DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Board Decision* – SSI Percentage (Provider Specific)**
MultiCare Valley Hospital (Provider Number 50-0119)
FYE 09/30/2015
Case No. 19-1183

Dear Mr. Ravindran,

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

Background:

A. *Procedural History for Case No. 19-1183*

On August 6, 2018, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end September 30, 2015.

On January 31, 2019, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained five (5) issues:

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

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

[1] On August 23, 2019, this issue was transferred to PRRB Case No. 18-0552GC.
[2] On November 14, 2022, Federal Specialized Services ("FSS") filed a jurisdictional challenge over the Medicaid Eligible Days issue. On December 28, 2022, FSS filed a Request for Dismissal of the Medicaid Eligible Days issue. Subsequently, the Provider withdrew this issue on January 13, 2023.
[3] On August 23, 2019, this issue was transferred to PRRB Case No. 18-0555GC.
[4] On August 23, 2019, this issue was transferred to PRRB Case No. 18-0554GC.

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

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

> The Provider contends that its SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> . . .
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[5]

The Provider's appeal request described Issue 2 (DSH/SSI Percentage) 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 at 42 U.S.C. § 1395ww(d)(5)(F)(vi). The Provider contends that the SSI percentages calculated by [CMS] and used by the Lead MAC to settle their Cost Report were incorrectly computed.
>
> The Provider further contends that the SSI percentages calculated by [CMS] fail to address all the deficiencies as described in *Baystate Medical Center v. Michael O. Leavitt*, 545 F. Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37, 44 (D.D.C. 2008) and incorporates a new methodology inconsistent with the Medicare Statute.
>
> Providers [*sic*] 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

[5] Issue Statement at 1 (Jan. 31, 2019).

4. Not in agreement with provider's records
5. Paid days vs. Eligible days, and
6. Covered days vs. Total days.[6]

The Provider transferred its Issue 2 (DSH/SSI Percentage) to the CIRP group under Case Number 18-0552GC, *QRS CHS 2015 DSH SSI Percentage CIRP Group*, on August 23, 2019. The Group Issue Statement for that case is identical to the DSH/SSI issue in case 19-1183.

MAC'S Contentions:

On May 2, 2019, the MAC filed a Jurisdictional Challenge. The MAC argues that the Board lacks jurisdiction over the DSH SSI% - Provider Specific issue for two reasons. First, with regard to the realignment of the SSI percentage, the MAC argues that the appeal is premature and the Provider has not exhausted all available remedies.[7]

In addition, the MAC argues the DSH SSI% - Provider Specific issue and the DSH SSI% - Systemic issue are considered the same issue by the Board, and cites several past Board decisions to that end.[8]

Provider's Response:

On May 31, 2019, the Provider filed a Jurisdictional Response. In it, the Provider argues that the issues are not duplicative because "issues #1 and 2 represent different components of the SSI issue, which was specifically adjusted during the audit."[9] Additionally, the Provider argues that the issue is not duplicative because the Provider is "not addressing the errors which result from CMS' improper data matching process but is addressing the various errors of omission and commission that do not fit into the "systemic errors" category."[10]

Finally, the Provider contends the Provider Specific issue is appealable "because the MAC specifically adjust the Providers SSI percentage and the Provider is dissatisfied with the amount of DSH payments that it received for fiscal year 2015, resulting from its understated SSI percentage due to errors of omission and commission."[11]

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

[6] *Id.* at Issue 2.
[7] Jurisdictional Challenge at 6 (May 2, 2019).
[8] *Id*. at 5-6.
[9] Jurisdictional Response at 2 (May 31, 2019).
[10] *Id*. at 3.
[11] *Id*.

controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

A. SSI Provider Specific

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

1. First Aspect of Issue 1

The Board finds that the first aspect of Issue No. 1 (the DSH/SSI (Provider Specific) issue) —the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH/SSI issue that was appealed in Group Case No. 18-0552GC. The first aspect of Issue 1 in the present appeal concerns "whether the Medicare Administrative Contractor used the correct [SSI] percentage in the [DSH] Calculation."[12] 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)."[13] 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."[14] Issue 2, transferred to group Case No. 18-0552GC, similarly alleges that the Medicare Contractor and CMS improperly calculated the DSH/SSI Percentage, the DSH/SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F)(i).

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

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[12] Individual Appeal Request, Issue 1.
[13] *Id.*
[14] *Id.*
[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).

Accordingly, the Board must find that Issues 1 and the group issue in Group Case 18-0552GC, are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6 (2018), 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—must be dismissed for lack of jurisdiction and as premature. Under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request…" Without this written request, the Medicare Contractor cannot issue a final determination from which the Provider can be dissatisfied with for appealing purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding the Provider's DSH SSI Percentage realignment as such there is no "determination" to appeal and the appeal of this issue is otherwise premature. Further, the Provider's cost reporting year ends on 9/30, and as such, is the same as the federal fiscal year end. Thus, realignment of the SSI percentage in this case would have no effect.

Conclusion:

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

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

Board Members Participating:

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

For the Board:

2/3/2023

X Kevin D. Smith, CPA

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

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

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James Ravindran
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RE: ***Board Decision* – SSI Percentage (Provider Specific)**
Bartow Regional Medical Center (Provider Number 10-0121)
FYE 12/31/2015
Case No. 19-1711

Dear Mr. Ravindran,

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

Background:

A. *Procedural History for Case No. 19-1711*

On September 7, 2018, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end December 31, 2015.

On March 6, 2019, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained nine (9) issues:

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

[1] On October 22, 2019, this issue was transferred to PRRB Case No. 18-0588GC.
[2] On October 22, 2019, this issue was transferred to PRRB Case No. 18-0589GC.
[3] On October 22, 2019, this issue was transferred to PRRB Case No. 18-0584GC.
[4] On November 14, 2022, Federal Specialized Services ("FSS") filed a jurisdictional challenge over the Medicaid Eligible Days issue. On December 28, 2022, FSS filed a Request for Dismissal of the Medicaid Eligible Days issue. Subsequently, the Provider withdrew this issue on January 13, 2023.

- DSH Payment Medicaid Fraction/Medicare Managed Care Part C Days[5]
- DSH Payment Medicaid Fraction/Dual Eligible Days[6]
- Uncompensated Care Distribution Pool[7]
- 2 Midnight Census IPPS Payment Reduction[8]

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

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 18-0588GC

The Provider's appeal request described Issue 1- DSH/SSI Percentage (Provider Specific) - 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]

The Provider's appeal request described Issue 2 - DSH/SSI Percentage - 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 at 42 U.S.C. § 1395ww(d)(5)(F)(vi). The Provider contends that the SSI percentages calculated by [CMS] and used by the Lead MAC to settle their Cost Report were incorrectly computed.
>
> The Provider further contends that the SSI percentages calculated by [CMS] fail to address all the deficiencies as described in *Baystate Medical Center v. Michael O. Leavitt*, 545 F. Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37, 44 (D.D.C. 2008) and

[5] On October 22, 2019, this issue was transferred to PRRB Case No. 18-0591GC.
[6] On October 22, 2019, this issue was transferred to PRRB Case No. 18-0585GC.
[7] On October 22, 2019, this issue was transferred to PRRB Case No. 18-0587GC.
[8] On October 22, 2019, this issue was transferred to PRRB Case No. 18-0592GC.
[9] Issue Statement at 1 (Mar. 6, 2019).

> incorporates a new methodology inconsistent with the Medicare Statute.
>
> Providers [*sic*] in this case are also seeking resolution of the following additional aspects of the Medicare fraction that were not addressed in the Baystate case:
>
> 1. Availability of MEDPAR and SSA Records
> 2. Failure to adhere to required notice and comment rulemaking procedures
> 3. Fundamental problems in the SSI percentage calculation
> 4. Not in agreement with provider's records
> 5. Paid days vs. Eligible days, and
> 6. Covered days vs. Total days.[10]

The Provider transferred its Issue 2 – DSH/SSI to the CIRP group under Case Number 18-0588GC, *QRS HMA 2015 DSH SSI Percentage CIRP Group*, on October 22, 2019. The Group Issue Statement for that case is identical to the DSH/SSI issue in case 19-1711.

MAC'S Contentions:

On July 23, 2019, the MAC filed a Jurisdictional Challenge. The MAC argues that the Board lacks jurisdiction over the DSH SSI% - Provider Specific issue for two reasons. First, with regard to the realignment of the SSI percentage, the MAC argues that the appeal is premature and the Provider has not exhausted all available remedies.[11]

In addition, the MAC argues the DSH SSI% - Provider Specific issue and the DSH SSI% - Systemic issue are considered the same issue by the Board, and cites several past Board decisions to that end.[12]

Provider's Response:

The Board Rules require that Provider Responses to the MAC's Jurisdictional Challenge must filed within thirty (30) days of the filing of the Jurisdictional Challenge.[13] The Provider has not filed a response in this case and the time for doing so has elapsed.

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

[10] *Id.* at Issue 2.
[11] Jurisdictional Challenge at 6 (July 23, 2019).
[12] *Id*. at 5-6.
[13] Board Rule 44.4.3, v. 2. (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. SSI Provider Specific

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

1. First Aspect of Issue 1

The Board finds that the first aspect (the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage) of Issue 1 (the DSH/SSI Percentage (Provider Specific) issue) is duplicative of the DSH/SSI issue that was appealed in Group Case No. 18-0588GC. The first aspect of Issue 1 in the present appeal concerns "whether the Medicare Administrative Contractor used the correct [SSI] percentage in the [DSH] Calculation."[14] 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)."[15] 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."[16] Issue 2, transferred to group Case No. 18-0588GC, similarly alleges that the Medicare Contractor and CMS improperly calculated the DSH/SSI Percentage, the DSH/SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F)(i).

In making this finding, the Board further notes that CMS regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, the Provider is pursuing that issue as part of the group under Case No. 18-0588GC. 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. 18-0588GC.

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[14] Individual Appeal Request, Issue 1.
[15] *Id.*
[16] *Id.*
[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).

Accordingly, the Board must find that Issues 1 and the group issue in Group Case 18-0588GC, are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6 (2018), 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—must be dismissed for lack of jurisdiction and as premature. Under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request…" Without this written request, the Medicare Contractor cannot issue a final determination from which the Provider can be dissatisfied with for appealing purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding the Provider's DSH SSI Percentage realignment as such there is no "determination" to appeal and the appeal of this issue is otherwise premature.

Conclusion:

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

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

Board Members Participating:

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

For the Board:

2/3/2023

X Kevin D. Smith, CPA

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

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

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Via Electronic Delivery

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Arcadia, CA 91006

RE: ***Board Decision* – SSI Percentage (Provider Specific)**
Chester Regional Medical Center (Provider Number 42-0019)
FYE: 09/30/2016
Case Number: 19-1846

Dear Mr. Ravindran,

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

Background:

A. *Procedural History for Case No. 19-1846*

On September 27, 2018, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end September 30, 2016.

On March 26, 2019, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained nine (9) issues:

- DSH SSI Percentage (Provider Specific)
- DSH SSI Percentage[1]
- DSH SSI Fraction Medicare Managed Care Part C Days[2]
- DSH SSI Fraction Dual Eligible Days[3]
- DSH Medicaid Eligible Days[4]
- 2 Midnight Census IPPS Payment Reduction[5]
- DSH Medicaid Fraction Medicare Managed Care Part C Days[6]

[1] On October 22, 2019, this issue was transferred to PRRB Case No. 19-0173GC.
[2] On October 22, 2019, this issue was transferred to PRRB Case No. 19-0175GC.
[3] On October 22, 2019, this issue was transferred to PRRB Case No. 19-0198GC.
[4] On November 14, 2022, Federal Specialized Services ("FSS") filed a jurisdictional challenge over the Medicaid Eligible Days issue. On December 28, 2022, FSS filed a Request for Dismissal of the Medicaid Eligible Days issue.
[5] On October 22, 2019, this issue was transferred to PRRB Case No. 19-0185GC.
[6] On October 22, 2019, this issue was transferred to PRRB Case No. 19-0159GC.

- DSH Medicaid Fraction Dual Eligible Days[7]
- Uncompensated Care (UCC) Distribution Pool[8]

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

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 19-0173GC

The Provider's appeal request described Issue 1 (DSH/SSI Percentage (Provider Specific)) 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]

The Provider's appeal request described Issue 2 (DSH/SSI Percentage) 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 at 42 U.S.C. § 1395ww(d)(5)(F)(vi). The Provider contends that the SSI percentages calculated by [CMS] and used by the Lead MAC to settle their Cost Report were incorrectly computed.
>
> The Provider further contends that the SSI percentages calculated by [CMS] fail to address all the deficiencies as described in *Baystate Medical Center v. Michael O. Leavitt*, 545 F. Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37, 44 (D.D.C. 2008) and incorporate a new methodology inconsistent with the Medicare Statute.

[7] On October 22, 2019, this issue was transferred to PRRB Case No. 19-0197GC.
[8] On October 22, 2019, this issue was transferred to PRRB Case No. 19-0177GC.
[9] Issue Statement at 1 (Mar. 26, 2019).

> Providers [*sic*] in this case are also seeking resolution of the following additional aspects of the Medicare fraction that were not addressed in the Baystate case:
>
> 1. Availability of MEDPAR and SSA Records
> 2. Failure to adhere to required notice and comment rulemaking procedures
> 3. Fundamental problems in the SSI percentage calculation
> 4. Not in agreement with provider's records
> 5. Paid days vs. Eligible days, and
> 6. Covered days vs. Total days.[10]

The Provider transferred its Issue 2 (DSH/SSI Percentage) to the CIRP group under Case Number 19-0173GC, *CHS CY 2016 HMA DSH SSI Percentage (Systemic Errors) CIRP Group*, on October 22, 2019. The Group Issue Statement for that case is identical to the DSH/SSI issue in case 19-1846.

MAC'S Contentions:

On July 30, 2019, the MAC filed a Jurisdictional Challenge. The MAC argues that the Board lacks jurisdiction over the DSH SSI% - Provider Specific issue for two reasons. First, with regard to the realignment of the SSI percentage aspect, the MAC argues that the appeal is premature and the Provider has not exhausted all available remedies.[11]

In addition, the MAC argues the DSH SSI% - Provider Specific issue and the DSH SSI% - Systemic issue are considered the same issue by the Board, and cites several past Board decisions to that end.[12]

Provider's Response:

On September 24, 2019, the Provider filed a Jurisdictional Response. In it, the Provider argues that the issues are not duplicative because "issues #1 and 2 represent different components of the SSI issue, which was specifically adjusted during the audit."[13] Additionally, the Provider argues that the issue is not duplicative because the Provider is "not addressing the errors which result from CMS' improper data matching process but is addressing the various errors of omission and commission that do not fit into the "systemic errors" category."[14]

Finally, the Provider contends the Provider Specific issue is appealable "because the MAC specifically adjusted the Provider's SSI percentage and the Provider is dissatisfied with the

[10] *Id.* at Issue 2.
[11] Jurisdictional Challenge at 6 (July 30, 2019).
[12] *Id*. at 7.
[13] Jurisdictional Response at 1 (Sept. 24, 2019).
[14] *Id*. at 2.

amount of DSH payments that it received for fiscal year 2016, as a result of its understated SSI percentage due to errors of omission and commission."[15]

Board Analysis and Decision:

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

A. SSI Provider Specific

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

1. First Aspect of Issue 1

The Board finds that the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage - the first aspect of Issue 1 (the DSH/SSI Percentage (Provider Specific) issue) in this appeal is duplicative of Issue 2 (the DSH/SSI Percentage issue) that was appealed in Case No. 19-0173GC. The first aspect of Issue 1 in the present appeal concerns "whether the Medicare Administrative Contractor used the correct [SSI] percentage in the [DSH] Calculation."[16] 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)."[17] 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."[18] Issue 2, which was transferred to group Case No. 19-0173GC, similarly alleges that the Medicare Contractor and CMS improperly calculated the DSH/SSI Percentage, the DSH/SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F)(i).

In making this finding, the Board further notes that CMS regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, the Provider is pursuing that issue as part of the group under Case No. 19-0173GC. Further, any alleged "systemic" issues may not uniformly impact all providers but, as

[15] *Id*.
[16] Individual Appeal Request, Issue 1.
[17] *Id.*
[18] *Id.*

was the case in *Baystate*, may impact the SSI percentage for each provider differently.[19] The Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 19-0173GC.

Accordingly, the Board must find that the first aspect of Issue 1 and the group issue in Group Case 19-0173GC, 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 (2018), the Board dismisses this component of the DSH/SSI (Provider Specific) issue from the instant case.

2. Second Aspect of Issue 1

The second aspect of the DSH SSI Percentage (Provider Specific) issue—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—must be dismissed for lack of jurisdiction and as premature. Under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request…" Without this written request, the Medicare Contractor cannot issue a final determination from which the Provider can be dissatisfied with for appealing purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding the Provider's DSH SSI Percentage realignment as such there is no "determination" to appeal and the appeal of this issue is otherwise premature. Further, the Provider's cost reporting period is 9/30/2015, and as such, the same as the federal fiscal year. Thus, any realignment of the SSI percentage would have no effect.

Conclusion:

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

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

[19] 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).

Board Members Participating:

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

For the Board:

2/3/2023

X Kevin D. Smith, CPA

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Jurisdictional Determination***
Ridgeview Medical Center (Prov. No. 24-0056)
FYE 12/31/2013
Case No. 16-1932

Dear Mr. Shay and Ms. VanArsdale:

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

Background

The Board received the Provider's Appeal Request dated June 24, 2016, related to a Notice of Program Reimbursement ("NPR") dated December 30, 2015.[1] The Provider's appeal request included the following description of the Electronic Health Record ("EHR") Payment issue:

> The Provider is a "meaningful user" under Medicare's EHR Incentive Program and the formula used to determine a hospital's incentive payments includes the Provider's total inpatient days, which includes both inpatient Part A bed days and inpatient Part C bed days. The failure to include the Provide[r]s bed days attributable to Medicare part C enrollees results in a $130,041 reduction in the Provider's meaningful use incentive payments in 2013.
>
> ****
>
> The Provider contends that, consistent with CMS's instructions . . . the MAC in this case should have reviewed the documentation it offered to support the number of Medicare Part C bed days claimed in its 2013 cost report rather than simply disallowing the additional claimed Part C days because the Provider did not

[1] Provider's Request for Appeal (June 24, 2016).

> submits [sic] shadow claims for such services, and therefore, the days did not appear on the Provider's PS&R [Provider Statistical & Reimbursement Report]. According to the Provider's internal documentation, the MAC clearly should have allowed 817 Medicare Part C day[s] in the Provider's 2013 cost report.[2]

The Medicare Contractor filed a Jurisdictional Challenge on May 26, 2022. The Provider has not filed a response.

Medicare Contractor's Position

On May 26, 2022, the Medicare Contractor ("MAC") filed a Jurisdictional Challenge. The MAC argues that the Provider's appeal is from an NPR in which there was no final determination and "[t]he methodology used to calculate the EHR incentive payment . . .is prohibited from administrative and judicial review pursuant to 42 C.F.R. § 495.110."[3] The MAC goes on to say that:

> The date of the determination for the EHR/HIT Incentive Payment is no the date of the NPR. Rather, it is the date the payment contractor notifies the provider of the under/over payment. The NPR does not represent a final determination of the EHR incentive payment. The Provider incorrect takes its appeal from the NPR.[4]

The MAC also challenged the Jurisdiction on the basis that EHR incentive payments are prohibited from Board review under 42 C.F.R. 42 C.F.R. § 495.110. To further strengthen this argument, the MAC pointed out prior Board decisions, such as the September 16, 2020 Jurisdictional Decision in PRRB Case Number 19-1379.[5]

Provider's Response

Board Rule 44.4.3 specifies the time period allowed for a Provider to respond to a jurisdictional challenge and states as follows:

> 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.

Here, the Provider did not file a response to the Jurisdictional Challenge within 30 day period allowed under Board Rule 44.4.3. Instead, on July 13, 2022, the Provider simply requested

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[2] Statement of Issues Being Appealed at 3-4 (June 24, 2016).
[3] MAC's Jurisdictional Challenge at 2 (May 26, 2022).
[4] *Id*. at 3-4.
[5] *Id*. at 5; Ex. C-1.

postponement of the hearing to "permit time for narrowing of issues and resolution of the appeal without the need for a hearing."

Board Decision

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

The Board finds that it does not have jurisdiction over the EHR payment issue in the above-referenced appeal because the NPR being appealed includes no final determination over the EHR incentive payment. In their appeal request, the Provider acknowledges they do not qualify for Medicare Disproportionate Share ("DSH") payments and does not claim Medicare direct or indirect graduate medical education payments.[6] Accordingly, the Provider contended in its appeal request that it had no incentive to fill informational only or shadow bill to the Medicare program for those Part C patients. However, that contention ignores the fact that EHR reimbursement is in part dependent on those Part C informational only/shadow bills. In order to be reimbursed for the 817 Additional Patient Days attributable to Medicare Part C enrollees, the Provider is relying on their inclusion of inpatient Part C bed days in the Medicare EHR Incentive Program.[7] However, the NPR from which the Provider is appealing includes no final determination on the EHR incentive payment (moreover, there can be no actual amount in controversy based on the NPR at issue). As there is no final determination from which the Provider is appealing on this issue, the Board does not have jurisdiction under 42 C.F.R. § 405.1835(a).

Similarly, it appears that the Provider is at fault for the Part C days at issue not being part of the PS&R Report for FY 2013 and not properly reported on the cost report. As noted in the Provider's appeal request, the 1091 Part C days at issue are documented in "various patient logs." The Medicare Claims Processing Manual, CMS Pub. 100-04 ("MCPM"), Ch. 3, § 20.3(A) explains that hospitals must submit informational only bill for each Medicare Part C stay in order to ensure the days from that stay get reflected the hospital's SSI ratio.[8] As such, the

[6] Statement of Issues Being Appealed at 3.
[7] *Id*.
[8] *See also* MCPM, Transmittal 1311, Change Req. 5647 (Jul. 20, 2007) ("As of the implementation date of this CR, hospitals (including acute care hospitals paid under the inpatient prospective payment system, inpatient rehabilitation facilities (IRF), and long term care hospitals (LTCH)) must begin to submit "no pay" bills to their Medicare contractor for the MA beneficiaries they treat, *in order for these days to be eventually captured in the DSH* (or low income patient (LIP) for IRF) *calculations*." (emphasis added)); MCPM, Ch. 3, § 20.8 ("Teaching hospitals that operate GME programs (see 42 CFR §413.86) and/or hospitals that operate approved N&AH education programs (see 42 CFR §413.87) must submit separate bills for payment for MA enrollees. The MA inpatient days are recorded on PS&R report type 118. For services provided to MA enrollees by hospitals that do not have a contract with the enrollee's plan, non-IPPS hospitals and units are entitled to any applicable DGME and/or N&AH payments under these provisions. Therefore, such hospitals and units should submit bills to their A/B MAC (A) for these cases in accordance with this section's instructions. In addition to submitting the claims to the PS&R

exception under CMS Ruling 1727-R is not applicable. The April 27, 2016 final rule cited by the Provider in its appeal request had not been yet issued when the Provider filed its 2013 cost report and, as such, could not have been relied upon when the Provider failed to submit the informational only or shadow bills required for Part C days. Similarly, the final rule had not yet been issued when the Medicare Contractor conducted its audit of the FY 2013 cost report which would have been the nature time for the Provider to ask the Medicare Contractor to include the Part C days or when the Medicare Contractor issued the NPR at issue on December 30, 2015. Moreover, the final rule is not applicable to the Provider because, as the Provider admits, the rulemaking was only issued for Medicare Dependent Hospitals.

Finally, the Board finds that it does not have jurisdiction over the EHR payment issue in the above-referenced appeal because jurisdiction is precluded by 42 U.S.C. § 1395ww(n) and 42 C.F.R. § 495.110(b). Section 1395ww(n) provides for incentives for adoption and meaningful use of certified EHR technology. In particular, § 1395ww(n)(4)(A) states the following:

> **(4)Application.—**
>
> (A)Limitations On Review.— There shall be no administrative or judicial review under section 1395ff, section 1395oo, or otherwise, of-
>
> (i) the methodology and standards for determining payment amounts under this subsection and payment adjustments under subsection (b)(3)(B)(ix), including selection of periods under paragraph (2) for determining, ***and*** *making estimates or using proxies of, discharges* under paragraph (2)(C) and *inpatient-bed days*, *hospital charges*, charity charges, ***and*** *Medicare share* under paragraph (2)(D);
>
> (ii) the methodology and standards for determining a meaningful EHR user under paragraph (3), including selection of measures under paragraph (3)(B), specification of the means of demonstrating meaningful EHR use under paragraph (3)(C), and the hardship exception under subsection (b)(3)(B)(ix)(II); and
>
> (iii) the specification of EHR reporting periods under paragraph (6)(B) and the selection of the form of payment under paragraph (2)(F).[9]

The regulations at 42 C.F.R. § 495.110(b) also precludes administrative and judicial review of the following:

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report type 118, hospitals must properly report MA inpatient days on the Medicare cost report, Form 2552-96, on worksheet S-3, Part I, line 2 column 4, and worksheet E-3, Part IV, lines 6.02 and 6.06.").

[9] (Emphasis added.)

> (b) For eligible hospitals –
>
> (1) The methodology and standards for determining the incentive payment amounts made to eligible hospitals, including –
>
> (i) ***The estimates or proxies for determining discharges***, *inpatient-bed-days, hospital charges*, charity care charges, and ***Medicare share***; and
>
> (ii) The period used to determine such estimate or proxy.[10]

The Board concludes that it does not have jurisdiction over the EHR issue in the above referenced appeal because there is no final determination from which the Provider is appealing the issue and judicial and administrative review of the calculation is barred by statute and regulation. The Board dismisses this issue from the appeal. Case No. 16-1932 remains open as there is another issue pending. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877 upon final disposition of the appeal.

Board Members:

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

For the Board:

2/6/2023

X Clayton J. Nix

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

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

[10] (Emphasis added.)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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

RE: ***Board Decision***
Centinela Hospital Medical Center (Prov. No. 05-0739, FYE 12/31/2009);
Landmark Medical Center (Prov. No. 41-0011, FYE 09/30/2009);
St. Mary's General Hospital (Prov. No. 31-0006, FYE: 12/31/2009) *as participants in*:

14-1524GC – HRS Prime Healthcare 2009 DSH SSI Fract. Medicare Mngd Care Part C Days CIRP
14-1525GC – HRS Prime Healthcare 2009 DSH Medicaid Fract. Medicare Mngd. Care Part C Days CIRP

Dear Ms. Goron,

The Provider Reimbursement Review Board ("Board") has reviewed the documents in the above referenced-appeals and finds that it does not have jurisdiction over the Disproportionate Share Hospital ("DSH") Payment / Supplemental Security Income ("SSI") Fraction Medicare Managed Care Part C Days issue or DSH Payment / Medicaid Fraction Medicare Managed Care Part C Days issue for the participants, Centinela Hospital Medical Center ("Centinela") and Landmark Medical Center ("Landmark"), because the issue was not specifically revised in their respective Revised Notice of Program Reimbursement ("RNPR"), which is the basis for each participant's appeal and joinder to these groups. Further, the Board finds that it does not have jurisdiction over the same appealed issues for the participant, St. Mary's General Hospital ("St. Mary's"), because its cost report was reopened to realign the SSI fraction calculation from the federal fiscal year to its cost reporting period and this participant had no right to appeal that RNPR for the group issues. The jurisdictional decision of the Board is set forth below.

