 1498-R and closed the appeal.

Rule 41.1 Reinstatement and Bifurcation of Group Appeal regarding DSH Part C Days Issue

On **May 12, 2016**, the Board received a letter from Blumberg Ribner requesting Rule 41.1 Reinstatement and Bifurcation of Group Appeal regarding DSH Part C Days issue. The Providers argues that the references to dual eligible patient days were intended to refer to persons eligible for Part A and Part C.[1]

The Providers refer to a decision in Case No. 08-2624GC in which the Board granted bifurcation of dual eligible Part A and Part C days in Sutter Health 1998 DSH Dual Eligible Days CIRP Group. In that December 30, 2015 letter, the Board stated:

> [T]he Board acknowledges that *at the time that Sutter Health's individual and group appeals were filed, the issue of whether a Medicaid patient that was "dually eligible" for Medicare was not necessarily subdivided by Medicare Part A or HMO/Part C days.* Federal courts later ruled differently on the "dual eligibility" related to Part A and Part C days therefore necessitating the Board to bifurcate these issues. In this case, the Board finds that the *providers' individual appeals and the original optional group appeal added the dual eligible days issue using a broad issue statement that encompassed both dual eligible Part A non-covered days and HMO days.* (Emphasis in original).[2]

The Providers next reference an Affidavit of Isaac Blumberg, the Representative of the Providers to support the contention that "the Providers' use of the term 'dual eligible days' was ***intended***" to refer to Medicare Part A Days and Medicare Part C Days." However, the referenced affidavit was not executed for this case but rather for Case No. 09-1708GC entitled "QRS Providence Health 2004 Medicare Part C Days CIRP Group." As a result, this affidavit does ***not pertain*** to this case as it was executed for a different unrelated case and appears to have a different group issue statement.

Last, the Providers argue that their appeals were filed in accordance with Board Instructions in effect at the time the Providers filed their appeals. The Instructions stated:

---

[1] Bifurcation Request Letter at 1 (May 12, 2016).
[2] *Id.* at 2.

> Your hearing request must include an identification and statement of the issue(S) you are disputing. You must identify the specific issues, findings of fact and conclusions of law . . . **You must precisely identify the component of the DSH issue that is in dispute.**

The Providers argue that these Instructions did not require that they state the issue as "finely" as would be required under later rules. The Providers conclude that they were required to precisely define the DSH component at issue, which they did.

However, contrary to their assertion, the March 1, 2002 Board Instructions were ***not*** in effect *until* August 21, 200***9***. Rather, they were superseded by Board Rules issued *one year earlier* effective August 21, 200***8*** because the Board issued the August 21, 2008 revised Board Rules to implement changes to the Board's governing regulations *that were similarly effective August 21, 200**8*** and included material and significant clarifications on the minimum content for individual appeal requests (42 C.F.R. § 405.1835(b) (2009)) as well as group appeal requests (42 C.F.R. § 405.1837(c) (2009)).[3]

Decision of the Board

Board Rule 46.1 (July 1, 2015), in effect at the time the request was filed, addresses how the Board handles a 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 . . . 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."

> **46.1 – 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

[3] *See* 73 Fed. Reg. 30190 (May 23, 2008).

> had in its initial appeal. These requirements also apply to Rules 46.2 and 46.3 below.[4]

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

Notably, Ruling 1498-R ***does not*** address the Part C days issue. Had the Providers intended to pursue the Part C days issue, they should have notified the Board when it had notice of the upcoming remand. However, they failed to do so, notwithstanding the fact that a group may contain only one issue which should have been briefed in the position paper filed with the Board (but apparently was not). Accordingly, to the extent the alleged Part C issue was ever part of Case No. 08-2292GC, the Providers abandoned it by failing to bifurcate it was informed by the Board of the upcoming remand. Subsequently, the Provider's representative submitted a Schedule of Providers and did not request bifurcation or otherwise notify the Board of its allegation that the group contained another issue notwithstanding the fact that a group can contain only one issue per § 405.1837(a)(2). Accordingly, it is clear that the Providers have not established good cause to reinstate/reopen Case No. 08-2292GC.

For the reason set forth above, the Board **declines** to exercise its discretion to reopen and reinstate Case No. 08-2292GC and, thus, **denies** the request for reinstatement and rescission of remand. Accordingly, Case No. 08-2292GC remains closed.

Board Members Participating:

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

For the Board:

12/20/2023

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services

[4] (Emphasis added.)

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

Isaac Blumberg
Blumberg Ribner, Inc.
11400 W. Olympic Blvd. Suite 700
Los Angeles, CA 90064

Lorraine Frewert, JE Prov. Audit
Noridian Healthcare Solutions
P.O. Box 6782
Fargo, ND 58108-6782

RE: ***Request to Reinstate & Bifurcate DSH Part C Issue in Individual Appeal***
Providence Saint Joseph Medical Center (Prov. No. 05-0235)
FYE 12/31/2004
Case No. 09-0405

Dear Mr. Blumberg and Ms. Frewert:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Providers' June 3, 2016 request for Rescission of Remand and Bifurcation of Individual Appeal regarding DSH Part C Days for Provider Providence Saint Joseph Medical Center. As set forth below, the Board denies this request because the Provider is seeking bifurcation of Part C Days but the instant appeal did not include Part C Days.

Background:

A. Description of Issue and Background in Case No. 09-0405

On **November 24, 2008**, the Board received the appeal request. The initial appeal included two issues: Medicare SSI Percentage Realignment and Medicare/Medicaid Dual Eligible Patient Days. The description for the Medicare/Medicaid Dual Eligible Patient Days issue reads:

> Medicare/Medicaid Dual Eligible Patient Days (Audit Adjustments 13, 14, 47, 48 and 49) – The Disproportionate Share Adjustment is calculated according to a formula that includes the determination of a hospital's "disproportionate share percentage" 42 U.S.C. § 1395ww(d)(5)(F)(vi). This percentage is defined as the sum of the Medicaid fraction, and the Medicare fraction. The Provider contends that the [DSH] adjustment has not been calculated in accordance with Medicare regulations and Manual provisions as described in 42 CFR Section 412.106. Further, the Provider contends that the Medicare/Medicaid dual eligible patient days have not been properly included in the DSH calculation.

On **July 30, 2009**, the Provider filed its preliminary position paper. On **December 7, 2009**, the Medicare Contractor filed its preliminary position paper.

December 30, 2015, the Board remanded the Provider's appeal of DSH dual eligible days for discharges prior to October 1, 2004 based on CMS Ruling 1498-R. On that same day, the Board (1) transferred the DSH dual eligible days issue for discharges occurring from October 1, 2004 through December 31, 2004 to the CIRP group under Case No. 09-0937GC; and (2) dismissed the SSI realignment issue. Finally, the Board closed this case as no issues remained pending.

B. Description of Medicare/Medicaid Dual Eligible Patient Days Issue in the Commonly Owned Entities in Case No. 09-0748GC

PRRB Case No. 09-0748GC is a Dual Eligible Days case involving multiple providers that are commonly owned with the Provider at issue in this letter, Providence Saint Joseph Medical Center. In PRRB Case No. 09-0748GC, the Providers described the Dual Eligible days issue, which includes the same fiscal year end as in the instant appeal, as:

> Dual Eligible Days are patient days associated with those patients who were not included in the SSI denominator by CMS' design as they were not directly billed to Medicare and did not flow through the MEDPAR system via Fee For Service Medicare Part-A. Moreover, these days were disallowed from the Medicaid numerator as well. Hence, neither the Medicaid fraction nor the Medicare fraction captured the days associated with the undisputed indigent population. As the days represent patient who were Medicaid Eligible but not Medicare Entitled, the Provider contends that these days should be included in the Medicaid fraction.
>
> Dual Eligible Days were excluded from the Medicaid fraction for a variety of reasons. By way of example, certain Dual Eligible Days are days associated with patients who are eligible for Medicaid but have exhausted their Medicare Part A benefits ("Exhausted Days"). In Edgewater Medical Center (Chicago, IL.) v. Blue Cross and Blue Shield Association/ Blue Cross and Blue Shield of Illinois, PRRB Hearing Dec. No. 2000-D44 (April 7, 2000), the Board held
>
> > The Board continues to maintain that the DSH numerator should include days of dually eligible patients whose Medicare Part A benefits were exhausted and who were eligible for reimbursement under the State's Medicaid plan. *See Jersey Shore Medical Center v. Blue Cross and Blue Shield of New Jersey*, PRRB Case No. 99-D4, Medicare and Medicaid Guide (CCH) ¶80,083, October 30, 1998, *vacated and remanded*, HCFA Administrator, January 4, 1999, Medicare and Medicaid Guide (CCH) ¶80,153 ("*Jersey*").
>
> Thus, in accordance with the Board's holding in the Edgewater, the Provider's Medicaid fraction should include all "Exhausted Days".

On **May 13, 2013**, the Board, on its own motion, bifurcated the period from 10/1/2004 – 12/31/2004 and established a new group appeal for that period (09-0937GC), which was not subject to 1498-R Remand. The period prior to 10/1/2004 remained in the appeal. The Board concluded this letter:

> Finally, as noted earlier in this letter, the issue in dispute in case number 09-0748GC is subject to the provisions of CMS Ruling 1498-R. Therefore, the Board is requiring Blumberg Ribner, Inc. submit a ***final*** Schedule of Providers and the associated jurisdictional documentation for case number 09-0748GC to the Board within 60 days of the date of this letter.[1]

Blumberg Ribner submitted the final Schedule of Providers ("SOP") on July 11, 2013, and Providence Saint Joseph Medical Center was ***not*** included. The Board reviewed the SOP and remanded the Providers in Case No. 09-0748GC to the Medicare Contractor pursuant to CMS Ruling 1498-R on August 7, 2013, and closed the appeal. The Providers also requested Rescission of the Remand and Bifurcation of the Group Appeal issue in Case No. 09-0748GC, which the Board denied on August 14, 2023, under separate cover.

Provider's Request for Bifurcation

On **June 3, 2016**, the Board received a letter from the Provider requesting Recission [sic] of Remand and Bifurcation of Individual Appeal regarding DSH Part C Days issue. The Provider argues that the references to dual eligible patient days were intended to refer to persons eligible for Part A and Part C.[2] The Provider also argues that the factual and historical context of the appeal request supports the conclusion that the Provider's intended to appeal both issues and that at the time this appeal request was filed, providers commonly appealed the dual eligible days issue generally, contesting the categorical exclusion of all dual eligible days based on patients' status as Medicare beneficiaries.[3]

The Provider refers to a decision in Case No. 08-2624GC in which the Board granted bifurcation of dual eligible Part A and Part C days in Sutter Health 1998 DSH Dual Eligible Days CIRP Group. In that December 30, 2015 letter, the Board stated:

> [T]he Board acknowledges that *at the time that Sutter Health's individual and group appeals were filed, the issue of whether a Medicaid patient that was "dually eligible" for Medicare was not necessarily subdivided by Medicare Part A or HMO/Part C days.* Federal courts later ruled differently on the "dual eligibility" related to Part A and Part C days therefore necessitating the Board to bifurcate these issues. In this case, the Board finds that the

[1] Emphasis added.
[2] Provider Bifurcation Request Letter at 4 (June 3, 2016).
[3] *Id.* at 3-4.

> *providers' individual appeals and the original optional group appeal added the dual eligible days issue using a broad issue statement that encompassed both dual eligible Part A non-covered days and HMO days.* (Emphasis in original).[4]

Last, the Provider argues that they filed their *individual* appeals between March 1, 2002 and August 21, 200**9** in accordance with Board Instructions in effect during that time. The Board Instructions effective March 1, 2002 stated:

> Your hearing request must include an identification and statement of the issue(S) you are disputing. You must identify the specific issues, findings of fact and conclusions of law . . . **You must precisely identify the component of the DSH issue that is in dispute.**

The Providers argue that these Instructions did not require that they state the issue as "finely" as would be required under later rules. The Providers conclude that they were required to precisely define the DSH component at issue, which they did.

However, contrary to their assertion, the March 1, 2002 Board Instructions were ***not*** in effect *until* August 21, 200***9***. Rather, they were superseded by Board Rules issued *one year earlier* effective August 21, 200***8*** because the Board issued the August 21, 2008 revised Board Rules to implement changes to the Board's governing regulations *that were similarly effective August 21, 200**8*** and included material and significant clarifications on the minimum content for individual appeal requests (42 C.F.R. § 405.1835(b) (2009)) as well as group appeal requests (42 C.F.R. § 405.1837(c) (2009)).[5]

Board's Analysis and Decision

The regulations and Board Rules have long required that commonly owned providers ***must*** bring a group appeal for any issues in common in the same calendar year. 42 C.F.R. 405.1837(b) (2009) reads, in part:

> b) Usage and filing of group appeals.
> (1) Mandatory use of group appeals.
> (i) Two or more providers under common ownership or control that wish to appeal to the Board a specific matter at issue that involves a question of fact or interpretation of law, regulations, or CMS Rulings that is common to the providers, and that arises in cost reporting periods that end in the same calendar year, and for

[4] *Id.* at 2.
[5] *See* 73 Fed. Reg. 30190 (May 23, 2008).

> which the amount in controversy is $50,000 or more in the aggregate, ***must*** bring the appeal as a group appeal.[6]

Similarly, the relevant rule at the time of the creation of the CIRP Group appeal reads:

> **B. Mandatory Group Appeals: Common Issue Related Party (CIRP)**
>
> Providers that are commonly owned or controlled must bring a group appeal for any issue common to the related Provider and for which the amount in controversy for cost reporting periods ended in the same calendar year is, in the aggregate, at least $50,000. While one Provider may initiate a CIRP group, at least two different Provider must be in the group upon full formation (See Rule 19).[7]

When the Providers' representative submitted the ***final*** SOP in Case No. 09-0748GC on July 11, 2013, the CIRP group was deemed fully formed. Based on the arguments Blumberg Ribner has made in its request for rescission and bifurcation of Case No. 09-0748GC, Blumberg Ribner has asserted that the group was deemed fully formed with two issues pending: the dual eligible Part A and Part C days issues.

The Board finds that the Medicare/Medicaid Dual Eligible Patient Days issue was ***required*** to be pursued in the CIRP Group Case No. 09-0748GC in accordance with 42 C.F.R. § 405.1837(b) (2009) and Board Rule 12.5(B) (2008). Therefore, the Board ***grants*** the Provider's request to rescind the 1498-R remand for the dual eligible Part A issue that was issued on August 3, 2015, because the issue needed to be in the group appeal.

As the Provider was required to be a participant in Case No. 09-0748GC for the dual eligible Part A days issue, the Board cannot now grant bifurcation of that issue and the Part C days issue in this individual appeal. To the extent that the CIRP group was fully formed with two issues, both of those issues, both issues are in that group. The Board is however, concurrently denying the request for rescission and bifurcation in Case No. 09-0748GC, under separate cover, however, to the extent we would have granted bifurcation it would have been to that group which was fully formed with those two issues.

In summary, the Board rescinds the August 3, 2015 remand issued in Case No. 09-0405, and ***denies*** the Provider's request to bifurcate the Part C days issue in this individual appeal. Case No. 09-0405 remains closed.

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[6] Emphasis added.
[7] PRRB Rule 12.5(B) (PRRB Rules Version 1.0, Aug. 2008).

Board Members Participating:

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

For the Board:

12/20/2023

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Isaac Blumberg
Chief Operating Officer
Blumberg Ribner, Inc.
11400 W. Olympic Blvd. Suite 700
Los Angeles, CA 90064

John Bloom
Appeals Coordinator, JF Provider Audit
Noridian Healthcare Solutions
P.O. Box 6722
Fargo, ND 58108

RE: ***Request for Rule 41.1 Reinstatement and Bifurcation of Group Appeal Regarding DSH Part C Days***
Saint Francis HCS of Hawaii 2001 – 9/30/2004 Dual Eligible Days CIRP
Case No. 09-0896GC

Dear Mr. Blumberg and Mr. Bloom:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Providers' May 23, 2016 request for Rule 41.1 Reinstatement and Bifurcation of Group Appeal regarding DSH Part C Days for the Saint Francis HCS of Hawaii 2001 – 9/30/2004 Dual Eligible Days CIRP group. As set forth below, the Board denies this request.

Background:

On **February 12, 2009**, the Board received the group appeal request. The entire description for the Medicare/Medicaid Dual Eligible Patient Days issue reads:

> Dual Eligible Days Issue – Dual Eligible Days are patient days associated with those patients who were not included in the SSI denominator by CMS' design as they were not directly billed to Medicare and did not flow through the MEDPAR system via Fee for Service Medicare Part-A. Moreover, these days were disallowed from the Medicaid numerator as well. Hence, neither the Medicaid fraction nor the Medicare fraction captured the days associated with the undisputed indigent population. As the days represent patient who were Medicaid Eligible but not Medicare Entitled, the Provider contends that these days should be included in the Medicaid fraction.
>
> Dual Eligible Days were excluded from the Medicaid fraction for a variety of reasons. By way of example, certain Dual Eligible Days are days associated with patients who are eligible for Medicaid but have exhausted their Medicare Part A benefits ("Exhausted

> Days"). In Edgewater Medical Center (Chicago, IL.) v. Blue Cross and Blue Shield Association/ Blue Cross and Blue Shield of Illinois, PRRB Hearing Dec. No. 2000-D44 (April 7, 2000), the Board held
>
> > The Board continues to maintain that the DSH numerator should include days of dually eligible patients whose Medicare Part A benefits were exhausted and who were eligible for reimbursement under the State's Medicaid plan. *See Jersey Shore Medical Center v. Blue Cross and Blue Shield of New Jersey*, PRRB Case No. 99-D4, Medicare and Medicaid Guide (CCH) ¶80,083, October 30, 1998, *vacated and remanded*, HCFA Administrator, January 4, 1999, Medicare and Medicaid Guide (CCH) ¶80,153 ("*Jersey*").
>
> Thus, in accordance with the Board's holding in the Edgewater, the Provider's Medicaid fraction should include all "Exhausted Days."

On **October 29, 2015**, Blumberg Ribner sent a letter to the Board withdrawing a number of Providers and requested, "In accordance with CMS Ruling 1498-R, upon the withdrawal of the above referenced Providers and Fiscal Years (or portions thereof), the Provider hereby requests remand of the Group Appeal. As the Group Appeal will be remanded, a Final Position Paper will not be needed."

Subsequently, on **November 9, 2015**, Blumberg Ribner further clarified:

> The Group Representative wishes to clarify that it is ***only*** *pursuing those Dual Eligible Days issues that are subject to the CMS Ruling 1498-R remand*. To reiterate, we are requesting that the above referenced Group Appeal to be remanded in according with [sic] the Ruling.[1]

Accordingly, it is clear that Blumberg Ribner confirmed the group only contained the Dual Eligible days issue and no other issue.

On **November 25, 2015**, the Board remanded the group appeal pursuant to CMS Ruling 1498-R and closed the appeal.

[1] (Emphasis added.)

Rule 41.1 Reinstatement and Bifurcation of Group Appeal regarding DSH Part C Days Issue

On **May 23, 2016**, the Board received a letter from Blumberg Ribner requesting Rule 41.1 Reinstatement and Bifurcation of Group Appeal regarding DSH Part C Days issue. The Providers argues that the references to dual eligible patient days were intended to refer to persons eligible for Part A and Part C.[2]

The Providers refer to a decision in Case No. 08-2624GC in which the Board granted bifurcation of dual eligible Part A and Part C days in Sutter Health 1998 DSH Dual Eligible Days CIRP Group. In that December 30, 2015 letter, the Board stated:

> [T]he Board acknowledges that *at the time that Sutter Health's individual and group appeals were filed, the issue of whether a Medicaid patient that was "dually eligible" for Medicare was not necessarily subdivided by Medicare Part A or HMO/Part C days.* Federal courts later ruled differently on the "dual eligibility" related to Part A and Part C days therefore necessitating the Board to bifurcate these issues. In this case, the Board finds that the *providers' individual appeals and the original optional group appeal added the dual eligible days issue using a broad issue statement that encompassed both dual eligible Part A non-covered days and HMO days.* (Emphasis in original).[3]

The Providers next reference an Affidavit of Isaac Blumberg, the Representative of the Providers to support the contention that "the Providers' use of the term 'dual eligible days' was ***intended***" to refer to Medicare Part A Days and Medicare Part C Days." However, the referenced affidavit was not executed for this case but rather for Case No. 09-1708GC entitled "QRS Providence Health 2004 Medicare Part C Days CIRP Group." As a result, this affidavit does ***not pertain*** to this case as it was executed for a different unrelated case and appears to have a different group issue statement.

Last, the Providers argue that their appeals were filed in accordance with Board Instructions in effect at the time the Providers filed their appeals. The Instructions stated:

> Your hearing request must include an identification and statement of the issue(S) you are disputing. You must identify the specific issues, findings of fact and conclusions of law . . . **You must precisely identify the component of the DSH issue that is in dispute.**

[2] Bifurcation Request Letter at 1 (May 12, 2016).
[3] *Id.* at 2.

The Providers argue that these Instructions did not require that they state the issue as "finely" as would be required under later rules. The Providers conclude that they were required to precisely define the DSH component at issue, which they did.

However, contrary to their assertion, the March 1, 2002 Board Instructions were ***not*** in effect *until* August 21, 200***9***. Rather, they were superseded by Board Rules issued *one year earlier* effective August 21, 200***8*** because the Board issued the August 21, 2008 revised Board Rules to implement changes to the Board's governing regulations *that were similarly effective August 21, 200**8*** and included material and significant clarifications on the minimum content for individual appeal requests (42 C.F.R. § 405.1835(b) (2009)) as well as group appeal requests (42 C.F.R. § 405.1837(c) (2009)).[4]

Decision of the Board

Board Rule 46.1 (July 1, 2015), in effect at the time the request was filed, addresses how the Board handles a 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 . . . 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."

> **46.1 – 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. These requirements also apply to Rules 46.2 and 46.3 below.[5]

Ruling 1498-R was issued on April 28, 2010, by the CMS Administrator to address three specific issues regarding the calculation of the Medicare disproportionate share hospital ("DSH") payment adjustment: (1) the Medicare SSI fraction data matching process issue and the method for recalculating the hospital's Medicare SSI fraction, (2) the exclusion from the DSH

[4] *See* 73 Fed. Reg. 30190 (May 23, 2008).
[5] (Emphasis added.)

calculation of non-covered patient hospital days for patients entitled to Medicare Part A including days for which the patient's Part A inpatient hospital benefits were exhausted for cost reporting periods before October 1, 2004, and (3) the exclusion from the DSH calculation of the labor/delivery room ("LDR") inpatient days.

Notably, Ruling 1498-R ***does not*** address the Part C days issue. Had the Providers intended to pursue the Part C days issue, they should have notified the Board when it ***twice*** requested remand under 1498-R. Accordingly, to the extent the alleged Part C issue was ever part of Case No. 09-0896GC, the Providers abandoned it by failing to bifurcate prior to requesting remand under 1498-R. By failing to identify Part C days at that time, the Providers' representative was stating that the only Dual Eligible days issue being pursued was subject to 1498-R Remand, and therefore, abandoned any pursuit of the Part C Days issue. Indeed, in its second letter requesting remand, Blumberg Rimbenr *specifically confirmed* that the group "is ***only*** *pursuing those Dual Eligible Days issues that are subject to the CMS Ruling 1498-R remand*."[6] Significantly, the Request for Reinstatement fails to discuss or even recognize these remand request letters. Accordingly, it is clear that this case the Providers have not established good cause to reinstate/reopen Case No. 09-0896GC.

For the reason set forth above, the Board **declines** to exercise its discretion to reopen and reinstate Case No. 09-0896GC and, thus, **denies** the request for reinstatement and rescission of remand. Accordingly, Case No. 09-0896GC remains closed.

Board Members Participating:

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

For the Board:

12/20/2023

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services

[6] (Emphasis added.)

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

Isaac Blumberg
Chief Operating Officer
Blumberg Ribner, Inc.
11400 W. Olympic Blvd. Suite 700
Los Angeles, CA 90064

Lorraine Frewert
Noridian Healthcare Solutions
P.O. Box 6782
Fargo, ND 58108-6782

RE: ***Request to Reinstate and Bifurcate Group Appeal Regarding DSH Part C Days Issue***
Scripps Health 1998-2004 Dual Eligible CIRP Group
Case No. 09-1325GC

Dear Mr. Blumberg and Ms. Frewert:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Providers' May 12, 2016 request for Rule 41.1 Reinstatement and Bifurcation of Group Appeal regarding DSH Part C Days for the Scripps Health 1998-2004 Dual Eligible CIRP Group. As set forth below, the Board denies this request because the Providers are seeking bifurcation of Part C Days but the instant appeal did not include Part C Days.

