DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
7500 Security Boulevard
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Baltimore, MD 21244
410-786-2671

Via Electronic Delivery

Joseph Walker
General Counsel
Advanced Health Care Corporation
140 North Union Avenue
Suite 230
Farmington, UT 84025

RE: ***Notice of Dismissal***
AHC of Aurora (Prov. No. 06-5393)
FYE 12/31/2012
Case No. 15-1035

Dear Mr. Walker:

The above-captioned case is currently scheduled for a live hearing on June 7, 2023. Upon review of the case record, the Board has determined that AHC of Aurora (the "Provider") failed to comply with the Board's November 10, 2022 Scheduling Order directing the parties to provide supplemental briefing in this case. Accordingly, as set forth below, the Board is dismissing this case.

Procedural History

The Provider submitted a request for hearing on January 12, 2015, based on a Notice of Program Reimbursement ("NPR") dated July 31, 2014. The issue set forth in the request for hearing is whether the CMS "must bill" policy applies to the Provider's dual eligible bad debts when the Provider did not participate in Medicaid.

On March 10, 2021, the Board issued a Notice of Hearing in this case setting a hearing date of December 8, 2021. Subsequently the Board issued a Notice of Hearing – Rescheduled on February 4, 2022 setting a new hearing date of December 7, 2022 and requiring final position papers ("FPPs") to be filed by the Provider on September 8, 2022 and the Medicare Contractor on October 8, 2022. The Provider filed an FPP on September 8, 2022. The Medicare Contractor filed an FPP on October 5, 2022. The Provider subsequently filed a responsive final position paper on November 2, 2022.

On September 18, 2020, between the filing of this appeal and the parties filing their respective FPPs, CMS issued the FY 2021 Final Rule promulgating certain ***retroactive*** bad debt regulations that may impact this appeal. Specifically, the FY 2021 Final Rule amended 42 C.F.R. § 413.89(e)(2) which establishes what constitutes a reasonable collection effort for bad debts owed

by patients dually eligible for Medicare and Medicaid. The regulation at 42 C.F.R. § 405.1867 states, in relevant part, "*the Board* ***must comply with*** *all the* provisions of Title XVIII of the Act and ***regulations issued thereunder***. . . ."[1] Accordingly, the Board must follow the dictates of the bad debt regulations, promulgated in the FY 2021 Final Rule.

A review of the record demonstrated that neither party addressed the applicability of the new bad debt regulations, as promulgated in the FY 2021 IPPS Final Rule (in particular, the apparent retroactivity of the new regulation at 413.89(e)(2)(iii)). Based on this finding, it is unsurprising that neither party discussed the potential impact of this legal development on the Provider's appeal. Therefore, the Board determined that the record for the subject appeal needed to be supplemented to address the relevance of the bad debt regulations promulgated in the FY 2021 IPPS Final Rule.

On November 10, 2022, the Board issued a Scheduling Order directing the parties to explain the relevance of the bad debt regulations promulgated in the FY 2021 IPPS Final Rule and whether they directly address the issue in this appeal and the extent they retroactively apply to the fiscal year at issue. The Provider was also asked to explain whether it was challenging any aspect of the bad debt regulations promulgated in the FY 2021 Final Rule regulation and, if so, to describe that challenge.[2] The Board also directed the Parties to comment on how both prongs of the Bad Debt Moratorium operate in relation to the FT 2021 Final Rule regulation.[3] Finally, the Board directed the Parties to identify any material factual disputes about the bad debts at issue.

The Board ordered that the parties supplement the record as follows:

1. ***By Tuesday February 7, 2023,*** the Provider's representative must file a supplemental brief specifically addressing, as discussed more fully above, the relevance of the bad debt regulations promulgated in the FY 2021 IPPS Final Rule (including whether the Provider is challenging the procedural and/or substantive validity of these regulations).

2. ***By Tuesday March 7, 2023***, the Medicare Contractor must file a responsive brief.

3. ***By Monday, April 7, 2023***, the Provider's representative must file any responsive brief to the extend it wishes to respond to the Medicare Contractor's supplemental brief.