Pertinent Facts:

The Common Issue Related Party ("CIRP") Group appeals were established on December 27, 2013, appealing the DSH Payment / SSI Fraction Medicare Managed Part C Days issue in Case No. 14-1524GC and DSH Payment / Medicaid Fraction Medicare Managed Part C Days issue in Case No. 14-1525GC. Centinela was directly added to the appeals on January 23, 2018, appealing from a RNPR dated July 27, 2017. St. Mary's was directed added to the appeals on September 16, 2019, appealing from a RNPR dated March 14, 2019. Landmark was directly added to the appeals on February 28, 2020, appealing from a RNPR dated August 27, 2019.

Attached with Centinela and Landmark's respective Model Form E – Request to Join an Existing Group Appeal: Direct Appeal from Final Determination was the RNPR at issue and the

associated Audit Adjustment Report. The Audit Adjustment Report on each participant did ***not*** include an adjustment to the SSI percentage but rather only adjusted Medicaid eligible days adding 48 Medicaid eligible days for Landmark and 3950 Medicaid eligible days for Centinela.

Similarly, the record reflects that St. Mary's FY 2009 cost report was reopened on December 20, 2017 in response to St. Mary's "request to recalculate the hospital's Acute SSI percentage based on the hospital's fiscal year 12/31/2009" pursuant to 42 C.F.R. § 412.106(b)(3) and that RNPR was issued on March 14, 2019 in order to incorporate that realigned SSI percentage as confirmed by the citation to 42 C.F.R. 412.106(b)(3) as the basis for the revised SSI percentage.

Board Decision:

RNPR Appeal

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) 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.[1]

[1] 42 C.F.R. § 405.1889(b).

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.[2]

As outlined above, when a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]" Based on the foregoing, the Board finds that it lacks jurisdiction over these issues because it was not specifically revised in the RNPR which is the basis for the appeals.

As discussed above, Centinela Hospital Centinela Hospital (05-0739) is appealing from a RNPR that was issued on July 27, 2017. The Provider's July 12, 2013 Notice of Reopening indicates that the cost report was being reopened, "To include additional eligible Title XIX days based on the State's verification of Medi-Cal Title XIX eligibility." The Provider's audit adjustment report shows that it received additional eligible days and made the corresponding DSH adjustment. Therefore, the Provider's RNPR did not contemplate the SSI%, much less adjust for Part C days in the SSI% (where regulations specify Part C days are to be counted).

Similarly, Landmark Medical Center (41-0011) is appealing from a RNPR that was issued on August 27, 2019. The Provider's audit adjustment report shows that it received additional Medicaid eligible days and made the corresponding DSH adjustment. The Provider's RNPR did not contemplate the SSI%, much less adjust for Part C days in the SSI% (where regulations specify Part C days are to be counted).

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[2] (Emphasis added).

SSI Realignment

The Board finds that it does not have jurisdiction over the Part C Days issue in this appeal from St. Mary's General Hospital because the revised NPR was issued as a result of the Providers' SSI Realignment request, and did not make adjustments related to the Part C days issue. 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).

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[.]"[3] The reopening in this case were a result of the Providers' request to realign their SSI percentages from the federal fiscal year end to their individual cost reporting fiscal year end. The audit adjustments (#4) associated with the RNPR under appeal clearly only revise the SSI percentage in order to realign it from a federal fiscal year to the provider's respective fiscal year. The Board has consistently found that it does not have jurisdiction over revised NPRs that were issued as a result of a provider's request for realignment of its SSI percentage. As noted in 42 C.F.R. § 412.106(b)(2), CMS gathers data to be used in the SSI fraction on a month-by-month basis:

> (2) *First computation: Federal fiscal year*. **For each month** of the Federal fiscal year in which the hospital's cost reporting period begins, CMS -
>
> (i) Determines the number of patient days that -
>
> (A) Are associated with discharges occurring **during each month**; and
>
> (B) Are furnished to patients who **during that month** were entitled to both Medicare Part A (including Medicare Advantage (Part C)) and SSI, excluding those patients who received only State supplementation;
>
> (ii) Adds the results for the whole period; and
>
> (iii) Divides the number determined under paragraph (b)(2)(ii) of this section by the total number of days that -
>
> (A) Are associated with discharges that occur during that period; and
>
> (B) Are furnished to patients entitled to Medicare Part A (including Medicare Advantage (Part C)).[4]

[3] 42 C.F.R. § 405.1889(b)(1).
[4] (Emphasis added.)

The data matching process by which CMS gathers this *monthly* data is described in the FY 2011 IPPS Final Rule.[5] As described in the Federal Register, under the realignment process, CMS calculates the SSI fraction using the *previously-gathered* data for the months included in the published SSI fractions for 2 Federal fiscal years that encompass the hospital's cost reporting period:

1. *75 Fed. Reg. 50042, 50279 (Aug. 16, 2010)*.—"[W]e publish these [SSI fraction] data for every hospital based on the Federal fiscal year but, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived *from the data match process* ***for the two Federal fiscal years that spanned the hospital's cost reporting period***."[6]

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

   Beginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108–173), we will arrange to furnish, consistent with the Privacy Act, MedPAR LDS data for a hospital's patients eligible for both SSI and Medicare at the hospital's request, regardless of whether there is a properly pending appeal relating to DSH payments. *We will make the information available for either the Federal fiscal year or, if the hospital's fiscal year differs from the Federal fiscal year, for the* ***months included in the 2 Federal fiscal years that encompass the hospital's cost reporting period***. Under this provision, *the hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year*. The data set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year."[7]

Accordingly, the realignment process does not change any of the data underlying the realigned SSI fraction (*e.g.*, Part C days or Part A days) because that data had been previously gathered on

[5] 75 Fed. Reg. 50042, 50275-85 (Aug. 16, 2010).
[6] (Emphasis added.)
[7] (Emphasis added.)

a month-by-month basis and *there is no need for CMS to rerun the data matching process* in order to effectuate a realignment (*i.e.*, realigning the SSI fraction from the federal fiscal year to the provider's fiscal year). Indeed, as noted in the second Federal Register excerpt, CMS' stated realignment policy is that the provider "must accept" the realigned SSI percentage.

In other words, the determination was only being reopened to include realigned SSI percentages. Since the only matters specifically revised in the revised NPR was the adjustment to realign the SSI percentage from the federal fiscal year to the provider's fiscal year, the Board does not have jurisdiction over the revised NPR appeal of the DSH Part C days issues in these group cases. 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.[8]

As Part C days were not adjusted in the revised NPR as required by 42 C.F.R. § 405.1889, the Board finds that it does not have jurisdiction over St. Mary's because, pursuant to § 405.1889(b), the Provider did not have a right to appeal the revised NPR for the Part C days issues in these group cases. Accordingly, the Board dismisses St. Mary's from these group cases.

Conclusion:

The Board finds that it does not have jurisdiction over Centinela Hospital Medical Center, Landmark Medical Center, or St. Mary's General Hospital and dismisses these providers from Case Nos. 14-1524GC and 14-1525GC. PRRB Case Nos. 14-1524GC and 14-1525GC remain open for the remaining providers in the group appeals. The remaining providers are subject to CMS Ruling 1739-R, and will be addressed under separate cover.

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

Board Members Participating:

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

For the Board:

2/6/2023

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

[8] *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

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Via Electronic Delivery

James Ravindran
Quality Reimbursement Services, Inc.
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Arcadia, CA 91006

RE: ***Board Decision* – SSI Percentage (Provider Specific)**
Christus Lake Area Hospital (Provider Number 19-0201)
FYE: 06/30/2017
Case Number: 20-0191

Dear Mr. Ravindran,

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

Background:

A. *Procedural History for Case No. 20-0191*

On April 16, 2019, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end June 30, 2017.

On October 9, 2019, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained five (5) issues:

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

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

[1] On May 26, 2020, this issue was transferred to PRRB Case No. 20-0997GC.
[2] On November 14, 2022, Federal Specialized Services ("FSS") filed a jurisdictional challenge over the Medicaid Eligible Days issue. On December 28, 2022, FSS filed a Request for Dismissal of the Medicaid Eligible Days issue. Subsequently, the Provider withdrew this issue on January 13, 2023.
[3] The Provider withdrew this issue on January 13, 2023.
[4] On May 26, 2020, this issue was transferred to PRRB Case No. 20-0999GC.

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

The Provider's appeal request described Issue 1 (DSH/SSI – Provider Specific) as follows:

> The Provider contends that its SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> . . .
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[5]

The Provider's appeal request described Issue 2 (DSH/SSI Percentage) 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 at 42 U.S.C. § 1395ww(d)(5)(F)(vi). The Provider contends that the SSI percentages calculated by [CMS] and used by the Lead MAC to settle their Cost Report were incorrectly computed.
>
> . . .
>
> The Provider further contends that the SSI percentages calculated by [CMS] fail to address all the deficiencies as described in *Baystate Medical Center v. Michael O. Leavitt*, 545 F. Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37, 44 (D.D.C. 2008) and incorporates a new methodology inconsistent with the Medicare Statute.
>
> Providers [*sic*] 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

[5] Issue Statement at 1 (Oct. 9, 2019).

3. Fundamental problems in the SSI percentage calculation
4. Not in agreement with provider's records
5. Paid days vs. Eligible days, and
6. Covered days vs. Total days.[6]

The Provider also transferred its Issue 2 (DSH/SSI Percentage) to the CIRP group under Case Number 20-0997GC, *CHS CY 2017 DSH SSI Percentage CIRP Group*, on May 26, 2020. The Group Issue Statement for that case is identical to the DSH/SSI Percentage issue in case 20-0191.

MAC'S Contentions:

On August 11, 2020, the MAC filed a Jurisdictional Challenge. The MAC argues that the Board lacks jurisdiction over the DHS SSI Percentage - Provider Specific issue for two reasons. First, the MAC argues that the appeal is premature and the Provider has not exhausted all available remedies.[7]

In addition, the MAC argues the DSH SSI Percentage - Provider Specific issue and the DSH SSI Percentage - Systemic issue are considered the same issue by the Board, and cites several past Board decisions to that end.[8]

Provider's Response:

The Board Rules require that Provider Responses to the MAC's Jurisdictional Challenge must filed within thirty (30) days of the filing of the Jurisdictional Challenge.[9] The Provider has not filed a response to the challenge to the SSI Provider Specific issue and the time for doing so has elapsed.

Board Analysis and Decision:

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

A. SSI Provider Specific

The analysis for Issue 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

[6] *Id.* at Issue 2.
[7] Jurisdictional Challenge at 7 (Aug. 11, 2020).
[8] *Id*. at 6-7.
[9] Board Rule 44.4.3, v. 2. (Aug. 2018).

DSH percentage, and 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

1. First Aspect of Issue 1

The Board finds that the 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 (first aspect of the DSH/SSI Percentage (Provider Specific) issue) in this appeal is duplicative of Issue 2 (the DSH/SSI Percentage issue) that was appealed in Group Case No. 20-0997GC. The first aspect of Issue 1 in the present appeal concerns "whether the Medicare Administrative Contractor used the correct [SSI] percentage in the [DSH] Calculation."[10] The Provider's legal basis for this aspect of Issue 1 is simply that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[11] Similarly, the Provider argues that "it[s] SSI percentage published by [CMS] was incorrectly computed . . ." and it ". . . [s]pecifically . . . disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[12] Issue 2, which was transferred to group Case No. 20-0997GC, similarly alleges that the Medicare Contractor and CMS improperly calculated the DSH/SSI Percentage, the DSH/SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F)(i).

In making this finding, the Board further notes that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, the Provider is pursuing that issue as part of the group under Case No. 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.[13] The Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) 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.

Accordingly, the Board must find that Issue 1 and the group issue in 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 (2018), the Board dismisses this component of the DSH/SSI (Provider Specific) issue.

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[10] Individual Appeal Request, Issue 1.
[11] *Id.*
[12] *Id.*
[13] The types of systemic errors documented in the *Baystate* did not uniformly impact the SSI calculation for all providers but that does not 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).

2. Second Aspect of Issue 1

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

Conclusion:

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

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

Board Members Participating:

Clayton J. Nix, Esq.
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For the Board:

2/7/2023

X Kevin D. Smith, CPA

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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RE: ***Expedited Judicial Review Determination***
Case No. 23-0164GC – HonorHealth CY 2017 Capital DSH CIRP Group
Case No. 22-1089G – Bass, Berry & Sims, PLC CY 2017 Capital DSH Group
Case No. 22-1321G – Bass, Berry & Sims, PLC CY 2018 Capital DSH Group
Case No. 22-1106G – Bass, Berry & Sims, PLC CY 2019 Capital DSH Group

Dear Ms. Goldsmith:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' January 13, 2023 consolidated request for expedited judicial review ("EJR") in the above-referenced group appeals.[1] The decision with respect to EJR is set forth below.

Issue

In these four cases, 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.[2]

[1] The consolidated EJR request also included PRRB Case No. 22-1274GC; the EJR determination for that case will be decided under separate cover. Relevant to this determination, HonorHealth is a parent organization with multiple hospitals and is subject to the mandatory CIRP group regulations at 42 C.F.R. § 405.1837(b)(1) as it relates to the common issue in Case No. 23-0164GC for the year 2017. As HonorHealth designated the CIRP group fully formed, it is 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."

[2] Request for Expedited Judicial Review, 1 (Jan. 13, 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.[3] This case focuses 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[4] for purposes of receiving a higher payment rate if they meet certain criteria related to proximity and average hourly wage.[5] 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.[6] Under the operating IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[7]

The statute governing operating IPPS contains a number of provisions that adjust reimbursement based on hospital-specific factors.[8] 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.[9]

---

[3] 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 Jan. 26, 2023) ("*Significant Vulnerabilities*").
[4] *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).).
[5] Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, 103 Stat. 2106, 2154 (1989). *See also Significant Vulnerabilities* at 4-5.
[6] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[7] *Id.*
[8] *See* 42 U.S.C. § 1395ww(d)(5).
[9] *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").[10] 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.[11]

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.[12] 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**
>
> (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. . . .
>
> (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;
>
> (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*;
>
> (iii) may provide for such exceptions (including appropriate exceptions to reflect capital obligations) as the Secretary determines to be appropriate, and

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

> (iv) may provide for suitable adjustment to reflect hospital occupancy rate.
>
> (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.[13]

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.[14]

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.[15] 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)

[13] (Underline and italics emphasis added.)
[14] 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 Jan. 26, 2023).
[15] 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.[16]

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.
>
> 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.[17]

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.
>
> *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

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

> disproportionate share payments under § 412.106(C)(2) would also 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**.[18]

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.[19]

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

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, 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.[20]

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.[21]

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.[22]

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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[20] *Id.* at 43378.
[21] *Id.* at 43379.
[22] *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.
>
> *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.[23]

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.**
>
> (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).
>
> (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.[24]

[23] *Id.*
[24] *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.[25] 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.[26]

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

[25] BBRA, Pub. L. 106-113, App. F, § 401, 113. Stat. 1501A-321, 1501A-369 (1999).
[26] 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.

****

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.
>
> ****
>
> 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.
>
> ****
>
> *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.[27]

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:
>
> 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

[27] 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.
>
> (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.[28]

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.
>
> (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.
>
> (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**.[29]

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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[28] *Id*. at 47048.
[29] *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.[30] 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.[31] 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.[32]

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.[33] 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—

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

> (A) A Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget; or
>
> (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.
>
> (C) The term *rural area* means any area outside an urban area.
>
> (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.[34]

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

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.
>
> ****

[35] (Emphasis added.)
[36] 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.[37]

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

In the FY 2007 Proposed IPPS Rule, the Secretary[38] 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.[39]

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[37] 69 Fed. Reg. 48916, 49187-88 (Aug. 11, 2004).
[38] of the Department of Health and Human Services.
[39] 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.[40]

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.[41]

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.[42]

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[40] *Id.*
[41] *Id.*
[42] *Id.*

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:

> (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.[43]**

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*"),[44] 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.[45]

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

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

redesignate IPPS hospitals to different labor market areas in order to receive a different wage reimbursement rate.[46] The Court also noted how Congress enacted legislation in 1999[47] 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.[48] 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).[49] 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.[50]

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.[51]

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.[52] 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."[53]

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."[54]

    - "[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

[46] *Id.* at *2.
[47] 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.
[48] *Toledo* at *3.
[49] *Id.* at *3-4.
[50] *Id.* at *4.
[51] *Id.* at *5.
[52] *Id.* at *6-8.
[53] *Id.* at *11.
[54] *Id.*

cannot fall back on any purported general policy of using operating PPS geographic classifications for capital PPS reimbursements."[55]

- "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)."[56]

- "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."[57]

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."[58] Instead, the Court remanded the case to the Medicare Contractor for a redetermination on the appellants' eligibility for a capital DSH adjustment.[59]

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 Section 401 rural reclassifications pursuant to 42 C.F.R. § 412.103.[60]

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, the Providers argue that a rural reclassification under the subsection (d) operating PPS provisions does not apply for subsection (g) capital PPS purposes.[61]

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.[62] The Providers assert that the Secretary has implicitly

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[55] *Id.*
[56] *Id.*
[57] *Id.* at *11-12.
[58] *Id.* at *12.
[59] *Id.*
[60] Request for EJR at 7.
[61] *Id.* at 7.
[62] *Id.*

acknowledged that he cannot apply rural status for hospitals that have undergone a rural 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."[63] 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).[64]

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.[65]

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*.[66]

The Providers contend that since the Board is bound by the regulation being challenged,[67] 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 that the Board grant the EJR request.[68]

Board Decision

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 & Related Claims Filing Requirements

1. Dismissal of Provider No. 51-0058 From Case No. 22-1106G

As a preliminary matter, on review of each provider in each of the four group appeals at issue for meeting the requirements for filing appeals before the Board, the Board has been determined that one provider, Provider No. 51-0058, Camden-Clark Memorial Hospital, in Case No. 22-1106G filed its appeal request prematurely. This Provider was added to Case No. 22-1106G on August 20, 2022, and appealed from the non-issuance of a Notice of Program Reimbursement ("NPR"),

[63] *Id.* at 8, citing 70 Fed. Reg. 47278, 47437 (Aug. 12, 2005).
[64] *Id.*
[65] *Id.* at 8-9.
[66] *Id.* at 9, 11.
[67] *See* 42 C.F.R. § 405.1867.
[68] Request for EJR at 10-11.

or final determination, for its second amended cost report. The Provider indicated that it was filing the appeal request based on the failure of the Medicare Contractor to issue a timely determination under 42 C.F.R. § 405.1835(c)(1). The regulations governing appeals based on the failure of the Medicare Contractor to issue a timely determination are governed by § 405.1835(c)-(d) which states:

> (c) *Right to hearing based on untimely contractor determination*. Notwithstanding the provisions of paragraph (a) of this section, a provider (but no other individual, entity, or party) has a right to a Board hearing, as a single provider appeal, for specific items for a cost reporting period if—
>
> (1) A final contractor determination for the provider's cost reporting period is not issued (**through no fault of the provider**) within 12 months after the date of receipt by the contractor of the provider's perfected cost report or amended cost report (as specified in §413.24(f) of this chapter). The date of receipt by the contractor of the provider's perfected cost report or amended cost report is presumed to be the date the contractor stamped ''Received'' on such cost report unless it is shown by a preponderance of the evidence that the contractor received the cost report on an earlier date.
>
> (2) 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 is no later than 180 days after the expiration of the 12 month period for issuance of the final contractor determination (as determined in accordance with paragraph (c)(1) of this section); and
>
> (3) The amount in controversy (as determined in accordance with §405.1839) is $10,000 or more.
>
> (d) *Contents of request for a Board hearing based on untimely contractor determination*. The provider's request for a Board hearing under paragraph (c) 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 (d)(1) through (4) of this section. If the provider submits a hearing request that does not meet the requirements of paragraph (d)(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 (c) of this section**.
>
> (2) An explanation (for each specific item at issue) 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 Medicare 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, a description of the nature and amount of each self-disallowed item and the reimbursement or payment sought for the item.
>
> (3) A copy of any documentary evidence the provider considers necessary to satisfy the hearing request requirements of paragraphs (d)(1) and (d)(2) of this section.
>
> (4) With respect to a provider under common ownership or control, the name and address of its parent corporation, and a statement that meets all of the requirements of paragraphs (b)(4)(i) and (b)(4)(ii) of this section.[69]

However, the record shows that the Provider filed yet a ***third*** amended cost report that was accepted by the Medicare Contractor on July 22, 2022, *approximately one month* ***prior to*** *its filing of the appeal request in Case No. 22-1106G*. The Provider's filing of the third amended cost report and its acceptance by the Medicare Contractor is *an intervening event* that restarted the 12-month period from which the Medicare Contractor is required to issue a final determination.[70] The Board notes that the Provider caused the filing of the third amended cost report and there is no evidence in the record to suggest that the Provider is *not* at fault for its filing of the third amended cost report notwithstanding the Provider's burden of proof per § 405.1835(d)(1) (*i.e.*, the Provider must "demonstrate[e] that [it] satisfies the requirements of [§ 405.1835(c)]") . Accordingly, based on the record before it, the Board finds that it is clear that the Provider's filing of the third amended cost report is the reason why the Medicare Contractor did and could not issue an NPR on the second amended complaint. Therefore, twelve (12) months have not yet passed from the date of the filing of the third amended cost report, as required under 42 C.F.R. § 405.1835(c)(1), to file an appeal based on the failure of the Medicare contractor to issue a timely determination.

For these reasons, the Board dismisses Provider No. 51-0058, Camden-Clark Memorial Hospital's appeal request from Case No. 22-1106G as premature and not yet in compliance with 42 C.F.R.

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[69] (Bold and underline emphasis added.)

[70] *See also* 42 U.S.C. § 1395oo(a)(1)(C) allowing for appeals where the provider "has not received such final determination on a timely basis after filing a supplementary cost report, *where such cost report did* ***not*** *so comply* [with the rules and regulations of the Secretary relating to such report] ***and*** such *supplementary cost report did so comply*." Here, it is clear that neither the originally filed cost report nor the first and second amended cost reports complied "with the rules and regulations of the Secretary relating to such report" and that the third amended cost report did so comply because otherwise the third an amended cost report would not have been otherwise needed/required. Indeed, there is no evidence to the contrary in the record, and it is the Provider's burden to establish jurisdiction before the Board and to demonstrate it has met the claim filing requirements. *See* 42 C.F.R. §§ 405.1835(d)(1).

§ 405.1835(c)(1).[71] The other eight (8) providers in Case No. 22-1106G will remain in that appeal as each filed a timely appeal and the amount in controversy for the group exceeds $50,000.

2. Jurisdiction Over the 4 Groups and the Remaining Participants Therein

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 four cases have fiscal years that began after January 1, 2016, the claim-specific dissatisfaction requirement is not applicable.

The remaining participants that comprise the four group appeals have filed appeals involving fiscal years ending in 2017, 2018 or 2019. 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 four group appeals (except for Provider No. 51-0058, Camden-Clark Memorial Hospital in Case No.

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[71] The Board notes that the Group Representative could have held this group open to allow the Provider to appeal from the NPR (or if the Medicare Contractor failed to timely issue the NPR based on the third amended cost report, within 180 days after 12 months with no NPR elapsed). However, the Group Representative certified that the group was complete and concurrently requested EJR, foreclosing the possibility of such an appeal (since the EJR request forecloses any future potential discretion from the Board to consider reopening the CIRP group). *See* 42 C.F.R. § 405.1837(e)(1) (stating "The Board determines that a group appeal brought under paragraph (b)(2) of this section is fully formed upon a notice in writing from the group that it is fully formed, or following an order from the Board that in its judgment, that the group is fully formed, or through general instructions that set forth a schedule for the closing of group appeals brought under paragraph (b)(2) of this section. *When the Board has determined that a group appeal brought under paragraph (b)(1) of this section 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*."). In this regard, the Board further notes that the Group Representative filed notice that the group was complete on December 1, 2022 and then, 43 days later, concurrently filed both its Board Rule 20 Certification and EJR request on January 13, 2023. The fact that the Certification and the EJR request were filed simultaneously is material because it is the Certification that triggers the start of the jurisdictional review process where the Medicare Contractor normally has 60 days to review and file, as relevant Jurisdictional Challenges. The Group Representative chose not to wait for the completion of the jurisdictional review process before filing its EJR request.

[72] 80 Fed. Reg. 70298, 70551-70580 (Nov. 13, 2015).

[73] *Id.* at 70555.

22-1106G, as discussed above,) 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 twelve months after the submission of their cost report or 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 all four of the cases at issue.

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.[74]

These regulations are applicable to all of the cost reporting periods under appeal for all of the participants in all four group appeals, which all have cost reporting periods ending 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] In these four group cases, the Medicare Contractor has failed to file a Substantive Claim Challenge[77] consistent with § 405.1873(a) within the time frame specified by Board Rule 44.5.1 (2021) for any of the Providers in these cases.

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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] Board Rule 44.5 states: "The Board adoption of the term 'Substantive Claim Challenge' simply refers to any question raised by a party concerning whether the cost report at issue included an appropriate claim for one or more of the specific items being appealed in order to receive or potentially qualify for reimbursement for those specific items."

As such, since no party to the appeal has questioned, pursuant to § 405.1873(a), whether an appropriate claim was made,[78] 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 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 these four group appeals are entitled to a hearing before the Board *except for the following participant in Case No. 22-1106G*:

    - The Board dismisses Provider No. 51-0058, Camden-Clark Memorial Hospital, in Case No. 22-1106G from the appeal because this provider's request for hearing was premature and not yet in accordance with 42 C.F.R. § 405.1835(c)(1);

2) No findings regarding whether the Providers' cost reports included an appropriate claims for the specific item at issue in this appeals because the review process in 42 C.F.R. § 405.1873(a)-(b) has not been triggered;

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 four cases, the Board hereby closes these cases.

[78] 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."

Board Members Participating:

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

For the Board:

2/8/2023

X Clayton J. Nix

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

Enclosures: Schedules of Providers

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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

RE: ***Board Decision* – SSI Percentage (Provider Specific)**
Lower Keys Medical Center (Provider Number 10-0150)
FYE: 09/30/2016
Case Number: 19-2769

Dear Mr. Ravindran,

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

Background:

A. *Procedural History for Case No. 19-2769*

On March 7, 2019, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end September 30, 2016.

On August 28, 2019, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained nine (9) issues:

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

[1] On March 19, 2020, this issue was transferred to PRRB Case No. 19-0173GC.
[2] On March 19, 2020, this issue was transferred to PRRB Case No. 19-0175GC.
[3] On March 19, 2020, this issue was transferred to PRRB Case No. 19-0198GC.
[4] On November 14, 2022, Federal Specialized Services ("FSS") filed a jurisdictional challenge over the Medicaid Eligible Days issue. On December 28, 2022, FSS filed a Request for Dismissal of the Medicaid Eligible Days issue. Subsequently, the Provider withdrew this issue on January 13, 2023.
[5] On March 19, 2020, this issue was transferred to PRRB Case No. 19-0159GC.

- Uncompensated Care Distribution Pool[6]
- Medicaid Fraction Dual Eligible Days[7]
- 2 Midnight Census IPPS Payment Reduction[8]

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

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 19-0173GC

The Provider's appeal request described Issue 1 (DSH/SSI Percentage – Provider Specific) 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]

The Provider's appeal request described Issue 2 (DSH/SSI Percentage) 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 at 42 U.S.C. § 1395ww(d)(5)(F)(vi). The Provider contends that the SSI percentages calculated by [CMS] and used by the Lead MAC to settle their Cost Report were incorrectly computed.
>
> The Provider further contends that the SSI percentages calculated by [CMS] fail to address all the deficiencies as described in *Baystate Medical Center v. Michael O. Leavitt*, 545 F. Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37, 44 (D.D.C. 2008) and incorporates a new methodology inconsistent with the Medicare Statute.