Background:

On **March 18, 2009**, the Board received the group appeal request. The entire description for the Medicare/Medicaid Dual Eligible Patient Days issue reads:

> Dual Eligible Days – The enclosed listing represents patients that are dually eligible for Medicaid during their service dates (See Exhibit P-3). The days associated with these patients were not included in the SSI denominator by CMS' design as they were not directly billed to Medicare and did not flow through the MEDAPR system via Fee For Service Medicare Part-A. Moreover, these days were disallowed from the Medicaid numerator as well. Hence, neither the Medicaid fraction nor the Medicare fraction captured the days associated with the undisputed indigent population. As the days represent who were Medicaid Eligible but not Medicare Entitled, the Provider contends that these days should be included in the Medicaid fraction.
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> The listed Dual Eligible Days were excluded from the Medicaid fraction for a variety of reasons. By way of example, certain Dual Eligible Days are days associated with patients who are eligible for Medicaid but have exhausted their Medicare Part A benefits ("Exhausted Days"). In Edgewater Medical Center (Chicago, IL.) v. Blue Cross and Blue Shield Association/ Blue Cross

> and Blue Shield of Illinois, PRRB Hearing Dec. No. 2000-D44 (April 7, 2000), the Board held
>
> > The Board continues to maintain that the DSH numerator should include days of dually eligible patients whose Medicare Part A benefits were exhausted and who were eligible for reimbursement under the State's Medicaid plan. *See Jersey Shore Medical Center v. Blue Cross and Blue Shield of New Jersey*, PRRB Case No. 99-D4, Medicare and Medicaid Guide (CCH) ¶80,083, October 30, 1998, *vacated and remanded*, HCFA Administrator, January 4, 1999, Medicare and Medicaid Guide (CCH) ¶80,153 ("*Jersey*").
>
> Thus, in accordance with the Board's holding in the Edgewater, the Provider's Medicaid fraction should include all "Exhausted Days".

On **June 15, 2015**, the Board, on its own motion, bifurcated participants with FYEs after 10/1/2004 and established a new group appeal for that period (Case No. 15-2739GC), which was not subject to 1498-R Remand. The period prior to 10/1/2004 remained in the appeal. At that time, the Board informed the Group Representative that the group was subject to remand under 1498-R. As the Board needed to make a jurisdictional determination, the Board requested a Schedule of Providers ("SoP") and associated jurisdictional documentation within 30 days of that notice.

On **July 10, 2015**, Blumberg Ribner filed the SoP. Significantly, Blumberg Ribner failed to notify the Board of its allegation that the group contained another issue, namely the Part C days issue, notwithstanding the Board's stated intention to remand the case pursuant to CMS Ruling 1498-R and the regulation at 42 C.F.R. § 405.1837(a)(2) specifying that a group may contain only one issue.

On **November 23, 2015**, the Board issued a Jurisdictional Decision that dismissed two of the Common Issue Related Party ("CIRP") group participants. In a separate action on the same date, the Board remanded the group appeal of DSH dual eligible days based on CMS Ruling 1498-R, and the appeal was closed.

Rule 41.1 Reinstatement and Bifurcation of Group Appeal regarding DSH Part C Days Issue

On **May 12, 2016**, the Board received a letter from Blumberg Ribner requesting Rule 41.1 Reinstatement and Bifurcation of Group Appeal regarding DSH Part C Days issue. The Providers argues that the references to dual eligible patient days were intended to refer to persons eligible for Part A and Part C.[1]

[1] Bifurcation Request Letter at 1 (May 12, 2016).

The Providers refer to a decision in Case No. 08-2624GC in which the Board granted bifurcation of dual eligible Part A and Part C days in Sutter Health 1998 DSH Dual Eligible Days CIRP Group. In that December 30, 2015 letter, the Board stated:

> [T]he Board acknowledges that *at the time that Sutter Health's individual and group appeals were filed, the issue of whether a Medicaid patient that was "dually eligible" for Medicare was not necessarily subdivided by Medicare Part A or HMO/Part C days.* Federal courts later ruled differently on the "dual eligibility" related to Part A and Part C days therefore necessitating the Board to bifurcate these issues. In this case, the Board finds that the *providers' individual appeals and the original optional group appeal added the dual eligible days issue using a broad issue statement that encompassed both dual eligible Part A non-covered days and HMO days.* (Emphasis in original).[2]

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Last, the Providers argue that their appeals were filed in accordance with Board Instructions in effect at the time the Providers filed their appeals. The Instructions stated:

> Your hearing request must include an identification and statement of the issue(S) you are disputing. You must identify the specific issues, findings of fact and conclusions of law . . . **You must precisely identify the component of the DSH issue that is in dispute.**

The Providers argue that these Instructions did not require that they state the issue as "finely" as would be required under later rules. The Providers conclude that they were required to precisely define the DSH component at issue, which they did.

However, contrary to their assertion, the March 1, 2002 Board Instructions were ***not*** in effect *until* August 21, 200***9***. Rather, they were superseded by Board Rules issued *one year earlier* effective August 21, 200***8*** because the Board issued the August 21, 2008 revised Board Rules to implement changes to the Board's governing regulations *that were similarly effective August 21, 200**8*** and included material and significant clarifications on the minimum content for individual

[2] *Id.* at 2.

appeal requests (42 C.F.R. § 405.1835(b) (2009)) as well as group appeal requests (42 C.F.R. § 405.1837(c) (2009)).[3]

Decision of the Board

Board Rule 46.1 (July 1, 2015), in effect at the time the request was filed, addresses how the Board handles a 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 . . . 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."

> **46.1 – 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. These requirements also apply to Rules 46.2 and 46.3 below.[4]

As discussed above, on June 15, 2015, Blumberg Ribner received notice that the Board considered the appeal as subject to remand under CMS Ruling 1498-R. Notwithstanding this notice and the fact that a group may only have one issue per 42 C.F.R. § 405.1837(a)(2), Blumberg failed to notify the Board of its contention that the group contained another issue, Part C Days. In particular, the SoP that Blumberg Ribner filed failed to include such notification.

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

[3] *See* 73 Fed. Reg. 30190 (May 23, 2008).
[4] (Emphasis added.)

reporting periods before October 1, 2004, and (3) the exclusion from the DSH calculation of the labor/delivery room ("LDR") inpatient days.

Notably, Ruling 1498-R ***does not*** address the Part C days issue. Had the Providers intended to pursue the Part C days issue, they should have notified the Board when it submitted those letters explaining that the group issue was subject to remand, ***if not sooner***. Accordingly, to the extent the alleged Part C issue was ever part of Case No. 09-1325GC, the Providers abandoned it by failing to properly notify the Board the alleged Part C days issue, especially after the Board gave Blumberg advance notice of its intention to remand this case per 1498-R. Accordingly, it is clear that the Providers have not established good cause to reinstate/reopen Case No. 09-1325GC.

There is a separate and independent bases to deny reinstatement. The Board also notes that the issue statement of the group appeal defines the days at issue in as "Fee For Service Medicare Part-A" days which is clearly the dual eligible days Part A issue, and does *not* contemplate alleged Medicare+Choice Managed Care/Part C days issue since "Fee For Service Medicare Part-A" does not encompass Part C. Accordingly, a second and independent basis upon which to deny reinstatement/reopening is that the alleged Part C Days issue was never part of the group appeal issue statement and, as such, it is clear that the proposed reinstatement for purposes of bifurcation has no merit.

As pointed out in the rescission and bifurcation request, regulations and Board rules require specificity with regards to each item under appeal. 42 C.F.R. § 405.1835(b)(2) (2009) reads, in part:

> (2) An explanation (for each specific item at issue . . .) of the provider's dissatisfaction with the intermediary's or Secretary's determination under appeal, including an account of the following:
>
> (i) Why the provider believes Medicare payment is incorrect *for each disputed item* . . .[5]
>
> (ii) How and why the provider believes Medicare payment must be determined differently *for each disputed item*.[6]

Board Rules have also long required that providers include identification of the issues in dispute with specificity:

> Your hearing request must include an identification and statement of the issue(s) you are disputing. You must identify the specific issues, findings of fact and conclusions of law with which the affected parties disagree; and you must specify the basis for contending the findings and conclusions are incorrect . . . You must clearly and specifically identify your position in regard to the

[5] (Emphasis added.)
[6] 42 C.F.R § 405.1835(b)(1)-(2) (emphasis added.)

> issues in dispute. For instance, if you are appealing an aspect of the disproportionate share (DSH) adjustment factor or calculation, do not definite the issue as "DSH". You must precisely identify the component of the DSH issue that is in dispute.[7]

The Board finds that the issue statement for the group appeal can only be read to encompass the dual eligible Part A days issue. The group appeal issue language does not meet the specificity requirements as set forth in the regulation and Board rules to have appealed the dual eligible Part C days issue.

This finding is consistent with the recent ruling by the U.S. District Court for the District of Columbia in *Evangelical Community Hospital, et al. v. Becerra*.[8] In that case, the provider's issue was tied to improper calculation to DSH payment and read in part, "[t]he intermediary erred by incorrectly calculating the SSI percentage for inclusion in the 'Medicare Fraction' for purposes of the calculation of the provider's [disproportionate share] payment . . ."[9] The Court found that "[t]his description does not specify which portion of the calculation was incorrect nor how the fraction should have been calculated differently."[10] The Court found that this was a description of the issue was a violation of Board rules and a proper basis on which for the Board to dismiss the appeal.[11] Here, the Board makes the same finding based on similarly overly generalized language.

For the reasons set forth above, the Board **declines** to exercise its discretion to reopen and reinstate Case No. 09-1325GC and, thus, **denies** the request for reinstatement and rescission of remand in order to bifurcate a single participant from the group appeal regarding the Part C Days issue. Accordingly, Case No. 09-1325GC remains closed.

Board Members Participating:

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

For the Board:

12/20/2023

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services

[7] Provider Reimbursement Review Board, Part I, B, II. (March 1, 2002).
[8] 21-cv-01368 (APM) (D.D.C. Sep. 30, 2022).
[9] *Id*. at 11.
[10] *Id.*
[11] *Id.*

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

Isaac Blumberg
Blumberg Ribner, Inc.
11400 W. Olympic Blvd. Suite 700
Los Angeles, CA 90064

Lorraine Frewert, JE Prov. Audit
Noridian Healthcare Solutions
P.O. Box 6782
Fargo, ND 58108-6782

RE: ***Request to Reinstate & Bifurcate Group Appeal Regarding DSH Part C Days Issue***
Blumberg Ribner Independent Hosps 2003 Dual Eligible Days- 2nd Group
Case No. 09-1924G

Dear Mr. Blumberg and Ms. Frewert:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Providers' May 12, 2016 request for Rule 41.1 Reinstatement and Bifurcation of Group Appeal regarding DSH Part C Days for the Blumberg Ribner Independent Hospitals 2003 2nd Group. As set forth below, the Board denies this request because the Providers are seeking bifurcation of Part C Days but the instant appeal did not include Part C Days.

Background

On **June 23, 2009**, the Board received the group appeal request. The entire description for the Medicare/Medicaid Dual Eligible Patient Days issue reads:

> Dual Eligible Days Issue – Dual Eligible Days are patient days associated with those patients who were not included in the SSI denominator by CMS' design as they were not directly billed to Medicare and did not flow through the MEDPAR system via Fee For Service Medicare Part-A. Moreover, these days were disallowed from the Medicaid numerator as well. Hence, neither the Medicaid fraction nor the Medicare fraction captured the days associated with the undisputed indigent population. As the days represent patient who were Medicaid Eligible but not Medicare Entitled, the Provider contends that these days should be included in the Medicaid fraction.
>
> Dual Eligible Days were excluded from the Medicaid fraction for a variety of reasons. By way of example, certain Dual Eligible Days are days associated with patients who are eligible for Medicaid but have exhausted their Medicare Part A benefits ("Exhausted Days"). In Edgewater Medical Center (Chicago, IL.) v. Blue Cross and Blue Shield Association/ Blue Cross and Blue Shield of Illinois, PRRB Hearing Dec. No. 2000-D44 (April 7, 2000), the Board held

> The Board continues to maintain that the DSH numerator should include days of dually eligible patients whose Medicare Part A benefits were exhausted and who were eligible for reimbursement under the State's Medicaid plan. *See Jersey Shore Medical Center v. Blue Cross and Blue Shield of New Jersey*, PRRB Case No. 99-D4, Medicare and Medicaid Guide (CCH) ¶80,083, October 30, 1998, *vacated and remanded*, HCFA Administrator, January 4, 1999, Medicare and Medicaid Guide (CCH) ¶80,153 ("*Jersey*").

Thus, in accordance with the Board's holding in the Edgewater, the Provider's Medicaid fraction should include all "Exhausted Days".

On **August 31, 2010**, Blumberg Ribner submitted a letter to the Board indicating that it would not be submitting a Preliminary Position Paper because the appeal issue is subject to remand. They stated:

> In accordance with the PRRB's recently issued Alert 7, Blumberg Ribner (BRI) herby identifies the subject of the group appeal, dual eligible days, as governed by CMS – 1498-R. Accordingly, BRI will not be submitting a Preliminary Position Paper (PPP) by the May 1, 2011 deadline. Please notify us should the Board determine that a PPP is necessary. BRI hereby requests that the group appeal be remanded under the Standard Procedure. Finally, we reserve the right to challenge both the CMS Ruling and any remand order at the appropriate time.

On **July 2, 2013**, the Board requested Blumberg Ribner to file a Schedule of Providers ("SoP") with supporting documentation within 30 days as the group was subject to CMS Ruling 1498-R and the SoP was need to permit process for that remand.

On **July 12, 2013**, Blumberg Ribner filed an extension request for an additional 30 days to respond to the Board's request. On **July 29, 2013**, the Board granted the extension. On **August 28, 2013**, Blumberg Ribner filed the SoP. Significantly, Blumberg Ribner did not notify the Board of its contention that the group contained another issue notwithstanding the fact that a group may only contain one issue per 42 C.F.R. § 405.1837(a)(2) and the Board's notice of its intention to remand this group per 1498-R.

On **February 14, 2014**, the Board issued a jurisdictional decision dismissing a Provider, and a 1498-R remand for the remaining providers on February 14, 2014, and the appeal was closed.

Rule 41.1 Reinstatement and Bifurcation of Group Appeal regarding DSH Part C Days Issue

More than 2 years later, on **May 12, 2016**, the Board received a letter from Blumberg Ribner requesting Rule 41.1 Reinstatement and Bifurcation of Group Appeal regarding DSH Part C Days issue. The Providers argues that the references to dual eligible patient days were intended to refer to persons eligible for Part A and Part C.[1]

The Providers refer to a decision in Case No. 08-2624GC in which the Board granted bifurcation of dual eligible Part A and Part C days in Sutter Health 1998 DSH Dual Eligible Days CIRP Group. In that December 30, 2015 letter, the Board stated:

> [T]he Board acknowledges that *at the time that Sutter Health's individual and group appeals were filed, the issue of whether a Medicaid patient that was "dually eligible" for Medicare was not necessarily subdivided by Medicare Part A or HMO/Part C days.* Federal courts later ruled differently on the "dual eligibility" related to Part A and Part C days therefore necessitating the Board to bifurcate these issues. In this case, the Board finds that the *providers' individual appeals and the original optional group appeal added the dual eligible days issue using a broad issue statement that encompassed both dual eligible Part A non-covered days and HMO days.* (Emphasis in original).[2]

The Providers next reference an Affidavit of Isaac Blumberg, a representative of the Providers, who affirms that the Providers' use of the term "dual eligible days" was intended to refer to both Medicare Part A and Medicare Part C days.

Last, the Providers argue that their appeals were filed in accordance with Board Instructions in effect at the time the Providers filed their appeals. The Instructions stated:

> Your hearing request must include an identification and statement of the issue(S) you are disputing. You must identify the specific issues, findings of fact and conclusions of law . . . **You must precisely identify the component of the DSH issue that is in dispute.**

The Providers argue that these Instructions did not require that they state the issue as "finely" as would be required under later rules. The Providers conclude that they were required to precisely define the DSH component at issue, which they did.

---

[1] Bifurcation Request Letter at 1 (May 12, 2016).
[2] *Id.* at 2.

Decision of the Board

Board Rule 46.1 (July 1, 2015), in effect at the time the request was filed, addresses how the Board handles a 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 . . . 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."

> **46.1 – 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. These requirements also apply to Rules 46.2 and 46.3 below.[3]

As discussed above, on August 31, 2010, Blumberg Ribner clearly and explicitly identified the group issue statement as subject to CMS Ruling 1498-R.

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

Notably, Ruling 1498-R ***does not*** address the Part C days issue. Had the Providers intended to pursue the Part C days issue, they should have notified the Board when it submitted that letter explaining that the group issue was subject to remand, ***if not sooner***. Accordingly, to the extent the alleged Part C issue was ever part of Case No. 09-1924G, the Providers abandoned it by failing to properly notify the Board the alleged Part C days issue when it specifically requested

[3] (Emphasis added.)

that the group be remanded, particularly in light of the fact that a group may contain only one issue. The Providers had another opportunity to notify the Board of its contention that the group contained another issue when the Board requested submission of the SoP; however, again, Blumberg Ribner failed to notify the Board of this contention. Accordingly, it is clear that the Providers have not established good cause to reinstate/reopen Case No. 09-1924G.

There is a separate and independent basis to deny reinstatement. The Board also notes that the issue statement of the group appeal defines the days at issue in as "Fee For Service Medicare Part-A" days which is clearly the dual eligible days Part A issue, and does *not* contemplate alleged Medicare+Choice Managed Care/Part C days issue since "Fee For Service Medicare Part-A" does not encompass Part C. Accordingly, a second and independent basis upon which to deny reinstatement/reopening is that the alleged Part C Days issue was never part of the group appeal issue statement and, as such, it is clear that the proposed reinstatement for purposes of bifurcation has no merit.

As pointed out in the rescission and bifurcation request, regulations and Board rules require specificity with regards to each item under appeal. 42 C.F.R. § 405.1835(b)(2) (2009) reads, in part:

> (2) An explanation (for each specific item at issue . . .) of the provider's dissatisfaction with the intermediary's or Secretary's determination under appeal, including an account of the following:
>
> (i) Why the provider believes Medicare payment is incorrect *for each disputed item* . . .[4]
>
> (ii) How and why the provider believes Medicare payment must be determined differently *for each disputed item*.[5]

Board Rules have also long required that providers include identification of the issues in dispute with specificity:

> Your hearing request must include an identification and statement of the issue(s) you are disputing. You must identify the specific issues, findings of fact and conclusions of law with which the affected parties disagree; and you must specify the basis for contending the findings and conclusions are incorrect . . . You must clearly and specifically identify your position in regard to the issues in dispute. For instance, if you are appealing an aspect of the disproportionate share (DSH) adjustment factor or calculation, do not definite the issue as "DSH". You must precisely identify the component of the DSH issue that is in dispute.[6]

---

[4] (Emphasis added.)
[5] 42 C.F.R § 405.1835(b)(1)-(2) (emphasis added.)
[6] Provider Reimbursement Review Board, Part I, B, II. (March 1, 2002).

The Board finds that the issue statement for the group appeal can only be read to encompass the dual eligible Part A days issue. The group appeal issue language does not meet the specificity requirements as set forth in the regulation and Board rules to have appealed the dual eligible Part C days issue.

This finding is consistent with the recent ruling by the U.S. District Court for the District of Columbia in *Evangelical Community Hospital, et al. v. Becerra*.[7] In that case, the provider's issue was tied to improper calculation to DSH payment and read in part, "[t]he intermediary erred by incorrectly calculating the SSI percentage for inclusion in the 'Medicare Fraction' for purposes of the calculation of the provider's [disproportionate share] payment . . ."[8] The Court found that "[t]his description does not specify which portion of the calculation was incorrect nor how the fraction should have been calculated differently."[9] The Court found that this was a description of the issue was a violation of Board rules and a proper basis on which for the Board to dismiss the appeal.[10] Here, the Board makes the same finding based on similarly overly generalized language.

For the reasons set forth above, the Board **declines** to exercise its discretion to reopen and reinstate Case No. 09-1924G and, thus, **denies** the request for reinstatement and rescission of remand in order to bifurcate a single participant from the group appeal regarding the Part C Days issue. Accordingly, Case No. 09-1924G remains closed.

Board Members Participating:

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

For the Board:

12/20/2023

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services

[7] 21-cv-01368 (APM) (D.D.C. Sep. 30, 2022).
[8] *Id*. at 11.
[9] *Id.*
[10] *Id.*

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

Isaac Blumberg
Blumberg Ribner, Inc.
11400 W. Olympic Blvd. Suite 700
Los Angeles, CA 90064

Byron Lamprecht
WPS Government Health Administrators
1000 N 90th Street, Suite 302
Omaha, NE 68114

RE: ***Request to Reinstate & Bifurcate Group Appeal Regarding DSH Part C Days***
SSM Health Care 2003 & 2004 Dual Eligible Days CIRP Group
Case No. 09-2149GC

Dear Messrs. Blumberg and Lamprecht:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Providers' June 2, 2016 request for Rescission of Remand and Bifurcation of Group Appeal regarding DSH Part C Days for the SSM Health Care 2003 & 2004 Dual Eligible Days CIRP group. As set forth below, the Board denies this request because the Providers are seeking bifurcation of Part C Days but the Provider's representative withdrew the case without qualification.

Background:

On **February 16, 2010**, the Board received the group appeal request. The entire description for the Medicare/Medicaid Dual Eligible Patient Days issue reads:

> Dual Eligible Days Issue – *Dual Eligible Days are patient days associated with those patients who were not included in the SSI denominator by CMS' design as they were not directly billed to Medicare and did not flow through the MEDPAR system* ***via Fee for Service Medicare Part-A***. Moreover, these days were disallowed from the Medicaid numerator as well. Hence, neither the Medicaid fraction nor the Medicare fraction captured the days associated with the undisputed indigent population. As the days represent patient who were Medicaid Eligible but not Medicare Entitled, the Provider contends that these days should be included in the Medicaid fraction.
>
> Dual Eligible Days were excluded from the Medicaid fraction for a variety of reasons. By way of example, certain Dual Eligible Days are days associated with patients who are eligible for Medicaid but have exhausted their Medicare Part A benefits ("Exhausted Days"). In Edgewater Medical Center (Chicago, IL.) v. Blue Cross and Blue Shield Association/ Blue Cross and Blue Shield of

> Illinois, PRRB Hearing Dec. No. 2000-D44 (April 7, 2000), the Board held
>
> > The Board continues to maintain that the DSH numerator should include days of dually eligible patients whose Medicare Part A benefits were exhausted and who were eligible for reimbursement under the State's Medicaid plan. *See Jersey Shore Medical Center v. Blue Cross and Blue Shield of New Jersey*, PRRB Case No. 99-D4, Medicare and Medicaid Guide (CCH) ¶80,083, October 30, 1998, *vacated and remanded*, HCFA Administrator, January 4, 1999, Medicare and Medicaid Guide (CCH) ¶80,153 ("*Jersey*").
>
> Thus, in accordance with the Board's holding in the Edgewater, the Provider's Medicaid fraction should include all "Exhausted Days."[1]

On **June 2, 2015**, the Board issued a partial remand for the periods under appeal prior to 10/1/2004.

The case remained open for the Providers that had 12/31/2004 FYEs, and was scheduled for hearing.

On **April 25, 2016**, Blumberg Ribner ***withdrew*** the appeal ***without qualification.*** Accordingly, on **May 2, 2016**, the Board acknowledged the withdrawal and closed the case.

Rule 41.1 Reinstatement and Bifurcation of Group Appeal regarding DSH Part C Days Issue

On **June 2, 2016**, the Providers requested rescission of the remand and bifurcation of the Part C issue. The Provider argues that the references to dual eligible patient days were intended to refer to persons eligible for Part A and Part C.[2]

The Providers argue that:

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

[1] (Emphasis added.)
[2] Bifurcation Request Letter at 1 (June 2, 2016).

The Providers refer to a decision in Case No. 08-2624GC in which the Board granted bifurcation of dual eligible Part A and Part C days in Sutter Health 1998 DSH Dual Eligible Days CIRP Group. In that December 30, 2015 letter, the Board stated:

> [T]he Board acknowledges that *at the time that Sutter Health's individual and group appeals were filed, the issue of whether a Medicaid patient that was "dually eligible" for Medicare was not necessarily subdivided by Medicare Part A or HMO/Part C days.* Federal courts later ruled differently on the "dual eligibility" related to Part A and Part C days therefore necessitating the Board to bifurcate these issues. In this case, the Board finds that the *providers' individual appeals and the original optional group appeal added the dual eligible days issue using a broad issue statement that encompassed both dual eligible Part A non-covered days and HMO days.* (Emphasis in original).[3]

The Providers next argue that the Board has the authority to reopen its remand decision and should do so. They reference 42 C.F.R. § 405.1885(b)(3), "A Secretary or contractor determination or decision by the reviewing entity may be reopened and revised at any time if it is established that the determination or decision was procured by fraud or similar fault of any party to the determination or decision." They conclude that the MAC was at fault in accepting the dual eligible days remand, and the Board should reopen the remand decision.