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[1] (Emphasis added)
[2] Pursuant to 42 C.F.R. § 405.1842(a)(1), "This section implements provisions in section 1878(f)(1) of the Act that give a provider the right to seek EJR of a legal question relevant to a specific matter at issue in a Board appeal if there is Board jurisdiction to conduct a hearing on the matter (as described in § 405.1840 of this subpart), and the Board determines it lacks the authority to decide the legal question (as described in § 405.1867 of this subpart, which explains the scope of the Board's legal authority)." Alternatively, "If the Board makes a finding that it has jurisdiction to conduct a hearing on a specific matter at issue in accordance with § 405.1840(a) of this part, it may consider on its own motion whether it lacks the authority to decide a legal question relevant to the matter at issue." 42 C.F.R. § 405.1842(c).
[3] Provider's Final Position Paper at 2.

Additionally, the Board postponed the hearing scheduled for December 7, 2022. The Board issued a Notice of Hearing – Rescheduled on November 18, 2022 setting a new hearing date of June 7, 2023.

The Board's Scheduling Order also stated:

> *Be advised that the above filing deadlines are **firm** and, given the fact that this case was scheduled for hearing, the Board is specifically **exempting** these deadlines from the Alert 19 suspension of Board-set deadlines.* Accordingly, failure of the Provider to comply with the Scheduling order and timely file the supplemental brief (without a Board-approved extension) will result in dismissal pursuant to its authority under 42 C.F.R. § 405.1868(a)-(b). Similarly, failure of the Medicare Contractor to so timely file may result in the Board issuing notice to CMS, pursuant to 42 C.F.R. § 405.1868(c), requesting that CMS take appropriate action such as review of the contractor's compliance with its contractual requirements.

<u>Board's Decision</u>

The Board finds that the Provider failed to file a supplemental brief as directed in the Board's November 10, 2022 Scheduling Order. Further, the Provider did not seek to extend the supplemental brief deadline by filing an extension request with the Board.

The regulation at 42 C.F.R. § 405.1868 states:

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

Board Rule 41.2 implements this regulation, stating:

> The Board may dismiss a case or an issue on its own motion:

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

The Board finds that: (1) the Provider failed to comply with the Board's November 10, 2022 Scheduling Order; (2) its Scheduling Order specifically exempted the filing deadlines from the Board Alert 19 suspension of Board-set filing deadlines; and, (3) it advised the Provider that failure to timely file (without a Board-approved extension) would result in dismissal of the Provider's case.

Accordingly, the Board concludes that dismissal is warranted, pursuant to its authority under 42 C.F.R. § 405.1868(a)-(b).

The Board hereby dismisses this appeal and removes it from the Board's docket.

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

Board Members Participating:

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

For the Board:

3/1/2023

X Robert A. Evarts, Esq.

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

cc: Bill Tisdale, Novitas Solutions, Inc. (J-H)
Wilson Leong, Federal Specialized Services

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James Ravindran
Quality Reimbursement Services, Inc.
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RE: ***Board Ruling on Transfer & Expansion of CY 2009 CIRP Group to Include CY 2008***
Transfer Request for: Baptist Med. Ctr.- Jacksonville (10-0088, FYE 9/30/2008) Case No. 14-0933
To: Baptist Health Sys. CY 2009 DSH SSI/Medicaid Medicare Mngd Care Part C Days CIRP, Case No. 21-1571GC

Dear Mr. Seely, Mr. Pike and Mr. Ravindran:

The Provider Reimbursement Review Board (the "Board") has reviewed a request from Quality Reimbursement Services, Inc. ("QRS"), filed on behalf of Baptist Health System ("Baptist Health"), dated March 23, 2022. In its correspondence, QRS requests:

1. The transfer of the Part C days issue (described as "DSH Exclusion of Part C Days-Denominator Medicare Ratio") from Case No. 14-0933 to the Baptist Health common issue related party ("CIRP") group for calendar year ("CY") 2009 under Case No. 21-1571GC; and