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[6] The Provider withdrew this issue on January 13, 2023.
[7] On March 19, 2020, this issue was transferred to PRRB Case No. 19-0197GC.
[8] On March 19, 2020, this issue was transferred to PRRB Case No. 19-0185GC.
[9] Issue Statement at 1 (Aug. 28, 2019).

> Providers [*sic*] in this case are also seeking resolution of the following additional aspects of the Medicare fraction that were not addressed in the Baystate case:
>
> 1. Availability of MEDPAR and SSA Records
> 2. Failure to adhere to required notice and comment rulemaking procedures
> 3. Fundamental problems in the SSI percentage calculation
> 4. Not in agreement with provider's records
> 5. Paid days vs. Eligible days, and
> 6. Covered days vs. Total days.[10]

The Provider also transferred its Issue 2 (DSH/SSI Percentage) to the CIRP group under Case Number 19-0173GC, *CHS CY 2016 HMA DSH SSI Percentage (Systemic Errors) CIRP Group*, on March 19, 2020. The Group Issue Statement for that case is identical to the DSH/SSI issue in case 19-2769.

MAC'S Contentions:

On January 2, 2020, the MAC filed a Jurisdictional Challenge. The MAC argues that the Board lacks jurisdiction over the DHS SSI Percentage - Provider Specific issue for two reasons. First, the MAC argues that the appeal is premature and the Provider has not exhausted all available remedies.[11]

In addition, the MAC argues the DSH SSI Percentage - Provider Specific issue and the DSH SSI Percentage - Systemic issue are "one and the same with same potential outcome and effective reimbursement amount."[12]

Provider's Response:

The Board Rules require that Provider Responses to the MAC's Jurisdictional Challenge must filed within thirty (30) days of the filing of the Jurisdictional Challenge.[13] The Provider has not filed a response to the Jurisdictional Challenge over the SSI Provider Specific issue in this case and the time for doing so has elapsed.[14]

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

[10] *Id.* at Issue 2.
[11] Jurisdictional Challenge at 7 (Jan. 2, 2020).
[12] *Id*.
[13] Board Rule 44.4.3, v. 2. (Aug. 2018).
[14] The Provider did file a response to the November 14, 2022 Jurisdictional Challenge over the Medicaid Eligible Days issue, but has since withdrawn that issue.

it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

A. SSI Provider Specific

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

1. First Aspect of Issue 1

The Board finds that the first aspect (the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage) of Issue 1 (the DSH/SSI Percentage (Provider Specific) issue) in this appeal is duplicative of Issue 2 (the DSH/SSI Percentage issue) that was appealed in Case No. 19-0173GC. The first aspect of Issue 1 in the present appeal concerns "whether the Medicare Administrative Contractor used the correct [SSI] percentage in the [DSH] Calculation."[15] 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)."[16] 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."[17] Issue 2, transferred to group Case No. 19-0173GC, similarly alleges that the Medicare Contractor and CMS improperly calculated the DSH/SSI Percentage, the DSH/SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F)(i).

In making this finding, the Board further notes that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, the Provider is pursuing that issue as part of the group under Case No. 19-0173GC. 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 can be

[15] Individual Appeal Request, Issue 1.
[16] *Id.*
[17] *Id.*
[18] The types of systemic errors documented in the *Baystate* did not uniformly impact the SSI calculation for all providers but that does not 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. 19-0173GC.

Accordingly, the Board must find that the first aspect of Issue 1 and the group issue in Group Case 19-0173GC, 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 (2018), the Board dismisses this component of the DSH/SSI Percentage (Provider Specific) issue.

2. Second Aspect of Issue 1

The second aspect of the DSH SSI Percentage (Provider Specific) issue—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—must be dismissed for lack of jurisdiction and as premature. Under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request…" Without this written request, the Medicare Contractor cannot issue a final determination from which the Provider can be dissatisfied with for appealing purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding the Provider's DSH SSI Percentage realignment as such there is no "determination" to appeal and the appeal of this issue is otherwise premature. Further, the Provider's cost reporting period ends on 9/30, which is the same as the federal fiscal year end. Therefore, any realignment from the federal fiscal year to the Provider's cost reporting period would have no effect on the SSI percentage calculation.

Conclusion:

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

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

Board Members Participating:

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For the Board:

2/8/2023

X Kevin D. Smith, CPA

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

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

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Via Electronic Delivery

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RE: ***Board Decision* – SSI Percentage (Provider Specific)**
Tennova Healthcare Harton (Provider Number 44-0144)
FYE: 05/31/2017
Case Number: 20-0333

Dear Mr. Ravindran,

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

Background:

A. *Procedural History for Case No. 20-0333*

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

On October 28, 2019, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained nine (9) issues:

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

[1] On May 27, 2020, this issue was transferred to PRRB Case No. 20-1332GC.
[2] On May 27, 2020, this issue was transferred to PRRB Case No. 20-1333GC.
[3] On May 27, 2020, this issue was transferred to PRRB Case No. 20-1334GC.
[4] On November 14, 2022, Federal Specialized Services ("FSS") filed a jurisdictional challenge over the Medicaid Eligible Days issue. On December 28, 2022, FSS filed a Request for Dismissal of the Medicaid Eligible Days issue. Subsequently, the Provider withdrew this issue on January 13, 2023.
[5] On May 27, 2020, this issue was transferred to PRRB Case No. 20-1335GC.

- Medicaid Fraction Dual Eligible Days[6]
- Uncompensated Care Distribution Pool[7]
- 2 Midnight Census IPPS Payment Reduction[8]

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

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

The Provider's appeal request described Issue 1 (DSH/SSI Percentage – Provider Specific) 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]

The Provider's appeal request described Issue 2 (DSH/SSI Percentage) 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 at 42 U.S.C. § 1395ww(d)(5)(F)(vi). The Provider contends that the SSI percentages calculated by [CMS] and used by the Lead MAC to settle their Cost Report were incorrectly computed.
>
> . . .
>
> The Provider further contends that the SSI percentages calculated by [CMS] fail to address all the deficiencies as described in *Baystate Medical Center v. Michael O. Leavitt*, 545 F. Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37, 44 (D.D.C. 2008) and

[6] On May 27, 2020, this issue was transferred to PRRB Case No. 20-1336GC.
[7] The Provider withdrew this issue on January 13, 2023.
[8] On May 27, 2020, this issue was transferred to PRRB Case No. 20-1337GC.
[9] Issue Statement at 1 (Oct. 28, 2019).

> incorporates a new methodology inconsistent with the Medicare Statute.
>
> Providers [*sic*] in this case are also seeking resolution of the following additional aspects of the Medicare fraction that were not addressed in the Baystate case:
>
> 1. Availability of MEDPAR and SSA Records
> 2. Failure to adhere to required notice and comment rulemaking procedures
> 3. Fundamental problems in the SSI percentage calculation
> 4. Not in agreement with provider's records
> 5. Paid days vs. Eligible days, and
> 6. Covered days vs. Total days.[10]

The Provider also transferred its Issue 2 (DSH/SSI Percentage) to the CIRP group under Case Number 20-1332GC, *CHS CY 2017 HMA DSH SSI Percentage CIRP Group*, on May 27, 2020. The Group Issue Statement for that case is identical to the DSH/SSI issue in case 20-0333.

MAC'S Contentions:

On August 17, 2020, the MAC filed a Jurisdictional Challenge. The MAC argues that the Board lacks jurisdiction over the DHS SSI Percentage - Provider Specific issue for two reasons. First, the MAC argues that the appeal is premature and the Provider has not exhausted all available remedies.[11]

In addition, the MAC argues the DSH SSI Percentage - Provider Specific issue and the DSH SSI Percentage issue are considered the same issue by the Board, and cites several past Board decisions to that end.[12]

Provider's Response:

The Board Rules require that Provider Responses to the MAC's Jurisdictional Challenge must filed within thirty (30) days of the filing of the Jurisdictional Challenge.[13] The Provider has not filed a response to the Jurisdictional Challenge over the SSI Provider Specific issue in this case and the time for doing so has elapsed.[14]

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[10] *Id.* at Issue 2.
[11] Jurisdictional Challenge at 9 (Aug. 17, 2020).
[12] *Id*. at 7-8.
[13] Board Rule 44.4.3, v. 2. (Aug. 2018).
[14] The Provider did file a response to the November 14, 2022 Jurisdictional Challenge over the Medicaid Eligible Days issue, but has since withdrawn that issue.

Board Analysis and Decision:

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

A. SSI Provider Specific

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

1. First Aspect of Issue 1

The Board finds that the first aspect – the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage - of Issue 1 (the DSH/SSI Percentage (Provider Specific) issue) in this appeal is duplicative of Issue 2 (the DSH/SSI Percentage issue) that was appealed in Case No. 20-1332GC. The first aspect of Issue 1 in the present appeal concerns "whether the Medicare Administrative Contractor used the correct [SSI] percentage in the [DSH] Calculation."[15] 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)."[16] 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."[17] Issue 2, transferred to group Case No. 20-1332GC, similarly alleges that the Medicare Contractor and CMS improperly calculated the DSH/SSI Percentage, the DSH/SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F)(i).

In making this finding, the Board further notes that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, the Provider is pursuing that issue as part of the group under Case No. 20-1332GC. 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

[15] Individual Appeal Request, Issue 1.
[16] *Id.*
[17] *Id.*
[18] The types of systemic errors documented in the *Baystate* did not uniformly impact the SSI calculation for all providers but that does not 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).

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. 20-1332GC.

Accordingly, the Board must find that the first aspect of Issue 1 and the group issue in Group Case 20-1332GC, 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 (2018), the Board dismisses this component of the DSH/SSI (Provider Specific) issue.

2. Second Aspect of Issue 1

The second aspect — the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period — of Issue 1 (the DSH/SSI Percentage (Provider Specific) issue) must be dismissed for lack of jurisdiction and as premature. Under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request…" Without this written request, the Medicare Contractor cannot issue a final determination with which the Provider can be dissatisfied for appeal purposes. There is nothing in the record to indicate that the Medicare Contractor has made a final determination regarding the Provider's DSH SSI Percentage realignment, and as such, there is no "determination" to appeal and the appeal of this issue is therefore premature.

Conclusion:

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

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

Board Members Participating:

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

For the Board:

2/8/2023

X Kevin D. Smith, CPA

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

cc: Wilson C. Leong, Esq., Federal Specialized Services
Byron Lamprecht, WPS Government Health Administrators (J-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 570A
Arcadia, CA 91006

RE: ***Board Decision* – SSI Percentage (Provider Specific)**
Southern Virginia Regional Medical Center (Provider Number 49-0097)
FYE: 02/28/2017
Case Number: 20-0488

Dear Mr. Ravindran,

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

Background:

A. *Procedural History for Case No. 20-0488*

On June 18, 2019, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end February 28, 2017.

On November 22, 2019, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained five (5) issues:

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

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

[1] On June 18, 2020, this issue was transferred to PRRB Case No. 20-0997GC.
[2] On November 14, 2022, Federal Specialized Services ("FSS") filed a jurisdictional challenge over the Medicaid Eligible Days issue. On December 28, 2022, FSS filed a Request for Dismissal of the Medicaid Eligible Days issue. Subsequently, the Provider withdrew this issue on January 13, 2023.
[3] The Provider withdrew this issue on April 30, 2021.
[4] On June 18, 2020, this issue was transferred to PRRB Case No. 20-0999GC.

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

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

> The Provider contends that its SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> . . .
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[5]

The Provider's appeal request described Issue 2 (SSI Percentage) 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 at 42 U.S.C. § 1395ww(d)(5)(F)(vi). The Provider contends that the SSI percentages calculated by [CMS] and used by the Lead MAC to settle their Cost Report were incorrectly computed.
>
> . . .
>
> The Provider further contends that the SSI percentages calculated by [CMS] fail to address all the deficiencies as described in *Baystate Medical Center v. Michael O. Leavitt*, 545 F. Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37, 44 (D.D.C. 2008) and incorporates a new methodology inconsistent with the Medicare Statute.
>
> Providers [*sic*] 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

[5] Issue Statement at 1 (Nov. 22, 2019).

3. Fundamental problems in the SSI percentage calculation
4. Not in agreement with provider's records
5. Paid days vs. Eligible days, and
6. Covered days vs. Total days.[6]

As the Provider is commonly owned by Community Health Systems, Inc. ("CHS"), the Provider also transferred its Issue 2 – SSI Percentage to the common issue related party ("CIRP") group under Case Number 20-0997GC, *CHS CY 2017 DSH SSI Percentage CIRP Group*, on June 18, 2020. The Group Issue Statement for 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/con-covered/eligible SSI days?
>
> **Statement of the Legal Basis**
>
> The Provider(s) contend(s) that the MAC's determination for their DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww(d)(5)(F)(vi). 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. 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

MAC's Contentions:

On October 2, 2020, the MAC filed a Jurisdictional Challenge. The MAC argues that the Board lacks jurisdiction over the SSI Percentage - Provider Specific issue for two reasons. First, the

[6] *Id.* at Issue 2.

MAC argues that the appeal is premature and the Provider has not exhausted all available remedies.[7]

In addition, the MAC argues the SSI Percentage - Provider Specific issue and the SSI Percentage issue are considered the same issue by the Board, and cites several past Board decisions to that end.[8]

Provider's Response:

The Board Rules require that Provider Responses to the MAC's Jurisdictional Challenge must filed within thirty (30) days of the filing of the Jurisdictional Challenge.[9] The Provider has not filed a response to the Jurisdictional Challenge over the SSI Provider Specific issue in this case and the time for doing so has elapsed.[10] 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 (2013), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

A. SSI Provider Specific

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

1. First Aspect of Issue 1

The Board finds that the first aspect (the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage) of Issue 1 (the SSI Percentage – Provider Specific issue) is duplicative of the SSI Percentage issue that was appealed in Group Case No. 20-0997GC. The first aspect of Issue 1 in the present appeal concerns "whether the Medicare Administrative Contractor used the correct [SSI] percentage in

[7] Jurisdictional Challenge at 7 (Oct. 2, 2020).
[8] *Id*. at 5-6.
[9] Board Rule 44.4.3, v. 2. (Aug. 2018).
[10] The Provider did file a response to the November 14, 2022 Jurisdictional Challenge over the Medicaid Eligible Days issue, but has since withdrawn that issue.

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] Issue 2, transferred to group Case No. 20-0997GC, similarly alleges that the Medicare Contractor and CMS improperly calculated the DSH/SSI Percentage, the DSH/SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F)(i).

In making this finding, the Board further notes that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, the Provider is pursuing that issue as part of the group under Case No. 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] 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.

Accordingly, the Board must find that the first aspect of Issue 1 and the group issue in 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 (2018), the Board dismisses this component of the SSI Percentage (Provider Specific) issue.

2. Second Aspect of Issue 1

The second aspect of the SSI Percentage (Provider Specific) issue—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—must be dismissed for lack of jurisdiction and as premature. Under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request…" Without this written request, the Medicare Contractor cannot issue a final determination with which the Provider can be dissatisfied for appeal purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination

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

regarding the Provider's DSH SSI Percentage realignment and, as such, there is no "determination" to appeal and the appeal of this issue is otherwise premature.

Conclusion:

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

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

Board Members Participating:

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

For the Board:

2/8/2023

X Kevin D. Smith, CPA

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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

RE: ***Board Decision* – SSI Percentage (Provider Specific)**
Alliance Health Ponca City (Provider Number 37-0006)
FYE: 05/31/2018
Case Number: 21-0302

Dear Mr. Ravindran,

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

Background:

A. *Procedural History for Case No. 21-0302*

On April 17, 2020, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end May 31, 2018.

On October 5, 2020, the Board received the 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[2]

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

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

[1] On May 20, 2021, this issue was transferred to PRRB Case No. 21-1206GC.
[2] On November 14, 2022, Federal Specialized Services ("FSS") filed a jurisdictional challenge over the Medicaid Eligible Days issue. On December 28, 2022, FSS filed a Request for Dismissal of the Medicaid Eligible Days issue. Subsequently, the Provider withdrew this issue on January 13, 2023.

The Provider's appeal request described Issue 1 (DSH/SSI Percentage – Provider Specific) 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's appeal request described Issue 2 (DSH/SSI Percentage) 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 at 42 U.S.C. § 1395ww(d)(5)(F)(vi). The Provider contends that the SSI percentages calculated by [CMS] and used by the Lead MAC to settle their Cost Report were incorrectly computed.
>
> . . .
>
> The Provider further contends that the SSI percentages calculated by [CMS] fail to address all the deficiencies as described in *Baystate Medical Center v. Michael O. Leavitt*, 545 F. Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37, 44 (D.D.C. 2008) and incorporates a new methodology inconsistent with the Medicare Statute.
>
> Providers [*sic*] 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

[3] Issue Statement at 1 (Oct. 5, 2020).

5. Paid days vs. Eligible days, and
6. Covered days vs. Total days.[4]

The Provider also transferred its Issue 2 – DSH/SSI Percentage to the CIRP group under Case Number 21-1206GC, *CHS CY 2018 DSH SSI Percentage CIRP Group*, on May 20, 2021. The Group Issue Statement for that case is identical to the DSH/SSI Percentage issue in case 21-0302.

MAC'S Contentions:

On July 30, 2021, the MAC filed a Jurisdictional Challenge. 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 and the Provider has not exhausted all available remedies.[5]

In addition, the MAC argues the DSH SSI Percentage - Provider Specific issue and the DSH SSI Percentage - Systemic issue are considered the same issue by the Board, and cites several past Board decisions to that end.[6]

Provider's Response:

The Board Rules require that Provider Responses to the MAC's Jurisdictional Challenge must filed within thirty (30) days of the filing of the Jurisdictional Challenge.[7] The Provider has not filed a response to the Jurisdictional Challenge over the SSI Provider Specific issue in this case and the time for doing so has elapsed.[8]

Board Analysis and Decision:

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

A. SSI Provider Specific

The analysis for Issue 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

[4] *Id.* at Issue 2.
[5] Jurisdictional Challenge at 7 (July 30, 2021).
[6] *Id*. at 5-6.
[7] Board Rule 44.4.3, v. 2. (Aug. 2018).
[8] The Provider did file a response to the November 14, 2022 Jurisdictional Challenge over the Medicaid Eligible Days issue, but has since withdrawn that issue.

the DSH percentage, and 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

1. First Aspect of Issue 1

The Board finds that the first aspect (the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage) of Issue 1 (the DSH/SSI – Provider Specific issue) is duplicative of Issue 2 (the DSH/SSI Percentage issue) that was appealed in Group Case No. 21-1206GC. The first aspect of Issue 1 in the present appeal concerns "whether the Medicare Administrative Contractor used the correct [SSI] percentage in the [DSH] Calculation."[9] 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)."[10] 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."[11] Issue 2, transferred to group Case No. 21-1206GC, similarly alleges that the Medicare Contractor and CMS improperly calculated the DSH/SSI Percentage, the DSH/SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F)(i).

In making this finding, the Board further notes that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, the Provider is pursuing that issue as part of the group under Case No. 21-1206GC. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[12] The Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 21-1206GC.

Accordingly, the Board must find that the first aspect of Issue 1 and the group issue in Group Case 21-1206GC, 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 (2018), the Board dismisses this component of the DSH/SSI Percentage (Provider Specific) issue.

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

2. Second Aspect of Issue 1

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

Conclusion:

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

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

Board Members Participating:

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

For the Board:

2/8/2023

X Kevin D. Smith, CPA

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Stephanie Webster, Esq.
Ropes & Gray, LLP
2099 Pennsylvania Ave NW
Washington, DC 20006

RE: ***Expedited Judicial Review Determination***
16-0557GC HCA 2014 Medicaid Fraction Medicare Advantage Plan Days (Pre 10/1/13) CIRP Group
16-0733GC HCA 2014 DSH SSI Fraction Medicare Advantage Days CIRP (2013 Fractions)

Dear Ms. Webster:

The above-referenced two (2) common issue related party ("CIRP") group appeals[1] include a challenge to the inclusion of Medicare Part C days in the Medicare fraction of the disproportionate share ("DSH") percentage and/or the exclusion of Medicare Part C days for patients who are dually eligible for Medicaid from the Medicaid fraction of the DSH percentage, for patient discharges *before* October 1, 2013. The Centers for Medicare & Medicaid Services' ("CMS") Ruling CMS-1739-R ("CMS Ruling 1739-R" or "Ruling") addresses how the Provider Reimbursement Review Board ("Board" or "PRRB") must treat provider appeals of the Medicare Part C Days issue. Under the terms of the Ruling, the Board must remand this issue to the Medicare Contractor for calculation of the DSH payment adjustment in accordance with the forthcoming final rule CMS will issue "to govern the treatment of [Medicare Part C] patient days with discharge dates before October 1, 2013." *See also* 58 Fed. Reg. 47723 (Aug. 6, 2020).

The subject CIRP groups are fully formed.[2] On January 13, 2023, the Providers in the above-referenced CIRP group appeals filed a request for Expedited Judicial Review ("EJR") of the Part C Days issue, asking the Board to grant EJR despite the issuance of CMS Ruling 1739-R, and further challenging said Ruling.[3] Set forth below is the Board's decision to grant, in part, and deny, in part, the EJR request.

Statutory and Regulatory Background

Medicare Advantage Program

The Medicare program permits its beneficiaries to receive services from managed care entities. The managed care statute implementing payments to health maintenance organizations

[1] 42 C.F.R. § 405.1837(b)(1) (mandating use of groups by related providers for common issues).
[2] The Board notes that, with respect to fully formed or complete CIRP groups, 42 C.F.R. § 405.1837(e)(1) states, in pertinent part: "When the Board has determined that a group appeal brought under paragraph (b)(1) of this section 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." (Emphasis added.)
[3] Providers' Petition for Expedited Judicial Review (Jan. 13, 2023), Case No. 16-0557GC; *Id*. at Case No. 16-0733GC.

("HMOs") and competitive medical plans ("CMPs") is found at 42 U.S.C. § 1395mm. The statute at 42 U.S.C. § 1395mm(a)(5) provides for "payment to the eligible organization under this section for individuals enrolled under this section with the organization and entitled to benefits under part A of this subchapter and enrolled under part B of this subchapter . . ." Inpatient hospital days for Medicare beneficiaries enrolled in HMOs and CMPs prior to 1999 are referred to as Medicare HMO patient care days.

In the September 4, 1990 Federal Register, the Secretary[4] stated that:

> Based on the language of section 1886(d)(5)(F)(vi) of the Act [42 U.S.C. § 1395ww(d)(5)(F)(vi)], which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A," we believe it is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs, and therefore, were unable to fold this number into the calculation [of the DSH adjustment]. However, as of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[5]

At that time, Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[6]

With the creation of Medicare Part C in 1997,[7] Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C days in the SSI ratios used by the Medicare contractors to calculate DSH payments for the fiscal years 2001-2004.[8]

No further guidance regarding the treatment of Part C days in the DSH calculation was provided until the 2004 Inpatient Prospective Payment System ("IPPS") proposed rules were published in the Federal Register. In that notice, the Secretary stated that:

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[4] of Health and Human Services.
[5] 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).
[6] *Id.*
[7] The Medicare Part C program did not begin operating until January 1, 1999. *See* P.L. 105-33, 1997 HR 2015, *codified as* 42 U.S.C. § 1394w-21 Note (c) "Enrollment Transition Rule.- An individual who is enrolled [in Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered to be enrolled with that organization on January 1, 1999, under part C of Title XVIII . . . if that organization as a contract under that part for providing services on January 1, 1999 . . . ." This was also known as Medicare+Choice. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub.L. 108-173), enacted on December 8, 2003, replaced the Medicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.
[8] 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).

> . . . once a beneficiary has elected to join an M+C plan, that beneficiary's benefits are no longer administered under Part A . . . . *once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage. These patient days should be included in the count of total patient days in the Medicaid fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction . . . .*[9]

The Secretary purportedly changed her position in the Federal fiscal year ("FFY") 2005 IPPS final rule, by noting she was "revising our regulations at [42 C.F.R.] § 412.106(b)(2)(i) to include the days associated with [Part C] beneficiaries in the Medicare fraction of the DSH calculation."[10] In response to a comment regarding this change, the Secretary explained that:

> *. . . We do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A*. We agree with the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are *not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction . . . .* if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.[11]

This statement would require inclusion of Medicare Part C inpatient days in the Medicare fraction of the DSH calculation.

Although the change in DSH policy regarding 42 C.F.R. § 412.106(b)(2)(i) was included in the August 11, 2004 Federal Register, no change to the regulatory language was published until August 22, 2007, when the FFY 2008 IPPS final rule was issued.[12] In that publication, the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change adopted in the FFY 2005 IPPS final rule. These "technical corrections" are reflected at 42 C.F.R. §§

[9] 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).
[10] 69 Fed. Reg. at 49099.
[11] *Id.* (emphasis added).
[12] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).

412.106(b)(2)(i)(B) and (b)(2)(iii)(B).[13] As a result of these rulemakings, Part C days were required to be included in the Medicare fraction as of October 1, 2004 (the "Part C DSH policy"). Subsequently, as part of the FFY 2011 IPPS final rule published on August 15, 2010, CMS made a minor revision to §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) "to clarify" the Part C DSH policy by replacing the word "or" with "including."[14]

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[15] vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.[16] In *Allina Health Services v. Price* ("*Allina II*")*,*[17] the D.C. Circuit confirmed that the Secretary's 2004 attempt to change the standard to include Part C days in the Medicare fraction had been vacated in *Allina I*.[18] The D.C. Circuit further found in *Allina II* that the Secretary failed to provide proper notice and comment before including Part C days in the Medicare fractions published for FY 2012.[19] Most recently, the Supreme Court affirmed the D.C. Circuit Court's judgment in *Allina II*.[20]

CMS Ruling 1739-R

On August 17, 2020, in response to the *Allina* decisions, CMS issued ruling 1739-R (the "Ruling"). The Ruling states that the Board, and other Medicare administrative appeals tribunals, lack jurisdiction over certain provider appeals. The appeals subject to the Ruling involve the treatment of certain patient days, associated with patients enrolled in Medicare Advantage plans, in the Medicare and Medicaid fractions of the disproportionate patient percentage. The Ruling applies only to appeals that: (1) concern patient days with discharge dates before October 1, 2013; and (2) arise from Notices of Program Reimbursement ("NPR") issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013. The Ruling also applies to appeals based on an untimely NPR under 42 U.S.C. § 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for a fiscal year that pre-dates the new final rule.[21] Further, the Ruling requires that the Board remand any otherwise

[13] *Id*. at 47411.
[14] 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: "We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word 'or' with the word 'including' in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B)."); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff'd in part and rev'd in part*, 746 F. 3d 1102 (D.C. Cir. 2014).
[15] 746 F. 3d 1102 (D.C. Cir. 2014).
[16] *Id*. at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").
[17] 863 F.3d 937 (D.C. Cir. 2017).
[18] *Id.* at 943.
[19] Id. at 943-945.
[20] *Azar v. Allina Health Services*, 139 S. Ct. 1804 (June 3, 2019).
[21] CMS Ruling 1739-R (Aug. 17, 2020).

jurisdictionally proper challenge raising this issue to the appropriate Medicare contractor.[22] The Ruling explains that Medicare contractors will then calculate the provider's DSH payment adjustment pursuant to the forthcoming final rule.[23]

Regarding EJRs for this Issue, and the fate of these appeals, the ruling notes, specifically, that:

> In many such cases [Part C Days in the SSI/Medicare Fraction], the PRRB has granted expedited judicial review (EJR). After the Supreme Court's decision, the United States District Court for the District of Columbia granted the Secretary's motion to consolidate most of these cases (in re: Allina II-Type DSH Adjustment Cases, 19-mc-190). Prior to consolidation, many such cases had been stayed pending the outcome of the Allina proceedings. The Secretary has since moved for a voluntary remand of these consolidated cases so that he can re-examine the claims in light of the Supreme Court's decision and take further action as necessary to comply with the applicable legal standards announced therein. The Secretary has determined that he has no choice but to engage in a new rulemaking to resolve the issue.
>
> Although the Supreme Court has resolved the legal issue, the PRRB has continued to grant EJR to appeals presenting Allina-type claims. By this Ruling, the Administrator provides notice that the PRRB and other Medicare administrative appeals tribunals lack jurisdiction over the Part C days issue for years before FY 2014 as to any appeals arising from NPRs from that period that pre-dates the forthcoming rule or that arise from an appeal based on an untimely NPR under 42 U.S.C. 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for that fiscal year pre-dates the new final rule. The Supreme Court has made it clear that Medicare fractions and DSH payments in all Allina-like cases must be recalculated pursuant to a properly promulgated regulation. It will conserve administrative and judicial resources to remand qualifying appeals in recognition of controlling Supreme Court precedent instead of suits continuing to be filed and consolidated in federal district court, followed by the Secretary seeking remand for further proceedings consistent with the Supreme Court's decision. Instead, under this Ruling, the pertinent administrative appeals tribunal must remand each qualifying appeal to the appropriate Medicare contractor. CMS and the Medicare contractors will calculate DSH payment adjustments on remand in accordance with CMS's forthcoming rule.[24]

[22] *Id*.
[23] *Id*.
[24] CMS Ruling 1739-R at 6-7.