Last, the Providers argue that their appeals were filed in accordance with Board Instructions in effect at the time the Providers filed their appeals. The Instructions stated:

> Your hearing request must include an identification and statement of the issue(S) you are disputing. You must identify the specific issues, findings of fact and conclusions of law . . . **You must precisely identify the component of the DSH issue that is in dispute.**

The Providers argue that these Instructions did not require that they state the issue as "finely" as would be required under later rules. The Providers conclude that they were required to precisely define the DSH component at issue, which they did.

However, contrary to their assertion, the March 1, 2002 Board Instructions were ***not*** in effect *until* August 21, 200***9***. Rather, they were superseded by Board Rules issued *one year earlier* effective August 21, 200***8*** because the Board issued the August 21, 2008 revised Board Rules to implement changes to the Board's governing regulations *that were similarly effective August 21, 200**8*** and included material and significant clarifications on the minimum content for individual

[3] *Id.* at 2.

appeal requests (42 C.F.R. § 405.1835(b) (2009)) as well as group appeal requests (42 C.F.R. § 405.1837(c) (2009)).[4]

Decision of the Board

Board Rule 46.1 (July 1, 2015), in effect at the time the request was filed, addresses how the Board handles a 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 . . . 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."

> **46.1 – 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. These requirements also apply to Rules 46.2 and 46.3 below.[5]

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

Notably, Ruling 1498-R ***does not*** address the Part C days issue. Had the Providers intended to pursue the Part C days issue, they should have notified the Board prior to withdrawing the case. Accordingly, to the extent the alleged Part C issue was ever part of Case No. 09-2149GC, the Providers abandoned it by failing to bifurcate prior to the withdrawal of the case without

[4] *See* 73 Fed. Reg. 30190 (May 23, 2008).
[5] (Emphasis added.)

qualification. By failing to identify Part C days at that time, the Providers' representative abandoned any pursuit of the Part C Days issue. Indeed, the request for reinstatement fails to discuss or even mention the withdrawal they had made just 4 weeks earlier. Accordingly, it is clear that the Providers have not established good cause to reinstate/reopen Case No. 09-2149GC.

There is a separate and independent bases to deny reinstatement. The Board also notes that the issue statement of the group appeal defines the days at issue in as "Fee For Service Medicare Part-A" days which is clearly the dual eligible days Part A issue, and does *not* contemplate alleged Medicare+Choice Managed Care/Part C days issue since "Fee For Service Medicare Part-A" does not encompass Part C. Accordingly, a second and independent basis upon which to deny reinstatement/reopening is that the alleged Part C Days issue was never part of the group appeal issue statement and, as such, it is clear that the proposed reinstatement for purposes of bifurcation has no merit.

As pointed out in the rescission and bifurcation request, regulations and Board rules require specificity with regards to each item under appeal. 42 C.F.R. § 405.1835(b)(2) (2009) reads, in part:

> (2) An explanation (for each specific item at issue . . .) of the provider's dissatisfaction with the intermediary's or Secretary's determination under appeal, including an account of the following:
>
> (i) Why the provider believes Medicare payment is incorrect *for each disputed item* . . .[6]
>
> (ii) How and why the provider believes Medicare payment must be determined differently *for each disputed item*.[7]

Board Rules have also long required that providers include identification of the issues in dispute with specificity:

> Your hearing request must include an identification and statement of the issue(s) you are disputing. You must identify the specific issues, findings of fact and conclusions of law with which the affected parties disagree; and you must specify the basis for contending the findings and conclusions are incorrect . . . You must clearly and specifically identify your position in regard to the issues in dispute. For instance, if you are appealing an aspect of the disproportionate share (DSH) adjustment factor or calculation, do not definite the issue as "DSH". You must precisely identify the component of the DSH issue that is in dispute.[8]

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[6] (Emphasis added.)
[7] 42 C.F.R § 405.1835(b)(1)-(2) (emphasis added.)
[8] Provider Reimbursement Review Board, Part I, B, II. (March 1, 2002).

The Board finds that the issue statement for the group appeal can only be read to encompass the dual eligible Part A days issue. The group appeal issue language does not meet the specificity requirements as set forth in the regulation and Board rules to have appealed the dual eligible Part C days issue.

This finding is consistent with the recent ruling by the U.S. District Court for the District of Columbia in *Evangelical Community Hospital, et al. v. Becerra*.[9] In that case, the provider's issue was tied to improper calculation to DSH payment and read in part, "[t]he intermediary erred by incorrectly calculating the SSI percentage for inclusion in the 'Medicare Fraction' for purposes of the calculation of the provider's [disproportionate share] payment . . ."[10] The Court found that "[t]his description does not specify which portion of the calculation was incorrect nor how the fraction should have been calculated differently."[11] The Court found that this was a description of the issue was a violation of Board rules and a proper basis on which for the Board to dismiss the appeal.[12] Here, the Board makes the same finding based on similarly overly generalized language.

For the reason set forth above, the Board **declines** to exercise its discretion to reopen and reinstate Case No. 09-2149GC and, thus, **denies** the request for reinstatement and rescission of remand. Accordingly, Case No. 09-2149GC remains closed.

Board Members Participating:

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

For the Board:

12/20/2023

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services

[9] 21-cv-01368 (APM) (D.D.C. Sep. 30, 2022).
[10] *Id*. at 11.
[11] *Id.*
[12] *Id.*

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Board Decision***
San Angelo Community Medical Center (Prp45-0340)
FYE 08/31/2014
Case No. 17-0383

Dear Mr. Ravindran,

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

Background:

A. Procedural History for Case No. 17-0383

On **November 3, 2016**, San Angelo Community Medical Center filed a request for hearing from a Notice of Program Reimbursement ("NPR") dated May 10, 2016. The hearing request included the following issues involving the disproportionate share hospital ("DSH") payment:

Issue 1: DSH Payment Supplemental Security Income (SSI) Percentage-Provider Specific
Issue 2: DSH- Medicaid Eligible Day

As the Provider is commonly-owned by Community Health Systems ("CHS"), the Provider was also directly added to various CHS Common Issue Related Party Groups ("CIRP"), including Case No. 16-1192GC, "Community Health Systems 2014 DSH Post 1498R SSI Data Match CIRP Group on August 24, 2016.

On **June 27, 2017**, the Provider filed its preliminary position paper (providing a complete copy to the Medicare Contractor but filing only the cover page with the Board consistent with Board Rules[1]). Similarly, on **October 31, 2017**, the Medicare Contractor filed its preliminary position paper.

[1] Effective for cases filed on or after August 29, 2019, providers are required to file the complete preliminary position paper (including any exhibits).

On **April 23, 2018**, the Medicare Contractor filed a Jurisdictional Challenge over Issue 1- DSH SSI Percentage- Provider Specific. On **May 22, 2018**, the Provider *timely* filed a response to the MAC's Jurisdictional Challenge.

On **April 19, 2023**, the Board issued the revised Notice of Hearing and set the deadlines for the final position papers as May 24, 2023 and June 23, 2023 for the Provider and the Medicare Contractor, respectively. The Notice included the following instructions for the Provider's final position paper:

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

On **May 11, 2023**, the Medicare Contractor filed a Motion to Dismiss Issue 2- DSH Medicaid Eligible Days. However, the Provider ***failed*** to file any response to the Medicare Contractor Motion to Dismiss which, per Board Rule 44.3 was due within 30 days.

On **May 23, 2023**, the Provider timely filed its final position paper. The final position paper include as Exhibit P-1 a listing "1115 Waive and Additional ME Days Consolidated." At no point does the position paper discuss the Motion to Dismiss.

On **June 20, 2023**, the Medicare Contractor timely filed its final position paper.

On **August 3, 2023**, the Provider designated Mr. Ravindran at Quality Reimbursement Services ("QRS") as its new representative.

On **August 7, 2023**, QRS filed a request to postpone the hearing suggesting that the Medicare Contractor would review the eligible days listing filed with the final position paper but, in same breath, notes the Medicare Contractor ***opposes*** postponement and similarly fails to acknowledge (much less discuss) the pending Motion to Dismiss.

On **October 16, 2023**, the Board rescheduled the hearing to allow the Board time to rule on the pending motion and jurisdictional challenges.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 16-1192GC

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 Provider was also directly added into a mandatory group under Case No. 16-1192GC, Community Health Systems 2014 DSH Post 1498R SSI Data Match CIRP Group. This CIRP group has the following issue statement:

> CMS's improper treatment and policy changes resulted in an underpayment to the Providers as DSH program eligible providers of services to indigent patients, and includes any other related adverse impact to DSH payments, such as reduced-capital DSH payments or LIP -adjustments. Also, this treatment is not consistent with Congressional intent to reimburse hospitals for treatment of indigent patients when determining DSH program eligibility and payment pursuant to 42 U.S.C. § I 395ww(d)(5)(F), 42 C.F.R. § 412.106, Medicare Intermediary Manual § 3610.15, or any other applicable statutes, regulations, program guidelines, or case law.[3]

On May 23, 2023, the Provider filed its final position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

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[2] Provider's Request for Hearing, Issue Statement (Nov. 3, 2016)
[3] Case No. 16-1192GC, Statement of Issue, Tab 2

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 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 L*oma Linda Community Hospital v. Dept of Health and Human Services*, No. CVT94- 0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records. However, at this time, the Provider has been unable to analyze the Medicare Part A data because it has not yet received the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR"), HHS/HCFAIOIS, 09-07-009, which was published in the Federal Register on August 18, 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). The [provider] hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra (Appellants' reply brief included as Exhibit P-3).

Medicare Contractor's Contentions

Issue 1 – DSH SSI Percentage (Provider Specific)

On April 23, 2018, 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. 16-1192GC, *Community Health Systems 2014 DSH Post 1498R SSI Data Match CIRP Group*. The Portion of Issue 1 concerning realignment should be dismissed because there was no final determination

over SSI realignment and the Provider's appeal is premature as the Provider has not exhausted all available remedies.[4]

Issue 2 – DSH Medicaid Eligible Days

On May 11, 2023, the Medicare Contractor filed a Motion to Dismiss the Medicaid Eligible Days issue arguing that the Provider has effectively abandoned the issue by failing to furnish documentation in support of its claim for additional Medicaid Eligible Days or describe why such documentation was and continues to be unavailable. The Motion outlines the Board's Rules which require a Provider to submit supporting documentation with its appeal or otherwise explain why it is unavailable, and what steps are being taken to obtain it. The Medicare Contractor also points to 42 C.F.R. § 412.106(b)(4)(iii) and § 413.24(c), which places the burden on the Provider with regard to furnishing this documentation. Finally, the Motion notes that both the Provider's Preliminary and Final Position Papers stated that an eligibility listing was being sent under separate cover. The Medicare Contractor claims that no listing has ever been provided in the 76 months since the appeal was filed. The MAC requests the Board to dismiss the additional Medicaid Eligible Days issue because the Provider has failed to furnish documentation in support of its claim.[5]

Provider's Response

The Provider filed a response to the Jurisdictional Challenge on May 22, 2018. The Provider contends Issue 1 represent different and separate components of the SSI Issue and request the Board to find jurisdiction over the DSH/SSI provider specific issue. The Provider cites to Board Rule 8.1, which 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…"[6]

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

Board Analysis and Decision:

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

[4] MAC's Jurisdictional Challenge, at 2.
[5] MAC's Motion to Dismiss.
[6] Provider Response to MAC's Jurisdictional Challenge on May 22, 2018.

A. 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 several relevant aspects to consider: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage; 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period; and 3) the Provider incorporating the arguments from *Advocate Christ*[7] into its appeal.

1. First and Third Aspects of Issue 1

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH/SSI Percentage (Systemic Errors) issue that was appealed in PRRB Case No. 16-1192GC.

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."[8] 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)."[9] 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."[10]

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 16-1192GC 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. 16-1192GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.5[11], the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

In making this finding, the Board further notes that CMS regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, is pursuing that issue as part of the group under Case No. 16-1192GC. Further,

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

[8] Issue Statement at 1.

[9] *Id.*

[10] *Id.*

[11] PRRB Rules v. 1.3 (July 2015).

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] 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. 16-1192GC.

To this end, the Board also reviewed the Provider's Preliminary Position Paper (as attached to the Medicare Contractor's Motion to Dismiss) to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 16-1192GC, 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.[13] 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 Final Position Paper and include *all* exhibits.

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

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

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[12] 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).

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

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.[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 finds that the remaining issue in the instant appeal and the group issue from Group Case 16-1192GC are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5, the Board dismisses this component of the DSH – SSI Percentage (Provider Specific) issue.

The Board also reviewed the Provider's Final Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 17-1532GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider's Final Position Paper failed to comply with the Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" in its Final Position Paper and include *all* exhibits. For example, it requests to incorporate "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 Bacerra* (Appellants' reply brief included as Exhibit 3)" but fails to explain how or why

[14] Last accessed February 24, 2023.
[15] Emphasis added.

that this case is relevant here and *only* provider specific. This reference is perfunctory. Indeed, the *Advocate Christ* issue is a common issue subject to the CIRP group rules which under Board Rules was required to be transferred to a CIRP ***prior to*** filing preliminary position papers.

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*.[16]

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

Accordingly, *based on the record before it*, the Board finds that Issue 1 and the group issue from Group Case No. Case No. 16-1192GC 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 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 dismisses this aspect of the appeal.

B. DSH- Medicaid Eligible Days

According to its Appeal Request filed on November 3, 2016, the Provider asserts that all Medicaid eligible days were not included in the calculations of the DSH calculations for FY 2014. The Provider states Issue 2 as:

[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 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's appeal request did not include a list of the specific additional Medicaid eligible days that are in dispute in this appeal and desire to be included in their Medicaid percentage and DSH computations, with their appeal request. Further, the appeal request did ***not*** reference or refer to 1115 waiver days (*e.g.*, the provider did not appeal a protested item for 1115 waiver days).

With regard to the filing of an individual appeal, Board Rule 7 (Support for Appealed Final Determination, Issue-Related Information and Claim of Dissatisfaction) (Dec. 2013) 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.

However, when CHS filed the November 3, 2016 appeal request, CHS did not indicate that there were issues with accessing information underlying the adjustment to its Medicaid eligible days.

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

> (b) *Position papers*. . . . (2) The Board has the discretion to extend the deadline for submitting a position paper. **Each position paper must set forth the relevant facts and arguments regarding** the Board's jurisdiction over each remaining matter at issue in the appeal (as described

[17] Provider's Appeal Request (Nov. 3, 2016).

> 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.[18]

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

The Board has issues Rules to implement c. Board Rule 27.2 (2021) specifies that "[t]he final position paper should address each remaining issue" and that "[t]he ***minimum*** requirements for the position paper narrative and exhibits are the ***same*** as those outlined for preliminary position papers at Rule 25."[19] Board Rule 25 (2021) gives the following instruction on the content of position papers:

> **25.1 Content of Position Paper Narrative**
> The text of the position papers must include the elements addressed in the following sub-sections.
>
> **25.1.1 Provider's Position Paper**
>
> The Provider's preliminary position paper must:
>
> A. Identify any issues that were raised in the appeal but are already resolved (whether by administrative resolution, agreement to reopen, transfer, withdrawal, dismissal, etc.) and require no further documentation to be submitted.
>
> B. For *each* issue that has not been fully resolved, provide a *fully* developed narrative. . .
>
> C. Comply with Rule 25.2 addressing Exhibits.
>
> ****

[18] (Bold emphasis added.)
[19] (Bold emphasis added.)

25.2 Position Paper Exhibits

25.2.1 General

With the position papers, the parties must exchange ***all*** available documentation as exhibits to fully support your position. The Medicare contractor must also give the provider all evidence the Medicare contractor considered in making the determination (see 42 C.F.R. § 405.1853(a)(3)) and identify any documentary evidence that the Medicare contractor believes is necessary for resolution but has not been submitted by the provider. When filing those exhibits in the preliminary position paper, ensure that the documents are redacted in accordance with Rule 1.4. Unredacted versions should be exchanged by the parties separately from the position paper, if necessary.

25.2.2 Unavailable and Omitted Documents

If documents necessary to support your position are still unavailable, then provide the following information in the position papers:

1. Identify the missing documents;
2. Explain why the documents remain unavailable;
3. State the efforts made to obtain the documents; and
4. Explain when the documents will be available.

Once the documents become available, promptly forward them to the Board and the opposing party. 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.

25.2.3 List of Exhibits

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

25.3 Filing Requirements to Board

The Board requires the parties file a ***complete*** preliminary position paper with a fully developed narrative (Rule

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

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

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

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.

On May 23, 2023, the Provider filed their preliminary position paper in which it indicated that it would be sending the eligibility listing under separate cover.[20] The position paper did not identify how many Medicaid eligible days remained in dispute in this case. Specifically, the Provider's complete briefing of this issue in its position paper is as follows:

[20] Provider's Preliminary Position Paper (June 27, 2017).

Calculation of Medicaid Eligible Days

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

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

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

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

Based on the Listing of Medicaid Eligible Days being sent under separate cover, the Provider contends that the total number of days reflected in its' [*sic*] 2014 cost report does not reflect an accurate number of Medicaid eligible days, as required by HCFA Ruling 97-2 and the pertinent Federal Court decisions.

In its Motion to Dismiss, the MAC asserts that the Provider has failed to submit a list of additional Medicaid eligible days with its appeal request, its preliminary position paper (notwithstanding the promise made therein that it was being sent under separate cover), and in

response to specific requests for that listing that the Medicare Contractor sent the Provider on January 9, 2023 and February 6, 2023. While the Calculation Support filed with their appeal notes a net impact of $27,000, with an increase in days, it is unclear whether this amount continues to be in dispute as of the Provider's filing of the position paper. Moreover, the MAC asserts that the Provider neglected to include in its preliminary position paper 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 MAC thus asserts that the Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it cannot produce those documents, as required by the regulations and the Board Rules.[21]

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. Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. § 412.106(b)(iii) and 405.1853(b)(2)-(3) and Board Rules 25.2.1 and 25.2.2 related to the submission of documentary evidence required to support its claims or describe why said evidence is unavailable as well as failed to fully develop the merits of the Medicaid eligible days issue because CHS has failed to identify any specific Medicaid eligible days at issue and failed to produce a listing of the specific days at issue (much less any supporting documentation for those days.)[22] 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"[23] 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. In this regard, the Board notes that the Provider represented in its preliminary position paper filed on June 27, 2017 that "the Listing of Medicaid Eligible days [are] being sent under separate cover."[24] This was suggestive that a listing had been completed and was imminent. However, no such listing has ever been received by either the Board or the Medicare Contractor until ***after*** the Medicare Contractor filed its Motion to Dismiss, ***almost 6 years after*** it had initially promised in its preliminary psotion paper that a listing was being sent under separate cover.

The fact that the Provider subsequently submitted a listing with its final position paper (*6 years after its preliminary position paper*) does not change the fact that its preliminary position paper filing was fatally flawed by not including the listing at that time or explaining why that listing was not available consistent with 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(iii) and Board Rule 25 (in particular Board Rule 25.2.2). Regardless, the Board notes that the Provider

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[21] *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.
[22] Board Rule 25, of which 25.2.1 and 25.2.2 are a part, is applicable to final position papers via Board Rule 27.2.
[23] (Emphasis added.)
[24] Provider Preliminary Position Paper at 8.

improperly added 1115 waiver days as an issue in its final position paper (more than 6 ½ years after the appeal was filed) since it was not included in the appeal request notwithstanding Board Rule 8

Regardless, the Board notes that QRS did not brief § 1115 waiver days as a separate issue in its final position paper but rather discussed them as part of the Issue 1, Medicaid Eligible Days, discussion and to this end included as Exhibit P-1 to its final position paper entitled "1115 Waiver and Additional ME Days Consolidated." Similarly, in looking at the preliminary position paper (as attached to the Jurisdictional Challenge as Exhibit C-2), CHS did not mention 1115 waiver days at all but rather filed a perfunctory terse 5-sentence argument.

In the alternative, to the extent that the Provider could argue that the Section 1115 Waiver Days was presented as a separate issue (separate and apart from Medicaid Eligible Days) and that its withdrawal of Issue 7 without qualification did not otherwise include Medicaid eligible days (notwithstanding the fact that the official record in OH CDMS does not list 1115 waiver days as a separate issue pending in this case), the Board would find that the 1115 waiver days issue: (1) was ***not*** properly included in the appeal request; (2) was ***not*** timely added to the appeal; and (3) was ***not*** properly briefed in either the preliminary position paper or even the final position paper. Any of these 3 reasons would be sufficient separate and independent bases to dismiss the 1115 waiver days issue. In this regard, the Board finds the Section 1115 Waiver Days issue is a separate issue that should have been appealed separately and briefed separately because it is a component of DSH different from the *generic* Medicaid eligible days issue and, thus, must be separately identified and appealed pursuant to Board Rule 8.1.

In this regard, the Board notes that § 1115 Waiver days are not traditional Medicaid eligible days. Indeed, it was only effective January 20, 2000, that the Secretary incorporated certain specific types of § 1115 Waiver days were incorporated into the DSH calculation *at her discretion* (*i.e*., it is the Secretary's position that no statute requires that § 1115 waiver days be included).[25] Rather, they relate to Medicaid expansion program(s) and are only includable in the DSH adjustment calculation if they meet the requirements in 42 C.F.R. § 412.106(b)(4) relating to § 1115 Waiver days. Indeed, not every state Medicaid program has a qualifying § 1115 expansion program ***and*** not every inpatient day associated with beneficiary enrolled in a § 1115 waiver program necessarily qualifies to be included in the Medicaid fraction. In contrast, every state has a Medicaid state plan and every state Medicaid plan includes inpatient hospital benefits and, by statute at 42 U.S.C. § 1395ww(5)(F)(vi)(II), the numerator of the DSH Medicaid fraction must include§ inpatient days of patients "who . . . were eligible for medical assistance under a

[25] 65 FR 47054, 47087 (Aug. 1, 2000). The Secretary's discussion in the preambles to the final rules revising 42 C.F.R. § 412.106(b)(4) to address 1115 waiver days demonstrates this as well as subsequent cases disputing the meaning of those revisions. Further, the Board has found that when a class of days (e.g., 1115 waiver days) is excluded due to choice, error, and/or advertence from the as-filed cost report, then that class of days is an unclaimed cost for which the Board would lack jurisdiction under 42 U.S.C. § 1395oo(a). *See, e.g.,* PRRB Jurisdictional Decision, Case Nos. 06-1851, 061852 (Nov. 17, 2017) (dismissing the class of adolescent psychiatric days from the appeal because no days were claimed with the as-filed cost report due to choice, error and/or inadvertence and, as such, the practical impediment standard or futility concept in the *Norwalk* and *Danbury* Board decisions is not applicable) (available at: https://www.cms.gov/regulations-andguidance/review-boards/prrbreview/downloads/jd-2017-11.pdf (last accessed Dec. 15, 2023)).

State plan approved under subchapter XIX" but who were not entitled to Medicare Part A. The appeal request only references Medicaid eligible days notwithstanding the fact that 1115 waiver days are treated very differently from regular Medicaid eligibility. The documentation verifying eligibility is different and the standard for determining eligibility is different. Further, it was not a given that all 1115 waiver days are necessarily days that would qualify under 412.106(b)(4) as demonstrated by Board decisions and case law.[26] Here, 42 C.F.R. § 405.1835(b) and Board Rule 8 required each separate issue to be identified. The Provider failed to do so. The Board recognizes that the appeal statement states that "The MAC, contrary to the regulation, failed to include all Medicaid eligible days, *including but not limited to* Medicaid paid days, unpaid eligible days eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation." However, the "including but not limited to" phrase only pertained to traditional Medicaid eligible days and reasons why they may not have been included in the fraction. It did not expand to include other classes of days such as general assistance, State-only days or 1115 waiver days. A generic catchall phrase cannot be used to essentially shoehorn in the later addition of issue on ***untimely*** basis in contravention to Board Rules and regulations.

In practice, new issues had to be added to this case no later than 240 days after receipt of the contractor's determination. However, there is no evidence in the record to indicate the Provider added the § 1115 Waiver days to the case properly or timely prior to the Tuesday, January 10, 2017.

Because the Provider did not either appeal the § 1115 Waiver days or add it to the appeal prior to the deadline to add issues, and it is a distinct issue, the Board finds that the issue was not properly or timely appealed (indeed the final position paper is the first time 1115 waiver days is mentioned for the first time *roughly **6½ years after** the deadline to add issues to the appeal*). The DSH Medicaid Eligible Days issue as stated in the original appeal request cannot be construed to include § 1115 Waiver days. Additionally, there is no indication that any § 1115 waiver days were included with the as-filed cost report which, if true, would make them an unclaimed cost and provide an independent basis for dismissal.

Based on the above, The Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(iii) and Board Rules 25.2.1 and 25.2.2 related to identifying the days in dispute 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.