2. The expansion of Case No. 21-1571GC to include CY 2008.[1]

According to QRS, the transfer and expansion of the CY 2009 CIRP group would allow the transfer of the DSH Medicare Part C Days issue (Issue #3 relating to the Medicaid fraction) and the Exclusion of Part C Days from the Denominator of the Medicare Percentage issue (Issue #19 relating to the Medicare fraction) from the individual appeal of Baptist Medical Center Jacksonville ("Baptist Jacksonville") under Case No. 14-0933 for FYE 9/30/2008, since there is not a *pending* CIRP group for CY 2008 to which it can transfer. In support of the group expansion, QRS advised that there are no factual or regulatory differences between the CYs 2008 and 2009 for the Medicare Part C Days issues.

[1] QRS' correspondence addressed three Baptist Health System CIRP groups, including Case No. 21-1571GC. Because of varying fact patterns between the group issues and statuses of the groups, the Board will address each request for group expansion under separate cover.

Board Determination:

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

Board Rule 12.5 indicates that "[p]roviders in a group appeal must have final determinations for their cost reporting periods that end with the same calendar year. However, groups may submit a written request to include more than one calendar year to meet the minimum number of providers . . . requirements."[2] In addition, "[o]ne or more of the providers bringing a group appeal . . . **subject to the Board's discretion**, may appeal more than one cost reporting period with respect to the issue that is the subject of the group appeal for other purposes. . . ".[3]

Upon review of Baptist Jacksonville's individual appeal, the Board notes that, on January 14, 2015, Baptist Jacksonville transferred Issue #3 (the DSH Medicare Part C Days issue) *from Case No. 14-0933* to the Baptist Health 2008 CIRP group under Case No. 15-0970GC entitled "Baptist Health System Medicare Managed Care Part C Days CIRP Group." According to the Board's docket, the Board dismissed the Baptist Health CIRP group under Case No. 15-0970GC on February 10, 2016 because the group representative failed to timely file the group's preliminary position paper.

With regard to the remaining Part C Days issue (Issue #19) in Case No. 14-0933, which was characterized as "Exclusion of Part C Days from the Denominator of the Medicare Percentage," the Board finds this issue to be duplicative of the Medicare Part C Days issue previously transferred to Case No. 15-0970GC. The basis for this finding is pursuant to the 2014 decision of the D.C. Circuit in *Allina Health Servs. v. Sebelius* ("*Allina*"),[4] where it was determined that Part C days ***must*** be included in either the SSI fraction or Medicaid fraction:

> [T]he statute [at 42 U.S.C. § 1395ww(d)(5)(F)(vi)] ***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) . . . .[5]

The Board is bound by the D.C. Circuit's 2014 interpretation of this statutory provision.[6] Thus, the disposition of the Medicaid Fraction Medicare Part C Days issue dictates the disposition of

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[2] Board Rules (Nov. 1, 2021).
[3] 42 C.F.R. § 405.1837(B)(2)(ii) (emphasis added).
[4] 746 F.3d 1102 (D.C. Cir. 2014).
[5] *Id.* at 1108 (emphasis added).
[6] The CMS Administrator generally has applied as controlling precedent the law of the Circuit in which the Provider is located. *See, e.g., QRS CHW DSH Labor room Days Grps. v. BlueCross BlueShield Ass'n*, Adm'r Dec. (Apr. 13, 2009), affirming, PRRB Dec. No. 2009-D11 (Feb. 27, 2009); *St. Vincent Mercy Med. Ctr. v. BlueCross BlueShield Ass'n*, Adm'r Dec. (Nov. 17, 2008), *affirming in part and reversing in part*, PRRB Dec. No. 2008-D35 (Sept. 15, 2008). In recognizing that providers may file suit with the appropriate District Court either in the Circuit in which they are located or the D.C. Circuit, the Administrator also applies as controlling precedent the law of the D.C.

the SSI Fraction Medicare Part C Days issue, as *Allina* indicates Part C days must be counted in one fraction or the other.

42 C.F.R. § 405.1842(b)(1) mandates that commonly owned or controlled providers must pursue a common issue for a particular year as part of a group that the Board refers to as a common issue related party ("CIRP") group. Similarly, Board Rule 4.6 prohibits duplicate appeal.