Providers' Request for EJR

The Providers within the CIRP group appeals are challenging their Medicare reimbursement for the fiscal year 2014 cost reporting period, solely for days *before* October 1, 2013. The Providers state that they "have been expecting that Medicare Part C days would be appropriately treated in their DSH calculations following the decisions in *Allina I* and *Allina II*."[25] The Providers further assert that, despite the federal court rulings in these cases, their respective DSH payment determinations remain "uncorrected" as these payment calculations were based on the "now-vacated [2004] rule."[26] The Providers argue that, under the applicable regulations, the Board is bound to apply the vacated 2004 rule that the Secretary has "left on the books."[27] As such, the Providers conclude that the Board is "required" to grant EJR.[28]

The Providers argue that the Board has jurisdiction but lacks authority to grant relief over the issue raised in this appeal, namely, "the substantive and procedural validity of the continued application of the vacated 2004 rule in the DSH payment determinations at issue."[29] The Providers disagree with CMS' instruction to the Board to remand this appeal, and argue that a remand is counter to the providers' right to appeal to federal court as set forth in 42 U.S.C. § 1395oo. The Providers conclude that EJR is appropriate because "the agency has still not acquiesced in the *Allina* decisions . . ."[30]

The Providers also argue that:

> CMS Ruling 1739-R by its own terms does not deprive the Board of the ability to determine that it has jurisdiction over these Providers' DSH Part C appeals and could not do so without violating provisions of the Medicare statute that are binding on the Board here.[31]
>
> First, the Ruling expressly directs the Board to determine its jurisdiction over pending Part C appeals. This approach is consistent with the accepted premise that the Board always has the ability to determine if it has jurisdiction, which the Ruling itself acknowledges. *See* CMS Ruling 1739-R at 7 (requiring that the Board determine whether an appeal "satisfies the applicable jurisdictional and procedural requirements"). This is a straightforward application of the familiar principle that the Board routinely applies in exercising jurisdiction to determine its jurisdiction. "[I]t is familiar law that a federal court always has

[25] Providers' Petition for Expedited Judicial Review, at 1, PRRB Case no. 16-0557GC.
[26] *Id*. at 1.
[27] *Id*.
[28] *Id*. at 1-2.
[29] *Id*. at 11-12.
[30] *Id*. at 22.
[31] *Id*. at 13.

> jurisdiction to determine its own jurisdiction." *U.S. v. Ruiz*, 536 U.S. 622, 627 (2002).[32]
>
> . . . .
>
> Section 1395oo(a) [of the Social Security Act] grants the Board jurisdiction over each of the DSH Part C group appeals at issue here. . . . [T]he Providers have submitted schedules of providers in each group appeal and supporting documentation that establish their satisfaction of the requirements for a hearing in section 1395oo(a). Congress granted the Board the subject-matter jurisdiction conferred by section 1395oo(a). Nothing in that section or any other statute authorizes the Secretary to divest the Board of subject-matter jurisdiction conferred to it by section 1395oo(a). CMS's attempt to do this via the Ruling violates the statute's grant of providers' substantive appeal rights and is invalid.[33]

Board's Decision and Analysis

After review of the Providers' EJR Request, the Board has determined that it contains two separate and distinct issues for the Board to consider.

The first issue is Providers' challenge to the inclusion of Medicare Part C days in the Medicare fraction of the DSH percentage and/or the exclusion of Medicare Part C days for patients who are dually eligible for Medicaid from the Medicaid fraction of the DSH percentage, as explained *supra*. This first issue is the ***substantive issue*** upon which the Providers established the CIRP group and the source of the Providers' dissatisfaction.

The second issue is a challenge to the validity of the mandate within CMS Ruling 1739-R that divests the Board of ***substantive jurisdiction*** over the Medicare Part C Days issue that, *but for the Ruling*, the Board would have jurisdiction to consider. This second issue arose when CMS issued CMS Ruling 1739-R on August 17, 2020 (well after these CIRP groups were established).

Board's Authority

The Board's authority to consider a provider's EJR request is contained within 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R.§ 405.1842(f)(1) (2019). Under its statutory and regulatory authority, the Board is required to grant a provider's EJR request if it determines that (1) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (2) 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.

The Board's analysis is detailed below.

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[32] *Id*. at 13-14.
[33] *Id.* at 16-17.

Jurisdictional Requirements for Providers

The Board's analysis begins with the question of whether it has jurisdiction to conduct a hearing on the specific matter at issue for each of the Providers requesting EJR. 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 for an individual appeal or $50,000 or more for a group, and the request for hearing was timely filed.[34, 35]

The Providers included in the instant consolidated EJR request filed appeals of original Notices of Program Reimbursement ("NPRs") in which the Medicare contractor settled cost reporting periods ending in 2014.

For Providers with appeals filed from original NPRs for cost reporting periods ending on December 31, 2008 and which began before January 1, 2016, CMS Ruling CMS-1727-R involves dissatisfaction with the Medicare Contractor determinations. The Board determines whether the participants' appeals involved with the instant EJR requests are governed by CMS-1727-R.[36]

Upon review of the jurisdictional documentation, the DSH percentage and Part C days were specifically adjusted or protested in each cost report. In addition, the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal[37] and that the appeals were timely filed. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount. Accordingly, including the directives provided in CMS Ruling 1727-R, the Board finds that it has jurisdiction for the referenced appeals and the participants.

However, the Board also notes that the 2 groups are duplicates since they have the same issue for the same year as well as the same participants. In the 2014 decision for *Allina Health Servs. v. Sebelius* ("*Allina*"), the D.C. Circuit reviewed how the whole class of patients who were enrolled in Medicare Part C should be treated under the DSH statute. Specifically, the D.C. Circuit in *Allina* stated: "*the **statute** unambiguously requires* that Part C days be counted in one fraction or the other (a Part C-enrolled individual is either eligible for Medicare Part A, or not)."[38] Accordingly, there are no separate Medicare or Medicaid fraction issues since Part C days must be counted in one fraction or the other (*i.e.*, excluding them from one means they must be

[34] 42 C.F.R. § 405.1835(a).
[35] For appeals filed on or after August 21, 2008, a hearing request is considered timely if it is filed within 180 days of the date of receipt of the final determination. 42 C.F.R. § 405.1835(a) (2008).
[36] Under ruling 1727-R, 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.
[37] *See* 42 C.F.R. § 405.1837.
[38] 746 F.3d 1102, 1108 (D.C. Cir. 2014) (emphasis added).

counted in the other). Rather than dismissing one group or consolidating, the Board is treating them as one group for purposes of its actions below which results in the closure of these cases.

Medicare Part C Days Issue

Under 42 C.F.R. § 405.1867, the Board must comply with the provisions of Title XVIII of the Act and regulations issued thereunder, *as well as CMS Rulings issued under the authority of the Administrator*.[39] As set out within CMS Ruling 1739-R, the Administrator mandates that the Board now "lack[s] jurisdiction over certain provider appeals regarding the treatment of days associated with patients enrolled in Medicare Advantage plans in the Medicare and Medicaid fractions of the disproportionate patient percentages[,]"[40] *i.e.*, the Part C Days issue. Specifically, CMS Ruling 1739-R applies "to appeals regarding patient days with discharge dates before October 1, 2013[,] that arise from [NPRs] that are issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013[,] or that arise from an appeal based on an untimely NPR . . . and any subsequently issued NPR for that fiscal year pre-dates the new final rule."[41] To date, CMS has yet to issue its new final rule.[42]

As the Providers' appeals concern the FY 2014 cost reporting period, for days *before* October 1, 2013, CMS Ruling 1739-R confirms that the Board lacks substantive jurisdiction over the providers' Part C Days issue *as of August 17, 2020* (*i.e.*, the date CMS Ruling 1739-R was issued). Under 42 C.F.R. § 405.1842(f)(2)(i), the Board *must* deny EJR for a legal question relevant to a specific matter at issue in a Board appeal if the Board determines that it lacks jurisdiction to conduct a hearing on the specific matter. Thus, the Board must deny providers' EJR request concerning the Medicare Part C Days issue.

CMS Ruling 1739-R also "requires that the [Board] remand any otherwise *jurisdictionally proper* challenge raising this issue to the appropriate Medicare contractor."[43] Accordingly, the Board will issue, under separate cover, a remand for the group appeal providers with a "qualifying" appeal determined to be "jurisdictionally proper" (*i.e.*, determine if they are ripe for remand under 1739-R) pursuant to the mandates set out in the Ruling.

Validity of CMS Ruling 1739-R

Within the EJR Request, the Providers also challenge the validity of CMS Ruling 1739-R, stating:

> Section 1395oo(a) [of the Social Security Act] grants the Board jurisdiction over each of the DSH Part C group appeals at issue here. . . . [T]he Providers have submitted schedules of providers in each group appeal and supporting documentation that establish

[39] (Emphasis added.)
[40] CMS Ruling 1739-R at 1-2.
[41] Id. at 2.
[42] CMS issued its proposed rule, CMS 1739-P, on August 6, 2020. *See* 85 Fed. Reg. 47723 (Aug. 6, 2020).
[43] (Emphasis added.)

> their satisfaction of the requirements for a hearing in section 1395oo(a). Congress granted the Board the subject-matter jurisdiction conferred by section 1395oo(a). Nothing in that section or any other statute authorizes the Secretary to divest the Board of subject-matter jurisdiction conferred to it by section 1395oo(a). CMS's attempt to do this via the Ruling violates the statute's grant of providers' substantive appeal rights and is invalid.[44]

The Board notes that it has previously been presented with, and considered, a similar argument within PRRB Dec. No. 2010-D36, *Southwest Consulting 2004 DSH Dual Eligible Days Group, et al. v. Blue Cross Blue Shield Ass'n*, PRRB Dec. No. 2010-D36 (June 14, 2010),[45] in which the providers challenged the validity of CMS Ruling CMS-1498-R. In its *Southwest* decision, the Board observed the following:

> The problem presented in this dispute is unique because the jurisdiction question arises only because the Ruling, which has been challenged as being invalid, is what purports to deprive the Board of jurisdiction it previously had over these appeals. But for the Ruling's provision divesting the Board of jurisdiction, there is no dispute that the Board has jurisdiction and would have authority to grant EJR pursuant to the Providers' challenge as to the other substantive provisions of the Ruling. The Board's dilemma in resolving the jurisdiction question is that the Ruling's provisions that purport to divest the Board of jurisdiction are inextricably intertwined with the substantive provisions of the Ruling challenged as being contrary to law and which the Board has no authority to invalidate.[46]

Here, as in *Southwest*, the Board finds that it does not have authority to consider the validity of CMS Ruling CMS 1739-R. Nonetheless, the Board questions whether a provider's claim that CMS has improperly treated Medicare Part C Days in the DSH calculation may be considered

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[44] EJR Request at 16-17.

[45] In *Southwest*, the Board considered whether it should grant the providers' request for EJR over the validity of the provisions of CMS Ruling 1498-R which, if valid, render moot and deny jurisdiction over the dual-eligible group appeals. The Board found that EJR was appropriate because the providers' appeals were properly pending before the Board as CMS 1498-R required the Board to determine whether the appeals satisfied the applicable jurisdictional and procedural requirements of section 1878 of the Act, but the Board lacked the authority to determine whether the Ruling deprived it of continuing jurisdiction. The Board's decision in *Southwest* was ultimately vacated by the Administrator. *See Southwest Consulting 2004 DSH Dual Eligible Days Grp., et al. v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (Aug. 12, 2010), *vacating and remanding*, PRRB Dec. No. 2010-D36 (June 14, 2010).

[46] *See Southwest* at 6-7.

moot simply by "the Ruling's mere declaration"[47] that it is so and, as such, serve as the basis to divest the Board of ***substantive*** jurisdiction over the claim.[48]

As noted prior, the Board must grant EJR 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.[49] Here, the Providers essentially challenge the Board's *application* of the CMS Ruling 1739-R. Specifically, the Providers challenge the validity of the mandate within the Ruling that purports to divest the Board of *substantive* jurisdiction over the Medicare Part C Days issue that, but for the Ruling, the Board has the authority to consider. The Board finds that it has jurisdiction over this challenge since it goes to the Board's application of the Ruling, ***but*** lacks the authority to decide the challenge because 42 C.F.R. § 405.1867 specifies that the Board must comply with such Rulings.

Conclusion

1) The Board finds it has jurisdiction to hear the appeals of all providers within the instant group appeals, for the days *before* October 1, 2013, under 1739-R: with the following clarifications:

   a) While the some of participants have fiscal years ending after October 1, 2013, the only days at issue are those ***prior to*** October 1, 2013.

   b) Consistent with the D.C. Circuit's decision in *Allina*, Case No. 16-0557GC and 16-0733GC are duplicates since they have the same issue for the same year as well as the same participants; however, for purposes of administrative ease, rather than dismissing one group or consolidating, the Board is treating them as one group for purposes of its actions below which will result in the closure of these cases;

2) The Board hereby **denies** the Providers' EJR Request regarding the substantive and procedural validity of the continued application of the vacated 2004 rule with respect to the treatment of Medicare Part C Days in the DSH payment determinations but, pursuant to CMS 1739-R, the Providers will receive a remand letter of this issue under separate cover, for the applicable days; and

3) The Board hereby **grants** EJR for the Providers for the *limited* question of the validity of the provision of CMS Ruling CMS 1739-R that divests the Board of substantive jurisdiction over the Medicare Part C Days issue that, *but for the Ruling*, the Board has the authority to consider.

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[47] *See Southwest* at 10. For brevity sake, the Board hereby incorporates by reference the detailed discussion regarding "mootness" contained within *Southwest* into the instant EJR determination.
[48] *See* CMS 1739-R at 8.
[49] 42 U.S.C. § 1395oo(f)(1); 42 C.F.R. § 405.1842(f)(1).

The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877 upon final disposition of the appeal.

Board Members Participating:

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

For the Board:

2/8/2023

X Clayton J. Nix

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

Enclosure: Exhibit A – Schedules of Providers for Case Nos. 16-0557GC & 16-0733GC

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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

RE: ***Board Decision* – SSI Percentage (Provider Specific)**
Lakeway Regional Hospital (Provider Number 44-0067)
FYE: 05/31/2018
Case Number: 21-0322

Dear Mr. Ravindran,

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

Background:

A. *Procedural History for Case No. 21-0322*

On June 17, 2020, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end May 31, 2018. On December 1, 2020, the Board received the 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[2]

As a result of the transfer of the SSI Percentage issue and the withdrawal of the Medicaid Eligible Days issue, the sole remaining issue is the DSH/SSI Percentage – Provider Specific Issue.

[1] On June 23, 2021, this issue was transferred to PRRB Case No. 21-1206GC.
[2] On November 14, 2022, Federal Specialized Services ("FSS") filed a jurisdictional challenge over the Medicaid Eligible Days issue. On December 28, 2022, FSS filed a Request for Dismissal of the Medicaid Eligible Days issue. Subsequently, the Provider withdrew this issue on January 13, 2023.

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

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

> The Provider contends that its SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> . . .
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. § 1395(d)(5)(F)(i).
>
> The Provider also contends that CMS inconsistently interprets the term "entitled" as it is used in the statute. CMS requires SSI payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the denominator. CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days of care) as Medicare Part A days, yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment. [3]

The Provider's appeal request described Issue 2 (DSH/SSI Percentage) 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 at 42 U.S.C. § 1395ww(d)(5)(F)(vi). The Provider contends that the SSI percentages calculated by [CMS] and used by the Lead MAC to settle their Cost Report were incorrectly computed.
>
> The Provider also contends that CMS inconsistently interprets the term "entitled" as it is used in the statute. CMS requires SSI payment for days to be counted in the numerator but does not

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

> require Medicare Part A payment for days to be counted in the denominator. CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days of care) as Medicare Part A days, yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment.
>
> The Provider further contends that the SSI percentages calculated by [CMS] fail to address all the deficiencies as described in *Baystate Medical Center v. Michael O. Leavitt*, 545 F. Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37, 44 (D.D.C. 2008) and incorporates a new methodology inconsistent with the Medicare Statute.
>
> Providers [*sic*] in this case are also seeking resolution of the following additional aspects of the Medicare fraction that were not addressed in the Baystate case:
>
> 1. Availability of MEDPAR and SSA Records
> 2. Failure to adhere to required notice and comment rulemaking procedures
> 3. Fundamental problems in the SSI percentage calculation
> 4. Not in agreement with provider's records
> 5. Paid days vs. Eligible days, and
> 6. Covered days vs. Total days.[4]

As the Provider is commonly owned by Community Health Systems, Inc. ("CHS"), the Provider transferred its Issue 2 – DSH/SSI Percentage to the CIRP group under Case Number 21-1206GC, *CHS CY 2018 DSH SSI Percentage CIRP Group*, on June 23, 2021. The Group Issue Statement for the group 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] *Id.* at Issue 2.

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 for both the DSH/SSI Percentage - Provider Specific and DSH/SSI Percentage issues are listed as $6,000.[6]

MAC'S Contentions:

On October 12, 2021, the MAC filed a Jurisdictional Challenge. 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 and the Provider has not exhausted all available remedies.[7]

In addition, the MAC argues the DSH/SSI Percentage - Provider Specific issue and the DSH/SSI Percentage issue are considered the same issue by the Board, and cites several past Board decisions to that end.[8]

Provider's Response:

The Board Rules require that Provider Responses to the MAC's Jurisdictional Challenge must filed within thirty (30) days of the filing of the Jurisdictional Challenge.[9] The Provider has not

[5] Case No. 21-1206GC Issue Statement.
[6] *See* Amounts in Controversy in Case Nos. 21-0322 and 21-1206GC.
[7] Jurisdictional Challenge at 7 (Oct. 12, 2021).
[8] *Id*. at 5-6.
[9] Board Rule 44.4.3, v. 2. (Aug. 2018).

filed a response to the Jurisdictional Challenge over the DSH/SSI Percentage - Provider Specific issue in this case and the time for doing so has elapsed.[10] 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 (2013), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

A. SSI Provider Specific

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

1. First Aspect of Issue 1

The Board finds that the first aspect (the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage) of Issue 1 (the DSH/SSI Percentage (Provider Specific) issue) in this appeal is duplicative of Issue 2 (the DSH/SSI Percentage issue) that was appealed in Case No. 21-1206GC. The first aspect of Issue 1 in the present appeal concerns "whether the Medicare Administrative Contractor used the correct [SSI] percentage in the [DSH] Calculation."[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] Issue 2, transferred to group Case No. 21-1206GC, similarly alleges that the Medicare Contractor and CMS improperly calculated the DSH/SSI Percentage, the DSH/SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F)(i).

---

[10] The Provider did file a response to the November 14, 2022 Jurisdictional Challenge over the Medicaid Eligible Days issue, but has since withdrawn that issue.
[11] Individual Appeal Request, Issue 1.
[12] *Id.*
[13] *Id.*

In making this finding, the Board further notes that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, the Provider is pursuing that issue as part of the group under Case No. 21-1206GC. 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] 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. 21-1206GC.

Accordingly, the Board must find that the first aspect of Issue 1 and the group issue in Group Case 21-1206GC, 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 (2018), the Board dismisses this component of the DSH/SSI Percentage (Provider Specific) issue.

2. Second Aspect of Issue 1

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

Conclusion:

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

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

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

Board Members Participating:

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

For the Board:

2/9/2023

X Kevin D. Smith, CPA

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

cc: Wilson C. Leong, Esq., Federal Specialized Services
Byron Lamprecht, WPS Government Health Administrators (J-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 570A
Arcadia, CA 91006

RE: ***Board Decision* – SSI Percentage (Provider Specific)**
Lakeway Regional Hospital (Provider Number 44-0067)
FYE: 05/31/2018
Case Number: 21-0322

Dear Mr. Ravindran,

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

Background:

A. *Procedural History for Case No. 21-0322*

On June 17, 2020, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end May 31, 2018. On December 1, 2020, the Board received the 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[2]

As a result of the transfer of the SSI Percentage issue and the withdrawal of the Medicaid Eligible Days issue, the sole remaining issue is the DSH/SSI Percentage – Provider Specific Issue.

[1] On June 23, 2021, this issue was transferred to PRRB Case No. 21-1206GC.
[2] On November 14, 2022, Federal Specialized Services ("FSS") filed a jurisdictional challenge over the Medicaid Eligible Days issue. On December 28, 2022, FSS filed a Request for Dismissal of the Medicaid Eligible Days issue. Subsequently, the Provider withdrew this issue on January 13, 2023.

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

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

> The Provider contends that its SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> . . .
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. § 1395(d)(5)(F)(i).
>
> The Provider also contends that CMS inconsistently interprets the term "entitled" as it is used in the statute. CMS requires SSI payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the denominator. CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days of care) as Medicare Part A days, yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment. [3]

The Provider's appeal request described Issue 2 (DSH/SSI Percentage) 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 at 42 U.S.C. § 1395ww(d)(5)(F)(vi). The Provider contends that the SSI percentages calculated by [CMS] and used by the Lead MAC to settle their Cost Report were incorrectly computed.
>
> The Provider also contends that CMS inconsistently interprets the term "entitled" as it is used in the statute. CMS requires SSI payment for days to be counted in the numerator but does not

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

> require Medicare Part A payment for days to be counted in the denominator. CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days of care) as Medicare Part A days, yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment.
>
> The Provider further contends that the SSI percentages calculated by [CMS] fail to address all the deficiencies as described in *Baystate Medical Center v. Michael O. Leavitt*, 545 F. Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37, 44 (D.D.C. 2008) and incorporates a new methodology inconsistent with the Medicare Statute.
>
> Providers [*sic*] in this case are also seeking resolution of the following additional aspects of the Medicare fraction that were not addressed in the Baystate case:
>
> 1. Availability of MEDPAR and SSA Records
> 2. Failure to adhere to required notice and comment rulemaking procedures
> 3. Fundamental problems in the SSI percentage calculation
> 4. Not in agreement with provider's records
> 5. Paid days vs. Eligible days, and
> 6. Covered days vs. Total days.[4]

As the Provider is commonly owned by Community Health Systems, Inc. ("CHS"), the Provider transferred its Issue 2 – DSH/SSI Percentage to the CIRP group under Case Number 21-1206GC, *CHS CY 2018 DSH SSI Percentage CIRP Group*, on June 23, 2021. The Group Issue Statement for the group 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] *Id.* at Issue 2.

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 for both the DSH/SSI Percentage - Provider Specific and DSH/SSI Percentage issues are listed as $6,000.[6]

MAC'S Contentions:

On October 12, 2021, the MAC filed a Jurisdictional Challenge. 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 and the Provider has not exhausted all available remedies.[7]

In addition, the MAC argues the DSH/SSI Percentage - Provider Specific issue and the DSH/SSI Percentage issue are considered the same issue by the Board, and cites several past Board decisions to that end.[8]

Provider's Response:

The Board Rules require that Provider Responses to the MAC's Jurisdictional Challenge must filed within thirty (30) days of the filing of the Jurisdictional Challenge.[9] The Provider has not

[5] Case No. 21-1206GC Issue Statement.
[6] *See* Amounts in Controversy in Case Nos. 21-0322 and 21-1206GC.
[7] Jurisdictional Challenge at 7 (Oct. 12, 2021).
[8] *Id*. at 5-6.
[9] Board Rule 44.4.3, v. 2. (Aug. 2018).

filed a response to the Jurisdictional Challenge over the DSH/SSI Percentage - Provider Specific issue in this case and the time for doing so has elapsed.[10] 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 (2013), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

A. SSI Provider Specific

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

1. First Aspect of Issue 1

The Board finds that the first aspect (the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage) of Issue 1 (the DSH/SSI Percentage (Provider Specific) issue) in this appeal is duplicative of Issue 2 (the DSH/SSI Percentage issue) that was appealed in Case No. 21-1206GC. The first aspect of Issue 1 in the present appeal concerns "whether the Medicare Administrative Contractor used the correct [SSI] percentage in the [DSH] Calculation."[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] Issue 2, transferred to group Case No. 21-1206GC, similarly alleges that the Medicare Contractor and CMS improperly calculated the DSH/SSI Percentage, the DSH/SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F)(i).

---

[10] The Provider did file a response to the November 14, 2022 Jurisdictional Challenge over the Medicaid Eligible Days issue, but has since withdrawn that issue.
[11] Individual Appeal Request, Issue 1.
[12] *Id.*
[13] *Id.*

In making this finding, the Board further notes that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, the Provider is pursuing that issue as part of the group under Case No. 21-1206GC. 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] 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. 21-1206GC.

Accordingly, the Board must find that the first aspect of Issue 1 and the group issue in Group Case 21-1206GC, 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 (2018), the Board dismisses this component of the DSH/SSI Percentage (Provider Specific) issue.

2. Second Aspect of Issue 1

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

Conclusion:

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

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

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

Board Members Participating:

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

For the Board:

2/9/2023

X Kevin D. Smith, CPA

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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

RE: ***Board Decision* – SSI Percentage (Provider Specific)**
South Baldwin Regional Medical Center (Provider Number 01-0083)
FYE: 09/30/2017
Case Number: 21-0350

Dear Mr. Ravindran,

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

Background:

A. *Procedural History for Case No. 21-0350*

On June 22, 2020, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end September 30, 2017.

On December 8, 2020, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained three (3) issues:

- SSI Percentage (Provider Specific)
- SSI Percentage[1]
- Medicaid Eligible Days[2]

After the Provider transferred the SSI Percentage issue and withdrew the Medicaid eligible days issue, the remaining issue is the DSH/SSI Percentage – Provider Specific Issue.

[1] On July 26, 2021, this issue was transferred to PRRB Case No. 20-0997GC.
[2] On November 14, 2022, Federal Specialized Services ("FSS") filed a jurisdictional challenge over the Medicaid Eligible Days issue. On December 28, 2022, FSS filed a Request for Dismissal of the Medicaid Eligible Days issue. Subsequently, the Provider withdrew this issue on January 13, 2023.