****

[26] *See, e.g., CCT&B 2005-2006 Hurricane Katrina § 1115 Waiver UCP Days Group v. Novitas Solutions, Inc.*, PRRB Dec. No. 2016-D18 (Sept. 16, 2016); *QRS 1993-2007 DSH/Iowa Indigent Patient/Charity Care (GA) Group v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (Jan. 15, 2013), *affirming* PRRB Dec. No. 2013-D02 (Nov. 21, 2012); *Singing River Health Sys. v. Novitas Solutions, Inc.*, PRRB Dec. 2016-D19 (Sept. 20, 2016); *Adventist Health Sys. v. Sebelius*, 715 F.3d 157 (6th Cir. 2013).

In summary, the Board hereby dismisses the SSI Provider Specific Issue from this appeal as it is duplicative of the issue in Case No. 16-1192GC, 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.

The Board also dismisses Issue 2, DSH Medicaid Eligible Days, as the Provider has failed to meet the Board requirements for preliminary position papers for this issue relative to developing the merits of its case and filing supporting exhibits as required under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)- (3) and Board Rules 27.2 and 25. Nor did the Provider provide a timely explanation to the MAC as to why the documentation was absent from that filing or what is being done to obtain it, notwithstanding the age of this case.

Further, the Board takes administrative notice that it has made similar dismissal in other cases in which CHS was the designated representative and, notwithstanding, CHS failed to provide the Medicaid eligible days listing with its preliminary position paper.

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:

12/20/2023

X Clayton J. Nix

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Russell Kramer
Quality Reimbursement Services, Inc.
150 N Santa Anita Ave., #570A
Arcadia, CA 91006

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

RE: ***Board Decision* – SSI Percentage (Provider Specific) and Medicaid Eligible Days**
Boone Hospital Center (Prov. No. 26-0068, FYE 12/31/2013)
Case No. 17-1471

Dear Messrs. Kramer and 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. 17-1471*

On **November 29, 2016**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end December 31, 2013.

On **May 16, 2017**, the Provider's representative, Mr. Kramer at Quality Reimbursement Services ("QRS"), filed the Provider's appeal request with the Board appealing the following two (2) issues:

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

Both the DSH Payment/SSI Percentage (Provider Specific) and DSH Payment – Medicaid Eligible Days issues remain pending in the appeal. As the Provider is commonly owned by BJC Healthcare ("BJC"), the Provider also requested to be directly added to various BJC group appeals, including Case No. 17-0834GC, QRS BJC 2013 DSH SSI Percentage CIRP.

On **January 26, 2018**, QRS filed the Provider's preliminary position paper.

On **April 5, 2018**, the Medicare Contractor filed a Jurisdictional Challenge over Issue 1 requesting that it be dismissed as a prohibited duplicate of the Provider's pursuit of the same issue in Case NO. 17-0834GC. On **April 23, 2018**, QRS timely filed the Provider's response.

On **May 22, 2018**, the Medicare Contractor filed its preliminary position paper.

On **December 30, 2022**, the Medicare Contractor filed its 3rd and Final Request for DSH Package for Issue 2. The Request asked the Provider to provide a lisitng of Medcaid eligible days on or before January 29, 2023. The Request further noted that the Medicare Contractor had previously requested the Provider furnish the listing on July 27, 2017 and on November 20, 2017 but received no response. The Provider did not file any response notwithstanding the instruction in 42 C.F.R. § 405.1853(e)(5) that "Each party is required to make a good faith effort to resolve or narrow any discovery dispute, regardless of whether the dispute is with another party or a nonparty."

As no response was received from the Provider, on **February 15, 2023**, the Medicare Contractor filed its Motion to Dismiss Issue 2. The Provider's response was due within 30 days pursuant to Board Rule 44.3 (*i.e*., no later than Friday, March 17, 2023).

On **April 10, 2023**, the Medicare Contractor filed a Jurisdictional Challenge requesting dismissal of Issue 1 as a prohibited duplicate of the issue the Provider is pursuing through its participation in Case No. 17-0834GC.

On **May 10, 2023**, QRS belatedly filed its response to the Jurisdictional and Motion to Dismiss. While the Response was timely as it relates to the April 10, 2023 Jurisdictional Challenge, ***it was not timely as it relates to the Motion to Dismiss*** (*since it was filed almost 8 weeks beyond the Friday, March 17, 2023 filing deadline without any explanation*) ***and, as a result, the Board declines to consider it***. With respect to the Medicaid eligible days issue, the Provider argues that it was not required to submit a listing with its preliminary position paper and ignores the 3rd and Final Request for DSH Package filed 4 months earlier on December 30, 2022. Indeed, QRS did not include a listing or even explain why a listing was not available at this late date.

On **December 13, 2023**, QRS filed the Provider's final position paper. Significantly, the final position paper does not include an eligible days listing or explain why a listing was not included, *notwithstanding the fact that this appeal has been pending for over 7 years now*. Rather, it simply states that "A listing of the additional Medicaid Eligible days being claimed will be submitted directly to the MAC" and that "A redacted version of the list will be uploaded ***soon*** to the portal."

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 17-0834GC

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

> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> . . .
>
> The Provider 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.[1]

As mentioned above, on May 16, 2017, the Provider was directly added to PRRB Case No. 17-0834GC, appealing from the same NPR as the instant appeal. This common issue related party ("CIRP") group issue statement reads:

> The Provider(s) contend(s) that the Lead MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww (d)(5)(F)(vi). The Provider(s) contend(s) that the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") and used by the Lead MAC to settle their Cost Report were incorrectly computed.
>
> The Provider(s) also contend(s) that CMS inconsistently interprets the term "entitled" as it is used in the statute. CMS requires 551 payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the denominator. CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days of care) as Medicare Part A days, yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment.
>
> The Provider(s) further contend(s) that the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") fail to address all the deficiencies as described in *Baystate Medical Center v. Michael O. Leavitt*, 545 F. Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37, 44 (D.D.C. 2008) and incorporate a new methodology inconsistent with the Medicare Statute.
>
> Providers in this case are also seeking resolution of the following additional aspects of the Medicare fraction that were not addressed in the Baystate case:
>
> 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

[1] Issue Statement at 1 (May 16, 2017).

5. Paid days vs. Eligible days, and
6. Covered days vs. Total days.[2]

On January 26, 2018, 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).
>
> 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 (September 30) when it determined the Provider's SSI. *See Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).[3]

MAC's Contentions

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

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

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

[2] Group Issue Statement in PRRB Case No. 17-0834GC (Jan. 13, 2017).
[3] Provider's Preliminary Position Paper at 8-9 (Jan. 26, 2018).

> 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.[4]

In addition, the MAC argues the DSH Payment/SSI Percentage (Provider Specific) issue and the DSH Payment/SSI (Systemic Errors) issue are considered the same issue by the Board, and the Provider is appealing this issue in PRRB Case No. 17-0834GC. The MAC requests the Board to dismiss the SSI data accuracy sub-issue as duplicate filing in violation of Board Rule 4.6.1.[5]

Issue 2 – DSH Payment – Medicaid Eligible Days

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

> a. That the Provider has failed to furnish documentation in supports 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, 27.2, 25.2.1 and 25.2.2.[6]
> d. That the Provider has effectively abandoned its claim for additional Medicaid Eligible Days. . .[7]

Provider's Response

Issue 1 – DSH SSI Percentage (Provider Specific)

The Provider argues that the issues are not duplicative because "issues #1 and the directly added issue represent different components of the SSI issue, which was specifically adjusted during the audit."[8] Additionally, the Provider argues that the issue is not duplicative because the Provider is

[4] Jurisdictional Challenge at 6 (Apr. 10, 2023).
[5] *Id*. at 4-5.
[6] PRRB Rules v. 2.0 (Aug. 2018).
[7] Motion to Dismiss at 6 (Feb. 15, 2023).
[8] Jurisdictional Response at 1 (May 10, 2023).

"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."[9]

Finally, the Provider contends the Provider Specific issue is appealable "because the MAC specifically adjusted the Providers SSI percentage and the Provider is dissatisfied with the amount of DSH payments that it received for fiscal year 2013, resulting from its understated SSI percentage due to errors of omission and commission."[10]

Issue 2 – Medicaid Eligible Days

The MAC's Motion to Dismiss was filed on February 15, 2023. The Provider filed a response to the MAC's Motion to Dismiss on May 10, 2023. PRRB Rule 44.3 requires an opposing party to file a response within 30 days from the date that the motion was sent to the Board and the opposing party. As the responsive document was filed after the deadline, it will not be considered by the Board.

Board Analysis and Decision:

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

A. 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 Payment/SSI (Systemic Errors) issue that was appealed in PRRB Case No. 17-0834GC.

The DSH Payment/SSI Percentage (Provider Specific) issue in the present appeal concerns "whether the Medicare Administrative Contractor used the correct Supplemental Security

[9] *Id*. at 2.
[10] *Id*.

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 Payment/SSI (Systemic Errors) issue in group Case No. 17-0834GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds the DSH Payment/SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH Payment/SSI (Systemic Errors) issue in Case No. 17-0834GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.5[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, is pursuing that issue as part of the group under Case 17-0834GC. 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] 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. 17-0834GC.

To this end, the Board also reviewed the Provider's Preliminary Position Paper (as attached to the Motion to Dismiss) 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. 17-0834GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. For example, the Provider asserts that "the SSI entitlement of individuals can be ascertained from State records" but fails to explain what that means, what the basis for the alleged fact is,[16] or why that it even relevant to the issue. 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

[11] Issue Statement at 1.
[12] *Id.*
[13] *Id.*
[14] PRRB Rules v. 1.3 (July 2015).
[15] 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).
[16] There are no exhibits or citations or examples of how SSI entitlement can be ascertained from state records.

necessary to provide a *thorough understanding* of their opponent's 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(B) (2015) to explain why the MEDPAR data is unavailable. In this regard, Board Rule 25.2(B) (2015) specifies:

> 25.2 (B) Unavailable and Omitted Preliminary Documents: If documents necessary to support your position are still unavailable, identify the missing documents, explain why the documents remain unavailable, state the efforts made to obtain the documents and explain when the documents will be available. Once the documents become available, promptly forward them to the opposing party.

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]

The Board also reviewed the Provider's Final Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 17-1532GC, but instead refers to systemic *Baystate* data matching issues that are the subject of

[17] Last accessed February 24, 2023.
[18] Emphasis added.

the issue in the group appeal. Moreover, the Board finds that the Provider's Final Position Paper failed to comply with the Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" in its Final Position Paper and include *all* exhibits. For example, it requests to incorporate "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 Bacerra* (Appellants' reply brief included as Exhibit 3)" but fails to explain how or why that this case is relevant here and *only* provider specific. This reference is perfunctory. Indeed, the *Advocate Christ* issue is a common issue subject to the CIRP group rules which under Board Rules was required to be transferred to a CIRP ***prior to*** filing preliminary position papers and indeed is already an issue in the CIPR group (Case No. 17-0834GC) in which the Provider is participating.

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*.[19]

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

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 17-0834GC are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

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

[19] (Emphasis added.)

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 dismisses this aspect of the appeal.

B. DSH Payment - Medicaid Eligible Days

According to its Appeal Request, the Provider asserts that all Medicaid eligible days were not included in the calculations of the DSH calculation. The Provider states Issue 2 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 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 7.2 (B) 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 2.
[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 (B).

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 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 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).

Similarly, with regard to position papers,[24] Board Rule 25.2 (A) 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 (B) 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.[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)(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.

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[24] The minimum requirements for Final Position Paper narratives and exhibits is 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 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"[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 (B). This case is over 7 years old and no listing was provided in the preliminary or final position papers or in response to the Medicare Contractor's intervening requests. The Provider has wholly abandoned this issue at this late state notwithstanding its empty statements to the contrary. Indeed, without any days identified in the position paper filings, the Board must assumes that there are no days at issue and the actual amount in dispute for this issue is $0 consistent with 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rule 25.

The Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 25 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.[28]

****

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. 17-0834GC 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 and failed to pursue and develop the merits of its case and instead has made empty perfunctory filings.

In so finding, the Board takes administrative notice that it has made similar dismissals in *numerous* other cases in which QRS was the designated representative.[29] Notwithstanding, QRS

[27] (Emphasis added).
[28] Board Rule 25, of which 25.2 (A) and 25.2 (B) are a part, is applicable to final position papers via Board Rule 27.2.
[29] Examples of QRS-represented individual provider cases which the Board dismissed the SSI Provider-Specific issue and/or the Medicaid eligible days issue include, but are not limited to: Case No. 14-2674 (Medicaid eligible days issue) dismissed by Board letter dated May 5, 2022 initiated by MAC filing dated Mar. 22, 2022); Case No. 16-2521 (Medicaid eligible days only dismissed by Board letter dated May 5, 2022 initiated by MAC filing dated Mar. 25, 2022); Case No. 16-0054 (Medicaid eligible days only dismissed by Board letter dated May 5, 2022 initiated by MAC filing dated Mar. 25, 2022); Case Nos. 13-3022, 13-3211, 14-2506, 14-4313, 16-1712 (Medicaid eligible days dismissed by Board letter dated Sept. 30, 2022 initiated by MAC filing dated Dec. 10, 2020, Dec. 11, 2020, Mar. 12,

failed to properly distinguish/develop the SSI Provider Specific issue in its appeal request or its preliminary position paper and failed to provide the Medicaid eligible days listing with its preliminary position paper.

As no issues remain pending, the Board hereby closes Case No. 17-1471 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:

12/20/2023

X Clayton J. Nix

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

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

2021, Mar. 12, 2021, and Nov. 12, 2021 respectively); Case No. 21-1723 (both issues dismissed by Board letter dated Nov. 21, 2022 initiated by MAC filing dated Sept. 1, 2022); Case No. 16-1016 (both issues dismissed by Board letter dated Nov. 29, 2022 initiated by MAC filings dated May 17, 2018 and Mar. 2, 2022); Case No. 17-1747 (both issues dismissed by Board letter dated Nov. 29, 2022 initiated by MAC filings dated May 24, 2018 and Oct. 17, 2022); Case No. 15-2294 (Medicaid eligible days issue dismissed by Board letter dated Dec. 20, 2022 initiated by MAC filing dated May 23, 2022); Case No. 20-2155 (both issues dismissed by Board letter dated Dec. 30, 2022 initiated by MAC filing dated Oct. 17, 2022); Case No. 16-2131 (both issues dismissed by Board letter dated Feb. 10. 2023 initiated by MAC filing dated Dec. 22, 2022); Case No. 21-1765 (both issues dismissed by Board letter dated Feb. 22, 2023 initiated by MAC filing dated Dec. 6, 2022); Case No. 22-0719 (both issues dismissed by Board letter dated Mar. 8, 2023 initiated by MAC filing Mar. 8, 2023).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Andrew Ruskin, Esq.
K&L Gates LLP
1601 K Street, NW
Washington, D.C. 20006-1600

RE: ***Expedited Judicial Review Determination***
Trinity Health CY 2018 IME Calculation – Labor & Delivery Beds CIRP Group
Case No. 21-1253GC

Dear Mr. Ruskin:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' request for expedited judicial review (EJR) filed on December 12, 2023 in the above-referenced common issue related party ("CIRP") group appeal. Set forth below is the Board's decision on jurisdiction and EJR.

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 (Dec. 12, 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.

#

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 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.*

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 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,

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[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 applied to the Provider Group's cost reporting periods at issue in this case. 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.
[13] *Id.*

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 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

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

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) implementing the FFY 2013 regulatory change to now 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]

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.[25]

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.[26] 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.[27] 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

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[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 3.
[26] *Id.*
[27] *Id.* at 8.

reimbursed under IPPS.[28] 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.[29] 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.[30] 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.[31]

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.[32]

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.[33]

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 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.[34]

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

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[28] *Id.*
[29] *Id.*
[30] *Id.*
[31] *Id.*
[32] *Id.* at 9.
[33] *Id.*
[34] *Id.* at 10.

justifies the differences in their treatment, and agencies are not allowed to treat similarly situated circumstances differently without sufficient justification.[35]

The Medicare Contractor has not filed a response to the request for EJR, and the time to do so has now passed.[36]

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

In the November 13, 2015 Final Outpatient Prospective Payment Rule,[37] the Secretary finalized new cost reporting regulations related to the substantive reimbursement requirement of an appropriate cost report claim.[38] The Secretary revised the Medicare cost reporting regulations in 42 C.F.R. part 413, subpart B, by requiring a provider to include an appropriate claim for a specific item in its Medicare cost report *beginning on or after January 1, 2016* in order to receive or potentially qualify for Medicare payment for the specific item. If the provider's cost report does not include an appropriate claim for a specific item, the Secretary stated that payment for the item will not be included in the Notice of Program Reimbursement ("NPR") issued by the Medicare Contractor or in any decision or order issued by a reviewing entity (as defined in 42 C.F.R. § 405.1801(a)) in an administrative appeal filed by a provider. In addition, the Secretary revised the appeals regulations in 42 C.F.R. part 405, subpart R, by eliminating the requirement that a provider must include an appropriate claim for a specific item in its cost report in order to meet the dissatisfaction requirement for jurisdiction before the Board (hereinafter the "claim-specific dissatisfaction requirement"), again, for cost reports beginning on or after January 1, 2016. As all of the participants in this group case have fiscal years that began after January 1, 2016, the claim-specific dissatisfaction requirement is not applicable.

The participants that comprise the group appeal have filed appeals involving fiscal year ending in 2018. All of the participants have appealed from an original NPR. Based on its review of the record, the Board finds that all of the providers in the group appeal filed their appeals within 180 days of the issuance of their respective final determinations as required by 42 C.F.R. § 405.1835.

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[35] *Id.*
[36] *See* Board Rule 42.4, which provides that the Medicare Contractor must file its response within five (5) business days of the filing of the EJR request. *See also* Board Rule 44.6, which provides the same deadline of five (5) business days for filing challenges (jurisdictional or substantive claim) in group cases when an EJR request is filed within 60 days of the final schedule of providers, as occurred in this case. Accordingly, the deadline for any Medicare Contractor filing was December 19, 2023.
[37] 80 Fed. Reg. 70298, 70551-70580 (Nov. 13, 2015).
[38] *Id.* at 70555.

The providers each appealed the issue in the EJR request, and the Board is not precluded by regulation or statute from reviewing the issue. Finally, the amount in controversy meets the $50,000 amount in controversy requirement for a group appeal pursuant to 42 C.F.R. § 405.1837(a)(3) in the cases at issue. Therefore, the Board has jurisdiction over the providers.

B. Compliance with the Reimbursement Requirement of an Appropriate Cost Report Claim Pursuant to 42 C.F.R. § 405.1873 (Cost Reports Beginning on or After January 1, 2016)

For cost report periods beginning on or after January 1, 2016, the regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 are applicable. The regulation, § 413.24(j), specifies that, in order for a specific item to be eligible for potential reimbursement, the provider must include an appropriate cost report claim for that specific item:

> (j) **Substantive reimbursement requirement of an appropriate cost report claim**—
>
> (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
>
> (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.

In conjunction with the regulation above, 42 C.F.R. § 405.1873(a) addresses when the Board must examine a provider's compliance with § 413.24(j):

> (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.[39]

These regulations are applicable to the cost reporting periods under appeal, which end after December 31, 2016. The regulation at § 405.1873(b) sets out certain procedures that must be followed in the event a party questions whether the cost report included an appropriate claim for a specific item under appeal. *In such situations where a party raises that question*, the regulation requires the Board to give the parties an adequate opportunity to submit factual evidence and legal arguments regarding whether the provider's cost report included an appropriate claim for the specific item under appeal, and upon receipt of the factual evidence or legal argument (if any), the Board must review the 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 the cost report claim requirements of § 413.24(j).

The Board interprets the regulation at 42 C.F.R. § 405.1873 to only require the Board to review a provider's "compliance"[40] 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.[41] Board Rule 42.4[42] provides that if the Medicare Contractor opposes an EJR request filed by a provider or group of providers, which includes a Substantive Claim Challenge,[43] then it must file its response within five (5) business days of the filing of the EJR request. Five (5) business days have passed since the Providers filed the EJR request, and the Medicare Contractor has not filed a response or a Substantive Claim Challenge.

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[39] (Bold emphasis added.)
[40] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."
[41] *See* 42 C.F.R. § 405.1873(a).
[42] The Board notes that Board Rule 10.2 states: "If the Medicare contractor opposes a provider's expedited judicial review request, . . . its response must be timely filed in accordance with Rules 42, 43, and 44."
[43] *See also* Board Rules 44.5.2 and 44.6.

As such, since no party to the appeal has questioned, pursuant to § 405.1873(a), whether an appropriate claim was made, the Board finds there is no regulatory obligation for the Board to affirmatively, on its own, review the appeal documents to determine whether an appropriate claim was made. As a result, Board review under 42 C.F.R. § 405.1873(b) has not been triggered. Accordingly, the Board need not include any findings regarding compliance with the substantive claim requirements and may proceed to rule on the EJR request pursuant to 42 C.F.R. § 405.1873(d).

C. 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 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 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 year 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 all of the participants in the group appeal are entitled to a hearing before the Board;

2) The review process in 42 C.F.R. § 405.1873(a)-(b) has not been triggered, and therefore, there are no findings regarding whether the Providers' cost reports included appropriate claims for the specific item at issue in this appeal;

3) Based upon the Providers' assertions regarding 42 C.F.R. § 412.105(b), 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 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 Providers have 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.
Ratina Kelly, CPA

FOR THE BOARD:

12/21/2023

X Clayton J. Nix

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

Enclosure: Schedule of Providers

cc: Byron Lamprecht, WPS Government Health Administrators (J-8)
Wilson C. Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Board Decision***
Alton Memorial Hospital (Prov. No. 14-0002)
FYE: 12/31/2016
Case No.: 19-0736

Dear Mr. Kramer:

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the documentation in Case No. 19-0736 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. 19-0736

On August 10, 2018, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end December 31, 2016.

On January 23, 2019, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained two (2) issues:

1. DSH – SSI Percentage (Provider Specific)
2. DSH – Medicaid Eligible Days[1]
3. Uncompensated Care ("UCC") Distribution Pool[2]

As the Provider is owned by BJC Healthcare and, thereby, subject to the mandatory Common Issue Related Party ("CIRP") group regulation at 42 C.F.R. § 405.1837(b)(1), the Provider was directly added to a CIRP Group for the SSI Percentage Issue, Case No. 19-0737GC, BJC Healthcare CY 2016 DSH SSI Percentage CIRP Group, on January 23, 2019. After the withdraw of issue 2, the DSH – SSI Percentage (Provider Specific) issue and Uncompensated Care ("UCC") Distribution Pool issue remain pending in this appeal.

[1] On October 4, 2023, the Provider withdrew this issue.
[2] Provider added issue on January 23, 2019.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 19-0737GC

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]

The Provider was also directly added to Case No. 19-0737GC, BJC Healthcare CY 2016 DSH SSI Percentage CIRP Group; the issue statement reads, in part:

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

[3] Issue Statement at 1 (Jan. 23, 2019).

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

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

On September 17, 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 (December 31).

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

Similar to *Loma Linda Community Hospital v. Dept of Health and Human Services*, No. CV-94-0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from 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).[4]

MAC's Contentions

Issue 1 – DSH – SSI Percentage (Provider Specific)

[4] MAC's Motion to Dismiss, Ex. C-1 at 8-9 (Feb. 23, 2023).

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 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.[5]

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.[6]

Issue 3 – 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)."[7]

Provider's Jurisdictional Response

The Board Rules require that Provider Responses to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[8] The Provider has not filed a response to the Jurisdictional Challenge and the time for doing so has elapsed. Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

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

[5] Jurisdictional Challenge at 6 (Sept. 21, 2023).
[6] *Id*. at 1.
[7] *Id*. at 13.
[8] 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 – SSI Percentage (Provider Specific)

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

1. *First Aspect of Issue 1*

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH/SSI Percentage (Systemic Errors) issue that was appealed in PRRB Case No. 19-0737GC.

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."[9] 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)."[10] 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."[11]

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 19-0737GC 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. 19-0737GC. 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 No. 19-0737GC. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in

[9] Issue Statement at 1.
[10] *Id.*
[11] *Id.*

Baystate, may impact the SSI percentage for each provider differently.[12] 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. 19-0737GC.

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. 19-0737GC, 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.[13]

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,

[12] 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).
[13] (Emphasis added).

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

> https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH.[14]
> This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows: "DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[15]

Accordingly, the Board finds that the remaining issue in the instant appeal and the issue in Group Case 19-0737GC 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 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 dismisses 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).[16]

1. *Bar on Administrative Review*

[14] Last accessed February 24, 2023.
[15] Emphasis added.
[16] The Provider was also a participant in PRRB Case Nos. 16-0769GC (appealing from the Fed. Reg. dated Aug. 17, 2015 and covers service dates July 1, 2016 through Sept. 30, 2016) and 17-1150GC (appealing from the Fed. Reg. dated Aug. 22, 2016 and covers service dates Oct. 1, 2016 through June 30, 2017). Both CIRP Group appeals have been dismissed for a lack of jurisdiction.