Here, Baptist Health *already* had a CIRP group for the 2008 Part C days issue under Case No. 14-0970GC entitled "Baptist Health 2008 Medicare Managed Care Part C Days CIRP Group." Significantly, Baptist Jacksonville was part of this CIRP group. However, on February 10, 2016, the Board dismissed that CIRP group for failure to timely file its preliminary position paper. Moreover, Baptist Health has *not* asked for reinstatement of this case and the 3-year period for reinstatement of this case has expired.[7] Accordingly, QRS request to transfer Issue #3 is denied as void since it no longer is part of the individual appeal.

Since the Board considers the Part C day issue to be a single issue across the DSH calculation (as required by the D.C. Circuit's decision in *Allina*),[8] the Board hereby **dismisses** the Exclusion of Part C Days from the Denominator of the Medicare Percentage issue from Case No. 14-0933 because it is a prohibited duplicate of the Baptist Health CIRP group for the same issue and year under Case No. 15-0970GC of which this provider was also a participant.[9] As there is no longer a CY 2008 Medicare Part C Days issue pending in Case No. 14-0933, the Board hereby denies QRS' request to transfer it to Case No. 21-1571GC and expand the 2009 Baptist Health CIRP group under Case No. 21-1571GC (entitled "Baptist Health System CY 2009 DSH SSI/Medicaid Medicare Managed Care Part C Days CIRP Group") to include CY 2008.

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 Case No. 14-0933.

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

For the Board:

3/1/2023

Clayton J. Nix Esq.
Chair
Signed by: PIV

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

Circuit. *See, e.g., Jordan Hosp. v. BlueCross BlueShield Ass'n.*, Adm'r Dec. (Apr. 30, 2007), *vacating*, PRRB Dec. No. 2007-D23 (Feb. 28, 2007).

[7] *See* 42 C.F.R. § 405.1885; Board Rule 47.1.

[8] Because Part C days must be counted in one fraction or the other, then an appeal requesting inclusion of Part C days in the Medicaid fraction is the same as one requesting exclusion from the Medicare fraction. Thus, if Part C days are excluded from the Medicare fraction (as advocated by Baptist Jacksonville), then per *Allina*, they must be counted in the Medicaid fraction (to the extent the underlying Part C patient is also Medicaid eligible).

[9] 42 C.F.R. § 405.1837(b)(1); Board Rule 4.6.

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RE: ***Duplication of Common Issue Related Party ("CIRP") Groups***

Case No.	Group Name
22-0170GC	(QRS) Providence Health CY 2017 DSH SSI Fract. Dual Eligible Days CIRP
20-1505GC	(Toyon) St. Joseph Health Sys. CY 2017 Inclusion of Medicare Part A Unpaid Days in the SSI Ratio CIRP Group
22-0171GC	(QRS) Providence Health CY 2017 DSH Medicaid Fract. Dual Elig. Days CIRP
20-1504GC	(Toyon) St. Joseph Health Sys. CY 2017 Exclusion of Dual Elig Part A Unpaid Days - Medicaid Ratio CIRP Group

Dear Mr. Ravindran, Mr. Bloom, Mr. Anderson and Mr. Chinea:

The Provider Reimbursement Review Board (the "Board") has begun a review of the above-captioned group appeals which involve the two fractions of the Dual Eligible Days issue for St. Joseph Health System (formerly Providence Health) for calendar year ("CY") 2017.[1] The background regarding the group cases and the Board's Determination are set forth below.

BACKGROUND:

A. Background for Case No. 20-1504GC and 20-1505GC

On April 1, 2020, Toyon Associates, Inc. ("Toyon") filed the two Medicaid Ratio and SSI Ratio CY 2017 Dual Eligible Days CIRP Groups under Case Nos. 20-1504GC and 20-1505GC, respectively.[2] The authorization of representative letters (dated on various dates in 2020 and 2022) were submitted on Providence St. Joseph Health letterhead, but the address information referenced Providence Health & Services. The authorization letters were all signed by Donald W. Anderson, Jr., Director of Reimbursement Administration for Providence Health & Services.