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

The Provider's appeal request described Issue 1 (DSH/SSI Percentage – Provider Specific) 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's appeal request described Issue 2 (DSH/SSI Percentage) 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 at 42 U.S.C. § 1395ww(d)(5)(F)(vi). The Provider contends that the SSI percentages calculated by [CMS] and used by the Lead MAC to settle their Cost Report were incorrectly computed.
>
> . . .
>
> The Provider further contends that the SSI percentages calculated by [CMS] fail to address all the deficiencies as described in *Baystate Medical Center v. Michael O. Leavitt*, 545 F. Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37, 44 (D.D.C. 2008) and incorporates a new methodology inconsistent with the Medicare Statute.
>
> Providers [*sic*] 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

[3] Issue Statement at 1 (Dec. 8, 2020).

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

As the Provider is commonly owned by Community Health Systems, Inc. ("CHS"), the Provider transferred Issue 2 – DSH/SSI Percentage to the CIRP group under Case Number 20-0997GC, *CHS CY 2017 DSH SSI Percentage CIRP Group*, on July 26, 2021. The Group Issue Statement for in Case No. 20-0997GC is, 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/con-covered/eligible SSI days?
>
> **Statement of the Legal Basis**
>
> The Provider(s) contend(s) that the MAC's determination for their DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww(d)(5)(F)(vi). 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. Failure to adhere to required notice and comment rulemaking procedures,
> 3. Fundamental problems in the SSI percentage calculation,
> 4. Not in agreement with provider's records,
> 5. Paid days vs. Eligible Days, and
> 6. Covered days vs. Total days.[5]

Further, the amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $29,000.

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[4] *Id.* at Issue 2.
[5] Group Issue Statement, Case No. 20-0997GC.

MAC'S Contentions:

On November 10, 2021, the MAC filed a Jurisdictional Challenge. 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 and the Provider has not exhausted all available remedies.[6]

In addition, the MAC argues the DSH/SSI Percentage - Provider Specific issue and the DSH/SSI Percentage - Systemic issue are considered the same issue by the Board, and cites several past Board decisions to that end.[7]

Provider's Response:

The Board Rules require that Provider Responses to the MAC's Jurisdictional Challenge must filed within thirty (30) days of the filing of the Jurisdictional Challenge.[8] The Provider has not filed a response to the Jurisdictional Challenge over the SSI Provider Specific issue in this case and the time for doing so has elapsed.[9] 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 (2013), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

A. SSI Provider Specific

The analysis for Issue 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.

[6] Jurisdictional Challenge at 7 (Nov. 10, 2021).
[7] *Id*. at 5-6.
[8] Board Rule 44.4.3, v. 2. (Aug. 2018).
[9] The Provider did file a response to the November 14, 2022 Jurisdictional Challenge over the Medicaid Eligible Days issue, but has since withdrawn that issue.

1. First Aspect of Issue 1

The Board finds that 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 Group Case No. 20-0997GC. The first aspect of Issue 1 in the present appeal concerns "whether the Medicare Administrative Contractor used the correct [SSI] percentage in the [DSH] Calculation."[10] The Provider's legal basis for this aspect of Issue 1 is simply that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[11] Similarly, the Provider argues that "it[s] SSI percentage published by [CMS] was incorrectly computed . . ." and it ". . . [s]pecifically . . . disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[12] Issue 2, transferred to group Case No. 20-0997GC, similarly alleges that the Medicare Contractor and CMS improperly calculated the DSH/SSI Percentage, the DSH/SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F)(i).

In making this finding, the Board further notes that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, the Provider is pursuing that issue as part of the group under Case No. 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.[13] The Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) 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.

Accordingly, the Board must find that the first aspect of Issue 1 and the group issue in 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 (2018), the Board dismisses this component of the DSH/SSI Percentage (Provider Specific) issue.

2. Second Aspect of Issue 1

The second aspect of the DSH SSI Percentage (Provider Specific) issue—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—must be dismissed for lack of jurisdiction and as premature. Under 42 C.F.R.

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[10] Individual Appeal Request, Issue 1.
[11] *Id.*
[12] *Id.*
[13] The types of systemic errors documented in the *Baystate* did not uniformly impact the SSI calculation for all providers but that does not 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).

§ 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request…" Without this written request, the Medicare Contractor cannot issue a final determination with which the Provider can be dissatisfied for appeal purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding the Provider's DSH SSI Percentage realignment as such there is no "determination" to appeal and the appeal of this issue is otherwise premature. Further, the Board notes that the Provider's cost reporting period ends on 9/30, which is the same as the federal fiscal year end. Thus, any realignment of the DSH/SSI percentage would have no effect in this case.

Conclusion:

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

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

Board Members Participating:

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For the Board:

2/9/2023

X Kevin D. Smith, CPA

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

cc: Wilson C. Leong, Esq., Federal Specialized Services
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RE: ***Board Decision*** **– SSI Percentage (Systemic Errors) & Medicaid Eligible Days**
Heart Hospital of Bakersfield (Prov. No. 05-0724)
FYE 09/30/2012
Case No. 16-2131

Dear Mr. Ravindran and Ms. Frewert:

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the documentation in Case No. 16-2131 in response to a jurisdictional challenge filed by the Medicare Contractor ("MAC"). The Board's decision is set forth below.

Background:

A. Procedural History

On August 3, 2016, Quality Reimbursement Services filed an individual appeal request on behalf of Heart Hospital of Bakersfield ("Provider") regarding the Notice of Program Reimbursement ("NPR") dated February 4, 2016 for the fiscal year ending September 30, 2012 ("FY 2012). The Provider's appeal request included the following eight (8) issues:

1. DSH Payment/SSI Percentage (Provider Specific)
2. DSH/SSI Percentage (Systemic Errors)
3. DSH Payment – SSI Fraction/Medicare Managed Care Part C Days
4. DSH Payment – SSI Fraction/Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)
5. DSH Payment – Medicaid Eligible Days
6. DSH Payment – Medicaid Fraction/Medicare Managed Care Part C Days
7. DSH Payment – Medicaid Fraction/Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)
8. Outlier Payments – Fixed Loss Threshold

On March 16, 2017, QRS transferred Issues 2-4 and 6-8, listed above, to group cases. The Medicare Contractor filed a jurisdictional challenge to Issues 1 and 5 on May 7, 2018.

A Notice of Hearing was issued on February 22, 2021, with a hearing date of November 22, 2021. However, on March 3, 2021, QRS filed a request to withdraw the Provider's case in full, and, on March 4, 2021, the Board acknowledged the withdrawal and closed the case on March 4, 2021. The withdrawal and closure of the case meant that the two remaining issues, Issues 1 and 5, were withdrawn/abandoned.

Thereafter, several of the group cases to which the Provider's individual issues were transferred were closed because these groups failed to meet the minimum group participant requirement. On January 13, 2022, the Board issued a letter reinstating two Bakersfield individual appeals (Case Nos. 15-3206 and 16-2131) to permit the transfer of the four specific group issues back to those individual appeals. For the instant case, individual Case No. 16-2131, the Board reinstated Case No. 16-2131 to allow the following four issues to be transferred back to it:

Issue 2 – DSH/SSI Percentage (Systemic Errors)

Issue 4 – DSH Payment – SSI Fraction/Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)

Issue 7 – DSH Payment – Medicaid Fraction/Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)

Issue 8 – Outlier Payments – Fixed Loss Threshold

As stated above, these issues were originally listed in the Provider's Appeal Request as Issues 2, 4, 7 and 8, respectively. Accordingly, the Issues/Providers tab in OH CDMS only reflected these 4 issues being reinstated and pending in Case No. 16-2131 and, to this end, continued to list Issues 1 and 5 as withdrawn and Issues 3 and 6 as transferred.

On January 18, 2022, the Board issued a new Critical Due Date notification, which was titled a Request for Information letter, asking the parties to submit preliminary positions papers briefing the four issues addressed in the reinstatement. The Provider's preliminary position paper was due on May 17, 2022, and the Medicare Contractor's preliminary position paper was due on September 19, 2022.

On April 5, 2022, a new Notice of Hearing was issued, setting the hearing date for February 8, 2023, which also set due dates for Final Position Papers and Witness Lists. The Provider's final position paper was due on November 10, 2022, and the Medicare Contractor's final position paper was due on December 10, 2022.

The Provider ***failed*** to submit its supplemental preliminary position paper by the May 17, 2022 deadline. Notwithstanding, the Medicare Contractor filed a supplemental position paper on September 21, 2022, relying on its originally submitted preliminary position paper since the Provider did ***failed*** to file its supplemental preliminary position paper.

On November 1, 2022, the Provider timely filed its final position paper. Shortly thereafter, on November 30, 2022, the Medicare Contractor timely filed its final position paper.

On December 22, 2022, the Medicare Contractor filed a jurisdictional challenge, contending that: (1) "[t]he Provider has failed to file a complete Position Paper addressing the issue appealed as Issue 2 DSH – SSI Percentage (Systemic Error)"; and (2) "[t]he Provider's FPP brief of Medicaid eligible days … is not proper as the issue .. was included in this case as Issue 5, and Issue 5 was withdrawn."

On January 11, 2023, QRS filed the Provider's "Response to MAC/FSS Jurisdictional Challenge." *However, that "response" **failed** to address (much less contest) the substance of the jurisdictional challenge*. Rather, QRS simply requested that the Board postpone the hearing in this case "pending the outcome of *Becerra v. Empire Health Foundation* … currently pending in the Ninth Circuit court of appeals [*sic*]" because it contends that "[t]he Empire … case deals with substantially similar issues to those addressed in PRRB Case Number 16-2131 namely the provider challenged the inaccuracy of the SSI Percentage." Finally, QRS submitted a correction to its final position paper, noting that it had "inadvertently mislabeled the SSI Systemic issue as the SSI – Provider Specific issue" and, accordingly, "[t]he correct issue title which should be referenced in the final paper should be: 'DSH – SSI (Systemic Errors).'"

On January 13, 2023, the Provider withdrew Issues 4, 7 and 8, which are the following issues: (4) DSH Payment – SSI Fraction/Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days); (7) DSH Payment – Medicaid Fraction/Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days); and (8) (Outlier Payments – Fixed Loss Threshold). As a result of these withdrawals, the ***only*** issue that remains is Issue 2, SSI (Systemic Errors).

B. Description of Parties' Contentions in Final Position Papers ("FPPs")

1. Provider's Contentions in FPP

The Provider briefed two issues in its FPP: SSI Systemic Errors,[1] and Medicaid Eligible Days.

The Provider contends that the Medicare Contractor's determination for Medicare reimbursement for DSH payments was not in accordance with the Medicare statute, 42 U.S.C. § 1395ww(d)(5)(F)(vi). The Provider disputes the calculation of Medicaid eligible days set forth in 42 C.F.R. § 412.106(b)(4), and states that a List of Medicaid Eligible Days was being sent under separate cover, which shows the total number of days reflected in its 2012 cost report does not reflect an accurate number of Medicaid eligible days, as required by HCFA Ruling 97-2 and pertinent Federal Court decisions that the Provider cited therein.

With regard to Issue 2, the Provider's complete briefing on this issue is as follows:

[1] The Provider initially labeled the issue as "SSI Provider Specific," but on January 11, 2023, the Provider clarified that the issue was mislabeled and that the issue actually addressed was the SSI Systemic Errors issue.

Calculation of the SSI Percentage

The Provider contends that the Lead MAC's determination of Medicare Reimbursement for DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww(d)(5)(F)(i). The Provider contends that the SSI percentages calculated by [CMS] and used by the Lead MAC to settle their Cost Report was incorrectly computed because of the following reasons:

Provider Specific

The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation. This is based on certain data from the State of California and the Provider that does not support the SSI percentage issued by CMS.

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

The Provider is seeking the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000, from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. *See* 65 Fed. Reg. 50,548 (2000). The Provider believes that upon completion of this review that it will be entitled to a correction of these errors of omission to its' SSI percentage based on CMS' admission in *Baystate Medical Center v. Leavitt,* 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction.[2]

2. *Medicare Contractor's Contentions in FPP*

The Medicare Contractor notes that the Provider's FPP addressed Issue 5, Medicaid Eligible Days. However, Issue 5 was ***not*** one of the four issues reinstated by the Board after the case was fully withdrawn by the Provider (as discussed in the Procedural History section, above).

The Medicare Contractor asserts that the Provider's briefing of the Medicaid Eligible Days issue is ***not*** proper. The Medicare Contractor contends that this is not in accordance with Board Rule

[2] Provider's Final Position Paper, at 8-9 (Nov. 1, 2022) (underline emphasis added).

4.6.3, which provides that an issue previously withdrawn may not be pursued, and that it is not appropriate for the Provider to attempt to reinstate this withdrawn issue through its FPP.

With regard to Issue 2, DSH/SSI Percentage (Systemic Errors), the Medicare Contractor asserts that CMS has arranged to comply with Section 951 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (the "MMA") by releasing the MEDPAR LDS data (which contains a summary of all services furnished to a Medicare beneficiary, from the time of admission through discharge, for a stay in an inpatient hospital or skilled nursing facility or both; SSI eligibility information; and enrollment data on Medicare beneficiaries) to providers. In the case at issue, the Medicare Contractor asserts that the Provider *has obtained*, through data use agreements, CMS' MEDPAR data supporting the number of SSI days used in CMS' calculation of SSI percentage.

The Medicare Contractor asserts the Provider's appeal is premature because it has failed to demonstrate the SSI ratio is inaccurate. The Medicare Contractor notes that, after it inquired of CMS about receiving the MEDPAR LDS data, based on CMS' response, the Provider received data related to its provider number and cost reporting period in contention multiple times, which CMS processed on May 15 and 17, 2019, and August 17, 2020. The Provider has not furnished any evidence to support its contention that the SSI ratios are flawed, or given any specific examples of patients that were erroneously excluded from the ratio, even though they have had the data for over three years. Without the Provider's analysis of the SSI data, it is impossible to determine if its claim that the SSI ratios are flawed has merit. Further, the Medicare Contractor notes that the concept of administrative finality is an important consideration, the SSI ratio is a proxy, and the goal is to determine SSI ratios that are reasonably accurate, as stated by CMS, and cites to language in the Federal Register that is attached as Exhibit C-8.

The Medicare Contractor emphasizes that the Provider did not provide a specific explanation for its dissatisfaction with the SSI ratio, and thus does not meet the requirements of 42 C.F.R. § 405.1835. The Medicare Contractor contends that the Medicare regulations at 42 C.F.R. §§ 413.20(a) and 413.24(c) require that providers maintain sufficient financial records and data for proper determination of costs payable under the program, and that adequate cost information must be obtained from the provider's records, which implies that the data be accurate and in sufficient detail to accomplish the purposes for which it is intended.

Finally, the Medicare Contractor asserts that the Provider's SSI ratio has been properly determined in accordance with the revised data matching process, and cites to *Baystate,* CMS Ruling 1498-R, and the August 16, 2010 Federal Register in which CMS adopted the revised data matching process for FY 2011 and beyond. CMS applied the revised data matching process in the determination of the Provider's SSI ratios that are in contention in this case.

C. Jurisdictional Challenge

1. Medicare Contractor's Jurisdictional Challenge

In its jurisdictional challenge, in regard to Issue 2, DSH – SSI Percentage (Systemic Error), the Medicare Contractor asserts that the Provider did not file a complete FPP in accordance with 42 C.F.R. § 405.1853 and Board Rules 25.2, 25.3 and 27.2, and that this issue should be dismissed accordingly. The Medicare Contractor contends that the Provider was in violation of Board Rule 25.3 when it failed to sufficiently develop and set forth the relevant facts and arguments regarding the merits of the claim in its FPP. Moreover, the Provider neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable in accordance with Board Rule 25.2.2. The Medicare Contractor further explains:

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

The Provider has not added any specific allegations, analysis or information related to the DSH – SSI (Systemic Error) issue that would satisfy the requirements set forth in Board Rules 25.1.1 or 25.2.2. The Provider has essentially abandoned the issue by failing to properly develop its arguments, to provide supporting documents or to explain why it cannot produce those documents, as required by the regulations and the Board Rules; therefore, the MAC requests that the Board dismiss this issue.

Further, the Medicare Contractor asserts that in the FPP, the Provider's briefing of Medicaid Eligible Days is not proper as the issue of Medicaid Eligible Days was included in this case as Issue 5, and Issue 5 was withdrawn. The Provider has not requested or received approval from the Board for reinstatement of Issue 5 in accordance with Board Rule 47. Moreover, it is not reasonable for the Provider to attempt to reinstate the withdrawn issue through its FPP. Accordingly, the Medicare Contractor asserts that Issue 5 should be dismissed. But even if Issue 5 were an active issue in this case, the Medicare Contractor asserts that the Provider abandoned the issue because it has not submitted a list of additional Medicaid days and has not fully addressed the issue in its FPP.

2. *Provider's "Response to MAC/FSS Jurisdictional Challenge" and Request for Postponement*

On January 11, 2023, QRS filed the Provider's "Response to MAC/FSS Jurisdictional Challenge" and that response was timely as it was filed within the 30-day period allotted under Board Rule 44.4.3. *However, that "response" **failed** to address (much less contest) the fatal procedural flaws raised in the jurisdictional challenge*.

Rather, QRS simply requested that the Board postpone the hearing in this case "pending the outcome of *Becerra v. Empire Health Foundation* … currently pending in the Ninth Circuit court of appeals [*sic*]" because it contends that "[t]he Empire … case deals with substantially similar issues to those addressed in PRRB Case Number 16-2131 namely the provider challenged the inaccuracy of the SSI Percentage." QRS fails to explain why the Board should postpone the hearing, notwithstanding the fatal procedural flaws that would render any potential postponement moot.

Finally, QRS submitted a correction to its final position paper, noting that it had "inadvertently mislabeled the SSI Systemic issue as the SSI – Provider Specific issue" and, accordingly, "[t]he correct issue title which should be referenced in the final paper should be: 'DSH – SSI (Systemic Errors).'"

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, and the request for a hearing is filed within 180 days of the date of receipt of the final determination. In this case, the Provider filed the appeal timely and the minimum amount in controversy requirement was met.

A. Issue 5: Medicaid Eligible Days

The Provider briefed Issue 5, Medicaid Eligible Days, in its FPP filed on November 1, 2022. However, this issue was previously withdrawn on March 4, 2021 upon the Provider's request to withdraw this case in full. While the Board reinstated Case No. 16-2131 to allow the reversal of the prior transfer of four issues (Issues 2, 4, 7 and 8), the Board did ***not*** reinstate Issue 5, as discussed above in the Procedural History. Moreover, the Provider did ***not*** request or receive approval from the Board for reinstatement of Issue 5 in accordance with Board Rule 47.

Board Rule 4.6.3 provides that once an issue is dismissed or withdrawn, the issue may ***not*** be appealed in any other case. In other words, the issue cannot be pursued again, and it is not appropriate to try to reinstate a withdrawn issue through briefing in the FPP. The Board may dismiss an issue on its own motion upon failure of the provider to comply with Board procedures

pursuant to 42 C.F.R. § 405.1868 and Board Rule 41.2. Accordingly, the Board dismisses Issue 5, and clarifies that this issue is ***not*** active in this case.[3]

B. Issue 2: SSI Systemic Errors

The Board has reviewed the Provider's FPP, particularly the Provider's briefing of Issue 2, as quoted above, and finds that the Provider did not file a complete position paper related to Issue 2 that was in accordance with 42 C.F.R. § 405.1853(a)-(b) and Board Rules 25.2, 25.3 and 27.2 (Nov. 2021). The Board concurs with the Medicare Contractor that the Provider is required to identify and provide documentation to establish what is at issue and what it may be entitled to consistent with 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rules 25 and 27.[4] Further, pursuant to Board Rule 25 (and consistent with 42 C.F.R. § 405.1853(b)(3)), the Provider has the burden to present such evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable.

The Notice of Hearing that required the Provider to file its final position paper by November 10, 2022 gave the following instructions:

> 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.

Board Rule 27.2 explains that the content requirements for preliminary position papers at Board Rule 25 is applicable to final position papers.

As explained in the Commentary to Board 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." The regulation at 42 C.F.R. § 405.1853 addresses position papers and specifies in pertinent part:

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[3] Moreover, even if the Board had reinstated Issue 5, the Board would still dismiss it because QRS failed to fully brief Issue 5 in its final position paper. Even though the fiscal year at issue is FY 2011 and ended more than 12 years ago, the position paper failed to identify what Medicaid eligible days are in dispute but stated that an eligibility listing is being sent under separate cover. Contrary to Board Rule 25.2.2, there is no explanation why the documents remain unavailable at this late date. Consistent with 42 C.F.R. § 405.1853(b)(2)-(3), Board Rules 25.1.1, 25.2, 25.3, and 27.2, the Commentary at Board Rules 23.3, 25, and 25.3 and the Notice of Hearing for this case, it is clear that position papers must be ***fully*** developed on the merits of each issue and include all available documentation necessary to provide a thorough understanding of the parties' positions on each issue. Here, QRS failed to do that by failing to identify in the ***final*** position paper what, if any, ***specific*** Medicaid eligible days are in dispute.

[4] *See also* 42 C.F.R. §§ 413.20, 413.24(c).

> (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*.[5]

Board Rule 25.2.2 specifies:

> 25.2.2 Unavailable and Omitted Documents If documents necessary to support your position are still unavailable,[6] 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.

Similarly, with regard to position papers,[7] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[8] This requirement is consistent with 42 C.F.R. § 405.1853(b)(3).

Here, the Provider failed to sufficiently develop and put forth relevant arguments regarding the merits of its claim, including an explanation of the nature of any alleged "errors," and failed to

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[5] (Emphasis added.)
[6] 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."
[7] The minimum requirements for Final Position Paper narratives and exhibits is the same as those for Preliminary Position Papers. *See* Board Rule 27.2.
[8] (Emphasis added.)

include *all* exhibits such as the submission of the "certain data from the State of California and provider" on which it relies. Further, the Medicare Contractor asserted that CMS provided MEDPAR data to the Provider on May 15 and 17, 2019 and August 17, 2020. It has now been over three years since the Provider received that MEDPAR data, and the Provider has not used the data to prove that relevant days were not counted in the SSI Medicare fraction. Instead, the Provider apparently misrepresented that it was still seeking the MEDPAR data and, at a minimum, withheld relevant information from the Board necessary to assess QRS' diligence in obtaining MEDPAR data at this late date (it has been more than 12 years since the fiscal year at issue ended). Moreover, it is unclear to what extent QRS has even started reviewing the MEDPAR data.

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

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

Further highlighting the perfunctory nature of the briefing is the fact that providers *can* obtain certain data used to calculate their DSH SSI ratios directly from CMS and in some cases on a self-service basis as explained on the following webpage: https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH.[9] This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows: "DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[10]

Similarly, QRS has stated that its contention that "CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation" is "based on certain data from the State

[9] (Last accessed Nov. 21, 2022.)
[10] (Emphasis added.)

of California ***and*** the Provider."[11] However, QRS' final position paper filing is fatally flawed because it failed to: (a) describe this data and include redacted copies in the record and/or furnish it to the MAC; and (b) explain in the ***final*** position paper what this data is, what it shows, and how it demonstrates not all SSI days were not included in the DSH calculation. Similarly, QRS contends that "the Provider has worked with the State of California and has learned that … the SSI entitlement of individuals can be ascertained from State records." However, QRS fails to explain in the ***final*** position paper what those alleged "State records" are, much less how they SSI entitlement can be "ascertained" from those "State records."[12]

In its FPP, the Provider did not: (1) state the efforts made to obtain the data/information used to calculate its DSH SSI ratio (whether from California data or MEDPAR data); (2) address the fact that providers can obtain certain data used to calculate their DSH SSI ratios directly from CMS; or (3) discuss the fact that, in some cases, the relevant data can be obtained on a self-service basis. The Provider's failures violated the obligation to state the efforts made to obtain documentation missing or unavailable in accordance with Board Rule 25.2.2.

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.

For the reasons discussed above, the Board finds that the Provider has failed to comply with the regulatory requirements and the Board's procedures with regard to filing its position paper and supporting documentation and, therefore, the Board dismisses this issue from the appeal pursuant to Board Rule 41.2.

Finally, the Board notes that QRS' timely response to the jurisdictional challenge ***failed*** to address the *fatal* procedural flaws that the MAC raised and the Board affirmed. Accordingly, it appears that QRS did not otherwise contest the MAC's challenge. Rather, QRS simply requested postponement of the hearing date pending the outcome of the *Empire* case pending in the Ninth Circuit based on its assertion that "[t]he Empire … case deals with substantially similar issues to those addressed in PRRB Case Number 16-2131 namely the provider challenged the inaccuracy of the SSI Percentage." However, QRS fails to explain why the Board should postpone the hearing, *notwithstanding the **fatal** procedural flaws that have rendered any potential postponement moot*.

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[11] (Emphasis added.)

[12] QRS has suggested that what the Provider learned from working with the State is "similar to *Loma Linda Community Hospital v. Dept of Health and Human Services,* No. CV-94-0055 (C.D. Cal. June 2, 1995)." However, again, QRS failed to explain what the Provider learned and how it is "similar." This goes to the merits of the Provider's position on the issue.

Regardless, QRS fails to even explain how the Empire case is even relevant to Issue 2 *as briefed in the **final** position paper*. In this regard, the Board notes that, even though the ***final*** position paper was filed just 2 months ago on November 1, 2022, it does not even mention the *Empire* case, much less the regulatory challenge that is pending before the Ninth Circuit (namely the challenge to the validity of the Secretary's regulatory interpretation of the phrase "entitled to security supplementary income benefits" as set forth in 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I)).[13,14] Accordingly, the Board finds that the *Empire* case is ***not*** relevant because the Provider's final position paper did ***not*** brief the regulatory challenge that is at issue in *Empire* and, thus, to the extent it was ever part of this appeal,[15] the Provider abandoned that issue by failing to brief it in the ***final*** position paper as explained in Board Rule 25.3 (as applicable via Board Rule 27.2).[16]

****

In summary, the Board hereby dismisses the SSI Systemic Errors issue from this appeal as the Provider failed to meet the regulatory and Board requirements for position papers. The Board also dismisses the Medicaid eligible days issue as this issue was previously withdrawn and was not reinstated in this appeal. As no issues remain pending, the Provider's request for postponement of the hearing is moot and denied; and the Board hereby closes Case No. 16-2131 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.
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Robert A. Evarts, Esq.
Kevin D. Smith, CPA
Ratina Kelly, CPA

For the Board:

2/10/2023

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services

[13] It is the Board's understanding that QRS is pursing the *Empire* litigation on behalf the *Empire* and, thus, has firsthand knowledge of the arguments and status of the case. In this regard, the Board notes that on December 5, 2022, the Ninth Circuit found that the District Court had subject-matter jurisdiction over Empire's alternative argument challenging the Secretary's interpretation of the phrase "entitled to supplemental security benefits." *Empire Health Found. v. Azar*, No. 18-35845, 2022 WL 17411382 (9th Cir., Dec. 5, 2022).

[14] QRS failure to brief the merits of this issue meant that the opposing party was not notice of the Provider's continued pursuit of that *unbriefed* issue and, thereby, did not have an opportunity to brief its position on the merits of that *unbriefed* issue. To this point, the MAC final position paper does not address the Provider's ***unbriefed*** challenge to the Secretary's interpretation of the statutory phrase "entitled to supplemental security income benefits."

[15] The Board need ***not*** address (or make any findings on) whether it was part of the appeal since it is clear that it was *not* briefed in the ***final*** position paper.