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).[17]
>
> (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*"),[18] the U.S. Court of Appeals for the District of Columbia Circuit ("D.C. Circuit") upheld the D.C. District Court's decision[19] 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."[20] 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.[21]

---

[17] 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.
[18] 830 F.3d 515 (D.C. Cir. 2016).
[19] 89 F. Supp. 3d 121 (D.D.C. 2015).
[20] 830 F.3d 515, 517.
[21] *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.[22]

b. DCH Regional Med. Ctr. v. Azar

The D.C. Circuit Court revisited the judicial and administrative bar on review of uncompensated care DSH payments again in *DCH Regional Med. Ctr. v. Azar* ("*DCH v. Azar*").[23] 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."[24] 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.[25]

c. Scranton Quincy Hosp. Co. v. Azar

Recently, in *Scranton Quincy Hosp. Co. v. Azar* ("*Scranton*"),[26] 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.[27] 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.[28] 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.[29] Nevertheless, the Secretary used each

[22] *Id.* at 521-22.
[23] 925 F.3d 503 (D.C. Cir. 2019) ("*DCH v. Azar*").
[24] *Id.* at 506.
[25] *Id.* at 507.
[26] 514 F. Supp. 249 (D.D.C. 2021).
[27] *Id.* at 255-56.
[28] *Id.* (quoting 79 Fed. Reg. 49854, 50018 (Aug. 22, 2014)).
[29] *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.

hospital's shorter cost reporting period in calculating the Factor 3 values for their FY 2015 DSH payments.[30]

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.[31]

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."[32] 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.[33] 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.[34]

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.[35] 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*

[30] *Id.*
[31] *Id.* at 262-64.
[32] *Id.* at 265.
[33] *Id.* (discussing *Leedom v. Kyne*, 358 U.S. 184, 188 (1958)).
[34] *Id.* at 264 (quoting *DCH v. Azar*, 925 F.3d at 509-510).
[35] *Id.* at 264-6511 (quoting *DCH v. Azar*, 925 F.3d at 509).

("*Ascension*").[36] 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.[37] 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."[38] The D.C. Circuit further dismissed the applicability of the Supreme Court's 2019 decision in *Azar v. Allina Health Servs*.[39] 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***."[40]

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 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 duplicative of the issue in PRRB Case No. 19-0737GC, in which the Provider is a participant. Further, 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 because the Board does not have jurisdiction pursuant to 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2) which preclude administrative and judicial review of certain aspects of the UCC payment calculation.

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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[36] Civ. No. 20-139, 2021 WL 3856621 (D.D.C. August 30, 2021).
[37] *Id*. at *4.
[38] *Id.* at *9.
[39] 139 S. Ct. 1804 (2019).
[40] *Ascension* at *8 (bold italics emphasis added).

Board Members Participating:

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

For the Board:

12/21/2023

X Robert A. Evarts, Esq.

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

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

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

RE: ***Board Decision***
Lake Granbury Medical Center – (Prov. No. 45-0596)
FYE 11/30/2016
Case No.: 19-2367

Dear Mr. Summar:

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the documentation in Case No. 19-2367 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. 19-2367

On February 22, 2019, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end November 30, 2016.

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

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

As the Provider is owned by Community Health Systems, Inc. (hereinafter "CHS") and, thereby, 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 CHS groups on March 22, 2019.

[1] This issue was transferred to case PRRB Case No. 19-1409GC on March 20, 2020.
[2] This issue was withdrawn on March 2, 2023.
[3] This issue was transferred to case PRRB Case No. 19-1410GC on March 20, 2020.

After the withdrawal of Issue 3, Issue 1, the DSH – SSI Percentage (Provider Specific) and Issue and 4, Uncompensated Care Distribution Pool, are the only issues remaining in this appeal.

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

In the 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 CHS, the Provider transferred its Issue 2 – DSH/SSI Percentage to the CIRP group appeal No. 19-1409GC, CHS CY 2016 DSH SSI Percentage CIRP Group, on March 20, 2020. The Group Issue Statement in Case No. 19-1409GC reads:

> **Statement of the Issue:**
>
> Whether the Medicare/SSI fraction used in the Medicare Disproportionate Share Hospital and LIP payment calculations accurately and correctly counted the correct number of patient days to be included in the numerator and denominator of the Medicare/SSI fraction calculation per the Medicare Statute at 42 U.S.C. §1395ww(d)(5)(F)(vi)?
>
> **Statement of the Legal Basis:**
>
> The Provider(s) contend(s) that the Lead MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww (d)(5)(F)(vi). The Provider(s) contend(s) that the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") and used by the Lead MAC to settle their Cost Report were incorrectly computed.

[4] Issue Statement at 1 (Aug. 6, 2019).

The Provider(s) also contend(s) that CMS inconsistently interprets the term "entitled" as it is used in the statute. CMS requires SSI payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the denominator. CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days of care) as Medicare Part A days, yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment.

The Provider(s) further contend(s) that the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") fail to address all the deficiencies as described in Baystate Medical Center v. Michael 0. Leavitt, 545 F. Supp. 2d 20, as amended, 587 F. Supp. 2d 37, 44 (D.D.C. 2008) and incorporate a new methodology inconsistent with the Medicare Statute.

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

1. Availability of MEDPAR and SSA records,
2. 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]

On March 27, 2020, 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 the Centers for Medicare and Medicaid Services ("CMS") was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation based on the Provider's Fiscal Year End (November 30).

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

> 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 8.
>
> 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 SST who were not included in the SSI percentage detennined by CMS based on the Federal Fiscal Year End (September 30) when it determined the Provider's SSL 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 – SSI Percentage (Provider Specific)[7]

The MAC filed its jurisdictional challenge on October 23, 2019, and 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 elects to use its own fiscal year end, it is bound by that decision, regardless of reimbursement impact.
>
> . . .

[6] Provider Preliminary Position Paper at 8-9 (March 27, 2020).
[7] The MAC also challenged jurisdiction over the IPPS Payment issue, however the Provider has since transferred that issue.

> There was no final determination over the SSI alignment and the appeal is premature as the Provider has not exhausted all available remedies. This issue should be dismissed.[8]

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

Issue 4 – UCC Distribution Pool

The MAC states that:

> The Board lacks jurisdiction over the UCC DSH issue because judicial and administrative review of the calculation is barred by statute and regulation. The Board is respectfully requested to follow the lead of the D.C. Circuit Court of Appeals in Tampa General and dismiss the instant appeal for lack of jurisdiction.
>
> Issue 4 is duplicative of the Provider's appeal in PRRB Group case #16-0769GC and #17-1042GC, and therefore, should be dismissed in accordance with PRRB Rule 4.6.2.[10]

Provider's Jurisdictional Response:

Issue 1 – DSH – SSI Percentage (Provider Specific)

The Provider filed its jurisdictional response on November 18, 2019, and argues that the board has jurisdiction over the DSH – SSI Percentage (Provider Specific) issue, stating that it is separate from the DSH – SSI Percentage (Systemic) issue:

> *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.*
>
> . . .
>
> *Accordingly, this is an appealable item because the MAC specifically adjusted the Provider's SSI percentage and the Provider is dissatisfied with the amount of DSH payments that it received for fiscal year 2016, resulting from its understated SSI percentage due to errors of omission and commission.*[11]

[8] Jurisdictional Challenge at 2,7 (October 23, 2019).
[9] *Id*. at 6-7.
[10] Jurisdictional Challenge at 11.
[11] Jurisdictional Response at 2 (Nov. 18, 2019).

Issue 4 – UCC Distribution Pool

The Provider presents a series of arguments as to why the Board has jurisdiction over the UCC Distribution Pool issue. First, the Provider states that the appeal in PRRB Case No. 19-2367 is separate and not duplicative of the appeals in Case Nos. 16-0769GC and 17-1042GC:

> *Provider's appeals in PRRB CN #16-0769GC, 17-1042GC and #19-2367 are from two separate and distinct determinations, and appeal rights associated with Federal Register Publications vary from those of appeal rights based upon NPRs. Therefore, Provider contends there is no conflict with PRRB Rule 4.6.2.*[12]

Second, the Provider states that:

> *The MAC argues that the Secretary's "estimates" are shielded from judicial review. However, this ignores the central point that the Secretary is not authorized to "estimate" the uninsured patient percentage.*
>
> . . .
>
> *Therefore, the PRRB has jurisdiction over provider challenges to the uninsured patient percentage computed by the Secretary on the basis that such computation is not supposed to be an "estimate."*[13]

Furthermore, the Provider argues "the PRRB may review the Secretary's estimates because the federal courts may also conduct such review" for the following reasons:

> ***1. The provider is entitled to a writ of mandamus directing the Secretary to revise her estimates***
>
> *The appeal in this case challenges the Secretary's actions as ultra vires, outside the scope of her authority, and as a clear violation of her statutory obligations. Under these circumstances, the providers are entitled to a writ of mandamus directing her to comply with her non-discretionary statutory duties.*
>
> . . .
>
> *Thus, an agency that acts outside of the scope of its lawful authority or in an ultra vires manner may not be shielded from judicial review, notwithstanding the existence of a statutory ban on judicial review. For example, an agency's promulgation of a*

[12] *Id.* at 3.
[13] *Id.*

regulation without undertaking the required notice and comment procedures may be grounds for circumventing the preclusion of judicial review on the basis that the agency acted outside of the scope of its authority in issuing the regulation. In such a case, a provider may well be entitled to a writ of mandamus directing the agency to comply with notice and comment procedures, or to injunctive relief prohibiting the application of regulations which are issued by the agency outside of the scope of its lawful authority.

Moreover, statutory bans against judicial review have been circumvented when an agency fails to act within a reasonable timeframe.[14]

2. ***The Statute Does Not Preclude Challenges to The Regulations and Policies Relied Upon by the Secretary in Computing Estimates for DSH Factors 1-3, Even If Challenges to the Estimates Themselves Are Precluded.***

The present case before the PRRB involves a challenge not only to the amount of an estimate used by the Secretary in computing Factors 1-3, but also to the regulations or instructions relied upon by the Secretary in computing those estimates. Specifically, the providers are challenging the annual IPPS rule which incorporate the defective estimates used by the Secretary. As such, the statutory preclusion clause contained in 42 U.S.C. § 1395ww(r)(3) does not bar administrative or judicial review.[15]

3. ***Failure to Permit Mandamus Relief or to Allow Michigan Academy Type Claims Will Result in Serious Constitutional Issues.***

There is little doubt that serious due process concerns would arise if the federal government attempts to preclude all possible administrative and judicial remedies, especially if the Secretary were to commit blatant or otherwise clear errors in computing the estimates in DSH Factors 1-3.[16]

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

[14] *Id.* at 4-5.
[15] *Id.* at 6-7.
[16] *Id.* at 7.

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 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."[17] 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)."[18] 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."[19]

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[20], 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, 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

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

case in *Baystate,* may impact the SSI percentage for each provider differently.[21] 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 Position Papers 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.[22]

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,

[21] 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).

[22] (Emphasis added).

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 Provider does 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.[25] 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 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 dismisses this aspect of the appeal.

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[23] Last accessed December 12, 2023.
[24] Emphasis added.
[25] 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).

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:

> (A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).[26]
>
> (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*"),[27] the U.S. Court of Appeals for the District of Columbia Circuit ("D.C. Circuit") upheld the D.C. District Court's decision[28] 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

[26] 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.
[27] 830 F.3d 515 (D.C. Cir. 2016).
[28] 89 F. Supp. 3d 121 (D.D.C. 2015).

data as well."[29] 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.[30]

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.[31]

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*").[32] 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."[33] 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.[34]

c. Scranton Quincy Hosp. Co. v. Azar

Recently, in *Scranton Quincy Hosp. Co. v. Azar* ("*Scranton*"),[35] 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.[36] 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.[37] Since the providers in *Scranton* changed ownership in FY 2012, each had

[29] 830 F.3d 515, 517.
[30] *Id.* at 519.
[31] *Id.* at 521-22.
[32] 925 F.3d 503 (D.C. Cir. 2019) ("*DCH v. Azar*").
[33] *Id.* at 506.
[34] *Id.* at 507.
[35] 514 F. Supp. 249 (D.D.C. 2021).
[36] *Id.* at 255-56.
[37] *Id.* (quoting 79 Fed. Reg. 49854, 50018 (Aug. 22, 2014)).

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.[38] Nevertheless, the Secretary used each hospital's shorter cost reporting period in calculating the Factor 3 values for their FY 2015 DSH payments.[39]

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.[40]

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."[41] 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.[42] 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.[43]

The D.C. District Court found that the preclusion of review for this issue was express, not implied, which fails to satisfy the first prong of this test. Second, the departure from the period to be used announced in the Secretary's rulemaking does not satisfy the third prong, which

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[38] *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.
[39] *Id.*
[40] *Id.* at 262-64.
[41] *Id.* at 265.
[42] *Id.* (discussing *Leedom v. Kyne*, 358 U.S. 184, 188 (1958)).
[43] *Id.* at 264 (quoting *DCH v. Azar*, 925 F.3d at 509-510).

requires a violation of a clear statutory command.[44] 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*").[45] 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.[46] 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."[47] The D.C. Circuit further dismissed the applicability of the Supreme Court's 2019 decision in *Azar v. Allina Health Servs*.[48] 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***."[49]

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. 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.

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

In addition, the Board dismisses the UCC Distribution Pool issue 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. Therefore, the Board does not have jurisdiction.

Case No. 19-2367 is hereby closed and removed from the Board's docket because there are no remaining issues in this appeal.

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:

12/21/2023

X Robert A. Evarts, Esq.

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

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

RE: ***Board Dismissal of SSI Percentage (Provider Specific) & Medicaid Eligible Days Issues***
Martin General Hospital (Provider No. 34-0133)
FYE 04/30/2018
Case No. 22-0037

Dear Mr. Ravindran and Mr. Lamprecht,

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

Background:

A. *Procedural History for Case No. 22-0037*

On April 13, 2021, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end April 30, 2018.

On October 5, 2021, the Board received Provider's individual appeal request. The initial individual appeal request contained three (3) issues:

- DSH/SSI Percentage (Provider Specific)
- DSH/SSI Percentage[1]
- DSH – Medicaid Eligible Days

The Provider transferred Issue 2, DSH-SSI Percentage, to a Common Issue Related Party ("CIRP") group, Case No. 22-0977GC, on June 22, 2022.[2] As a result, the remaining issues in this appeal are Issues 1 and 3.

[1] On June 22, 2022, this issue was transferred to PRRB Case No. 22-0977GC.
[2] On May 9, 2022, the Board first received a request from the Provider to transfer Issue 2, DSH-SSI Percentage, to a "CIRP" group appeal titled *Quorum Health CY 2017 DSH SSI Percentage CIRP Group*, which was assigned case number 20-1339GC. The Board denied this request because, pursuant to Board Rule 12.5, a group appeal may cover only one calendar year unless the Board allows the group to be expanded. The Provider did not file any formal notice to expand the years allowed, nor send any documentation confirming the Board granted an expansion. Consequently, the Board denied the request, but permitted transfer of the issue to a CIRP group currently pending before the Board for the SSI percentage issue for Quorum Health's CY 2018, case number 22-0977GC.

On August 17, 2022, the Medicare Contractor filed a jurisdictional challenge, requesting the dismissal of Issue 1. The Provider has not filed a response. On January 10, 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 3, 2023, the Medicare Contractor filed its Motion to Dismiss Issue 3 as the Provider failed to file any response. QRS has not filed any response to the Medicare Contractor Motion to Dismiss which, per Board Rule 44.3 was due within 30 days.

B. ***Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 22-0977GC***

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

> The Provider contends that its' [sic] SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation[.]
>
> . . .
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395 (d)(5)(F)(i).[3]

As the Provider is commonly owned by Quorum Health, the Provider transferred its Issue 2 – DSH – SSI Percentage to the CIRP group under 22-0977GC, Quorum Health CY 2018 DSH SSI Percentage CIRP Group, on June 22, 2022. The Group Issue Statement in Case No. 22-0977GC reads, in part:

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

[3] Individual Appeal Request, Issue 1.

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.[4]

The amount in controversy listed for both Issues 1 and 3 in the Provider's individual appeal request is $31,500.[5]

On May 31, 2022, 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 the Centers for Medicare and Medicaid Services ("CMS") was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation based on the Provider's Fiscal Year End (April 30).

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

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

[4] Group Issue Statement, Case No. 22-0977GC.
[5] Individual Appeal Request at 6.

> 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/HCFNOIS, 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 SSL See Baystate Medical Center v. Leavitt, 545 F. Supp. 2d 20 (D.D.C. 2008).[6]

C. Filings Concerning the Jurisdictional Challenge and Motion to Dismiss

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.[7]

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

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[6] Provider's Preliminary Position Paper at 8-9 (May 31, 2022).
[7] Jurisdictional Challenge at 7-8 (Aug. 17, 2022).
[8] *Id*. at 5.

Issue 3 – DSH Payment – Medicaid Eligible Days

In its July 3, 2023, Motion to Dismiss, the MAC argued that the Provider abandoned Issue 3, the DSH – Medicaid Eligible Days issue, because it has not submitted a list of the Medicaid eligible days at issue in this case and has not fully addressed the issue in its May 31, 2022, preliminary position paper in violation of Board Rule 25.3. The MAC notes that it specifically requested this listing from the Provider on: January 10, 2023. However, the Provider never responded to the request. The MAC then requested the Board make the following findings and Order 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.
f. That the only remaining issue in the case is issue 1, Disproportionate Share Hospital Payment/Supplemental Security Income Percentage (Provider Specific) including SSI Realignment, to which the MAC filed jurisdictional challenge on August 17, 2022.[9]

Accordingly, the MAC requested that the Board dismiss the Medicaid eligible days issue.

Provider's Jurisdictional Response

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

[9] Motion to Dismiss at 4-5 (July 4, 2023).
[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 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. 22-0977GC.

The Board finds that the first aspect of Issue 1 (the DSH/SSI (Provider Specific) issue) in this appeal is duplicative of the DSH/SSI (Systemic Errors) issue that was directly filed into Case No. 22-0977GC. The first aspect of Issue 1 in the present appeal concerns "[w]hether the Medicare Administrative Contractor ("MAC") used the correct Supplemental Security Income ("SSI") percentage in the Disproportionate Share Hospital ("DSH") calculation."[11] 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)."[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 DSH systemic issues filed into Case No. 22-0977GC, 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. 22-0977GC, for this same provider and fiscal year. 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.*

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, is pursuing that issue as part of the group under Case No. 22-0977GC. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[14] Provider is misplaced in referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) 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. 22-0977GC.

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. 22-0977GC, 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,

[14] 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).

"[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.[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 remaining issue in the instant appeal and the group issue from Group Case 22-0977GC 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. 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 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.

[15] Last accessed October 4, 2023.
[16] Emphasis added.

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.[17]

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

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

[17] Individual Appeal Request, Issue 3.
[18] Provider's Preliminary Position Paper at 13.

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.[19]

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

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

---

[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 is the same as those for Preliminary Position Papers. *See* Board Rule 27.2.

[22] (Emphasis added).

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.[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)(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.

As stated by the MAC and uncontested by the Provider, when the Provider filed their preliminary position paper it indicated that it would be sending the eligibility listing under separate cover. The position paper did not identify how many Medicaid eligible days remained in dispute in this case. While the Calculation Support filed with their appeal notes a net impact of $25,028, with an increase in days, it is unclear whether this amount continues to be in dispute as of the

[23] (Emphasis added).

Provider's filing of the position paper. Moreover, the MAC asserts that 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 even after the MAC submitted a follow up request for the listing on January 10, 2023 in OH CDMS and failing to respond to that request. The MAC thus asserts that the Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it cannot produce those documents, as required by the regulations and the Board Rules.[24]

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"[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.

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"[26] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. 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 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.[27]

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

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[24] *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.
[25] (Emphasis added).
[26] (Emphasis added).
[27] Board Rule 25, of which 25.2.1 and 25.2.2 are a part, is applicable to final position papers via Board Rule 27.2.

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)(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.

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. 22-0977GC and 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.

The Board also dismisses Issue 3, DSH Medicaid Eligible Days, as the Provider has failed to meet the Board requirements for position papers for this issue relative to developing the merits of its case and filing supporting exhibits as required under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)- (3) and Board Rules 27.2 and 25. Nor has the Provider provided any timely explanation to the MAC as to why the documentation was absent or what is being done to obtain it, notwithstanding a second request for the documentation and a follow-up Motion to Dismiss for failure to reply.

As no issues remain pending, the Board hereby closes Case No. 22-0037 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:

12/21/2023

X Robert A. Evarts, Esq.

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Brian Cocciolo
Mayo Clinic
4500 San Pablo Road
Jacksonville, FL 32224

Geoff Pike
First Coast Service Options, Inc.
Provider Audit and Reimbursement Dept.
532 Riverside Avenue
Jacksonville, FL 32202

RE: ***Board Decision***
Mayo Clinic (Prov. No. 10-0151)
FYE 12/31/2015
PRRB Case No. 22-1127

Dear Messrs. Cocciolo and Pike:

The Provider Reimbursement Review Board ("Board") reviewed the documents in the above referenced appeal in response to a April 18, 2023 Jurisdictional Challenge from the Medicare Contractor. The decision of the Board is set forth below.

Pertinent Facts

On **March 10, 2021**, the Provider was issued a Notice of Reopening on March 10, 2021, which reopened its cost report for the following reasons:

- To recalculate additional payments to hospitals for costs of nursing and allied health education associated with Medicare Advantage (MA) days in accordance with CR11642.
- To recalculate payments that are made to teaching hospitals for costs of direct GME associated with Medicare Advantage (MA) days in accordance with CR11642[.]
- To incorporate settlement (final, tentative, or HITECH) or lump sum amounts from the previous cost report settlement to ensure proper determination of payments, as necessary.
- To address cost report software updates and edits and correct cost report mathematical and flow errors, as necessary[.]

On **March 21, 2022**, the Provider was issued a Revised Notice of Program Reimbursement ("RNPR") for fiscal year end December 31, 2015.

On **June 19, 2022**, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained ***only*** one (1) issue:

1. GME Weighted Cap Calculation

In their Individual Appeal Request, Provider summarizes its GME Weight Cap Calculation issue as follows:

> The Provider challenges the amount of its Direct Graduate Medical Education (DMGE) payment, which the MAC calculated pursuant to an improper methodology invalidated in *Milton S. Hershey Med. Ctr. v. Becerra*, No. 19-CV-3411, 2021 WL 1966572, at *3 (D.D.C. May 17, 2021), *appeal dismissed*, No. 21-5169, 2021 WL 4057675 (D.C. Cir. Aug. 23, 2021). Under that methodology, CMS proportionally reduces the weighted full-time equivalent (FTE) count by the number of fellows trained in excess of the hospital's cap, improperly weighting those fellows at less than 0.5 FTEs. The Provider contends the regulation conflicts with the Medicare statute and that it is arbitrary and capricious under the Administrative Procedure Act.[1]

Further, included with the Statement of the Issue, the Provider submitted a statement entitled, "Basis for Jurisdiction". It reads, in relevant part:

> The issue is not related to a Revised Notice of Program Reimbursement adjustment per se, instead we are appealing the underlying calculation in the cost reporting instructions, which apply a proportional reduction to the weighted DGME FTE cap for training residents/fellows in excess of the FTE cap.
>
> ***
>
> In addition, the Provider must be dissatisfied with a final determination of the Medicare contractor. 42 U.S.C. § 1395oo(a)(1)(A); *see also* 42 C.F.R. § 1835(a)(1). Here, the Provider is dissatisfied with the MAC's final determination even in the absence of an audit adjustment specific to this issue. The Provider was required to complete its cost report in accordance with CMS's invalid regulations governing calculation of the DGME payment and counting of FTE residents. *See* 42 C.F.R. § 413.79(c)(2) (governing calculation of FTE resident count). It is well-settled that "submission of a cost report in full compliance with the unambiguous dictates of the Secretary's rules and regulations does not, by itself, bar the provider from claiming dissatisfaction with the amount of reimbursement allowed by those

[1] Statement of the Issue at 1 (June 19, 2022).

> regulations." *See Bethesda Hosp. Ass'n v. Bowen*, 485 U.S. 399, 404 (1988).[2]

On **April 18, 2023**, the Medicare Contractor filed a Jurisdictional Challenge requesting dismissal of the sole issue in this case due to the fact that the issue under appeal was not specifically adjusted in the RNPR upon which this appeal is based. The Provider failed to file a response with the 30-day period allotted under Board Rules.

Board Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2020), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

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

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

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

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

[2] *Id*. at 5-6.