[1] An internet search indicates Providence Health merged with St. Joseph Health in July 2016.
[2] Both groups had seventeen participants.

In Case 20-1504GC, the group issue statement indicates that the providers in the group dispute the *exclusion* of dual eligible Medicare Part A Unpaid Days from the Medicaid ratio.[3]

In Case No. 20-1505GC the group indicates the providers dispute the *inclusion* of Medicare Part A Unpaid Days in the SSI ratio.[4]

On September 14, 2022, Toyon *withdrew* ***both*** Dual Eligible Days CIRP groups resulting in the closure of Case Nos. 20-1504GC and 20-1505GC. When these cases were withdrawn, there were at least 17 participants.

B. Background for Case Nos. 22-0170GC and 22-0171

On November 19, 2021, Quality Reimbursement Services, Inc. ("QRS") filed Medicaid Ratio and SSI Ratio CY 2017 Dual Eligible Days CIRP Groups under Case No. 22-0171GC and 22-0170GC, respectively. The authorization of representative letters were all dated on November 18, 2021 and were submitted on the ***same*** Providence St. Joseph Health letterhead, and again were signed by Donald W. Anderson, Jr., Director of Reimbursement Administration for Providence Health & Services.[5]

The group issue statement in Case No. 22-0171GC indicates that the 3 participants in the group are appealing whether patient days associated with Part A and Title XIX eligible patients should be ***included in the DSH Medicaid percentage*** calculation, as well as patient days for patients who were eligible for both Medicare and Medicaid where Part A did not make payment.[6]

In Case No. 22-0170GC, the 3 participants are appealing whether patient days associated with Part A and Title XIX eligible patients should be ***excluded from the DSH SSI percentage*** calculation, as well as patient days for patients who were eligible for both Medicare and Medicaid where Part A did not make payment.[7]

C. Parent Organization Request for Group to Group Transfers

On October 25, 2022, Donald Anderson, Jr. of Providence Health & Services requested the group-to-group transfer of the ***sole*** three hospitals from the QRS CIRPs under Case Nos. 22-0170GC and 22-0171GC to Toyon CIRPs under Case Nos. 20-1505GC and 20-1504GC, respectively:

- Providence St. John's Health Center (Prov. No. 05-0290);
- Providence Williamette Falls Medical Center (Prov. No. 38-0038); and
- Kadlec Regional Medical Center (Prov. No. 50-0058)

[3] Case No. 20-1504GC Group Issue Statement dated 4/1/2020
[4] Case No. 20-1505GC Group Issue Statement dated 4/1/2020.
[5] On February 15, 2023, QRS submitted a request to change the representative for Case Nos. 22-0170GC and 22-0171GC from QRS to Toyon. The Board confirmed the change on March 1, 2023.
[6] Case No. 22-0171GC Group Issue Statement dated 11/19/2021.
[7] Case No. 22-0170GC Group Issue Statement dated 11/19/2021.

The transfer of these 3 participants would result in the closure of these cases since they were the only participants in these CIRP groups. Mr. Anderson also indicated that he was changing the authorization of representative for the three providers in both groups from QRS to Toyon, but provided no further explanation for the transfers. Significantly, Mr. Anderson's transfer requests did ***not*** acknowledge the fact that Toyon had already withdrawn the CIRPs under Case Nos. 20-1505GC and 20-1504GC over a month earlier on September 14, 2022.

Board Determination:

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

As the Parties are aware, it is the Board's policy to establish ***only*** one (1) CIRP group appeal per issue per fiscal year end.[8] In fact, the certification page of a group appeal request includes a statement that the Representative certifies ". . . the group issue filed . . . is *not* pending in any other appeal for the same period for the same provider, nor has it been adjudicated, withdrawn or dismissed from any other PRRB appeal."[9]

The Board directs the parent organization, St. Joseph Health, as well as both Representatives' attention to 42 C.F.R. § 405.1837*, which indicates that related providers appealing a common issue for the same calendar year are required to pursue that issue in* ***only*** *one CIRP group appeal.*[10]

Board Rule 4.6, also specifically prohibits "Duplicate Filings":

> **4.6 No Duplicate Filings**
>
> **4.6.1 Same Issue from One Determination**
> A provider may not appeal an issue from a single final determination in more than one appeal.