[16] Board Rule 25.3 states: "If the provider fails to brief an appealed issue in its position paper, the Board will consider the unbriefed issue abandoned and effectively withdrawn." This Rule is consistent with 42 C.F.R. § 405.1853(b)(2) which requires that "[e]ach position paper must set forth the relevant facts and arguments regarding . . . the merits of the provider's Medicare payment claims for each remaining issue." Further, as explained in *supra* note 13, the Provider's representative has firsthand knowledge of the *Empire* case but failed to include it (or the regulatory challenge pending therein) in the Provider's ***final*** position paper filing.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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410-786-2671

Via Electronic Delivery

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

RE: ***Board Decision* – SSI Percentage (Provider Specific)**
Tennova Healthcare Harton (Provider Number 44-0144)
FYE: 05/31/2016
Case Number: 19-1074

Dear Mr. Ravindran,

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

Background:

A. *Procedural History for Case No. 19-1074*

On August 6, 2018, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end May 31, 2016.

On January 15, 2019, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained nine (9) issues:

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

[1] On August 23, 2019, this issue was transferred to PRRB Case No. 19-0173GC.
[2] On August 23, 2019, this issue was transferred to PRRB Case No. 19-0175GC.
[3] On August 23, 2019, this issue was transferred to PRRB Case No. 19-0198GC.
[4] On November 14, 2022, Federal Specialized Services ("FSS") filed a jurisdictional challenge over the Medicaid Eligible Days issue. On December 28, 2022, FSS filed a Request for Dismissal of the Medicaid Eligible Days issue. Subsequently, the Provider withdrew this issue on January 13, 2023.
[5] On August 23, 2019, this issue was transferred to PRRB Case No. 19-0159GC.

- DSH Medicaid Fraction/Dual Eligible Days[6]
- Uncompensated Care (UCC) Distribution Pool[7]
- Two Midnight Census IPPS Payment Reduction[8]

After the Provider transferred 7 issues to group appeals and withdrew the Medicaid eligible days issue, the sole remaining issue is the DSH/SSI Percentage – Provider Specific Issue.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 19-0173GC

The Provider's appeal request described Issue 1 (DSH/SSI Percentage – Provider Specific) 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]

The Provider's appeal request described Issue 2 (DSH/SSI Percentage) 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 at 42 U.S.C. § 1395ww(d)(5)(F)(vi). The Provider contends that the SSI percentages calculated by [CMS] and used by the Lead MAC to settle their Cost Report were incorrectly computed.
>
> The Provider further contends that the SSI percentages calculated by [CMS] fail to address all the deficiencies as described in *Baystate Medical Center v. Michael O. Leavitt*, 545 F. Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37, 44 (D.D.C. 2008) and incorporates a new methodology inconsistent with the Medicare Statute.

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[6] On August 23, 2019, this issue was transferred to PRRB Case No. 19-0197GC.
[7] On August 23, 2019, this issue was transferred to PRRB Case No. 19-0177GC.
[8] On August 23, 2019, this issue was transferred to PRRB Case No. 19-0185GC.
[9] Issue Statement at 1 (Nov. 29, 2018).

> Providers [*sic*] in this case are also seeking resolution of the following additional aspects of the Medicare fraction that were not addressed in the Baystate case:
>
> 1. Availability of MEDPAR and SSA Records
> 2. Failure to adhere to required notice and comment rulemaking procedures
> 3. Fundamental problems in the SSI percentage calculation
> 4. Not in agreement with provider's records
> 5. Paid days vs. Eligible days, and
> 6. Covered days vs. Total days.[10]

As the Provider is commonly owned by Community Health Systems, Inc. ("CHS"), the Provider transferred its Issue 2 – DSH/SSI Percentage to the CIRP group under Case Number 19-0173GC, *CHS CY 2016 HMA DSH SSI Percentage (Systemic Errors) CIRP Group*, on August 23, 2019. The Group Issue Statement for Case No. 19-0173GC 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 for their DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww(d)(5)(F)(vi). 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,

[10] *Id.* at Issue 2.

5. Covered days vs. Total days, and
6. Failure to adhere to required notice and comment rulemaking procedures.

The amount in controversy listed for both issues 1 and 2 in the Provider's individual appeal request is $31,000.

MAC'S Contentions:

On May 6, 2019, the MAC filed a Jurisdictional Challenge. 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 and the Provider has not exhausted all available remedies.[11]

In addition, the MAC argues the DSH/SSI Percentage - Provider Specific issue and the DSH SSI Percentage issue are considered the same issue by the Board, and cites several past Board decisions to that end.[12]

Provider's Response:

On June 7, 2019, the Provider filed a Jurisdictional Response. In it, the Provider argues that the issues are not duplicative because "issues #1 and 2 represent different components of the SSI issue, which was specifically adjusted during the audit."[13] Additionally, the Provider argues that the issue is not duplicative because the Provider is "not addressing the errors which result from CMS' improper data matching process but is addressing the various errors of omission and commission that do not fit into the "systemic errors" category."[14]

Finally, the Provider contends the Provider Specific issue is appealable "because the MAC specifically adjust the Providers SSI percentage and the Provider is dissatisfied with the amount of DSH payments that it received for fiscal year 2016, resulting from its understated SSI percentage due to errors of omission and commission."[15]

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.

[11] Jurisdictional Challenge at 6 (May 6, 2019).
[12] *Id*. at 7.
[13] Jurisdictional Response at 2 (June 7, 2019).
[14] *Id*. at 3.
[15] *Id*.

A. SSI Provider Specific

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

1. First Aspect of Issue 1

The Board finds that the 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 issue that was appealed in Group Case No. 19-0173GC. The first aspect of Issue 1 in the present appeal concerns "whether the Medicare Administrative Contractor used the correct [SSI] percentage in the [DSH] Calculation."[16] 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)."[17] 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."[18] Issue 2, transferred to group Case No. 19-0173GC, similarly alleges that the Medicare Contractor and CMS improperly calculated the DSH/SSI Percentage, the DSH/SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F)(i).

In making this finding, the Board further notes that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, the Provider is pursuing that issue as part of the group under Case No. 19-0173GC. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[19] The Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 19-0173GC.

Accordingly, the Board must find that the first aspect of Issue 1 and the group issue in Group Case 19-0173GC, are the same issue. Because the issue is duplicative, and duplicative issues

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[16] Individual Appeal Request, Issue 1.
[17] *Id.*
[18] *Id.*
[19] 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).

appealed from the same final determination are prohibited by Board Rule 4.6 (2018), the Board dismisses this component of the DSH/SSI Percentage (Provider Specific) issue.

2. Second Aspect of Issue 1

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

Conclusion:

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

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

Board Members Participating:

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

For the Board:

2/13/2023

X Kevin D. Smith, CPA

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

James Ravindran
Quality Reimbursement Services, Inc.
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RE: ***Board Decision* – SSI Percentage (Provider Specific)**
MultiCare Deaconess Hospital (Provider Number 50-0044)
FYE: 06/30/2017
Case Number: 21-0696

Dear Mr. Ravindran,

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

Background:

A. *Procedural History for Case No. 21-0696*

On August 27, 2020, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end June 30, 2017.

On February 4, 2021, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained three (3) issues:

- SSI Percentage (Provider Specific)
- SSI Percentage[1]
- Medicaid Eligible Days[2]

After the Provider transferred the SSI Percentage issue and withdrew the Medicaid eligible days issue, the remaining issue is the DSH/SSI Percentage – Provider Specific Issue.

[1] On September 23, 2021, this issue was transferred to PRRB Case No. 20-0997GC.
[2] On November 14, 2022, Federal Specialized Services ("FSS") filed a jurisdictional challenge over the Medicaid Eligible Days issue. On December 28, 2022, FSS filed a Request for Dismissal of the Medicaid Eligible Days issue. Subsequently, the Provider withdrew this issue on January 13, 2023.

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

The Provider's appeal request described Issue 1 (DSH/SSI Percentage – Provider Specific) 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's appeal request described Issue 2 (DSH/SSI Percentage) 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 at 42 U.S.C. § 1395ww(d)(5)(F)(vi). The Provider contends that the SSI percentages calculated by [CMS] and used by the Lead MAC to settle their Cost Report were incorrectly computed.
>
> . . .
>
> The Provider further contends that the SSI percentages calculated by [CMS] fail to address all the deficiencies as described in *Baystate Medical Center v. Michael O. Leavitt*, 545 F. Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37, 44 (D.D.C. 2008) and incorporates a new methodology inconsistent with the Medicare Statute.
>
> Providers [*sic*] 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

[3] Issue Statement at 1 (Feb. 4, 2021).

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

As the Provider is commonly owned by Community Health Systems, Inc. ("CHS"), the Provider transferred Issue 2 – SSI Percentage to the CIRP group under Case Number 20-0997GC, *CHS CY 2017 DSH SSI Percentage CIRP Group*, on September 23, 2021. The Group Issue Statement for 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/con-covered/eligible SSI days?
>
> **Statement of the Legal Basis**
>
> The Provider(s) contend(s) that the MAC's determination for their DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww(d)(5)(F)(vi). 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. Failure to adhere to required notice and comment rulemaking procedures,
> 3. Fundamental problems in the SSI percentage calculation,
> 4. Not in agreement with provider's records,
> 5. Paid days vs. Eligible Days, and
> 6. Covered days vs. Total days.[5]

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $29,000.

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[4] *Id.* at Issue 2.
[5] Group Issue Statement, Case No. 20-0997GC.

MAC'S Contentions:

On December 27, 2021, the MAC filed a Jurisdictional Challenge. 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 and the Provider has not exhausted all available remedies.[6]

In addition, the MAC argues the DSH/SSI Percentage - Provider Specific issue and the DSH/SSI Percentage issue are considered the same issue by the Board, and cites several past Board decisions to that end.[7]

Provider's Response:

The Board Rules require that Provider Responses to the MAC's Jurisdictional Challenge must filed within thirty (30) days of the filing of the Jurisdictional Challenge.[8] The Provider has not filed a response to the Jurisdictional Challenge over the SSI Percentage - Provider Specific issue in this case and the time for doing so has elapsed.[9] 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 (2013), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

A. SSI Provider Specific

The analysis for Issue 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.

[6] Jurisdictional Challenge at 7 (Dec. 27, 2021).
[7] *Id*. at 5-6.
[8] Board Rule 44.4.3, v. 2. (Aug. 2018).
[9] The Provider did file a response to the November 14, 2022 Jurisdictional Challenge over the Medicaid Eligible Days issue, but has since withdrawn that issue.

1. First Aspect of Issue 1

The Board finds that 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 issue that was appealed in Group Case No. 20-0997GC. The first aspect of Issue 1 in the present appeal concerns "whether the Medicare Administrative Contractor used the correct [SSI] percentage in the [DSH] Calculation."[10] The Provider's legal basis for this aspect of Issue 1 is simply that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[11] Similarly, the Provider argues that "it[s] SSI percentage published by [CMS] was incorrectly computed . . ." and it ". . . [s]pecifically . . . disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[12] Issue 2, transferred to group Case No. 20-0997GC, similarly alleges that the Medicare Contractor and CMS improperly calculated the DSH/SSI Percentage, the DSH/SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F)(i).

In making this finding, the Board further notes that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, the Provider is pursuing that issue as part of the group under Case No. 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.[13] The Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) 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.

Accordingly, the Board must find that the first aspect of Issue 1 and the group issue in 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 (2018), 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—must be dismissed for lack of jurisdiction and as premature. Under 42

[10] Individual Appeal Request, Issue 1.
[11] *Id.*
[12] *Id.*
[13] The types of systemic errors documented in the *Baystate* did not uniformly impact the SSI calculation for all providers but that does not 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).

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

Conclusion:

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

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

Board Members Participating:

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

For the Board:

2/13/2023

X Kevin D. Smith, CPA

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

cc: Wilson C. Leong, Esq., Federal Specialized Services
Byron Lamprecht, WPS Government Health Administrators (J-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 570A
Arcadia, CA 91006

RE: ***Board Decision* – SSI Percentage (Provider Specific)**
MultiCare Valley Hospital (Provider Number 50-0119)
FYE: 06/30/2017
Case Number: 21-1509

Dear Mr. Ravindran,

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

Background:

A. *Procedural History for Case No. 21-1509*

On January 26, 2021, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end June 30, 2017.

On July 13, 2021, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained three (3) issues:

- SSI Percentage (Provider Specific)
- SSI Percentage[1]
- Medicaid Eligible Days[2]

After the Provider transferred the SSI Percentage issue and withdrew the Medicaid eligible days issue, the only remaining issue is the DSH/SSI Percentage – Provider Specific Issue.

[1] On February 9, 2022, this issue was transferred to PRRB Case No. 20-0997GC.
[2] On November 14, 2022, Federal Specialized Services ("FSS") filed a jurisdictional challenge over the Medicaid Eligible Days issue. On December 28, 2022, FSS filed a Request for Dismissal of the Medicaid Eligible Days issue. Subsequently, the Provider withdrew this issue on January 13, 2023.

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

The Provider's appeal request described Issue 1 (DSH/SSI Percentage – Provider Specific) 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's appeal request described Issue 2 (DSH/SSI Percentage) 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 at 42 U.S.C. § 1395ww(d)(5)(F)(vi). The Provider contends that the SSI percentages calculated by [CMS] and used by the Lead MAC to settle their Cost Report were incorrectly computed.
>
> . . .
>
> The Provider further contends that the SSI percentages calculated by [CMS] fail to address all the deficiencies as described in *Baystate Medical Center v. Michael O. Leavitt*, 545 F. Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37, 44 (D.D.C. 2008) and incorporates a new methodology inconsistent with the Medicare Statute.
>
> Providers [*sic*] 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

[3] Issue Statement at 1 (July 13, 2021).

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

As the Provider is commonly owned by Community Health Systems, Inc. ("CHS"), the Provider transferred Issue 2 – SSI Percentage to the CIRP group under Case Number 20-0997GC, *CHS CY 2017 DSH SSI Percentage CIRP Group*, on February 9, 2022. The Group Issue Statement for 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 for their DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww(d)(5)(F)(vi). 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. Failure to adhere to required notice and comment rulemaking procedures,
> 3. Fundamental problems in the SSI percentage calculation,
> 4. Not in agreement with provider's records,
> 5. Paid days vs. Eligible Days, and
> 6. Covered days vs. Total days.[5]

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $27,000.

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[4] *Id.* at Issue 2.
[5] Group Issue Statement, Case No. 20-0997GC.

MAC'S Contentions:

On June 1, 2022, the MAC filed a Jurisdictional Challenge. 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 and the Provider has not exhausted all available remedies.[6]

In addition, the MAC argues the DSH/SSI Percentage - Provider Specific issue and the DSH SSI Percentage - Systemic issue are considered the same issue by the Board, and cites several past Board decisions to that end.[7]

Provider's Response:

The Board Rules require that Provider Responses to the MAC's Jurisdictional Challenge must filed within thirty (30) days of the filing of the Jurisdictional Challenge.[8] The Provider has not filed a response to the Jurisdictional Challenge over the SSI Provider Specific issue in this case and the time for doing so has elapsed.[9] 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 (2013), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

A. SSI Provider Specific

The analysis for Issue 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.

---

[6] Jurisdictional Challenge at 7 (June 1, 2022).
[7] *Id*. at 5-6.
[8] Board Rule 44.4.3, v. 2. (Aug. 2018).
[9] The Provider did file a response to the November 14, 2022 Jurisdictional Challenge over the Medicaid Eligible Days issue, but has since withdrawn that issue.

1. First Aspect of Issue 1

The Board finds that 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 issue that was appealed in Group Case No. 20-0997GC. The first aspect of Issue 1 in the present appeal concerns "whether the Medicare Administrative Contractor used the correct [SSI] percentage in the [DSH] Calculation."[10] The Provider's legal basis for this aspect of Issue 1 is simply that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[11] Similarly, the Provider argues that "it[s] SSI percentage published by [CMS] was incorrectly computed . . ." and it ". . . [s]pecifically . . . disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[12] Issue 2, transferred to group Case No. 20-0997GC, similarly alleges that the Medicare Contractor and CMS improperly calculated the DSH/SSI Percentage, the DSH/SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F)(i).

In making this finding, the Board further notes that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, the Provider is pursuing that issue as part of the group under Case No. 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.[13] The Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) 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.

Accordingly, the Board must find that the first aspect of Issue 1 and the group issue in 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 (2018), the Board dismisses this component of the DSH/SSI Percentage (Provider Specific) issue.

2. Second Aspect of Issue 1

The second aspect of the DSH SSI Percentage (Provider Specific) issue—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—must be dismissed for lack of jurisdiction and as premature. Under 42 C.F.R.

---

[10] Individual Appeal Request, Issue 1.
[11] *Id.*
[12] *Id.*
[13] The types of systemic errors documented in the *Baystate* did not uniformly impact the SSI calculation for all providers but that does not 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).

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

Conclusion:

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

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

Board Members Participating:

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

For the Board:

2/13/2023

X Kevin D. Smith, CPA

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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

RE: ***Board Decision* – SSI Percentage (Provider Specific)**
Dupont Hospital LLC (Provider Number 15-0150)
FYE: 03/31/2018
Case Number: 21-1795

Dear Mr. Ravindran,

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

Background:

A. *Procedural History for Case No. 21-1795*

On May 3, 2021, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end March 31, 2018.

On September 28, 2021, the Board received the 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[2]

After the Provider transferred the SSI Percentage (Systemic Errors) issue to a group and withdrew the Medicaid eligible days issue, the only remaining issue is the DSH/SSI Percentage – Provider Specific Issue.

[1] On April 13, 2022, this issue was transferred to PRRB Case No. 21-1206GC.
[2] On November 14, 2022, Federal Specialized Services ("FSS") filed a jurisdictional challenge over the Medicaid Eligible Days issue. On December 28, 2022, FSS filed a Request for Dismissal of the Medicaid Eligible Days issue. Subsequently, the Provider withdrew this issue on January 13, 2023.

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

The Provider's appeal request described Issue 1 (DSH/SSI Percentage – Provider Specific) 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's appeal request described Issue 2 (DSH/SSI Percentage – Systemic Errors) 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 at 42 U.S.C. § 1395ww(d)(5)(F)(vi). The Provider contends that the SSI percentages calculated by [CMS] and used by the Lead MAC to settle their Cost Report were incorrectly computed.
>
> . . .
>
> The Provider further contends that the SSI percentages calculated by [CMS] fail to address all the deficiencies as described in *Baystate Medical Center v. Michael O. Leavitt*, 545 F. Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37, 44 (D.D.C. 2008) and incorporates a new methodology inconsistent with the Medicare Statute.
>
> Providers [*sic*] 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

[3] Issue Statement at 1 (Sept. 28, 2021).

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

As the Provider is commonly owned by Community Health Systems, Inc. ("CHS"), the Provider transferred its Issue 2 – DSH/SSI to the CIRP group under Case Number 21-1206GC, *CHS CY 2018 DSH SSI Percentage CIRP Group*, on April 13, 2022. The Group Issue Statement for Case No. 21-1206GC 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 for their DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). The Provider(s) further contend(s) that the SSI percentages calculated by [CMS] and used by the MAC to settle their Cost Reports incorporates a new methodology inconsistent with the Medicare statute.
>
> The Providers challenge their SSI percentages based on the following reasons:
>
> 1. Availability of MEDPAR and SSA records,
> 2. Paid days vs. Eligible days.
> 3. Not in agreement with provider's records,
> 4. Fundamental problems in the SSI percentage calculation,
> 5. Covered days vs. Total days and
> 6. Failure to adhere to required notice and comment rulemaking procedures.[5]

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $8,915.

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[4] *Id.* at Issue 2.
[5] Group Issue Statement, Case No. 20-0997GC.

MAC'S Contentions:

On September 7, 2022, the MAC filed a Jurisdictional Challenge. 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 and the Provider has not exhausted all available remedies.[6]

In addition, the MAC argues the DSH/SSI Percentage - Provider Specific issue and the DSH/SSI Percentage - Systemic Errors issue are considered the same issue by the Board, and cites several past Board decisions to that end.[7]

Provider's Response:

The Board Rules require that Provider Responses to the MAC's Jurisdictional Challenge must filed within thirty (30) days of the filing of the Jurisdictional Challenge.[8] The Provider has not filed a response to the Jurisdictional Challenge over the SSI Provider Specific issue in this case and the time for doing so has elapsed.[9] 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 (2013), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

A. SSI Provider Specific

The analysis for Issue 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.

[6] Jurisdictional Challenge at 7 (Sept. 7, 2022).
[7] *Id*. at 5-6.
[8] Board Rule 44.4.3, v. 2. (Aug. 2018).
[9] The Provider did file a response to the November 14, 2022 Jurisdictional Challenge over the Medicaid Eligible Days issue, but has since withdrawn that issue.

1. First Aspect of Issue 1

The Board finds that 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 issue that was appealed in Group Case No. 21-1206GC. The first aspect of Issue 1 in the present appeal concerns "whether the Medicare Administrative Contractor used the correct [SSI] percentage in the [DSH] Calculation."[10] The Provider's legal basis for this aspect of Issue 1 is simply that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[11] Similarly, the Provider argues that "it[s] SSI percentage published by [CMS] was incorrectly computed . . ." and it ". . . [s]pecifically . . . disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[12] Issue 2, transferred to group Case No. 21-1206GC, similarly alleges that the Medicare Contractor and CMS improperly calculated the DSH/SSI Percentage, the DSH/SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F)(i).

In making this finding, the Board further notes that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, the Provider is pursuing that issue as part of the group under Case No. 21-1206GC. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[13] The Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 21-1206GC.

Accordingly, the Board must find that the first aspect of Issue 1 and the group issue in Group Case 21-1206GC, 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 (2018), the Board dismisses this component of the DSH/SSI Percentage (Provider Specific) issue.

2. Second Aspect of Issue 1

The second aspect of the DSH/SSI Percentage (Provider Specific) issue—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—must be dismissed for lack of jurisdiction and as premature. Under 42

[10] Individual Appeal Request, Issue 1.
[11] *Id.*
[12] *Id.*
[13] The types of systemic errors documented in the *Baystate* did not uniformly impact the SSI calculation for all providers but that does not 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).

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

Conclusion:

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

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

Board Members Participating:

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

For the Board:

2/13/2023

X Kevin D. Smith, CPA

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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

RE: ***Board Decision* – SSI Percentage (Provider Specific)**
Chestnut Hill Hospital (Provider Number 39-0026)
FYE: 06/30/2017
Case Number: 22-0123

Dear Mr. Ravindran,

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

Background:

A. *Procedural History for Case No. 22-0123*

On May 24, 2021, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end June 30, 2017.

On November 10, 2021, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained three (3) issues:

- SSI Percentage (Provider Specific)
- SSI Percentage (Systemic Errors)[1]
- Medicaid Eligible Days[2]

After the Provider transferred the SSI Percentage (Systemic Errors) issue and withdrew the Medicaid eligible days issue, the sole remaining issue is the DSH/SSI Percentage – Provider Specific Issue.

[1] On June 10, 2022, this issue was transferred to PRRB Case No. 20-0997GC.
[2] On November 14, 2022, Federal Specialized Services ("FSS") filed a jurisdictional challenge over the Medicaid Eligible Days issue. On December 28, 2022, FSS filed a Request for Dismissal of the Medicaid Eligible Days issue. Subsequently, the Provider withdrew this issue on January 13, 2023.

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

The Provider's appeal request described Issue 1 (DSH/SSI Percentage – Provider Specific) 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's appeal request described Issue 2: DSH/SSI 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 at 42 U.S.C. § 1395ww(d)(5)(F)(vi). The Provider contends that the SSI percentages calculated by [CMS] and used by the Lead MAC to settle their Cost Report were incorrectly computed.
>
> . . .
>
> The Provider further contends that the SSI percentages calculated by [CMS] fail to address all the deficiencies as described in *Baystate Medical Center v. Michael O. Leavitt*, 545 F. Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37, 44 (D.D.C. 2008) and incorporates a new methodology inconsistent with the Medicare Statute.
>
> Providers [*sic*] 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

[3] Issue Statement at 1 (Nov. 10, 2021).

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

As the Provider is commonly owned by Community Health Systems, Inc. ("CHS"), the Provider transferred Issue 2– DSH/SSI Percentage (Systemic Errors) to the CIRP group under Case Number 20-0997GC, *CHS CY 2017 DSH SSI Percentage CIRP Group*, on June 10, 2022. The Group Issue Statement for 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 for their DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww(d)(5)(F)(vi). 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. Failing 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 $46,493.

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[4] *Id.* at Issue 2.
[5] Group Issue Statement, Case No. 20-0997GC.

MAC'S Contentions:

On September 30, 2022, the MAC filed a Jurisdictional Challenge. 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 and the Provider has not exhausted all available remedies.[6]

In addition, the MAC argues the DSH/SSI Percentage - Provider Specific issue and the DSH SSI Percentage - Systemic Errors issue are considered the same issue by the Board, and cites several past Board decisions to that end.[7]

Provider's Response:

The Board Rules require that Provider Responses to the MAC's Jurisdictional Challenge must filed within thirty (30) days of the filing of the Jurisdictional Challenge.[8] The Provider has not filed a response to the Jurisdictional Challenge over the SSI Provider Specific issue in this case and the time for doing so has elapsed.[9] 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 (2013), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

A. SSI Provider Specific

The analysis for Issue 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.

[6] Jurisdictional Challenge at 7 (Sept. 30, 2022).
[7] *Id*. at 5-6.
[8] Board Rule 44.4.3, v. 3.1 (Nov. 2021).
[9] The Provider did file a response to the November 14, 2022 Jurisdictional Challenge over the Medicaid Eligible Days issue, but has since withdrawn that issue.

1. First Aspect of Issue 1

The Board finds that 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 issue that was appealed in Group Case No. 20-0997GC. The first aspect of Issue 1 in the present appeal concerns "whether the Medicare Administrative Contractor used the correct [SSI] percentage in the [DSH] Calculation."[10] The Provider's legal basis for this aspect of Issue 1 is simply that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[11] Similarly, the Provider argues that "it[s] SSI percentage published by [CMS] was incorrectly computed . . ." and it ". . . [s]pecifically . . . disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[12] Issue 2, transferred to group Case No. 20-0997GC, similarly alleges that the Medicare Contractor and CMS improperly calculated the DSH/SSI Percentage, the DSH/SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F)(i).

In making this finding, the Board further notes that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, the Provider is pursuing that issue as part of the group under Case No. 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.[13] The Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) 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.

Accordingly, the Board must find that the first aspect of Issue 1 and the group issue in 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 4.6.1 (2021), 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—must be dismissed for lack of jurisdiction and as premature. Under 42 C.F.R.

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[10] Individual Appeal Request, Issue 1.
[11] *Id.*
[12] *Id.*
[13] The types of systemic errors documented in the *Baystate* did not uniformly impact the SSI calculation for all providers but that does not 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).

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

Conclusion:

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

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

Board Members Participating:

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

For the Board:

2/13/2023

X Kevin D. Smith, CPA

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

James Ravindran
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RE: ***Board Decision* – SSI Percentage (Provider Specific)**
Tennova Healthcare Harton (Provider Number 44-0144)
FYE: 05/31/2018
Case Number: 22-0328

Dear Mr. Ravindran,

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

Background:

A. *Procedural History for Case No. 22-0328*

On July 7, 2021, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end May 31, 2018.

On December 28, 2021, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained three (3) issues:

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

After the Provider transferred 3 issues to group appeals and withdrew one issue, the remaining issue is the DSH/SSI Percentage – Provider Specific Issue.

[1] On July 12, 2022, this issue was transferred to PRRB Case No. 21-1206GC.
[2] The Provider withdrew this issue on January 13, 2023.
[3] On July 12, 2022, this issue was transferred to PRRB Case No. 20-2149GC.
[4] On July 12, 2022, this issue was transferred to PRRB Case No. 21-0066GC.