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

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

> (a) *Right to hearing on final contractor determination*. A provider . . . has a right to a Board hearing, as a single provider appeal, with respect to a final contractor or Secretary determination for the provider's cost reporting period, if -
>
> (1) The provider is dissatisfied with the contractor's final determination of the total amount of reimbursement due the provider, as set forth in the contractor's written notice specified under § 405.1803. **Exception**: If a final contractor determination is reopened under § 405.1885, **any review by the Board must be limited solely to those matters that are specifically revised in the contractor's revised final determination** (§§ 405.1887(d), 405.1889(b), and the "Exception" in § 405.1873(c)(2)(i)).
>
> (2) The amount in controversy (as determined in accordance with § 405.1839) must be $10,000 or more.
>
> (3) Unless the provider qualifies for a good cause extension under § 405.1836, the date of receipt by the Board of the provider's hearing request must be no later than 180 days after the date of receipt by the provider of the final contractor or Secretary determination.[3]

The Board agrees with the Medicare Contractor's Jurisdictional Challenge and finds that it does not have jurisdiction over the GME Weighted Cap Calculation issue in this appeal as the Provider filed from a RNPR in which there were no adjustments related to the GME Weighted Cap Calculation issue. The Notice of Reopening indicates that the cost report was reopened in order to recalculate payments related to MA days for nursing and allied health and direct GME, neither of which is the issue under appeal in this case. Additionally, the Provider admits in its jurisdictional statement that the issue under appeal is ***not*** related to the RNPR, and that there is an ***absence of an audit adjustment specific to this issue***. The Provider is misplaced in its reliance on *Bethesda* in support of its position, as that decision is not controlling in RNPR appeals.[4] Thus, the provider does not have the right to appeal under 42 C.F.R. § 405.1889(b) as referenced in § 405.1835(a)(1).

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[3] (Emphasis added).
[4] *See infra* note 7.

When a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[5] There is no dispute between the parties as to whether there was a revision to the appealed issue in the RNPR.[6] Since the specific item on appeal was neither addressed nor specifically adjusted in the RNPR, the Providers do not have a right to appeal under 42 C.F.R. §§ 405.1889(b) and 405.1835(a)(1) for the GME Weighted Cap Calculation issue. In making this ruling, the Board notes that its application of 42 C.F.R. § 405.1889(b) has been upheld by courts on review.[7]

Conclusion

The Board finds that, pursuant to 42 C.F.R. § 405.1889(b) as referenced in § 405.1835(a)(1), it lacks jurisdiction over the remaining issue on appeal because it was not specifically revised in the RNPR which is the basis for the appeal. Since this was the last remaining issue in the case, the Board hereby closes Case No. 22-1127 and removes it from its docket.

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

Board Members:

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

For the Board:

12/21/2023

X Clayton J. Nix

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

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

[5] 42 C.F.R. § 405.1889(b)(1).
[6] *See* Statement of the Issue at 5-6. *See also* Jurisdictional Challenge at 2 (Apr. 18, 2023).
[7] *See St. Mary's of Mich. V. Azar*, No. 18-01790, 2020 WL 4049912 (D.D.C. July 20, 2020); *McLaren Flint v. Azar*, No. 18-2005, 2020 WL 2838566 (D.D.C. May 31, 2020), *Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F.Supp.3d 348 (D.D.C. 2014); *HCA Health Servs. of OK v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Isaac Blumberg
Blumberg Ribner, Inc.
11400 W. Olympic Blvd. Suite 700
Los Angeles, CA 90064

RE: ***Provider's Request for Rescission of Remand and Bifurcation of Individual Appeal***
Providence Saint Joseph Medical Center (Prov. No. 05-0235)
PRRB Case No. 07-1391
FYE 12/31/2002

Dear Mr. Blumberg:

The Provider Reimbursement Review Board (the "Board") has reviewed the above-referenced appeal in response to the Provider's Request for Rescission of Remand and Bifurcation of Individual Appeal Regarding DSH Part C Days issue. The Board hereby denies the request for rescission of the remand and bifurcation of the dual eligible Part A non-covered and Part C days issues. The decision of the Board is set forth below.

Background

A. Background of Individual Appeal, Case No. 07-1391

On **March 19, 2007**, the Board received the Provider's initial appeal request. The appeal was from a Notice of Program Reimbursement ("NPR") dated September 27, 2006. The initial appeal included two issues: Medicare SSI Percentage and Medicare/Medicaid Dual Eligible Patient Days. The description for the Medicare/Medicaid Dual Eligible Patient Days issue, at issue in the Provider's request for rescission of the remand and bifurcation, reads:

> Medicare/Medicaid Dual Eligible Patient Days (Audit Adjustments 8, 29, 31, and 32) – The Provider contends that the Disproportionate Share (DSH) adjustment has not been calculated in accordance with Medicare regulations and Manual provisions as described in 42 CFR Section 412.106. Further, the Provider contends that the Medicare/Medicaid dual eligible patient days have not been properly included in the DSH calculation.[1]

[1] Request for Medicare Appeal at 2 (Mar. 19, 2007).

On **June 11, 2007** and **October 15, 2007**, the Provider filed preliminary position papers with the Board. Significantly, Board Rule Part II.B.IV.b (March 1, 2002) specified that the position paper must brief each issue and contain all relevant documentary evidence and corroboration for the positions taken.

On **August 3, 2015**, the Provider Reimbursement Review Board (the "Board") remanded the Provider's appeal of DSH dual eligible days based on CMS Ruling 1498-R. The case remained open for other issues in the appeal

On **August 24, 2015**, Blumberg Ribner withdrew the appeal ***without qualification***. Accordingly, on **August 26, 2015**, the Board closed the appeal.

B. Description of Medicare/Medicaid Dual Eligible Patient Days Issue in the Commonly Owned Entities in Case No. 09-0748GC

PRRB Case No. 09-0748GC is a Dual Eligible Days case involving multiple providers that are commonly owned with the Provider at issue in this letter, Providence Saint Joseph Medical Center. In PRRB Case No. 09-0748GC, the Providers described the Dual Eligible days issue, which includes the same fiscal year end as in the instant appeal, as:

> Dual Eligible Days are patient days associated with those patients who were not included in the SSI denominator by CMS' design as they were not directly billed to Medicare and did not flow through the MEDPAR system via Fee For Service Medicare Part-A. Moreover, these days were disallowed from the Medicaid numerator as well. Hence, neither the Medicaid fraction nor the Medicare fraction captured the days associated with the undisputed indigent population. As the days represent patient who were Medicaid Eligible but not Medicare Entitled, the Provider contends that these days should be included in the Medicaid fraction.
>
> Dual Eligible Days were excluded from the Medicaid fraction for a variety of reasons. By way of example, certain Dual Eligible Days are days associated with patients who are eligible for Medicaid but have exhausted their Medicare Part A benefits ("Exhausted Days"). In Edgewater Medical Center (Chicago, IL.) v. Blue Cross and Blue Shield Association/ Blue Cross and Blue Shield of Illinois, PRRB Hearing Dec. No. 2000-D44 (April 7, 2000), the Board held
>
> > The Board continues to maintain that the DSH numerator should include days of dually eligible patients whose Medicare Part A benefits were exhausted and who were eligible for reimbursement under the State's Medicaid plan. *See Jersey Shore Medical Center v. Blue Cross and Blue Shield of New Jersey*, PRRB Case No. 99-D4, Medicare and Medicaid Guide (CCH) ¶80,083, October 30, 1998, *vacated and remanded*, HCFA Administrator, January 4, 1999, Medicare and Medicaid Guide (CCH) ¶80,153 ("*Jersey*").

> Thus, in accordance with the Board's holding in the Edgewater, the Provider's Medicaid fraction should include all "Exhausted Days".

On May 13, 2013, the Board, on its own motion, bifurcated the period from 10/1/2004 – 12/31/2004 and established a new group appeal for that period (09-0937GC), which was not subject to 1498-R Remand. The period prior to 10/1/2004 remained in the appeal. The Board concluded this letter:

> Finally, as noted earlier in this letter, the issue in dispute in case number 09-0748GC is subject to the provisions of CMS Ruling 1498-R. Therefore, the Board is requiring Blumberg Ribner, Inc. submit a ***final*** Schedule of Providers and the associated jurisdictional documentation for case number 09-0748GC to the Board within 60 days of the date of this letter.[2]

Blumberg Ribner submitted the final Schedule of Providers ("SOP") on July 11, 2013, and Providence Saint Joseph Medical Center was ***not*** included. The Board reviewed the SOP and remanded the Providers in Case No. 09-0748GC to the Medicare Contractor pursuant to CMS Ruling 1498-R on August 7, 2013, and closed the appeal. The Providers also requested Rescission of the Remand and Bifurcation of the Group Appeal issue in Case No. 09-0748GC, which the Board denied on August 14, 2023, under separate cover.

Provider's Request for Bifurcation

On June 3, 2016, the Board received a letter from the Provider requesting Recission [sic] of Remand and Bifurcation of Individual Appeal regarding DSH Part C Days issue. The Provider argues that the references to dual eligible patient days were intended to refer to persons eligible for Part A and Part C.[3] The Provider also argues that the factual and historical context of the appeal request supports the conclusion that the Provider's intended to appeal both issues and that at the time this appeal request was filed, providers commonly appealed the dual eligible days issue generally, contesting the categorical exclusion of all dual eligible days based on patients' status as Medicare beneficiaries.[4]

The Provider refers to a decision in Case No. 08-2624GC in which the Board granted bifurcation of dual eligible Part A and Part C days in Sutter Health 1998 DSH Dual Eligible Days CIRP Group. In that December 30, 2015 letter, the Board stated:

> [T]he Board acknowledges that *at the time that Sutter Health's individual and group appeals were filed, the issue of whether a Medicaid patient that was "dually eligible" for Medicare was not necessarily subdivided by Medicare Part A or HMO/Part C days.*

[2] Emphasis added.
[3] Provider Bifurcation Request Letter at 4 (June 3, 2016).
[4] *Id.* at 3-4.

> Federal courts later ruled differently on the "dual eligibility" related to Part A and Part C days therefore necessitating the Board to bifurcate these issues. In this case, the Board finds that the *providers' individual appeals and the original optional group appeal added the dual eligible days issue using a broad issue statement that encompassed both dual eligible Part A non-covered days and HMO days.* (Emphasis in original).[5]

Last, the Providers argue that they filed their *individual* appeals between March 1, 2002 and August 21, 200**9** in accordance with Board Instructions in effect during that time. The Board Instructions effective March 1, 2002 stated:

> Your hearing request must include an identification and statement of the issue(S) you are disputing. You must identify the specific issues, findings of fact and conclusions of law . . . **You must precisely identify the component of the DSH issue that is in dispute.**

The Providers argue that these Instructions did not require that they state the issue as "finely" as would be required under later rules. The Providers conclude that they were required to precisely define the DSH component at issue, which they did.

However, contrary to their assertion, the March 1, 2002 Board Instructions were ***not*** in effect *until* August 21, 200***9***. Rather, they were superseded by Board Rules issued *one year earlier* effective August 21, 200***8*** because the Board issued the August 21, 2008 revised Board Rules to implement changes to the Board's governing regulations *that were similarly effective August 21, 200**8*** and included material and significant clarifications on the minimum content for individual appeal requests (42 C.F.R. § 405.1835(b) (2009)) as well as group appeal requests (42 C.F.R. § 405.1837(c) (2009)).[6]

Board's Analysis and Decision

To the extent the Part C days issue could be considered part of this case, Blumberg abandoned the Part C days issue because, after this dual eligible days issue was remanded on August 3, 2015, this case remained open for other issues until Blumberg Ribner withdrew the case on August 24, 2015 ***without qualification***. At that point in time, it was clear that Part C days was a separate issue yet again Blumberg Ribner withdrew the case without qualification.

To the extent the Board were to reinstate, the Board would want to review the Provider's preliminary position paper to see if the Provider briefed the Part C issue or whether it was abandoned. In the respect, a position paper must brief all remaining issues per Board Rule 25 and 42 C.F.R. § 405.1853(b)(2).

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[5] *Id.* at 2.
[6] *See* 73 Fed. Reg. 30190 (May 23, 2008).

Finally, the Board notes that the regulations and Board Rules have long required that commonly owned providers ***must*** bring a group appeal for any issues in common in the same calendar year. 42 C.F.R. 405.1837(b) (2009) reads, in part:

> b) Usage and filing of group appeals.
> (1) Mandatory use of group appeals.
> (i) Two or more providers under common ownership or control that wish to appeal to the Board a specific matter at issue that involves a question of fact or interpretation of law, regulations, or CMS Rulings that is common to the providers, and that arises in cost reporting periods that end in the same calendar year, and for which the amount in controversy is $50,000 or more in the aggregate, ***must*** bring the appeal as a group appeal.[7]

Similarly, the relevant rule at the time of the creation of the CIRP Group appeal reads:

> **B. Mandatory Group Appeals: Common Issue Related Party (CIRP)**
>
> Providers that are commonly owned or controlled must bring a group appeal for any issue common to the related Provider and for which the amount in controversy for cost reporting periods ended in the same calendar year is, in the aggregate, at least $50,000. While one Provider may initiate a CIRP group, at least two different Provider must be in the group upon full formation (See Rule 19).[8]

When the Providers' representative submitted the ***final*** SOP in Case No. 09-0748GC on July 11, 2013, the CIRP group was deemed *fully formed*. Based on the arguments Blumberg Ribner has made in its request for rescission and bifurcation of Case No. 09-0748GC, the group was deemed fully formed with two issues pending: the dual eligible Part A and Part C days issues. However, by letter dated August 14, 2023, the Board denied that request because Blumberg Ribner abandoned the Part C issue and because the Board found that that issue was not part of that group in the first instance.

Upon review, the Board finds that the Medicare/Medicaid Dual Eligible Patient Days issue was ***required*** to be pursued in the CIRP Group Case No. 09-0748GC in accordance with 42 C.F.R. § 405.1837(b) (2009) and Board Rule 12.5(B) (2008). As the Provider was required to be a participant in 09-0748GC for the dual eligible Part A days issue, the Board rescinds the remand and dismisses the Dual Eligible days issue from this case because it was required to be part of 09-0748GC. That said, the Board denies bifurcation of Part C days issue for the reasons stated above.

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[7] Emphasis added.
[8] PRRB Rule 12.5(B) (PRRB Rules Version 1.0, Aug. 2008).

In summary, the Board rescinds the August 3, 2015 remand issued in Case No. 07-1391, dismissed the dual eligible days issue as it was required to be part of Case No. 09-0748GC, and ***denies*** the Provider's request to bifurcate the Part C days issue in this individual appeal. Case No. 07-1391 remains closed.

Board Members Participating:

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

For the Board:

12/22/2023

X Clayton J. Nix

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Request for Reconsideration***
08-2559GC Novant 1998 DSH Medicaid Eligible Days Group
08-2570GC Novant 2000 DSH Medicaid Eligible Days Group
08-2581GC Novant 2005-2006 DSH Medicaid Eligible Days Group

Dear Mr. Ravindran,

The Provider Reimbursement Review Board ("Board") has reviewed the Motion for Reinstatement filed on August 30, 2023, by Quality Reimbursement Services ("QRS" or "Representative") on behalf of three Common Issue Related Party ("CIRP") Groups, ("Novant" or "the Groups"), regarding the above-captioned cases. The decision of the Board is set forth below.

Pertinent Facts

On August 11, 2008, QRS established these cases by filing a request for hearing for the three above-referenced group appeals.

All three groups included the same issue statement:

Identification of the Issue

Whether Cahaba Safeguard Administrators ("Intermediary") included all Medicaid eligible days in the Provider's DSH calculations.

Statement of the Issue

The Providers contend that the Intermediary did not determine Medicare reimbursement for DSH in accordance with the statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II). Specifically, the Providers disagree with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 C.F.R. 412.106(b)(4) of the Secretary's regulations. The Intermediary, contrary to the regulation, failed to include as

> Medicaid eligible days services to all patients eligible for Medicaid.

A. Additional Background for Case No. 08-2570GC

On February 23, 2011, the Providers' representative, Quality Reimbursement Services ("QRS") filed the coversheet for the Providers' ***first*** preliminary position paper in compliance with the Board Rules then in effect.[1] QRS filed a ***final*** position paper on **July 26, 2011**. This final position paper generically discussed Medicaid eligible days and did not specifically identify the adolescent psychiatric days as an issue in the group. The Medicare Contractor did not file a preliminary position paper or final position paper at this time as the mediation was approved on **October 14, 2011**.

On October 13, 2015, QRS filed the group's ***second*** final position paper. On **November 23, 2015**, the Medicare Contractor filed its ***first*** final position paper for the group.

QRS initially requested an accelerated hearing, but then requested several different postponements of the hearing date on **January 27, 2016**, **May 11, 2016**, **July 29, 2016**,[2] and **November 28, 2016**, with a revised request filed on **November 30, 2016**,[3] in which QRS indicating that the parties were working towards an Administrative Resolution ("AR") and that a hearing would *not* be necessary. The November 30, 2016 revised request added an explanation that was not in the prior postponement requests:

> 7. Additionally, the parties have stipulated the issue of whether the days for inpatient stays in the adolescent psychiatric unit should be counted and included in the DSH calculation be held in abeyance pending the board ruling in Case No. 06-1851 and 06-1852.

The stipulations were submitted to the Board on August 8, 2016, and are the first time in the record of this case identified the Adolescent Psychiatric Days are mentioned. Notably, the stipulations are ***only for one of the Providers in the group***:

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[1] Prior to the Board Rule changes on August 29, 2018, parties only filed the first page of their preliminary position paper with the Board, but exchanged the full or complete position with the opposing party. The Board Rules in effect (Mar. 1, 2013) at the time of the preliminary position paper filings specified the preliminary position paper was to be fully developed and include all exhibits. *See, e.g.*, Commentary to Board Rule 23.3 (Mar. 1, 2013) ("the Board expects preliminary position papers to be fully developed and include all available documentation necessary to give the parties a thorough understanding of their opponent's position."); Commentary to Board Rule 25 (Mar. 1, 2013) ("preliminary position papers now are expected to present fully developed positions of the parties and, therefore, require analysis well in advance of the filing deadline."); Board Rule 25.2 (Mar. 1, 2013) ("With preliminary position papers, the parties must exchange all available documentation . . . . 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.").

[2] QRS identifies this appeal as the ***Second*** Postponement Request, however based on the Board's records this is the group's ***third*** postponement request.

[3] QRS refers to these as the ***third*** and revised ***third*** postponement requests, however based on the Board's records they are the ***fourth*** postponement requests.

> Pursuant to Rule 35.1 of the [PRRB] Rules, the Provider Presbyterian Hospital, Provider no. 34-0053 ("Presbyterian") and the [MAC], and Federal Specialized Services (the "ASC") hereby stipulate as follows:
>
> 1. Presbyterian is a certified acute care provider located in Charlotte, NC.
> 2. The Provider appealed whether the MAC included all eligible Medicaid Eligible days, regardless of whether such days were paid days, in the numerator of the Medicaid fraction of the DSH calculation.
> 3. The Provider contends that any day for inpatient stay that occurred in the adolescent psychiatric unit should be counted and included in the DSH calculation.
> 4. The MAC contends that any inpatient days that occurred in the adolescent Psychiatric unit should not be counted or included in the DSH calculations. . .
> 6. The same issue of whether the days for inpatient stays in the adolescent psychiatric unit should be included in the DSH calculation was heard by the PRRB in a live hearing involving the same parties…
> 8. For the sake of economy and efficiency, the parties stipulate that the issue of whether the days for inpatient stays in the adolescent psychiatric unit should be counted and included in the DSH calculation in the instant case be held in abeyance pending the board ruling in Case Numbers 06-1851 and 06-1852.

On March 17, 2017, QRS submitted a partial Administrative Resolution ("AR") for the Medicaid eligible days issue. The AR also states, "Please note, the issue of *Days for Inpatient Stays that Occurred in the Adolescent Psychiatric Unit* remains in abeyance pending the final outcome in The Matter of: Novant Presbyterian Hospital vs. Palmetto Government Benefits Administrators, LLC and Blue Cross Blue Shield, in Case Numbers 06-1851 and 06-1852."[4]

On November 11, 2017, the Board issued a decision in Case Nos. 06-1851 and 06-1852 denying jurisdiction over the adolescent psychiatric days based on a finding that they were unclaimed costs.

[4] Emphasis in original.

B. Additional Information in Case No. 08-2559GC

On April 29, 2013, QRS filed the coversheet for the Providers' preliminary position paper in compliance with the Board Rules then in effect.[5] Similarly, the Medicare Contractor filed its preliminary position paper on **August 23, 2013**.

On September 16, 2015, QRS filed the group's ***first*** final position paper. On **November 23, 2015**, the Medicare Contractor filed its ***first*** final position paper for the group.

The Medicare Contractor filed a jurisdictional challenge over the Medicaid eligible days issue on **January 19, 2016**, to which the Provider responded on **February 12, 2016**.

The case was initially scheduled for hearing on January 19, 2016, however QRS requested several different postponements of the hearing date on **January 21, 2016**, **May 10, 2016**, **July 7, 2016**,[6] and **October 13, 2016**, in which the parties indicated that they were working towards an AR and that a hearing would not be necessary. The October 13, 2016 request added an explanation that was not in the prior postponement requests:

> 4. Parties submitted stipulations that the above referenced case should be governed by the Board's forthcoming decision on the merits in PRRB Case Nos. 06-0851 and 06-0852 (FYEs 12/31/01 and 12/31/02, respectively), involving the same provider and the same issue. . .
>
> 6. Providers hereby request a postponement of the adolescent psych days remaining case number 08-2259GC [*sic*] pending the final outcome in PRRB Cases 06-0851 and 06-0852.

On October 14, 2016, QRS submitted a partial AR for the Medicaid eligible days issue for both Providers in the group. For Presbyterian Hospital (34-0053, FYE 12/31/1998), only, the AR states, "The unresolved issue is with regard to the adolescent psychiatric days. The parties agree that the DSH sub-issue should be held in abeyance and governed by the forthcoming decision in Novant Presbyterian FYEs 12/31/2001 and 12/31/2002, PRRB Case Nos. 06-1851 and 06-1852."

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[5] Prior to the Board Rule changes on August 29, 2018, parties only filed the first page of their preliminary position paper with the Board, but exchanged the full or complete position with the opposing party. The Board Rules in effect (Mar. 1, 2013) at the time of the preliminary position paper filings specified the preliminary position paper was to be fully developed and include all exhibits. *See, e.g.*, Commentary to Board Rule 23.3 (Mar. 1, 2013) ("the Board expects preliminary position papers to be fully developed and include all available documentation necessary to give the parties a thorough understanding of their opponent's position."); Commentary to Board Rule 25 (Mar. 1, 2013) ("preliminary position papers now are expected to present fully developed positions of the parties and, therefore, require analysis well in advance of the filing deadline."); Board Rule 25.2 (Mar. 1, 2013) ("With preliminary position papers, the parties must exchange all available documentation . . . . 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.").

[6] QRS identifies this appeal as the ***Second*** Postponement Request, however based on the Board's records this is the group's ***third*** postponement request.

On November 11, 2017, the Board issued a decision in Case Nos. 06-1851 and 06-1852 denying jurisdiction over the adolescent psychiatric days based on a finding that they were unclaimed costs.

C. Additional Information in Case No. 08-2581GC

On January 30, 2015, QRS filed the coversheet for the Providers' preliminary position paper in compliance with the Board Rules then in effect.[7] Similarly, the Medicare Contractor filed its preliminary position paper on **May 21, 2015**.

On August 25, 2015, QRS filed the group's ***first*** final position paper. On **September 10, 2015**, the Medicare Contractor filed its ***first*** final position paper for the group.

The Medicare Contractor filed a jurisdictional challenge over the Medicaid eligible days issue on **January 20, 2016**, to which the Provider responded on **February 19, 2016**.

The case was initially scheduled for hearing on December 1, 2015, and was then rescheduled to June 20, 2016 due to the jurisdictional challenge. QRS requested several different postponements of the hearing date on **June 15, 2016**, in which the parties indicated that they were working towards an AR and that a hearing would not be necessary. This postponement request did not mention adolescent psychiatric days as an issue in the appeal.

On October 14, 2016, QRS submitted a partial AR for the Medicaid eligible days issue for both Providers in the group. For Presbyterian Hospital (34-0053, FYE 12/31/1998), only, the AR states, "The unresolved issue is with regard to the adolescent psychiatric days. The parties agree that the DSH sub-issue should be held in abeyance and governed by the forthcoming decision in Novant Presbyterian FYEs 12/31/2001 and 12/31/2002, PRRB Case Nos. 06-1851 and 06-1852."