[8] *See* Board Rules 4.6, 5.4, 7.1.1. *See also* 42 C.F.R. § 405.1837(b).
[9] Appendix B: Model Form B – Group Appeal Request at time of filing (March 1, 2013, revised July 1, 2015, August 29, 2018 and November 1, 2021) (emphasis added).
[10] *See* 42 C.F.R. § 405.1837(b)(i) (stating "*Two or more providers under common ownership or control that wish to appeal* to the Board *a specific matter at issue* that involves a question of fact or interpretation of law, regulations, or CMS Rulings that is common to the providers, and *that arises in cost reporting periods that end in the same calendar year*, and for which the amount in controversy is $50,000 or more in the aggregate, ***must*** *bring the appeal as a group appeal*." (emphasis added)); 42 C.F.R. § 405.1837(b)(3) (stating "With respect to group appeals brought under paragraph (b)(1) of this section, one or more commonly owned or operated providers must make a written request for a Board hearing as a group appeal in accordance with paragraph (c) of this section. *Any group appeal filed by a single provider* ***must be joined*** *by related providers on common issues in accordance with paragraphs (b)(1) and (e) of this section*. (emphasis added)).

> **4.6.2 Same Issue from Multiple Determinations**
> Appeals of the same issue from distinct determinations must be pursued in a single appeal. For example, a provider may not appeal an issue from a Medicare contractor's failure to issue a timely Notice of Program Reimbursement ("NPR") and then appeal the same issue from the NPR in separate appeals. Provider Reimbursement Review Board Rules Version 2.0 9 Issue
>
> **4.6.3 Previously Dismissed or Withdrawn**
> Once an issue is dismissed or withdrawn, the issue may not be appealed in any other case.

The Board directs the parent organization, St. Joseph Health, as well as both Representatives' attention to 42 C.F.R. § 405.1837(b)(1), which indicates that related providers appealing a common issue for the same calendar year are required to pursue that issue in only one CIRP group appeal.

> *Two or more providers under common ownership or control that wish to appeal to the Board a specific matter at issue that involves a question of fact or interpretation of law, regulations, or CMS Rulings that is common to the providers, and that arises in cost reporting periods that end in the same calendar year, and for which the amount in controversy is $50,000 or more in the aggregate, must bring the appeal as a group appeal.*[11]

Board Rule 4.6, also specifically prohibits "Duplicate Filings":

> **4.6 No Duplicate Filings**
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> **4.6.1 Same Issue from One Determination**
> A provider may not appeal an issue from a single final determination in more than one appeal.
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> **4.6.2 Same Issue from Multiple Determinations**
> Appeals of the same issue from distinct determinations must be pursued in a single appeal. For example, a provider may not appeal an issue from a Medicare contractor's failure to issue a timely Notice of Program Reimbursement ("NPR") and then appeal the same issue from the NPR in separate appeals. Provider Reimbursement Review Board Rules Version 2.0 9 Issue
>
> **4.6.3 Previously Dismissed or Withdrawn**
> Once an issue is dismissed or withdrawn, the issue may not be appealed in any other case.

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[11] 42 C.F.R. § 405.1837(b)(1).

Because there can be only one CIRP group for each CY, for each issue, and there can be only one authorized Representative, the Board finds that:

- the "Providence Health CY 2017 DSH SSI Fraction Dual Eligible Days CIRP Group" filed by QRS under ***Case No. 22-0170GC is duplicative*** of the "St. Joseph Health System CY 2017 Inclusion of Medicare Part A Unpaid Days in the SSI Ratio CIRP Group" filed by Toyon under ***Case No. 20-1505GC***. The appeal was invalid at submission. Indeed, this is confirmed by the fact that Mr. Anderson requested the group-to-group transfer of the 3 participants in Case No. 22-0170GC to Case No. 20-1505GC which had at least 17 participants.