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

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

> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> . . .
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[5]

The Provider's appeal request described Issue 2 (DSH/SSI Percentage – Systemic Errors) 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 at 42 U.S.C. § 1395ww(d)(5)(F)(vi). The Provider contends that the SSI percentages calculated by [CMS] and used by the Lead MAC to settle their Cost Report were incorrectly computed.
>
> . . .
>
> The Provider further contends that the SSI percentages calculated by [CMS] fail to address all the deficiencies as described in *Baystate Medical Center v. Michael O. Leavitt*, 545 F. Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37, 44 (D.D.C. 2008) and incorporates a new methodology inconsistent with the Medicare Statute.
>
> Providers [*sic*] in this case are also seeking resolution of the following additional aspects of the Medicare fraction that were not addressed in the Baystate case:

[5] Issue Statement at 1 (Dec. 28, 2021).

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

As the Provider is commonly owned by Community Health Systems, Inc. ("CHS"), the Provider transferred its Issue 2 – DSH/SSI Percentage (Systemic Errors) to the CIRP group under Case Number 21-1206GC, *CHS CY 2018 DSH SSI Percentage CIRP Group*, on July 12, 2022. The Group Issue Statement in Case No. 21-1206GC reads, in part:

> **Statement of the Issue:**
>
> Whether the Secretary properly calculated the Provider's [DSH]/[SSI] percentage, and whether CMS should be required to recalculate the SSI percentages using a denominator based solely upon covered and paid for Medicare Part A days, or alternatively, expand the numerator of the SSI percentage to include paid/covered/entitled as well as unpaid/non-covered/eligible SSI days?
>
> **Statement of the Legal Basis**
>
> The Provider(s) contend(s) that the MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute at 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). The Provider(s) further contend(s) that the SSI percentages calculated by [CMS] and used by the MAC to settle their Cost Reports incorporates a new methodology inconsistent with the Medicare statute.
>
> The Providers challenge their SSI percentages based on the following reasons:
> 1. Availability of MEDPAR and SSA records,
> 2. Paid days vs. Eligible days,
> 3. Not in agreement with provider's records,
> 4. Fundamental problems in the SSI percentage calculation,
> 5. Covered days vs. Total days and
> 6. Failure to adhere to required notice and comment rulemaking procedures.[7]

[6] *Id.* at Issue 2.
[7] Group Issue Statement, Case No. 21-1206GC.

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $25,092.

On August 2 2022, the Provider filed its preliminary position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Calculation of the SSI Percentage**
>
> **Provider Specific**
>
> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation based on the Provider's Fiscal Year End (May 31).
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.
>
> Similar to *Loma Linda Community Hospital v. Dept of Health* and Human Services, No. CV-94-0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records. However, at this time, the Provider has been unable to analyze the Medicare Part A data because it has not yet received the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR"), HHS/HCFA/OIS, 09-07-009, which was published 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).[8]

The only exhibit included with the preliminary position paper that relates to the SSI Provider Specific issue was Exhibit 2, which shows that the amount in controversy for the issue is $25,092. This is the same amount that is listed as the amount in controversy for this Provider as a participant in 21-1206GC.

[8] Provider's Preliminary Position Paper at 8-9 (Aug. 2, 2022).

MAC'S Contentions:

On November 15, 2022, the MAC filed a Jurisdictional Challenge. 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 and the Provider has not exhausted all available remedies.[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, and cites several past Board decisions to that end.[10]

Provider's Response:

The Board Rules require that Provider Responses to the MAC's Jurisdictional Challenge must filed within thirty (30) days of the filing of the Jurisdictional Challenge.[11] The Provider has not filed a response to the Jurisdictional Challenge over the SSI Provider Specific issue in this case and the time for doing so has elapsed.[12] 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 (2013), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

A. SSI Provider Specific

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

1. First Aspect of Issue 1

The Board finds that the 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

[9] Jurisdictional Challenge at 7 (Nov. 15, 2022).
[10] *Id*. at 6.
[11] Board Rule 44.4.3, v. 3.1 (Nov. 2021).
[12] The Provider did file a response to the November 14, 2022 Jurisdictional Challenge over the Medicaid Eligible Days issue, but has since withdrawn that issue.

percentage—is duplicative of the DSH/SSI issue that was appealed in Group Case No. 21-1206GC. The first aspect of Issue 1 in the present appeal concerns "whether the Medicare Administrative Contractor used the correct [SSI] percentage in the [DSH] Calculation."[13] The Provider's legal basis for this aspect of Issue 1 is simply that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[14] Similarly, the Provider argues that "it[s] SSI percentage published by [CMS] was incorrectly computed . . ." and it ". . . [s]pecifically . . . disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[15] Issue 2, which was transferred to group Case No. 21-1206GC, similarly alleges that the Medicare Contractor and CMS improperly calculated the DSH/SSI Percentage, the DSH/SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F)(i).

In making this finding, the Board further notes that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, the Provider is pursuing that issue as part of the group under Case No. 21-1206GC. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[16] The Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 21-1206GC.

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

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[13] Individual Appeal Request, Issue 1.
[14] *Id.*
[15] *Id.*
[16] The types of systemic errors documented in the *Baystate* did not uniformly impact the SSI calculation for all providers but that does not 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).

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.

Accordingly, the Board finds that the first aspect of Issue 1 and the group issue in Group Case 21-1206GC, 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 Percentage (Provider Specific) issue. As an alternative basis, the Board dismisses the first aspect of Issue 1 for failure of the Provider to properly brief the issue in its position paper in compliance with Board Rules.

2. Second Aspect of Issue 1

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

Conclusion:

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

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

Board Members Participating:

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

For the Board:

2/15/2023

X Kevin D. Smith, CPA

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

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

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RE: ***Board Decision*** **– SSI Percentage (Provider Specific) and Medicaid Eligible Days**
The Hospital of Central Connecticut (Prov. No. 07-0035)
FYE 09/30/2017
Case No. 21-1765

Dear Mr. Ravindran and Ms. Decker:

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the documentation in Case No. 21-1765 in response to a jurisdictional challenge filed by the Medicare Contractor ("MAC"). The Board's decision is set forth below.

Background:

A. Procedural History for Case No. 21-1765

On August 24, 2021, The Hospital of Central Connecticut appealed a Notice of Program Reimbursement ("NPR") dated March 4, 2021, for its fiscal year ending September 30, 2017 ("FY 2017"). The Provider appealed the following issues:[1]

- **Issue 1** – Disproportionate Share Hospital (DSH) – Supplemental Security Income (SSI) Percentage (Provider Specific)
- **Issue 2** – DSH SSI Percentage[2]
- **Issue 3** – DSH – Medicaid Eligible Days
- **Issue 4** –Medicare Managed Care Part C Days (SSI Fraction & Medicaid Fraction)[3]
- **Issue 5** –DSH-Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, & No-Pay Part A Days)- (SSI Fraction & Medicaid Fraction)[4]
- **Issue 6** – Standardized Payment Amount[5]

[1] Provider's Request for Hearing, Issue Statement (Aug. 24, 2021).
[2] On December 17, 2021, the Provider transferred this issue to Group Case No. 21-0425GC.
[3] On December 17, 2021, the Provider transferred this issue to Group Case No. 21-0426GC.
[4] On December 17, 2021, the Provider transferred this issue to Group Case No. 21-0427GC.
[5] On December 17, 2021, the Provider transferred this issue to Group Case No. 21-0430GC.

As the Provider is part of Hartford Health, Issues 2, 4, 5 and 6 were transferred to common issue related party ("CIRP") groups for Hartford Health. As a result of these transfers, only Issues 1 and 3 remain in this case.

On December 6, 2022, the Medicare Contractor filed a Jurisdictional Challenge regarding ***both*** Issues 1 and 3, addressing the DSH Supplemental Security Income ("SSI") Percentage related issue and the DSH Medicaid Eligible Days issue.[6]

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

B. Description of Issue 1 in the Appeal Request

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 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.[7]

[6] Medicare Contractor's Jurisdictional Challenge, at 1 (Dec. 6, 2022).
[7] Provider's Request for Hearing, Issue Statement (Aug. 24, 2021).

The Provider transferred Issue 2 to the CIRP group under Case No. 21-0425GC entitled "Hartford Health CY 2017 DSH SSI Percentage CIRP Group." This CIRP group has the following issue statement:

> **Statement of the Issue:**
>
> Whether the Secretary properly calculated the Provider's [DSH]/[SSI] percentage, and whether CMS should be required to recalculate the SSI percentages using a denominator based solely upon covered and paid for Medicare Part A days, or alternatively, expand the numerator of the SSI percentage to include paid/covered/entitled as well as unpaid/con-covered/eligible SSI days?
>
> **Statement of the Legal Basis**
>
> The Provider(s) contend(s) that the MAC's determination for their DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww(d)(5)(F)(vi). 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

On April 3, 2022, the Provider filed its preliminary position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Calculation of the SSI Percentage**
>
> **Provider Specific**
>
> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation. This is based on certain data from the State of Connecticut and the Provider that does not support the SSI percentage issues by CMS.

> The Provider has worked with the State of Connecticut and has learned that similar to *Loma Linda Community Hospital v. Dept of Health* and Human Services, No. CV-94- 0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records.
>
> The Provider is seeking the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000, from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. S*ee* 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.

MAC's Contentions:

A. Issue 1 – DSH SSI Percentage (Provider Specific)

The MAC contends that the portion of Issue 1 concerning SSI data accuracy should be dismissed because it is duplicative of Issue 2, which was directly filed into Group Case No. 21-0425GC, *Hartford Health CY 2017 DSH SSI Percentage CIRP Group*.[8] 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.[9]

Lastly, the MAC argues that Issue 1 should be dismissed because 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.

B. Issue 3 – DSH Medicaid Eligible Days

The MAC also argues that the Provider has abandoned the DSH – Medicaid Eligible Days issue. Pursuant to Board Rule 25.3, parties should file a complete preliminary position paper with a fully developed narrative, all exhibits, 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, which the Provider did not do with respect to the Medicaid eligible days issue.[10]

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[8] Medicare Contractor's Jurisdictional Challenge, (Dec. 6, 2022).
[9] *Id*.
[10] *Id*.

Provider's Response:

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

Board Analysis and Decision:

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

A. SSI Provider Specific

The analysis for Issue 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 directly filed into Case No 21-0425GC, *Hartford Health CY 2017 DSH SSI Percentage CIRP Group*.

The Board finds that the first aspect of Issue 1 (the DSH/SSI (Provider Specific) issue) in this appeal is duplicative of Issue 2 (the DSH/SSI (Systemic Errors) issue) that was transferred to Case No. 21-0425GC. The first aspect of Issue 1 in the present appeal concerns "whether the Medicare Administrative Contractor used the correct [SSI] percentage in the [DSH] Calculation."[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]

[11] Individual Appeal Request, Issue 1.
[12] *Id.*
[13] *Id.*

The DSH systemic issue transferred to Case No. 21-0425GC similarly alleges that the Medicare Contractor and CMS improperly calculated the DSH/SSI Percentage, the DSH/SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F)(i). Indeed, the Provider has the same amount in controversy for both Issue 1 and for its participation in the CIRP group, namely $79,000.

Thus, the Board finds that the first aspect of Issue 1 in this appeal is duplicative of the group issue in Case No. 21-0425GC, for this same provider and fiscal year. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6 (Nov. 1, 2021), 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 21-0425GC. 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] 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) 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 transferred to Case No. 21-0425GC.

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 21-0425GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with the Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" in its Preliminary Position Paper and include *all* exhibits.

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

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

[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 Med. Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). *See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).

> 2. Explain why the documents remain unavailable;
> 3. State the efforts made to obtain the documents; and
> 4. Explain when the documents will be available.
>
> Once the documents become available, promptly forward them to the Board and the opposing party. Common examples of unavailable documentation include pending discovery requests, pending requests filed under the federal Freedom of Information Act (also known as FOIA requests), or similar requests for information pending with a state Medicaid agency.

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

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

Similarly, the Provider has asserted that it "worked with the State of Connecticut and has learned that similar to Loma Linda Community Hospital v. Dept of Health and Human Services, No. CV-94- 0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records"; however, the Provider has filed to describe how SSI entitlement can be ascertained from State records, the import of this information, and how this is specific to the Provider (as opposed to common to all Hartford Health hospitals).

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

Accordingly, the Board must find that Issues 1 and the group issue in Group 21-0425GC, are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (2015), the Board dismisses this component of the DSH/SSI (Provider Specific) issue. As an alternative basis the Board dismisses Issue 1 for failure of the Provider to properly brief the issue in its position paper in compliance with Board Rules.

2. Second Aspect of Issue 1

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

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 calculations. 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 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 [*sic*] 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.

On April 3, 2022, the Provider filed their preliminary position paper in which it indicated that it would be sending the eligibility listing under separate cover.[18] Indeed, the position paper did not even 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:

> **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,

[17] *Id*.
[18] Provider's Preliminary Position Paper at 8 (April 3, 2022).

> 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*] 2017 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 jurisdictional challenge, the MAC asserts that the Provider has failed to submit a list of additional Medicaid eligible days. While the Calculation Support filed with their appeal notes a net impact of $58,000, 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.

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 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

[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.

> § 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).

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;
> 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.[23]

[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.)
[23] (Emphasis added.)

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"[24] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. Based on the record before the Board, the Board finds that the Provider has failed to provide a listing or other supporting documentation for the Medicaid Eligible Days issue as required by the controlling regulations and Board Rules. Nor has the Provider provided any explanation as to why the documentation was absent or what is being done to obtain it consistent with Board Rule 25.2.2. *Indeed, as the Provider has failed to identify any days in dispute in its position paper, the Board must conclude that there are no days or amount in dispute for this issue*.

[24] (Emphasis added.)

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.[25] The Board takes administrative notice that it has made similar dismissal in other cases in which QRS was the designated representative and, notwithstanding, QRS failed to provide the Medicaid eligible days listing with its preliminary position paper.[26]

****

In summary, the Board hereby dismisses the SSI Provider Specific issue from this appeal as it is duplicative of the issue in Case No. 21-0425GC, 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 the Medicaid eligible days issue as the Provider also failed to meet the Board requirements for position papers for this issue. As no issues remain pending, the Board hereby closes Case No. 21-1765 and removes it from the Board's docket.

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

Board Members Participating:

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

For the Board:

2/22/2023

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services

[25] 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.
[26] Examples of cases in which QRS was the designated representative and which the Board dismissed for failure of the Provider to provide a listing of Medicaid eligible days at issue include, but are not limited to: Case No. 14-2674 (by letter dated 5/5/2022); Case No. 16-2521 (by letter dated 5/5/2022); Case No. 16-0054 (by letter dated 5/5/2022); Case Nos. 13-3022, 13-3211, 14-2506, 14-4313, 16-1712 (by letter dated 9/30/2022). Moreover, the Board's attention to the filing deficiency was brought to the Board's attention via a motion to dismiss filed by the Medicare Contractor (as a motion or in a position paper) well in advance of the position paper filed in this case.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Nathan Summar
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WPS Government Health Administrators
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RE: ***Board Decision* – SSI Percentage (Provider Specific) and Medicaid Eligible Days**
Greenbrier Valley Medical Center (Prov. No. 51-0002)
FYE 04/30/2018
Case No. 22-0376

Dear Messrs. Summar and Lamprecht:

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the documentation in Case No. 22-0376 in response to a jurisdictional challenge filed by the Medicare Contractor ("MAC"). The Board's decision is set forth below.

Background:

A. Procedural History for Case No. 22-0376

Greenbrier Medical Center, appealed a Notice of Program Reimbursement ("NPR") dated July 16, 2021, for its fiscal year end ("FYE") April 30, 2018 cost reporting period. On January 7, 2022, the Provider filed an individual appeal request which contained the following issues:

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

As the Provider is part of Community Health Systems, Inc. ("CHS"), the Provider transferred Issues 2, 4 and 5 to common issue related party ("CIRP") groups for CHS.

On December 15, 2022, the Medicare Contractor filed a Jurisdictional Challenge regarding the remaining issues on appeal, the DSH/SSI Percentage (Provider Specific) issue and the DSH Medicaid Eligible Days issue.

[1] On August 15, 2022, this issue was transferred to PRRB Case No. 21-1206GC.
[2] On August 15, 2022, this issue was transferred to PRRB Case No. 20-2149GC.
[3] On August 15, 2022, this issue was transferred to PRRB Case No. 21-0066GC.

Significantly, the Provider did not file a response to the Jurisdictional Challenge within the 30 days allotted under Board Rule 44.4.3 which specifies:

> Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record.

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

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

> …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.[4]

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.[5] The amount in controversy was listed as $18,643.

In the SSI percentage issue in CIRP group case 21-1206GC, which includes the provider in this case, and the same fiscal year, the Providers assert that:

> 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 the [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;

[4] Provider's Request for Hearing, Tab 3, at Issue Statement, Issue 1 (Jan. 7, 2022).
[5] *Id.*

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

The amount in controversy for Provider 51-0002 in 21-1206GC, is $18,463, the same amount as issue #1 in the individual appeal.

On May 14, 2022, the Provider filed its preliminary position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Calculation of the SSI Percentage**
>
> **Provider Specific**
>
> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation based on the Provider's Fiscal Year End (June 30).
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.
>
> Similar to *Loma Linda Community Hospital v. Dept of Health* and Human Services, No. CVT94- 0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records. However, at this time, the Provider has been unable to analyze the Medicare Part A data because it has not yet received the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR"), HHS/HCFAIOIS, 09-07-009, which was published in the Federal Register on August 18, 2000 from CMS. *See* 65 Fed. Reg. 50,548 (2000). Upon release of the complete MEDPAR data, the Provider will seek to reconcile its' records with that of CMS, and identify patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS based on the Federal Fiscal Year End (September 30) when it determined the Provider's SSI. *See Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).[7]

[6] See Group Issue Statement, PRRB Case no. 21-1206GC.
[7] Provider's Preliminary Position Paper at 8 (May 14, 2022).

The only exhibit included with the preliminary position paper that relates to Issue 1 was Exhibit 2, which shows that the amount in controversy for the issue is $18,463. This is the same amount that is listed as the amount in controversy for this Provider as a participant in 21-1206GC.

MAC's Contentions:

Issue 1 – DSH SSI Percentage (Provider Specific)

The MAC contends that the portion of Issue 1 concerning SSI data accuracy should be dismissed because it is duplicative of Issue 2, which was directly filed into Group Case No. 21-1206GC, *CHS CY 2018 DSH SSI Percentage CIRP Group*.[8] 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.[9]

Lastly, Issue 1 should be dismissed because 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.[10]

Issue 2 – DSH Medicaid Eligible Days

The MAC also argues that the Provider has abandoned the DSH – Medicaid Eligible Days issue. Pursuant to Board Rule 25.3, parties should file a complete preliminary position paper with a fully developed narrative, all exhibits, 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.[11]

Provider's Response:

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

Board Analysis and Decision:

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

[8] Jurisdictional Challenge at 2 (Dec. 15, 2022).
[9] *Id*.
[10] *Id*.
[11] *Id*.

A. SSI 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 directly filed into Case No. 21-1206GC, *CHS CY 2018 DSH SSI Percentage CIRP Group*.

The Board finds that the first aspect of Issue 1 (the DSH/SSI (Provider Specific) issue) in this appeal is duplicative of Issue 2 (the DSH/SSI (Systemic Errors) issue) that was directly filed into Case No. 21-1206GC. The first aspect of Issue 1 in the present appeal concerns "whether the Medicare Administrative Contractor used the correct [SSI] percentage in the [DSH] Calculation."[12] 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)."[13] 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."[14] The DSH systemic issues filed into Case No. 21-1206GC, similarly alleges that the Medicare Contractor and CMS improperly calculated the DSH/SSI Percentage, the DSH/SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F)(i). Indeed, the Provider has the same amount in controversy for both Issue 1 and for its participation in the CIRP group, namely $18,463.

Thus, the Board finds that the first aspect of Issue 1 in this appeal is duplicative of the group issue in Case No. 21-1206GC, for this same provider and fiscal year. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6 (Nov. 1, 2021), 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 21-1206GC. 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

[12] Individual Appeal Request, Issue 1.
[13] *Id.*
[14] *Id.*
[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.*,

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. 21-1206GC.

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

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

> 25.2.2 Unavailable and Omitted Documents If documents necessary to support your position are still unavailable, then provide the following information in the position papers:
>
> 1. Identify the missing documents;
> 2. Explain why the documents remain unavailable;
> 3. State the efforts made to obtain the documents; and
> 4. Explain when the documents will be available.
>
> Once the documents become available, promptly forward them to the Board and the opposing party. 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

PRRB Dec. No. 2006-D20 (Mar. 17, 2006). *See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).

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 Issues 1 and the group issue in Group Case 21-1206GC, are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (2015), the Board dismisses this component of the DSH/SSI (Provider Specific) issue. As an alternative basis the Board dismisses Issue 1 for failure of the Provider to properly brief the issue in its position paper in compliance with Board Rules.

2. Second Aspect of Issue 1

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

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 calculations. The Provider states Issue 3 as:

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[16] (Last accessed Nov. 21, 2022.)
[17] (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.[18]

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.

On August 24, 2022, the Provider filed their preliminary position paper in which it indicated that it would be sending the eligibility listing under separate cover.[19] As of the filing of the jurisdictional challenge in December 2022, the MAC asserts that the Provider has failed to submit a list of additional Medicaid eligible days, though their Calculation Support filed with their appeal notes a net impact of $30,663, with an increase in days. To date, the Provider has not responded to the challenge alleging the listing was submitted as required, nor has the Board been notified by either party that the listing was eventually submitted.

Specifically, the Provider's complete briefing of this issue in its position paper is as follows:

Calculation of Medicaid Eligible Days

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

The Sixth Circuit Court of Appeals, in *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.*, 19 F.3d 270 (6th Cir. 1994), held that all patient days for which the patient was eligible for Medicaid,

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

> 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.
>
> Base 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*] 2018 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.[20]

In its jurisdictional challenge, the MAC asserts that the Provider has failed to submit a list of additional Medicaid eligible days. While the Calculation Support filed with their appeal notes a net impact of $30,663, 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.

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.

[20] *Id*. at 7-8.

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 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).

---

[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.)

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;
> 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.

[25] (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"[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 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 SSI Provider Specific issue from this appeal as it is duplicative of the issue in Case No. 21-1206GC, 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 the Medicaid eligible days issue as the Provider also failed to meet the Board requirements for position papers for this issue. As no issues remain pending, the Board hereby closes Case No. 22-0376 and removes it from the Board's docket.

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

Board Members Participating:

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

For the Board:

2/22/2023

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services

[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.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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410-786-2671

Via Electronic Delivery

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

Wilson C. Leong
PRRB Appeals
Federal Specialized Services
1701 S. Racine Avenue
Chicago, IL 60608-4058

RE: ***Board Determination on Provider's Motion for Reinstatement***
River Regional Medical Corp. (Prov. No. 25-0031)
FYE 06/30/2011
Case No. 16-0050

Dear Mr. Kramer and Mr. Leong:

Quality Reimbursement Services, Inc. ("QRS") filed a Motion for Reinstatement on February 21, 2023, and requested that the Provider Reimbursement Review Board ("Board") grant a good cause exception to reinstate this case pursuant to Board Rule 47.3. The pertinent facts of the case and the Board's determination are set forth below.

Pertinent Facts:

On January 30, 2023, the Board dismissed this case because the Provider failed to meet the Board-set filing deadline for its final position paper ("FPP"). According to the Notice of Hearing issued on December 12, 2022, the Provider was required to file its FPP by January 18, 2023. However, the Provider failed to file its FPP by that deadline.

In its Motion for Reinstatement, QRS requests reinstatement under Board Rule 47.3 claiming that there was good cause for having the missed January 18, 2023 due dates as set by the December 12, 2022 Notice of Hearing. QRS explained that "[t]he employee responsible for all of the Position Paper filings and deadlines, Dayani Ratnavira, was hospitalized in critical condition *at that time*"[1] and that "she subsequently succumbed to her illness." QRS further stated that she "was part of the original team at QRS when it first opened for business and loss was a very significant loss to our firm; and also a very large disruption to our ordinay [*sic* ordinary] operations." QRS asserts that, due to this unfortunate event, it missed the due date for the final position paper. QRS filed a copy of the final position paper with the Motion for Reinstatement.

Board Determination:

Board Rule 47.3 provides as follows:

[1] (Emphasis added.)

47.3 Dismissals for Failure to Comply with Board Procedures

> Upon written motion *demonstrating <u>good cause</u>*, 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, then the motion for reinstatement must, as a prerequisite, include the required filing before the Board will consider the motion.[2]

QRS filed its FPP with its Motion for Reinstatement, thereby meeting the prerequisite for the Board to consider the motion. As described above, QRS requested that the Board consider good cause to reinstate the case. While the Board is sympathetic, QRS failed to establish good cause to reinstate the case. QRS has not provided specific dates around the illness and hospitalization of Ms. Ratnavira. If she was hospitalized "at that time" in December, it is unclear why someone else was not covering for her, especially given the size of QRS' docket before the Board, or why someone else did not request an extension due to the illness of Ms. Ratnavira. Moreover, Ms. Ratnavira is not listed as a user of the Office of Hearings Case and Document Management System ("OH CDMS") and, as such, is not recorded as making any filings for QRS.[3]

Instead, the record indicates that another QRS employee, Philip Payne, was monitoring the case because, on December 16, 2022, Mr. Payne filed a response to the Medicare Contractor's Motion to Dismiss (which had been filed on December 8, 2022) and his filing occurred ***after*** the December 12, 2022 Notice of Hearing was issued ***but before*** the January 18, 2023 due date for the Provider's FPP. Even if Mr. Payne was not the typical internal QRS employee responsible for filing the FPP, QRS had notice of the FPP due date and failed to timely file it, or file an extension request.[4] Therefore, the Board denies QRS' Motion for Reinstatement.

<u>Board Members</u>:

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

For the Board:

2/24/2023

X Clayton J. Nix

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

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

[2] (Italics and underline emphasis added.)
[3] QRS' registered users are Philip Payne, Russell Kramer, and Susan Wooten.
[4] QRS had multiple employees registered to make Board filings as noted in *supra* note 3. Further, the Board notes that, per 42 C.F.R. § 405.1853(b)(1)-(2), the Board has discretion to establish deadlines for submitting position papers to the Board as well as discretion to extend the deadline for submitting a position paper. Here, QRS missed the deadline and failed to timely submit an extension request. The Board exercised is discretion under 42 C.F.R. § 405.1868(b) to dismiss the appeal for failure to meet the filing deadline.

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Arcadia, CA 91006

Wilson C. Leong
PRRB Appeals
Federal Specialized Services
1701 S. Racine Avenue
Chicago, IL 60608-4058

RE: ***Board Determination on the Motion for Reinstatement***
Merit Health River Region (Prov. No. 25-0031)
FYE 06/30/2013
Case No. 16-1674

Dear Mr. Kramer and Mr. Leong:

Quality Reimbursement Services, Inc. ("QRS") filed a Motion for Reinstatement on February 21, 2023, and requested that the Provider Reimbursement Review Board ("Board") grant a good cause exception to reinstate this case pursuant to Board Rule 47.3. The pertinent facts of the case and the Board's determination are set forth below.

Pertinent Facts:

On January 30, 2023, the Board dismissed this case because the Provider failed to meet the Board-set filing deadline for its final position paper ("FPP"). According to the Notice of Hearing issued on December 12, 2022, the Provider was required to file its FPP by January 18, 2023. However, the Provider failed to file its FPP by that deadline.

In its Motion for Reinstatement, QRS requests reinstatement under Board Rule 47.3 claiming that there was good cause for having the missed January 18, 2023 due dates as set by the December 12, 2022 Notice of Hearing. QRS explained that "[t]he employee responsible for all of the Position Paper filings and deadlines, Dayani Ratnavira, was hospitalized in critical condition *at that time*"[1] and that "she subsequently succumbed to her illness." QRS further stated that she "was part of the original team at QRS when it first opened for business and loss was a very significant loss to our firm; and also a very large disruption to our ordinay [*sic* ordinary] operations." QRS asserts that, due to this unfortunate event, it missed the due date for the final position paper. QRS filed a copy of the final position paper with the Motion for Reinstatement.