D. Subsequent Filings in Cases

On April 28, 2020, the Board issued a Notice of Hearing - Rescheduled that required the Providers' representative and the Medicare Contractor to file final position papers on October 23, 2020, and November 22, 2020 respectively. This Notice included the following instruction on

[7] Prior to the Board Rule changes on August 29, 2018, parties only filed the first page of their preliminary position paper with the Board, but exchanged the full or complete position with the opposing party. The Board Rules in effect (Mar. 1, 2013) at the time of the preliminary position paper filings specified the preliminary position paper was to be fully developed and include all exhibits. *See, e.g.*, Commentary to Board Rule 23.3 (Mar. 1, 2013) ("the Board expects preliminary position papers to be fully developed and include all available documentation necessary to give the parties a thorough understanding of their opponent's position."); Commentary to Board Rule 25 (Mar. 1, 2013) ("preliminary position papers now are expected to present fully developed positions of the parties and, therefore, require analysis well in advance of the filing deadline."); Board Rule 25.2 (Mar. 1, 2013) ("With preliminary position papers, the parties must exchange all available documentation . . . . 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.").

the content of the position paper filing consistent with Board Rule 25 as applicable by Board Rule 27.2 (2018):

> The text of the position papers ***must*** include the elements addressed in the following sub-sections.
>
> A. Identify any issues that were raised in the appeal but are already resolved . . .
> B. For each issue that has not been fully resolved, ***state the material facts*** *that support the provider's claim.*
> C. ***identify*** *the controlling authorit*y (e.g., statutes, regulations, policy, or case law) supporting the provider's position, [***and***]
> D. Provide a conclusion applying the material facts to the controlling authorities.[8]

On October 19, 2020, QRS timely filed its ***third***[9] final position paper in the groups. However, it generically discussed Medicaid eligible day without any reference or discussion of the Psychiatric Adolescent Unit or days associated with that Unit. It also *generically* promised that "Eligibility Listings… [are] being sent under separate cover." **On November 11, 2020**, the Medicare Contractor timely filed its ***second*** final position papers for all three groups.

On **November 19, 2020**, the Medicare Contractor submitted a jurisdictional challenge on the remaining issue of adolescent psychiatric unit days, contending that the Groups abandoned the sole remaining issue in the appeal, DSH Adolescent Psychiatric Unit Days, when it failed to brief this issue in its final position paper submitted on October 19, 2020. Specifically, the Groups effectively abandoned the sole remaining sub-issue in the appeal when it:

- Failed to state the material facts that support its claims that the MAC failed to include the disputed adolescent psychiatric days in the DSH calculation;
- Failed to identify or produce any documents explaining or demonstrating that those Medicaid eligible days should have been included; and
- Failed to reference the Partial Administrative Resolution and the fact that the appeal related to DSH Medicaid Eligible Days was partially resolved.

Board Rule 44.4.3 specifies that responses to a jurisdictional challenge be filed within 30 days of the Medicare contractor's jurisdictional challenge,[10] making the filing deadline to be Monday December 21, 2020.[11] However, QRS *failed* to timely file its response to the Jurisdictional

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[8] (Emphasis added.)
[9] This is the fourth final position paper in Case No. 08-2570GC.
[10] Board Rule 44.4.3 (Aug. 2018) states: "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."
[11] As the 30th day fell on Saturday, December 19, 2020, the filing deadline gets moved to the next business day. The next business day was Monday, December 21, 2020.

Challenge by the Monday December 21, 2020, deadline, as no response was filed at all for any of the instant cases.

On January 6, 2021, the Board issued its determination to dismiss Case Nos. 08-2559GC; 08-2570GC; and 08-2581GC. The following excerpt summarizes the basis for the dismissal:

> The Board finds that the Providers in the instant group appeals abandoned the sole remaining alleged "sub-issue" in their appeals, DSH Medicaid Eligible Days for the Adolescent Psychiatric Unit of Presbyterian Hospital, when they failed to brief the issue in their final position papers submitted on October 19, 2020. The regulation at 42 C.F.R. § 405.1853(b)(2), as well as Board Rules 25 and 27, make it clear that Final Position Papers must address ***each*** remaining issue in the appeal. As Board Rule 25.3 [states], "Parties should file a **complete** . . . position paper with a fully developed narrative . . . [and] all exhibits." As such, the Board concludes that the Group Representative abandoned any alleged "sub-issue" involving the Presbyterian adolescent psychiatric unit and dismisses it from the appeal. As no issues remain in the CIRP group appeals, the Board hereby dismisses them and removes them from the Board's docket.[12]

Providers' Motion for Reinstatement

On August 30, 2023, the Provider filed a Motion for Reinstatement, stating (in part):

> The Board takes the position that regulation 405.1832(b)(2), as added by the May 23, 2008 final rule (73 Fed. Reg. 30190), justifies dismissal of this appeal, but the Provider respectfully disagrees. As the Board notes, section 405.1832(b)(2) provides that
>
> > 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, and the merits of the provider's Medicare payment claims for each remaining issue.
>
> Both the June 25, 2004 proposed rule (69 Fed. Reg. 35716) and the 2008 final rule indicate that an "issue" is encapsulated by a specific cost report adjustment. They do not slice and dice an "issue" into component parts, including the specific reason why Medicaid eligible days were not counted -in the numerator of the Medicaid Fraction of the Disproportionate Payment Percentage. The text of 405.1811 and 405.1835, and the discussion of these

[12] (Footnotes omitted, italics emphasis and bold in original.)

sections in the proposed and final rules are clear that in order to add an "issue" or claim or self-disallow an issue, it is necessary only to identify the specific adjustment that would result in additional reimbursement.

Nor do the applicable Board Rules support the dismissal. The Providers' appeals were filed on:

Provider #	Provider Name	FYE	Appeal Date
34-0053	Presbyterian Hospital	12/31/1998	1/8/2003
34-0053	Presbyterian Hospital	12/31/2000	1/27/2005
34-0053	Presbyterian Hospital	12/31/2005	2/21/2008
34-0053	Presbyterian Hospital	12/31/2006	5/10/2010

and the Board's dismissal letter is dated January 6, 2021. Therefore, the applicable versions of the Board Rules governing the Provider's appeal and the filing of its Final Position Paper are the July 1, 2015 and the August 29, 2018 versions. As of the August 29, 2018 version of the Board's Rules, the requirements for a final position paper were considerably less detailed than what the Board asserts was necessary in its dismissal letter. See Board Rule 27.2 of the 2015 version. In its dismissal letter, the Board cites Board Rule 25, governing *preliminary* position papers. However, it is clear from the 2018 version of the Board rules, that the detail required under Rule 25 for preliminary position papers and incorporated into final position papers is applicable only for appeals filed *after* the effective date of the 2018 version. The 2018 version of the Board Rules states that the heightened requirements for preliminary position papers is "a change in previous Board practice." *See* Commentary to Board Rule 25.3 (2018). The 2018 version of the Board Rules then states, at Rule 27.1 that:

> For new appeals filed on or after the effective date of the rules, the parties will have exchanged, and the Board will have received a copy of, a full preliminary position paper setting forth the arguments and legal authorities for each issue in the appeal. Therefore, for appeals filed after the effective date of the rules, the final position paper is an optional filing, intended to hone the issue if necessary, but is not required. If no paper is submitted, the arguments related to the issues under appeal will be limited to those set forth in the

> preliminary position paper.
>
> For appeals filed prior to the effective date of the rules, the final position paper remains a required filing, and failure to timely file the final position papers may result in dismissal of the case, or any of the actions under 42 C.F.R. § 405.1868.

The above-quoted language is clear that, because final position papers would now be optional, appeals filed *after* the effective date of the 2018 version of the Board Rules should comply with the *new* requirements for preliminary position papers, but for appeals filed *prior to* the effective date of the 2018 version of the Board Rules, the *existing rules* for final position papers (which state that only failure to timely file the final position paper is grounds for dismissal) remain in effect. Moreover, the 2015 and 2018 versions of the Board Rules state what a provider should do with respect to the content of the final and preliminary position papers, not what they *must* do. In *Harris County Hospital v. Shalala*, 863 F. Supp. 404 (S.D. Tex. 1994), the court found that the Provider Reimbursement Manual's use of "should" was suggestive and not a requirement. The same applies here.

Finally, even if there were legitimate grounds for dismissing the Provider's appeal, it was arbitrary and capricious and an abuse of discretion for the Board to do so. As stated above, the MAC was aware of the controversy surrounding the adolescent psych days, understood what the Provider's position was concerning such days (among other things, it knew that Provider's position was fully explicated in the previous appeals of 08-651 and 08-652), and there was no prejudice to the MAC if the appeal was not dismissed. Instead, the Board's dismissal was simply borne out of a desire to reduce its pending case backlog.

MAC Opposition to Provider's Motion for Reinstatement

On September 13, 2023, the MAC filed an Opposition to Provider's Motion for Reinstatement stating (in part):

> The QRS Motion fails to mention that the MAC's November 19, 2020 jurisdictional challenges contend that the providers abandoned the adolescent psychiatric days sub-issue by failing to brief the issue in the October 19, 2020 Final Position Papers. Specifically, the MAC's jurisdictional challenges asserted that the providers' Final Position Papers failed to meet the applicable

> regulatory and Board Rules. Of note, the Providers did not submit jurisdictional responsive briefs.
>
> It is clear that the providers failed to properly brief the issue in the Final Position Papers. Instead, the providers allege that there was no intent to abandon this sub-issue, and claims that the MAC was aware of the sub-issue. However, any argument that MAC had prior knowledge of the sub-issue totally misses the point and is irrelevant. The providers' obligation to properly brief this sub-issue and provide supporting documentation is an independent obligation under 42 C.F.R. § 405.1853(b)(2), as well as Board Rules 25 and 27. No amount of knowledge, whether actual or imputed, on the part of the MAC, excuses or waives the providers obligations under the regulations and the Board Rules. In addition, the MAC does not have the authority to excuse or waive the providers' obligations under the regulations and the Board Rules.
>
> …
>
> Board Rule 47 addresses reinstatement. While the Rule allows a motion for reinstatement up to three years from the date of Board dismissal, the request must set out the reasons in support of reinstatement. Further, the Rule continues, stating that the "Board will not reinstate an issue(s)/case if the provider was at fault."
>
> The QRS Motion attempts to deflect the requirements of Board Rules 25 and 27. Regardless of whether Version 2.0 or Version 3.1 of Board Rules apply, Rule 27 sets out the minimum requirements for the final position paper narrative and are the same as those outlined at Rule 25. The QRS Motion clearly fails to support reinstatement by demonstrating compliance with the applicable regulation and Board Rules. Further, the dismissal was based on the fault of the providers.

Statutory and Regulatory Background

The regulations governing position papers can be found at 42 C.F.R. § 405.1853(b)(2)-(3):

> (b) *Position papers*. . . .
>
> (2) The Board has the discretion to extend the deadline for submitting a position paper. *Each position paper* ***must*** *set forth the relevant facts* ***and*** *arguments* ***regarding the Board's jurisdiction*** *over* ***each*** *remaining matter at issue in the appeal* (as described in

> § 405.1840 of this subpart), ***and the merits*** *of the provider's Medicare payment claims for* ***each*** *remaining issue*.
>
> (3) In the absence of a Board order or general instructions to the contrary, ***any*** *supporting exhibits* ***regarding Board jurisdiction must*** *accompany the position paper*. Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board through a schedule applicable to a specific case or through general instructions.[13]

These position paper requirements are consistent with its "burden of production of evidence and burden of proof" that 42 C.F.R. § 405.1871(a)(3) places on providers pursuing appeals before the Board:

> (3) The [Board] decision must include findings of fact and conclusions of law regarding the Board's jurisdiction over each specific matter at issue (see § 405.1840(c)(1)), and *whether the* ***provider*** *carried its* ***burden of production of evidence and burden of proof*** *by establishing, by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue*.[14]

Failure to comply with the Board's briefing requirements for a Final Position Paper can be found at 42 C.F.R. § 405.1868(a)-(b):

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

[13] (All emphasis added except for the title of subsection (b) "*Position papers*").
[14] (Emphasis added.)

When QRS filed the Provider ***first*** final position papers in August through October of 2015, the relevant portions of Board Rules 25 and 27 (2015) set forth the following position paper requirements and notably the instructions for preliminary position papers are applicable to final position papers since final position papers are a "refinement" of the preliminary position paper:

Rule 25 – Preliminary Position Papers

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

25.1 – Content: The text of the Preliminary Position Papers must include the following:

A. Provider's Preliminary Position Paper

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

2. Identify the controlling authority (e.g., statutes, regulations, policy, or case law) supporting your position.

3. Provide a conclusion applying the material facts to the controlling authorities.

****

C. Provider Response to Intermediary Preliminary Position Paper

1. Address rebuttal or Intermediary arguments not previously addressed.

2. Attach documentation not previously furnished with the Provider's preliminary position paper that is responsive to arguments raised by the Intermediary in its responsive preliminary position paper.

25.2 – Preliminary Documents:

A. General: With the preliminary position papers, the parties must exchange *all available* documentation as preliminary exhibits to

fully support your position. The Intermediary must also give the Provider all evidence the Intermediary considered in making the determination (see 42 C.F.R. § 405.1853(a)(3)) and identify any documentary evidence that the Intermediary believes is necessary for resolution which has not been submitted by the Provider.

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

C. Preliminary Documentation List: Parties must attach a list of the exhibits exchanged with the preliminary position paper.

****

27.1 – General

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

27.2 – Content

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

a. Identification of each issue and its reimbursement impact.
b. Procedural history of the dispute.
c. A statement of facts that:

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

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

27.3 – Revised or Supplemental Final Position Papers

Except on written agreement of the parties, revised or supplemental position papers should not present new positions, arguments or evidence. However, the Board encourages revised or supplemental final position papers which, for administrative efficiency, further **narrow** the parties' positions or provide legal development (such as new case law) that has occurred since the final position paper was filed. Prior to filing such papers, the parties should contact each other

> to discuss the anticipated substance of such papers and anticipated objections. If a revised or supplemental position paper is filed to further refine or narrow the issues, the opposing party may file a rebuttal or reserve such rebuttal for hearing.
>
> **27.4 – Arguments Expanding the Scope of Final Position Papers**
>
> If at hearing or through a revised position paper, a party presents an argument or evidence expanding the scope of the position papers, the Board may, upon objection, exclude such arguments or evidence from consideration.[15]

When QRS filed the Provider's ***second*** final position paper on October 19, 2020 (for all three cases), the relevant portions of Board Rules 25 and 27 (Aug. 2018) set forth the following final position paper requirements:

> **Rule 25 Preliminary Position Papers**
>
> ****
>
> **25.1 Content of Position Paper Narrative**
>
> The text of the position papers must contain the elements addressed in the following sub-sections.
>
> **25.1.1 Provider's Position Paper**
>
> A. Identify any issues that were raised in the appeal but are already resolved (whether by administrative resolution, agreement to reopen, transfer, withdrawal, dismissal, etc.) and require no further documentation to be submitted.
>
> B. For ***each*** issue that has not been fully resolved, state the material facts the support the provider's claim.
>
> C. Identify the controlling authority (e.g., statutes, regulations, policy, or case law) supporting the provider's position.
>
> D. Provide a conclusion applying the material facts to the controlling authorities.
>
> ****
>
> **25.2 Position Paper Exhibits**
>
> **25.2.1 General**

[15] Board Rules effective July 1, 2015 (underline and italics emphasis added).

With the position papers, the parties must exchange ***all*** available documentation as exhibits to fully support your position. . . .

25.2.2 Unavailable and Omitted Documents

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

****

25.3 – Filing Requirements to Board

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

****

Rule 27 Final Position Papers

27.1 General

The Board will set due dates for the final position papers in its Notice of Hearing, generally 90 days before the scheduled hearing date for the provider; 60 days for the Medicare contractor; and 30 days for provider response (optional).

27.2 Content

The final position paper should address each issue remaining issue. The *minimum* requirements for the position paper narrative and exhibits are the same as those outlined for preliminary position papers at Rule 25.

27.3 Revised or Supplemental Final Position Papers

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

> revised or supplemental position paper is filed to further refine or narrow the issues, the opposing party may file a rebuttal or reserve such rebuttal for hearing.
>
> **27.4 Expanding Scope of Arguments at the Hearing or in Revised or Supplemental Final Position Papers Is Prohibited**
>
> If at hearing or through a revised or supplemental position paper, a party presents an argument or evidence *expanding* the scope of the position papers, the Board may, upon objection or its own motion, exclude such arguments or evidence from consideration.[16]

Board Rule 41.2 outlines the circumstances in which the Board may dismiss a case:

> **41.2 Own Motion**
>
> The Board may dismiss a case or an issue on its own motion:
>
> - *if it has a reasonable basis to believe that the issues have been* fully settled or *abandoned*;
> - *upon failure of the provider* or group *to comply with Board procedures* (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.[17]

Board's Decision

As set forth below, the Board declines to exercise its authority to reconsider its dismissal and/or reinstate this case. The Board maintains its position outlined in the January 6, 2021, decision that the Groups failed to brief the Adolescent Psychiatric Unit days issue in compliance with 42 C.F.R. § 405.1853(a)-(b) Board Rule 25 (via Board Rule 27.2) in the Groups' Final Position Papers filed on October 19, 2020. The Groups' arguments are meritless, and its request failed to include any new arguments or information that would change the Board's decision that the issue was not briefed.

Furthermore, the Board finds that the Provider misconstrues 42 C.F.R. § 405.1853(b)(2)-(3) and the Board Rules for position papers, which *did require* the Provider to specifically brief each open issue, including the Adolescent Psychiatric Unit days issue (including the merits and jurisdiction) *both* in its ***first*** Final Position Papers filed in August through October of 2015 *and* in its ***second*** final position paper filed *5 years later* in October 2020. The Provider's final position paper filings did not identify the Adolescent Psychiatric Unit days issue, did not identify the reimbursement

[16] (Underline emphasis added and italics and bold emphasis in original.)
[17] (Italics and underline emphasis added and bold emphasis in original.)

impact, did not give a procedural history or statement of the facts, and did not cite to any authorities for the Adolescent Psychiatric Unit days issue.[18]

As explained at 42 C.F.R. § 405.1871(a)(3), it is the Provider's "burden of production of evidence and burden of proof . . . [to] establish[], by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue." Similarly, 42 C.F.R. § 412.106(b)(4)(iv) specifies: "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."[19] Finally, 42 C.F.R. § 405.1871(a)(3) confirms that the Provider has the "burden of production of evidence and burden of proof by establishing, by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue." Accordingly, in the Board's January 6, 2021 dismissal determination, the Board concluded:

> The Board finds that the Providers in the instant group appeals abandoned the sole remaining alleged "sub-issue" in their appeals, DSH Medicaid Eligible Days for the Adolescent Psychiatric Unit of Presbyterian Hospital, when they failed to brief the issue in their final position papers submitted on October 19, 2020. The regulation at 42 C.F.R. § 405.1853(b)(2), as well as Board Rules 25 and 27, make it clear that Final Position Papers must address ***each*** remaining issue in the appeal. As Board Rule 25.3 [states], "Parties should file a **complete** . . . position paper with a fully developed narrative . . . [and] all exhibits." As such, the Board concludes that the Group Representative abandoned any alleged "sub-issue" involving the Presbyterian adolescent psychiatric unit and dismisses it from the appeal. As no issues remain in the CIRP group appeals, the Board hereby dismisses them and removes them from the Board's docket.[20]

Finally, the Board reaffirms its decision that, *even if the Provider had properly and timely briefed the adolescent psychiatric days issue*, the Board would lack still lack jurisdiction over the issue as explained in its January 6, 2021, determination. In this regard, the Board notes that the

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[18] QRS filed the Groups' ***first*** final position papers on **August 25, 2015** (CN. 08-2581GC), **September 16, 2015** (CN. 08-2559GC), **and October 13, 2015** (CN. 08-2570GC) (before the Board issued its jurisdictional dismissal determination in all three cases ***and*** the Provider's ***second*** final position paper on ***October 19, 2020***. However, both position paper filings are perfunctory and virtually identical. Significantly, neither position paper filing discusses or mentions the unique issues associated with the Adolescent Psychiatric Unit days issue both in terms of the jurisdiction and merits as laid out in the Board's January 6, 2021, dismissal determination for all three cases.

[19] *See also* HCFA Ruling 97-2 (Feb. 1997) (stating: "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 cannot be verified by State records to have fallen within a period wherein the patient was eligible for Medicaid cannot be counted.").

[20] (Footnotes omitted, italics emphasis and bold in original.)

Provider *failed* to timely brief its opposition to the Medicare Contractor's jurisdictional challenge but rather filed no response at all.

*****

In summary, the Board declines to exercise its discretion to reopen Case Nos. 08-2559GC, 08-2581GC, and 08-2570GC, and its decision to dismiss this case pursuant to Board Rule 47.1-47.3 and 42 C.F.R. § 405.1885. Accordingly, the Board denies the Provider's request for reinstatement, the Board's January 6, 2021, dismissal determination remains in effect/unchanged, and Case Nos. 08-2559GC, 08-2581GC, and 08-2570GC remain closed.

Board Members Participating:

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

For the Board:

12/22/2023

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)

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

Isaac Blumberg
Chief Operating Officer
Blumberg Ribner, Inc.
11400 W. Olympic Blvd. Suite 700
Los Angeles, CA 90064

RE: ***Board Decision to Dismiss 3 Participants***
Sutter Health 1995-1997 DSH Dual Eligible Days CIRP Group
Case No. 16-0446GC
Participants Dismissed:
Sutter Memorial Hospital (Prov. No. 05-0108, 12/31/1996);
Sutter Roseville Community Hospital (Prov. No. 05-0309, 12/31/1997); and
Sutter Medical Center of Santa Rosa (Prov. No. 05-0291, 06/30/1997)

Dear Mr. Blumberg,

The Provider Reimbursement Review Board ("Board") has reviewed the documents in the above referenced common issue related party ("CIRP") group appeal and finds that it does not have jurisdiction over the DSH Dual Eligible Days issue for 2 of the participants (Sutter Memorial Hospital and Sutter Roseville Community Hospital) because the issue was not specifically revised in the *Revised* Notice of Program Reimbursement ("RNPR"), which is the basis for their appeals. Further, the Board dismisses another participant (Medical Center of Santa Rosa) because the participant failed to *timely* file its original request for hearing. The decision of the Board is set forth below.

Pertinent Facts:

This group appeal was created as the result of a bifurcation of the dual eligible Part A and dual eligible Part C days issues in Case No. 08-2624GC, Sutter Health 1998 DSH Dual Eligible Days CIRP Group. In a letter dated August 6, 2010 (received by the Board on August 11, 2010), Blumberg Ribner, Inc., requested that the Board transfer 8 providers into Case No. 08-2624GC. After reviewing the transfer requests and the documents in Case No. 08-2624GC, the Board granted bifurcation, established Case No. 16-0446GC, and transferred those 8 Providers to this group instead, all of which remain pending in the appeal.

On May 22, 2023, Blumberg Ribner confirmed that the CIRP group was complete. Further, on June 5, 2023, Blumberg Ribner requested that the Board remand the group pursuant to CMS Ruling 1498-R.

A. Sutter Memorial Hospital (Prov. No. 05-0108 12/31/1996)

Sutter Memorial Hospital's revised Notice of Program Reimbursement ("RNPR") was issued on March 14, 2003, and indicated that a Notice of Reopening had been issued: "To reflect Disproportionate Share Adjustment & Medi-Cal Eligible Days." The Provider's audit adjustment report included an adjustment to DSH as well as an adjustment to HMO XIX days, "To adjust Medi-Cal days in wkst. S-3 line 1 and 2 per audit findings." In other words, the Medicare Contractor reopened to adjust Medicaid fraction to include additional Medicaid eligible days. There is no indication that there was any adjustment of dual eligible days.

B. Sutter Roseville Community Hospital (Prov. No. 05-0309, FYE 12/31/1997)

Sutter Roseville's RNPR was issued on April 11, 2003, and indicated that a Notice of Reopening had been issued, "To reflect Disproportionate Share Adjustment & Medi-Cal Eligible Days." The Provider's audit adjustment report included am adjustment to DSH as well as an adjustment that says, "Propose to adjust title XIX days on wkst. S-3, line 1, Col. 5, based on the reopening audit determination." In other words, the Medicare Contractor reopened to adjust Medicaid fraction to include additional Medicaid eligible days. There is no indication that there was any adjustment of dual eligible days.

C. Sutter Medical Center of Santa Rose (05-0291, 6/30/1997)

Sutter Medical Center of Santa Rosa, was issued its Notice of Program Reimbursement on December 2, 1999, however the Board did not receive the Provider's appeal request until 347 days later on November 13, 2000.

Board Decision:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2001), 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. Revised Notice of Program Reimbursement

The Code of Federal Regulations provides for an opportunity for a reopening and RNPR at 42 C.F.R. § 405.1885 (2003), which provides in relevant part:

> (a) A determination of an intermediary . . . may be reopened with respect to finds on matters at issue in such determination or decision, by such intermediary officer . . . on the motion of the provider affected by such determination or decision to revise any matter in issue at any such proceedings.