- the "Providence Health CY 2017 DSH Medicaid Fraction Dual Eligible Days CIRP Group" filed by QRS under ***Case No. 22-0171GC is duplicative*** of the "St. Joseph Health System CY 2017 Exclusion of Dual Elig Part A Unpaid Days - Medicaid Ratio CIRP Group" filed by Toyon under ***Case No. 20-1504GC***. The appeal was invalid at submission. Indeed, this is confirmed by the fact that Mr. Anderson requested the group-to-group transfer of the 3 participants in Case No. 22-0170GC to Case No. 20-1505GC which had at least 17 participants.

Further, the Board finds that Toyon, on behalf of Providence Health/St. Joseph, withdrew the two Dual Eligible Days CIRP Groups, Case Nos. 20-1505GC and 20-1504GC, on September 14, 2022, which was over one year after the two QRS duplicative CIRPS were filed with the Board (and one month prior to Mr. Anderson's request for the group-to-group transfer of the 3 participants in Case Nos. 22-0170GC and 22-0170GC to Case Nos. 20-1505GC and 20-1505GC respectively). Because the Toyon groups are now closed (and had already been closed for over a month when the transfer request was made), the Board hereby denies the transfers of the three participants from the QRS SSI and Medicaid Fraction Dual Eligible Days groups, Case Nos. 22-0170GC and 22-0171GC, to the respective Toyon groups, Case Nos. 20-1505GC and 20-1504GC. Further, as Toyon's withdrawal of the Dual Eligible Days issues for Providence Health eliminates the ability of the same chain to pursue the issue in a separate appeal (and in this case the separate appeals are also invalid duplicative appeals), *see* 42 C.F.R. § 405.1837(b)(1) and (e), the Board hereby dismisses Case Nos. 22-0171GC and 22-0170GC.[12]

Finally, the Board admonishes St. Joseph Health for authorizing QRS to pursue an issue, in this instance, the two Dual Eligible Days issues, that it had previously authorized Toyon to pursue and for which proper appeals were pending. In addition, the Board reprimands QRS for filing the duplicate group appeals. When QRS formed these groups in the Office of Hearings Case & Document Management System (" OH CDMS"), it certified that ". . . to the best of my knowledge that there are no other providers to which this provider is related by common ownership or control that have a pending request for a Board hearing on this issue for a cost

[12] The facts that 2 CIRP groups that Toyon filed were filed prior to the QRS CIRP groups and also had at least 17 participants. Since they were filed prior to the QRS CIRP groups, had more participants than the QRS CIRP groups and Providence/St. Joseph intended to close the QRS CIRP groups (as confirmed by the transfer requests and the statement that Toyon would be the surviving representative), all confirm that the withdrawal of Case Nos. 20-1505GC and 20-1504GC eliminated the ability of the Providence/St. Joseph Health chain from pursuing these issues unless Case Nos. 20-1505GC and 20-1504GC are reinstated pursuant to Board Rule 47.1 and 42 C.F.R. § 405.1885.

reporting period that ends in the same calendar year cover in this request. ***See*** 42 C.F.R. § 405.1835 (b)(4)(i)." At the time QRS filed Case Nos. 22-0171GC and 22-0170GC, the Toyon CIRP groups for the same issues and chain organization had been pending for more than a year and a half. Accordingly, the Board reminds QRS that, as a CIRP group representative, it has a responsibility to confer with its client(s) ***prior to*** making such a certification.

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

FOR THE BOARD:

3/1/2023

X Clayton J. Nix

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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RE: ***Board Decision***
Monongahela Valley Hospital, Prov. No. 39-0147, FYE 06/30/2015
Case No. 18-0298

Dear Messrs. Simmons and Snyder:

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the documentation in Case No. 18-0298, pursuant to a jurisdictional challenge filed by the Medicare Contractor ("MAC"). The Board's decision is set forth below.