Board Determination:

Board Rule 47.3 provides as follows:

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QRS filed its FPP with its Motion for Reinstatement, thereby meeting the prerequisite for the Board to consider the motion. As described above, QRS requested that the Board consider good cause to reinstate the case. While the Board is sympathetic, QRS failed to establish good cause to reinstate the case. QRS has not provided specific dates around the illness and hospitalization of Ms. Ratnavira. If she was hospitalized "at that time" in December, it is unclear why someone else was not covering for her, especially given the size of QRS' docket before the Board, or why someone else did not request an extension due to the illness of Ms. Ratnavira. Moreover, Ms. Ratnavira is not listed as a user of the Office of Hearings Case and Document Management System ("OH CDMS") and, as such, is not recorded as making any filings for QRS.[3]

Instead, the record indicates that another QRS employee, Philip Payne, was monitoring the case because, on December 16, 2022, Mr. Payne filed a response to the Medicare Contractor's Motion to Dismiss (which had been filed on December 8, 2022) and his filing occurred ***after*** the December 12, 2022 Notice of Hearing was issued ***but before*** the January 18, 2023 due date for the Provider's FPP. Even if Mr. Payne was not the typical internal QRS employee responsible for filing the FPP, QRS had notice of the FPP due date and failed to timely file it, *or* file an extension request.[4] Therefore, the Board denies QRS' Motion for Reinstatement.

<u>Board Members</u>:

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For the Board:

2/24/2023

X Clayton J. Nix

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Chair
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cc: Bill Tisdale, Novitas Solutions, Inc. (J-H)

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RE: ***Jurisdictional Decision***
ThedaCare FY 2014 Reclassification of Certified EHR Technology Costs CIRP Group
Case No. 17-0587GC

Dear Mr. Miller and Ms. VanArsdale:

The Provider Reimbursement Review Board ("Board") has reviewed jurisdiction in the above-captioned appeal and finds that it does not have jurisdiction over the appeal. The jurisdictional decision of the Board is set forth below.

Issue

The issue under appeal in this CIRP group is as follows:

> Whether the Medicare Contractor's reclassification of the costs claimed by the Providers as its cost incurred for the purchase and implementation of certified electronic health record technology from capital costs to operating costs on the Providers' fiscal year 2014 Medicare Cost reports was proper.[1]

The Board must now determine whether its review of ThedaCare's CIRP group appeal is precluded, in whole or in part, by 42 U.S.C. § 1395f(l)(5) and 42 C.F.R. §§ 413.70(a)(7) and 495.106(f).

Background

ThedaCare's stated issue is that the Medicare Contractor improperly reclassified EHR costs from capital costs to operating costs during an audit of ThedaCare's FY 2014 cost report. The authority to receive incentive payments for EHR costs was granted by the Health Information Technology for Economic and Clinical Health ("HITECH") act and implemented by the regulations at 42 C.F.R. §§ 413.70 and 495.106. After the parties briefed the issue in this appeal, a live hearing was held on September 18, 2018 and post-hearing briefs were filed by both parties, as requested by the Board.

[1] Transcript of September 18, 2018 hearing at 6.

Following its review of the record, the parties' Post-Hearing Briefs ("PHBs"), as well as the Final Position Papers ("FPPs"), exhibits and testimony, the Board identified additional questions regarding the appeal that were not addressed in the parties' FPPs, PHBs, or hearing presentations.

The Board noted that the parties are required to brief jurisdiction as part of their position papers pursuant to 42 C.F.R. § 405.1853(b)(2) which states in pertinent part: "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)…." However, neither ThedaCare nor the Medicare Contractor complied with § 405.1853(b)(2) because neither parties' FPP included the requisite briefing on jurisdiction.[2]

As a result, on October 5, 2022, the Board issued a Request for Information ("RFI") directing the parties to submit a response explaining the impact of certain statutory and regulatory provisions on the Board's substantive jurisdiction over this appeal, in particular, whether Board review of ThedaCare's CIRP group appeal is precluded, in whole or in part, by 42 U.S.C. § 1395f(l)(5) and 42 C.F.R. §§ 413.70(a)(7) and 495.106(f).

Relevant Law and Regulations

The following excerpts from 42 U.S.C. § 1395f(l) address EHR reimbursement for CAHs:

> (3)(A) The following rules shall apply in determining payment and reasonable costs under paragraph (1) for costs described in subparagraph (C) *for a critical access hospital* that would be a meaningful EHR user (as would be determined under paragraph (3) of section 1395ww(n) of this title) for an EHR reporting period for a cost reporting period beginning during a payment year if such critical access hospital was treated as an eligible hospital under such section:
>
> (i) *The Secretary shall compute* ***reasonable costs*** *by expensing such costs in a single payment year* and not depreciating such costs over a period of years (and shall include as costs with respect to cost reporting periods beginning during a payment year costs from previous cost reporting periods to the extent they have not been fully depreciated as of the period involved).

[2] To highlight the parties' deficient FPP filings, the Board looks to Exhibit P-9 of ThedaCare's FPP. This exhibit is a complete copy of the Medicare Contractor's preliminary position paper ("PPP") with exhibits which, prior to ThedaCare's introduction of Exhibit P-9, was not in the record because the Medicare Contractor only filed the cover page of its PPP, per Board Rules in effect at the time of that filing. Following the hearing, the Board identified a jurisdictional issue raised by the Medicare Contractor in that PPP which was not addressed by either party in their subsequent FPP/PHB filings or hearing presentations. Namely, the Medicare Contractor asserted in its PPP that the Board did not have jurisdiction because 42 U.S.C. § 1395f(l)(5) precludes administrative review and, accordingly that a jurisdictional challenge would be filed. Neither party addressed the potential preclusion in their subsequent FPP/PHB briefings or hearing presentations.

(ii) There shall be substituted for the Medicare share that would otherwise be applied under paragraph (1) a percent (not to exceed 100 percent) equal to the sum of—

(I) the Medicare share (as would be specified under paragraph (2)(D) of section 1395ww(n) of this title) for such critical access hospital if such critical access hospital was treated as an eligible hospital under such section; and

(II) 20 percentage points.

(B) The payment under this paragraph with respect to a critical access hospital shall be paid through a prompt interim payment (subject to reconciliation) after submission and review of such information (as specified by the Secretary) necessary to make such payment, including information necessary to apply this paragraph. In no case may payment under this paragraph be made with respect to a cost reporting period beginning during a payment year after 2015 and in no case may a critical access hospital receive payment under this paragraph with respect to more than 4 consecutive payment years.

(C) ***The costs described in this subparagraph are costs for the purchase of certified EHR technology*** to which purchase depreciation (excluding interest) would apply if payment was made under paragraph (1) and not under this paragraph.

* * * *

(5) ***There shall be no administrative*** or judicial ***review*** under section 1869, section 1878, or otherwise, ***of***—

(A) ***the methodology and standards for determining the amount of payment and reasonable cost under paragraph (3)*** and payment adjustments under paragraph (4), including selection of periods under section 1395ww(n)(2) of this title for determining, *and making estimates or using proxies of, inpatient-bed-days, hospital charges, charity charges, and Medicare share* under subparagraph (D) of section 1395ww(n)(2) of this title;

(B) the methodology and standards for determining a meaningful EHR user under section 1395ww(n)(3) of this title as would apply if the hospital was treated as an eligible hospital under section 1886(n), and the hardship exception under paragraph (4)(C);

> (C) the specification of EHR reporting periods under section 1395ww(n)(6)(B) of this title as applied under paragraphs (3) and (4); and
>
> (D) ***the identification of costs for purposes of paragraph (3)(C).***[3]

The following excerpts from 42 C.F.R. § 413.70(a) addresses CAH reimbursement of certain EHR costs:

> (a) *Payment for inpatient services furnished by a CAH (other than services of distinct part units)*. (1) Effective for cost reporting periods beginning on or after January 1, 2004, payment for inpatient services of a CAH, other than services of a distinct part unit of the CAH and other than the items included in the incentive payment described in paragraph (a)(5) of this section and subject to the adjustments described in paragraph (a)(6) of this section, is 101 percent of the reasonable costs of the CAH in providing CAH services to its inpatients, as determined in accordance with section 1861(v)(1)(A) of the Act [*i.e.*, 42 U.S.C. § 1395x(v)(1)(A)] and the applicable principles of cost reimbursement in this part and in part 415 of this chapter, except that the following payment principles are excluded when determining payment for CAH inpatient services:
>
> * * * *
>
> (5) A qualifying CAH receives **an incentive payment for the reasonable costs of purchasing certified EHR technology** in a cost reporting period during a payment year as determined under § 495.106 of this chapter in lieu of payment for such reasonable costs under paragraph (a)(1) of this section.
>
> * * * *
>
> (7) **There is no administrative** or judicial **review** under section §§ 1869 and 1878 of the Act [*i.e.*, 42 U.S.C. §§ 1395ff and 1395oo] or otherwise of the following:
>
> (i) **The methodology and standards for determining the amount of payment under paragraph (a)(5) of this section, including the calculation of reasonable costs under § 495.106(c) of this chapter**.
>
> (ii) The methodology and standards for determining the amount of payment adjustments made under paragraph (a)(6).

[3] (Emphasis added.)

(iii) The methodology and standards for determining a CAH to be a qualifying CAH under §495.106 of this chapter.

(iv) The methodology and standards for determining if the hardship exemption applies to a CAH under paragraph (a)(6)(ii) of this section.

(v) The specification of the cost reporting periods, payment years, or fiscal years as applied under this paragraph.[4]

The following excepts from 42 C.F.R. § 495.106 addressing EHR incentive payments to CAHs:

(b) *Definitions*. In this section, unless otherwise indicated—

Payment year means a Federal fiscal year beginning after FY 2010 but before FY 2016.

Qualifying CAH means a CAH that would meet the definition of a meaningful EHR user at § 495.4, if it were an eligible hospital.

Reasonable costs incurred for the purchase of certified EHR technology for a qualifying CAH **means the reasonable acquisition costs incurred for the purchase of depreciable assets** as described in part 413 subpart G of this chapter, such as computers and associated hardware and software, necessary to administer certified EHR technology as defined in § 495.4, **excluding any depreciation and interest expenses associated with the acquisition**.

(c) *General rule*. A qualifying CAH receives an incentive payment for its reasonable costs incurred for the purchase of certified EHR technology, as defined in paragraph (a) of this section, in the manner described in paragraph (c) of this section for a cost reporting period beginning during a payment year as defined in paragraph (a) of this section.

(d) *Payment methodology*—(1) *Payment amount*. A qualifying CAH receives an incentive payment amount equal to **the product of its reasonable costs incurred for the purchase of certified EHR technology and the Medicare share percentage**.

[4] (Bold and underline emphasis added.)

> (2) *Calculation of reasonable costs*. CMS or its Medicare contractor computes a qualifying CAH's reasonable costs incurred for the purchase of certified EHR technology, as defined in paragraph (a) of this section, as the sum of—
>
> (i) The reasonable costs incurred for the purchase of certified EHR technology during the cost reporting period that begins in a payment year; and
>
> (ii) Any reasonable costs incurred for the purchase of certified EHR technology in cost reporting periods beginning in years prior to the payment year which have not been fully depreciated as of the cot reporting period beginning in the payment year.
>
> * * * *
>
> (f) *Administrative or judicial review*. **There is no administrative** or judicial **review** under sections 1869 or 1878 of the Act [*i.e.*, 42 U.S.C. §§ 1395ff and 1395oo], or otherwise, **of the**— . . . .
>
> (1) **Methodology and standards for determining the amount of payment, the reasonable cost**, and adjustments described in this section including selection of periods for determining, and making estimates or using proxies of, inpatient-bed-days, hospital charges, charity charges, and the Medicare share percentage as described in this section;
>
> (2) Methodology and standards for determining if a CAH is a qualifying CAH under this section;
>
> (3) Specification of EHR reporting periods, cost reporting periods, payment years, and fiscal years used to compute the CAH incentive payment as specified in this section; and
>
> (4) **Identification of the reasonable costs used to compute the CAH incentive payment under paragraph (c) of this section** including any reconciliation of the CAH incentive payment amount made under paragraph (d) of this section.[5]

Providers' Response to Board's RFI Filed October 6, 2022

The Providers state that the jurisdictional issue summarized in the Board's RFI was initially raised by the Medicare Contractor by letter dated August 29, 2017, when it submitted a notice of

[5] (Bold and underline emphasis added.)

jurisdictional impediment pursuant to Board Rule 22. The Medicare Contractor's Rule 22 letter cited the same statutory language referred to in the Board's RFI. The Providers submitted their response to the Board and the Medicare Contractor on December 4, 2017.[6] The Provider's response to the Board's RFI in essence quotes an excerpt from its December 4, 2017 response as summarized below.

In the December 4, 2017 letter, the Providers assert that the bar on administrative and judicial review does not apply to the claims of the participants in the ThedaCare group, because the Centers for Medicare and Medicaid Services ("CMS") has interpreted the appeal preclusion restrictions as inapplicable to critical access hospitals ("CAHs") as set forth in the final rule published on July 28, 2010.[7] With respect to the statutory language, the Providers assert that CMS has specifically considered this language in promulgating its implementing regulations at 42 C.F.R. § 495.106(f) and that it interpreted the limitation surrounding administrative and judicial review as *inapplicable* "to the amount of the CAH incentive payment." [8]

The Providers go on to assert that CMS has further elaborated that the "CAH may appeal the statistical and financial amounts from the Medicare cost report used to determine the CAH incentive payment. The CAH would utilize the current provider appeal process pursuant to section 1878 of the Act."[9] The Providers further assert that CMS subsequently conformed this position in a subsequent final rule published on September 4, 2012 (the Stage 1 final rule) that a CAH "may appeal the statistical and financial amounts from the Medicare cost report used to determine the CAH incentive payment."[10] As such, there is no jurisdictional impediment for the issue in this case.[11]

Finally, the Providers' October 6, 2022 response asserts that "the Medicare Contractor apparently accepted the legal authority submitted in its [December 4, 2017] Letter and did not file a jurisdictional objection or raise this issue at the time of the hearing that took place on 9/18/2018."[12]

Medicare Contractor's Response to Board's RFI Filed October 25, 2022

The Medicare Contractor asserts that clearly the issue in the appeal addresses costs claimed by the providers for the "purchase of certified EHR technology" as addressed at 42 U.S.C. § 1395f(l)(3)(C). The Medicare Contractor's reclassification of those claimed EHR costs from capital to operating costs are *precisely* the same costs referenced under the statute at 3(C) that are precluded from administrative review under the statute at (5)(D). Additionally, the Medicare Contractor asserts that the reclassification of those claimed EHR costs from capital to operating

[6] Providers' RFI Response at 1 (Oct. 6, 2022).
[7] 75 Fed. Reg. 44314 (July 28, 2010).
[8] Providers' RFI Response at 1-2 (Oct. 6, 2022).
[9] *Id.* at 2 (quoting its December 4, 2017 letter which is quoting 75 Fed. Reg. at 44464)).
[10] *Id.* (quoting its December 4, 2017 letter which is quoting 77 Fed. Reg. 53968, 541113 (Sept. 4, 2012).)
[11] *Id.*
[12] *Id.*

costs are *precisely* the same costs that are precluded from administrative review under the regulations at 42 C.F.R. § 413.70(a)(7) and § 495.106(f)(4).[13]

The Medicare Contractor notes that the Providers' argument against the preclusion from administrative review references responses in two federal registers. The first is found in the July 28, 2010 Federal Register, which contains the following:

> *Comment*: We received some comments requesting clarification of whether CAHs will be able to appeal their incentive payment amounts.
>
> *Response*: **We believe that the limitation of administrative and judicial review does not apply to the amount of the CAH incentive payment.** The CAH may appeal the statistical and financial amounts from the Medicare cost report used to determine the CAH incentive payment. The CAH would utilize the current provider appeal process pursuant to section 1878 of the Act. **Accordingly, after consideration of the public comments received, we are finalizing § 495.106(f) as proposed.**[14]

Citing similar comments from the Secretary, the Providers reference the September 4, 2012 final rule, which contains the following discussion:

> **As stated earlier, the HITECH Act prohibits both administrative and judicial review of the standards and methods used to determine eligibility and payment (including those governing meaningful use) (see 42 CFR 413.70(a)(7), 495.106(f), 495.110, 495.212). Any procedures would not allow administrative appeals of these issues**. As for reasonable costs reported by CAHs, we already stated in the Stage 1 final rule that a CAH "may appeal the statistical and financial amounts from the Medicare cost report used to determine the CAH incentive payment," but that the CAH "would utilize the current provider appeal process pursuant to section 1878 of the Act."[15]

The Medicare Contractor asserts that the Providers are incorrect when they state CMS has explicitly acknowledged that the statutory provisions referenced in the Board RFI do not foreclose administrative and judicial review. Both of the Federal Register references cited by the Providers specifically reference the prohibition of administrative and judicial review of the *standards and methods* used to determine a CAH's EHR payment. The statute and regulations referenced above ***specifically*** preclude administrative and judicial review of *the reasonable costs used to compute*

[13] Medicare Contractor's Response to October 5, 2022 Request for Information at 2.
[14] 75 Fed. Reg. 44314, 44464 (July 28, 2010) (bold emphasis added).
[15] 77 Fed. Reg. 53968, 541113 (Sept. 4, 2012).

the CAH's EHR payment. Even if the Providers' reading of the comments contained in the Federal Registers were correct (which it is not), the Secretary through notice and comment cannot change or eliminate a statutory prohibition of administrative review. Further troubling to the Providers' position is the assertion that the Secretary would promulgate a regulation prohibiting administrative or judicial review of the "reasonable cost used to compute the CAH incentive payment", and then state that administrative and judicial review is not foreclosed.[16]

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.

In reviewing the record in this group appeal, the Board finds that the issue under dispute is the reclassification of costs associated with services rendered to the Providers by Nordic Consulting from capital to operating expense. The Medicare Contractor believes these costs were consulting expenses related to customizing or optimizing the EHR system after the software was put in place. The Providers are challenging the Medicare Contractor's adjustment related to these expenses and in essence are challenging the determination or calculation of EHR reasonable costs.

The Providers point to the preamble of the July 28, 2010 final rule which states that, "[t]he CAH may appeal *the statistical and financial amounts* from the Medicare cost report used to determine the CAH incentive payment"[17] (as well as the reference back to the July 28, 2010 final rule that the Secretary made in the September 4, 2012 final rule[18]). The Board has quoted below the context for that 2010 statement:

> e. Reduction of Reasonable Cost Payment in FY 2015 and Subsequent Years for CAHs That Are Not Meaningful EHR Users
>
> ****
>
> Section 1814(l)(5) of the Act exempts the determinations made under paragraphs (l)(3) and (l)(4) from administrative and judicial review. Accordingly, **under § 413.70(a)(6)(iv) and § 495.106(f)**, **we proposed that there shall be no administrative or judicial review** under sections 1869 or 1878 of the Act, or otherwise, **of the following**:

[16] Medicare Contractor's Response to October 5, 2022 Request for Information at 5.
[17] 75 Fed. Reg. at 44464 (emphasis added).
[18] 77 Fed. Reg. at 54113 (stating: "As for reasonable costs reported by CAHs, *we already stated in the Stage 1 final rule* that a CAH 'may appeal the statistical and financial amounts from the Medicare cost report used to determine the CAH incentive payment,' but that the CAH 'would utilize the current provider appeal process pursuant to section 1878 of the Act.' (75 FR 44464)" (emphasis added)).

- **The methodology and standards for determining the amount of payment** under section 1814(l)(3) of the Act and payment adjustments under section 1814(l)(4) of the Act for CAHs, including selection of periods under section 1886(n)(2) of the Act for determining, and making estimates or using proxies of, inpatient-bed-days, hospital charges, charity charges, and the Medicare share under subparagraph (D) of section 1886(n)(2) of the Act;

- The methodology and standards for determining a CAH to be a meaningful EHR user under section 1886(n)(3) of the Act as would apply if the CAH was treated as an eligible hospital under section 1886(n) of the Act;

- The methodology and standards for determining if the hardship exemption under section 1814(l)(4)(C) of the Act applies to a CAH;

- The specification of EHR reporting periods under section 1886(n)(6)(B) of the Act as applied under section 1814(l)(3) and (4) of the Act for CAHs; and

- **The identification of reasonable costs** used to compute the CAH incentive payment under section 1814(l)(3)(C) of the Act.

Comment: We received some comments requesting clarification of whether CAHs will be able to appeal their incentive payment amounts.

Response: We believe that the limitation of administrative and judicial review does not apply to the amount of the CAH incentive payment. **The CAH may appeal <u>the statistical and financial amounts</u> from the Medicare cost report used to determine the CAH incentive payment**. The CAH would utilize the current provider appeal process pursuant to section 1878 of the Act.

Accordingly, after consideration of the public comments received, we are finalizing § 495.106(f) as proposed. **We have renumbered proposed § 413.70(a)(6)(iv) as § 413.70(a)(7), but are otherwise <u>finalizing</u> the provision <u>as proposed</u>**.[19]

[19] 75 Fed. Reg. at 44464 (bold and underline emphasis added.)

Consistent with the statutory and regulatory preclusion provisions, the Board finds that the carve out for review of "statistical and financial amounts" referenced therein can only relate to the general statistics used elsewhere in the cost report, *e.g*. bed days and Medicare utilization.[20] However, such statistical/financial amounts are not at issue in this case and, as such, this small carve out is not applicable here.

The Board's understanding of this carve out is the only way it can be harmonized with the statute and regulation precluding administrative and judicial review of certain aspects of the CAH incentive payments. In this regard, 42 U.S.C. § 1395f(l)(5) states: "there shall be no administrative review . . . of — (A) the methodology and standards for determining the amount of payment and ***reasonable cost*** *under paragraph (3)* … ; and (D) *the identification of* ***costs*** *for purposes of paragraph (3)(C)*."[21] Likewise, 42 C.F.R. § 413.70(a)(7) states that "[t]here is no administrative or judicial review . . . of the following: (i) The methodology and standards for determining the amount of payment under paragraph (a)(5) of this section, including the calculation of reasonable costs under § 495.106(c) of this chapter."[22] Both the statue and regulations apply to CAH EHR incentive payments and clearly state that the identification and calculation of reasonable costs is not subject to administrative and judicial review. As a result, the Board does not have jurisdiction over the issue in this group appeal.

Furthermore, the Board notes that, even if the Board had found that it had jurisdiction over the issue in this appeal, the Board would find that, based on the record before it, the costs at issue were not clearly identifiable as EHR capitalizable costs, but rather for optimization of the system after the software was put in place.[23] For costs related to purchased computer software to be

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[20] *See* 75 Fed. Reg. at 44453 ("For purposes of determining final incentive payments, we will employ the first 12-month cost reporting period that begins after the start of the payment year, in order to settle payments on the basis of the hospital's Medicare fee-for-service and managed care inpatient bed days, total inpatient bed-days, and charges for charity care data from that cost reporting period."); 77 Fed. Reg. at 13776-77 (stating "CAHs are required to file an annual Medicare cost report that is typically for a consecutive 12-month period. The cost report reflects the inpatient statistical and financial data that forms the basis of the CAH's Medicare reimbursement. Interim Medicare payments may be made to the CAH during the cost reporting period based on the previous year's data."). *See also id.* at 13788.

[21] (Emphasis added.) Note that 42 U.S.C. § 1395f(l)(3)(C) states: "[t]he costs described in this subparagraph are costs for the purchase of certified EHR technology to which purchase depreciation (excluding interest) would apply if payment was made under paragraph (1) and not under this paragraph."

[22] Note that 42 C.F.R. § 495.106(c) provides the payment methodology for CAH EHR incentive payments and, in particular, Paragraph 2 states in part: (2) *Calculation of reasonable costs*. CMS or its Medicare contractor computes a qualifying CAH's reasonable costs incurred for the purchase of certified EHR technology, as defined in paragraph (a) of this section, as the sum of— (i) The reasonable costs incurred for the purchase of certified EHR technology during the cost reporting period that begins in a payment year; and (ii) Any reasonable costs incurred for the purchase of certified EHR technology in cost reporting periods beginning in years prior to the payment year which have not been fully depreciated as of the cost reporting period beginning in the payment year."

[23] The various invoices included in Exhibits I-6 through I-9 merely identify various projects and the billable and consulting expenses related to those projects for the invoice period. It is not possible from the project descriptions (*e.g*., Epic Access/OpTime/Reporting/Rev Cycle/Willow/Ambulatory/Opt/PM/Resolute) whether these projects are part of the "purchase of certified EHR technology," as noted in 42 C.F.R. § 495.106(c), or simply additional modules of Epic which were purchased at the same time or optimizations/updates being made to the modules

appropriately capitalized and, therefore, eligible for the certified EHR incentive payment, such costs must be for the *initial* software customization and/or modification, or to put the software into use.[24] Therefore, consulting costs for any and all *subsequent* customization, or for optimizing a provider's use of the software *after it was put into place for use* would not be eligible for the EHR incentive payment.[25]

*****

In summary, the Board hereby dismisses this CIRP group appeal because, pursuant to 42 U.S.C. § 1395f(l)(5) and 42 C.F.R. § 413.70(a)(7), the Board does not have substantive jurisdiction over this CIRP group appeal.[26] Accordingly, the Board closes Case No. 17-0587GC 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.
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For the Board:

2/24/2023

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services

already in service. Further, Exhibit I-11 identifies no fewer than ***seven*** "EPIC Refresh" projects in the expenses which the Contractor disallowed. The record is not clear as to whether these Refresh projects are "initial software customization or modification" or subsequent "optimization or modification." *See also infra* note 25.

[24] *See* PRM 15-1 § 104.17 (stating: "The costs of initial customizing and/or modification of purchased computer software to function with the provider's computer hardware, or to put into place for use, should be capitalized as part of the historical cost of the software.") (copy included at Exhibit P-13).

[25] The hearing transcript reveals multiple date(s) on which the system was attested as being in service for "meaningful use" purposes. Indeed, the Provider had attested to "meaningful use" in 2012 and 2013, *prior to the cost report year under appeal* (*i.e.*, FY 2014), and the Provider's witness could not confirm whether the systems in place in 2012 to meet the 2012 "meaningful use" standards would necessarily have met the evolved "meaningful use" standards in place in 2014. Tr. at 255-56, 283-84, 376-77. Per the transcript, the Provider also attested to "meaningful use" in FY 2014, and, as part of the attestation process, tested/reported data to confirm meeting the "meaningful use" standards during the 3-month period from July 1, 2014 to September 30, 2014. Tr. at 92-94, 108-09, 123-24, 142-147, 158-59. However, many invoices in Exhibits P-6 through P-9 were for dates after the July 1, 2014 start of the 3-month testing period. Indeed, some were even after September 30, 2014 when the 3-month testing/reporting period ended. This further calls into question whether the invoices were for "initial software customization and/or modification" or for subsequent customization or optimization. *See supra* note 23.

[26] In denying jurisdiction, the Board notes that Board Rule 4.1 states that "[t]he Board may review jurisdiction on its own motion at any time" and that "[t]he parties cannot waive jurisdictional requirements." This Rule is rooted in 42 C.F.R. § 405.1840 and the statement at subsection (a)(3) that "[t]he Board may revise a preliminary determination of jurisdiction at any subsequent stage of the proceedings in a Board appeal." *See also* Board's RFI (Oct. 5, 2022).