Additionally, 42 C.F.R. § 405.1889 (2003) explains the effect of a cost report revision:

> Where a revision is made in a determination or decision on the amount of program reimbursement after such determination or decision has been reopened as provided in § 405.1885, such revision shall be considered a separate and distinct determination or decision to which the provisions of §§ 405.1811, 405.1835, 405.1875 and 405.877 are applicable.[1]

In *HCA Health Services of Oklahoma v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994), the court held that when a fiscal intermediary reopens its original determination regarding the amount of reimbursement that a Medicare provider is to receive and a provider appeals this decision, the Board's jurisdiction is limited to the specific issues revisited on reopening and does not extend further to all determinations underlying the original NPR.

As discussed above, Sutter Memorial Hospital (FYE 12/31/1996) and Sutter Roseville Community Hospital (12/31/1997) both appealed from RNPRs that adjusted Medi-Cal Days included in the Medicaid fraction of the DSH adjustment calculation, however there were no adjustments to the issue in the group appeal (i.e., no adjustment for dual eligible days) or even to the SSI fraction in general which is where the Medicare program requires that they be counted for purposes of the DSH adjustment calculation. Based on the foregoing, the Board finds that it lacks jurisdiction over these participants because the issue under appeal is not one of the issues specifically revised in their RNPRs. As a result, the Board dismisses these Providers from the appeal

B. Untimely Appeal

Under 42 C.F.R. § 405.1835(a) (2001), a provider has a right to a Board hearing for specific items claimed for a cost reporting period covered by a final contractor or Secretary determination as long as the provider meets certain jurisdictional requirements. One of the requirements is that the Board must receive the provider's appeal within 180 days of the date of receipt of the provider's final determination.[2] With respect to the provider, the applicable regulation defines the phrase "date of receipt" as the date on the return receipt of "return receipt requested" mail. More specifically, the regulatory definition states that the date of receipt of documents in proceedings before a reviewing entity (such as the Board) is presumed to be 5 days after the date of issuance of a contractor notice or a reviewing entity notice.[3]

As noted prior, the MAC issued Sutter Medical Center of Santa Rose's (05-0291, 6/30/1997) NPR on December 2, 1999. The Board received Sutter Medical Center of Santa Rosa's appeal request on November 13, 2000, 347 days after the date of issuance of the NPR. Accordingly, as the Board received appeal request after the applicable 180-day time limit, the Board must deny

[1] 42 C.F.R. § 405.1889 (2001).
[2] 42 C.F.R. § 405.1841(a)(1) (2001).
[3] 42 C.F.R. § 405.1801(a) (2001).

jurisdiction over the Provider as having filed its RFH untimely. As such, the Board dismisses the Provider from the appeal.

Conclusion:

The Board finds that it does not have jurisdiction over Sutter Memorial Hospital (Prov. No. 05-0108 12/31/1996) and Sutter Roseville Community Hospital (Prov. No. 05-0309, FYE 12/31/1997), as they are appealing from RNPRs that did not specifically revise the issue under appeal and hereby dismisses the Providers from the appeal. In making this ruling, the Board notes that its application of 42 C.F.R. § 405.1889 has been upheld by courts on review.[4]

The Board finds that it does not have jurisdiction over *Sutter Medical Center of Santa Rose's appeal (05-0291, 6/30/1997)* because it did not timely file its appeal, and hereby dismisses the Provider from the appeal.

Case No. 16-0446GC remains open for the remaining providers included in the group appeal, and will be remanded pursuant to CMS Ruling 1498-R under separate cover.

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

Board Members Participating:

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

For the Board:

12/22/2023

X Clayton J. Nix

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

cc: Wilson C. Leong, Esq., Federal Specialized Services
Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E)

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Board Decision and Scheduling Order***
Heartland Regional Medical Center (Prov. No. 14-0184, FYE 04/30/2015)
Case No. 17-1710

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the documentation in Case No. 17-1710 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. 17-1710*

On **January 17, 2017,** the Medicare Contractor issued a Notice of Program Reimbursement ("NPR") to the Provider for fiscal year end April 30, 2015 ("FY 2015").

On **June 9, 2017**, the Provider's filed its individual appeal request appealing the NPR for FY 2015. The initial Individual Appeal Request contained four (4) issues:

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

As the Provider is commonly owned by Quorum Health ("Quorum"), the Provider transferred issues 3 and 4 to common issue related party ("CIRP") group appeals for Quorum. As a result of these transfers, two issues remain pending in the appeal: Issue 1 – SSI (Provider Specific), Issue 2 – Medicaid Eligible Days.

On **February 27, 2018**, the Provider filed its preliminary position paper.

[1] On February 26, 2018, this issue was transferred to PRRB Case No. 18-0594GC.
[2] On February 26, 2018, this issue was transferred to PRRB Case No. 18-0595GC.

On **April 6, 2018**, the Medicare Contractor filed a Jurisdictional Challenge requesting dismissal of Issue 1. On **May 4, 2018**, the Provider timely filed its response.

On **January 9, 2023**, the Medicare Contractor filed its Final Request for DSH Package requesting the Provider to submit a listing of Medicaid eligible days at issue by February 8, 2023. The Medicare Contractor noted that "[w]e reached out multiple times from January 2019 through December 2021" but "[n]o DHS package was ever submitted." The Provider did not file a response by February 8, 2023 notwithstanding the instruction in 42 C.F.R. § 405.1853(e)(5)(i) that "[e]ach party is required to make a good faith effort to resolve or narrow any discovery dispute, regardless of whether the dispute is with another party or a nonparty."

As the Provider failed to respond, on **February 23, 2023**, the Medicare Contractor filed a Motion to Dismiss Issue 2. The Provider did not file any response to the Motion to Dismiss within the 30 days allotted under Board Rule 44.3.

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

On **December 8, 2023**, QRS filed the Provider's final position paper and it included as Exhibit P-1 a listing of "Additional ME Days" with the caveat that the "Listing is pending finalization upon receipt of State eligibility data." The position paper mentions for the first time a new issue of 1115 waiver days but no such days are specifically identified or called out in Exhibit P-1. Significantly, QRS does not explain why the list was not "final[]" at this late date (almost 7 years after this appeal was filed), much less why it was not filed sooner. Similarly, QRS makes no mention of the prior request filed by the Medicare Contractor or the Medicare Contractor's Motion to Dismiss.

On **December 20, 2023**, the Medicare Contractor filed its final position paper.

B. Description of Issue 1 – DSH Payment – SSI Percentage (Provider Specific)

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]

[3] Issue Statement at 1 (June 9, 2017).

On February 27, 2018, 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 (April 30).
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.
>
> Similar to *Loma Linda Community Hospital v. Dept of Health and Human Services*, No. CV-94-0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from 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).[4]

MAC's Contentions

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

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

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

[4] Provider's Preliminary Position Paper at 8-9 (Feb. 27, 2018).

> . . .
>
> In this situation, the MAC did not, and cannot, make a determination in terms of the provider's SSI percentage realignment. The only party that can make the election regarding the fiscal year end for the SSI percentage is the Provider. Since there is no MAC determination for the Provider to contest, only the Provider's own election, the PRRB does not have jurisdiction over this issue, pursuant to 42 C.F.R. § 405.1803. Keep in mind, the Provider has had more than enough opportunity between filing its cost report and filing a hearing request to formalize a request to CMS for such election. The fact that the Provider did not seek this administrative remedy does not make the SSI realignment an appealable issue.[5]

Issue 3 – DSH Payment – Medicaid Eligible Days

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

> a. That the Provider has failed to furnish documentation in supports 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, 27.2, 25.2.1 and 25.2.2.
> d. That the Provider has effectively abandoned its claim for additional Medicaid Eligible Days. . .[6]

Provider's Jurisdictional Response

Issue 1 – DSH SSI Percentage (Provider Specific)

The Provider contends the Provider Specific issue is appealable "because the MAC specifically adjusted the Providers SSI percentage and the Provider is dissatisfied with the amount of DSH payments that it received for fiscal year 2015 resulting from its understated SSI percentage."[7]

Issue 5 – Medicaid Eligible Days

The Provider did not file a response to the MAC's Motion to Dismiss and the time to do so has passed.

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[5] Jurisdictional Challenge at 3 (Apr. 6, 2018).
[6] Motion to Dismiss at 6 (Feb. 23, 2023).
[7] Jurisdictional Response at 1 (May 4, 2018).

Board Analysis and Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2014), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

A. DSH Payment – SSI Percentage (Provider Specific)

The jurisdictional analysis for Issue 1 has two relevant aspects to consider: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, and 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

1. First Aspect of Issue 1

The Board's review of 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—found that it is duplicative of the DSH SSI Percentage (Systemic Errors) issue filed by commonly owned entities in PRRB Case No. 18-1333GC, *QRS Quorum 2015 DSH SSI Percentage CIRP Group*. The DSH Payment – SSI Percentage (Provider Specific) issue in the present appeal is described as follows:

> [T]he MAC did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. §1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations.[8]

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.[9]

In the SSI percentage issue in group Case No. 18-1333GC, which currently does not include the provider in this case, but does include commonly owned entities, the providers assert that:

> The Provider contends that the Lead MAC's determination of Medicare Reimbursement for their DSH payments are not in accordance with the Medicare statute 42 U.S.C. §1395ww(d)(5)(F)(vi). The Provider contends that the SSI percentages calculated by [CMS] and used by the Lead MAC to settle their Cost Report was incorrectly computed.

[8] Issue Statement at 1.
[9] *Id.*

> The Provider(s) also contend that CMS inconsistently interprets the term "entitled" as it is used in the statute. CMS requires SSI payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the denominator. CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days of care) as Medicare Part A days, yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment.
>
> The Provider further contends that the SSI percentages calculated by [CMS] fail to address all the deficiencies as described in *Baystate Medical Center v. [Leavitt]*, 545 F. Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37, 44 (D.D.C. 2008) and incorporate a new methodology inconsistent with the Medicare Statute.
>
> Providers . . . 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.[10]

Significantly, QRS certified the Quorum CIRP group under Case No. 18-1333GC on November 22, 2023 in response to a Board request for a status update issued on October 23, 2023.

The Board finds that the first aspect of Issue 1 (the DSH/SSI (Provider Specific) issue) in this appeal is duplicative of the group issue in Case No. 18-1333GC. The first aspect of Issue 1 in the present appeal concerns "whether the [MAC] used the correct [SSI] percentage in the [DSH] calculation."[11] 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)."[12] Similarly, the Provider argues that "it[s] SSI percentage published by [CMS] was incorrectly computed . . ." and it ". . . [s]pecifically . . . disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[13] The DSH SSI Percentage CIRP

[10] Group Issue Statement, PRRB Case No. 18-1333GC.
[11] Issue Statement, Issue 1.
[12] *Id.*
[13] *Id.*

Group in Case No. 18-1333GC, 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)(vi).

Thus, the Board finds that the first aspect of Issue 1 in this appeal is duplicative of the group issue in Case No. 18-1333GC, for other commonly owned entities and the same fiscal year.

Pursuant to 42 C.F.R. § 405.1837(b)(1):

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

Because the issue is duplicative, the Board notes that QRS should have transferred the DSH/SSI (Provider Specific) to PRRB Case No. 18-1333GC, in order to become compliant with the CIRP regulation, quoted above. The Board takes administrative notice that it has dismissed many SSI Provider Specific issues (from an individual provider case in which QRS is the representative) as being prohibited duplicates of SSI Systemic issues being pursed in a CIRP group in which QRS also is the representative, and as a result, QRS should have known it needed to be transferred.[14]

In making this finding, the Board further notes that CMS regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, is pursuing that issue as part of the group under Case No. 18-1333GC for other providers which are under the same parent corporation. 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] 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 issue appealed in Case No. 18-1333GC, even if the Provider considers that issue to be "systemic" issues rather than provider-specific.

To this end, the Board also reviewed the Provider's Preliminary Position Paper (as attached to the Medicare Contractor's Motion to Dismiss) to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 16-

[14] Some recent examples include but are not limited to Board dismissals in the following cases: Case No. 13-3357 (Nov. 5, 2018), 13-3350 (Dec. 28, 2018), 14-1092 (Feb. 6, 2019), 14-2695 (Jul. 19, 2019), 14-2721 (Oct. 2, 2020), 17-0365 (Feb. 8, 2021), 14-3544 (Jul. 28, 2021), 14-0641 (Mar. 11, 2022), 17-2097 (Aug. 22, 2022), 22-0719 (Mar. 8, 2023), 21-0063 (Apr. 14, 2023), 22-0711 (Aug. 14, 2023), 22-0892 (Nov. 15, 2023), Moreover, the Board notes that the Provider transferred 2 other issues in this case (Issues 3 and 4) to Quorum CIRP groups.

[15] 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).

1192GC, 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.[16] 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 Final Position Paper and include *all* exhibits.

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

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

The Board further notes that the Provider only cites to the 2000 Federal Register but additional issuances and developments on the availability of data underlying the SSI fraction, such 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*

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

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]

The Board even reviewed the Provider's Final Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 17-1532GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider's Final Position Paper failed to comply with the Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" in its Final Position Paper and include *all* exhibits. For example, it requests to incorporate "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 Bacerra* (Appellants' reply brief included as Exhibit 3)" but fails to explain how or why that this case is relevant here and *only* provider specific. This reference is perfunctory as highlighted by the fact that the whole argument presented for this issue in the final position paper is a terse 7-sentences long. Indeed, the *Advocate Christ* issue is a common issue subject to the CIRP group rules which under Board Rules was required to be transferred to a CIRP ***prior to*** filing preliminary position papers and otherwise improperly duplicates the CIRP in which the Provider should be participating.

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*.[19]

[17] Last accessed February 24, 2023.
[18] Emphasis added.
[19] (Emphasis added).

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

Accordingly, *based on the record before it*, the Board finds that Issue 1 and the group issue in Case No. 18-1333GC, are the same issue. Because the issue is duplicative of the specific matter appealed in the group appeal for which there are other providers under the same common ownership as the Provider in this case, and the group in Case Nos. 18-1333GC is fully formed as of November 22, 2023,[20] ***the Board hereby dismisses this issue*** *as it was required to be part of that Quorum CIRP group under Case No. 18-1333GC and once a group becomes fully formed no other Quorum provider can pursue the same issue for the same year outside of that group consistent with 42 C.F.R. § 405.1837(b)(1) and 405.1837(e)(1)*.[21]

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

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 2 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

[20] *See* 42 C.F.R. § 405.1837(e), which provides that when the Board has determined that a group appeal brought under paragraph (b)(1) of this section (quoted above) is fully formed, no other provider under common ownership or control may appeal to the Board the issue that is the subject of the group appeal with respect to a cost reporting period that falls within the calendar year(s) covered by the group appeal.

[21] *See supra* note 14 and accompany text discussing fact that QRS should be aware that this issue was subject to mandatory CIRP regulation and rules and, thereby, needed to be transferred. Indeed it needed to be transferred as soon as possible but no later than the position papers. *See* Board Rule 12.11.

> 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.[22]

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

The Provider's preliminary position paper indicated that it would be sending the eligibility listing in a separate e-mail.[23]

Board Rule 7.2 (B) (July 1, 2015) 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 (B).

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.[24]

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*

[22] Individual Appeal Request, Issue 3.
[23] Provider's Preliminary Position Paper, Ex. P-1.
[24] *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.

> *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*.[25]

With regard to the filing of an individual appeal, Board Rule 7 (Issue Statement 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,[26] Board Rule 25.2 (A) requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[27] This requirement is consistent with 42 C.F.R. § 405.1853(b)(3).

Similarly, consistent with that regulation, Board Rule 25.2 (B) 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.[28]

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.

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

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)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[29] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its preliminary 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 in its preliminary position paper 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 (B). Indeed, the Medicare Contractor stated in its January 9, 2023 Final Request For DSH Package that that "[w]e reached out multiple times from January 2019 through December 2021" but "[n]o DHS package was ever submitted." Yest the Provider did not file a response by February 8, 2023 notwithstanding the instruction in 42 C.F.R. § 405.1853(e)(5)(i) that "[e]ach party is required to make a good faith effort to resolve or narrow any discovery dispute, regardless of whether the dispute is with another party or a nonparty." Similarly, after the Medicare Contractor filed a Motion to Dismiss on February 23, 2023, the Provider did not file any response to the Motion to Dismiss within the 30 days allotted under Board Rule 44.3. The Provider's silence and confirms its procedural abandonment of this issue since no specific days had been identified as being in dispute rendering the actual amount in controversy down to $0.

The Board recognizes that, after the Provider changes its representative to QRS, QRS included in the Provider's final position paper a purported listing of eligible days at issue. But this belated filing was ***fatally*** *flawed* ***and*** *cannot change the fact that it was* ***filed too late*** *in this case (almost*

[29] (Emphasis added).

7 years after this appeal was filed and more than more than 8 years after the fiscal year at issue closed). On **December 8, 2023**, QRS filed the Provider's final position paper and it included as Exhibit P-1 a listing of "Additional ME Days" with the caveat that the "Listing is pending finalization upon receipt of State eligibility data." The position paper mentions for the first time a new issue of 1115 waiver days but no such days are specifically identified or called out in Exhibit P-1. Significantly, QRS does not explain why the list was not "final[]" at this late date (almost 7 years after this appeal was filed), much less why it was not filed sooner in compliance with Board Rule 25.2.2. Similarly, QRS makes no mention of the prior request filed by the Medicare Contractor or the Medicare Contractor's Motion to Dismiss. Accordingly, the Board rejects this submission.

With respected to the 1115 waiver days issue included in the final position paper, the Board notes that QRS did not brief § 1115 waiver days as a separate issue in its final position paper but rather discussed them as part of the Issue 2, Medicaid Eligible Days, discussion and to this end included as Exhibit P-1 to its final position paper simply entitled "Additional ME Days." Similarly, in looking at the preliminary position paper (as attached to the Jurisdictional Challenge as Exhibit C-2), Quorium did not mention 1115 waiver days at all but rather filed a perfunctory terse 5-sentence argument.

In the alternative, to the extent that the Provider could argue that the Section 1115 Waiver Days was presented as a separate issue (separate and apart from Medicaid Eligible Days) and that its withdrawal of Issue 7 without qualification did not otherwise include Medicaid eligible days (notwithstanding the fact that the official record in OH CDMS does not list 1115 waiver days as a separate issue pending in this case), the Board would find that the 1115 waiver days issue: (1) was ***not*** properly included in the appeal request; (2) was ***not*** timely added to the appeal; and (3) was ***not*** properly briefed in either the preliminary position paper or even the final position paper. Any of these 3 reasons would be sufficient separate and independent bases to dismiss the 1115 waiver days issue. In this regard, the Board finds the Section 1115 Waiver Days issue is a separate issue that should have been appealed separately and briefed separately because it is a component of DSH different from the *generic* Medicaid eligible days issue and, thus, must be separately identified and appealed pursuant to Board Rule 8.1.

In this regard, the Board notes that § 1115 Waiver days are not traditional Medicaid eligible days. Indeed, it was only effective January 20, 2000, that the Secretary incorporated certain specific types of § 1115 Waiver days were incorporated into the DSH calculation *at her discretion* (*i.e*., it is the Secretary's position that no statute requires that § 1115 waiver days be included).[30] Rather, they relate to Medicaid expansion program(s) and are only includable in the

[30] 65 FR 47054, 47087 (Aug. 1, 2000). The Secretary's discussion in the preambles to the final rules revising 42 C.F.R. § 412.106(b)(4) to address 1115 waiver days demonstrates this as well as subsequent cases disputing the meaning of those revisions. Further, the Board has found that when a class of days (e.g., 1115 waiver days) is excluded due to choice, error, and/or advertence from the as-filed cost report, then that class of days is an unclaimed cost for which the Board would lack jurisdiction under 42 U.S.C. § 1395oo(a). *See, e.g.,* PRRB Jurisdictional Decision, Case Nos. 06-1851, 061852 (Nov. 17, 2017) (dismissing the class of adolescent psychiatric days from the appeal because no days were claimed with the as-filed cost report due to choice, error and/or inadvertence and, as such, the practical impediment standard or futility concept in the *Norwalk* and *Danbury* Board decisions is not applicable) (available at: https://www.cms.gov/regulations-andguidance/review-boards/prrbreview/downloads/jd-2017-11.pdf (last accessed Dec. 15, 2023)).

DSH adjustment calculation if they meet the requirements in 42 C.F.R. § 412.106(b)(4) relating to § 1115 Waiver days. Indeed, not every state Medicaid program has a qualifying § 1115 expansion program ***and*** not every inpatient day associated with beneficiary enrolled in a § 1115 waiver program necessarily qualifies to be included in the Medicaid fraction. In contrast, every state has a Medicaid state plan and every state Medicaid plan includes inpatient hospital benefits and, by statute at 42 U.S.C. § 1395ww(5)(F)(vi)(II), the numerator of the DSH Medicaid fraction must include§ inpatient days of patients "who . . . were eligible for medical assistance under a State plan approved under subchapter XIX" but who were not entitled to Medicare Part A. The appeal request only references Medicaid eligible days notwithstanding the fact that 1115 waiver days are treated very differently from regular Medicaid eligibility. The documentation verifying eligibility is different and the standard for determining eligibility is different. Further, it was not a given that all 1115 waiver days are necessarily days that would qualify under 412.106(b)(4) as demonstrated by Board decisions and case law.[31] Here, 42 C.F.R. § 405.1835(b) and Board Rule 8 required each separate issue to be identified. The Provider failed to do so. The Board recognizes that the appeal statement states that "The MAC, contrary to the regulation, failed to include all Medicaid eligible days, *including but not limited to* Medicaid paid days, unpaid eligible days eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation." However, the "including but not limited to" phrase only pertained to traditional Medicaid eligible days and reasons why they may not have been included in the fraction. It did not expand to include other classes of days such as general assistance, State-only days or 1115 waiver days. A generic catchall phrase cannot be used to essentially shoehorn in the later addition of issue on ***untimely*** basis in contravention to Board Rules and regulations.

In practice, new issues had to be added to this case no later than 240 days after receipt of the contractor's determination. However, there is no evidence in the record to indicate the Provider added the § 1115 Waiver days to the case properly or timely prior to the Tuesday, September 19, 2017.

Because the Provider did not either appeal the § 1115 Waiver days or add it to the appeal prior to the deadline to add issues, and it is a distinct issue, the Board finds that the issue was not properly or timely appealed (indeed the final position paper is the first time 1115 waiver days is mentioned for the first time *more than **6 years after** the deadline to add issues to the appeal*). The DSH Medicaid Eligible Days issue as stated in the original appeal request cannot be construed to include § 1115 Waiver days. Additionally, there is no indication that any § 1115 waiver days were included with the as-filed cost report which, if true, would make them an unclaimed cost and provide an independent basis for dismissal.

Based on the above, The Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its preliminary position paper and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R.

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[31] *See, e.g., CCT&B 2005-2006 Hurricane Katrina § 1115 Waiver UCP Days Group v. Novitas Solutions, Inc.*, PRRB Dec. No. 2016-D18 (Sept. 16, 2016); *QRS 1993-2007 DSH/Iowa Indigent Patient/Charity Care (GA) Group v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (Jan. 15, 2013), *affirming* PRRB Dec. No. 2013-D02 (Nov. 21, 2012); *Singing River Health Sys. v. Novitas Solutions, Inc.*, PRRB Dec. 2016-D19 (Sept. 20, 2016); *Adventist Health Sys. v. Sebelius*, 715 F.3d 157 (6th Cir. 2013).

§§ 405.1853(b)(2)-(3) and 412.106(b)(iii) and Board Rule 25 (including 25.2(A)-(B) (July 2015)) 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. As detailed above, the Provider has also flouted the Board's process and Rules (including failing to respond to the Motion to Dismiss) and, as a result, there multiple also other independent bases to dismiss this issue. Accordingly, the DSH Payment – Medicaid Eligible Days issue is dismissed.

Decision

The Board finds that the first aspect of Issue 1 (the DSH/SSI (Provider Specific) issue) is duplicative of the group issue being pursued in Case No. 18-1333GC. Because Case Nos. 18-1333GC is now fully formed as of November 22, 2023,[32] ***the Board hereby dismisses this issue*** *as it was required to be part of that Quorum CIRP group under Case No. 18-1333GC and once a group becomes fully formed no other Quorum provider can pursue the same issue for the same year outside of that group consistent with 42 C.F.R. § 405.1837(b)(1) and 405.1837(e)(1)*.[33] Further, there is no final determination from which the Provider can appeal the SSI realignment issue within Issue 1, and therefore that aspect of Issue 1 is dismissed.

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.

As no issues remain in this case, the Board closes it 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:

12/22/2023

X Clayton J. Nix

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

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

[32] *See* 42 C.F.R. § 405.1837(e), which provides that when the Board has determined that a group appeal brought under paragraph (b)(1) of this section (quoted above) is fully formed, no other provider under common ownership or control may appeal to the Board the issue that is the subject of the group appeal with respect to a cost reporting period that falls within the calendar year(s) covered by the group appeal.

[33] *See supra* note 14 and accompany text discussing fact that QRS should be aware that this issue was subject to mandatory CIRP regulation and rules and, thereby, needed to be transferred. Indeed it needed to be transferred as soon as possible but no later than the position papers. *See* Board Rule 12.11.