Background

A. Procedural History for Case No. 18-0298

On November 24, 2017, Monongahela Valley Hospital, appealed a Notice of Program Reimbursement (NPR) dated May 24, 2017, for its fiscal year dating June 30, 2015 ("FY 2015"). The Provider appealed the following issues:[1]

- Issue 1: DSH SSI Percentage (Provider Specific)
- Issue 2: DSH SSI Percentage
- Issue 3: DSH SSI Percentage - Medicare Managed Care Part C Days
- Issue 4: DSH SSI Percentage - Dual Elig. Days (Exhausted Part A Benefit Days, MSP Days & No-Part A Days)
- Issue 5: DSH - Medicaid Eligible Days
- Issue 6: DSH - Dual Elig. Medicaid Fract. (Medicare Mngd. Care Part C Days)
- Issue 7: DSH - Dual Elig. Days Medicaid Fract. (Exhausted Part A Benefit Days, MSP Days & No-Part A Days)
- Issue 8: DSH - Uncompensated Care
- Issue 9: Two Midnight Rule

All but three of the group issues were transferred to Group Cases. Three issues remain:

- Issue 1, DSH SSI Percentage (Provider Specific),

[1] Provider's Request for Hearing, Tab 3, at Issue Statement (Nov. 24, 2017).

- Issue 5, DSH – Medicaid Eligible Days, and
- Issue 8, DSH – Uncompensated Care.[2]

The Medicare Contractor filed a Jurisdictional Challenge on April 11, 2018, regarding Issues 1, 8, and 9, addressing the DSH SSI Percentage (Provider Specific) issue, the DSH – Uncompensated Care issue, and Issue 9, Two Midnight Rule.[3]

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 18-1409G

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

> The Provider contends that the MAC did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the MAC's calculation of how the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations.
>
> The provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both 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.[4]

The Provider was also directly added to an optional group under Case No. 18-1409G entitled "QRS 2015 DSH SSI Percentage Group." This CIRP group has the following issue statement:

> **<u>Statement of the Issue:</u>**
>
> 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

[2] MAC's Jurisdictional Challenge, at 1 (Apr. 11, 2018).
[3] Issue 9, Two Midnight Rule, was transferred to group case 19-0863G.
[4] Provider's Request for Hearing, Issue Statement (Nov. 24, 2017).

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 the Provider as a participant in Case No. 18-1409G is $26,000.

On June 26, 2018, 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 (December 31).

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

Similar to *Loma Linda Community Hospital v. Dept of Health* and Human Services, No. 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

[5] Group Issue Statement, Case No. 18-1409G.

> 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).

The only exhibit included with the preliminary position paper that relates to Issue 1 was Exhibit 1, which was listed as an Eligibility Listing, but noted that it would be sent under separate cover. Exhibit 2 shows the amount in controversy as $26,000. This is the same amount that is listed as the amount in controversy for this Provider as a participant in 18-1409G.

<u>MAC's Contentions</u>

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 transferred into Group Case No. 18-1409G, QRS 2015 DSH SSI Percentage Group. The Portion of Issue 1 concerning realignment should be dismissed because there was no final determination over SSI realignment and the Provider's appeal is premature as the Provider has not exhausted all available remedies.[6]

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.

Issue 8 – DSH – Uncompensated Care

The MAC argues that Congress, in enacting 42 U.S.C. § 1395ww(r)(3), explicitly barred administrative and judicial review of the new DSH payment methodology. Although the Board may have jurisdiction to determine if it has authority to hear the Provider's appeal, the statute's bar of administrative review means that it is without authority to decide the issues raised by the Provider in this appeal.[7]

Pursuant to these specific statutory provisions outlining the new DSH uncompensated care payment, the Board lacks authority to decide all aspects of the Provider's appeal. In enacting these provisions, Congress manifested its intent that the administration of the new DSH payment be free of the very kind of appeal filed by the provider here; namely a wholesale attack on how the new DSH payment is calculated and the data that serves as the basis for payments to individual providers.[8]

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[6] *Id*. at 2.
[7] MAC's Jurisdictional Challenge, at 4.
[8] *Id*.

Provider's Response

Provider contends that the Provider Specific issue is not duplicative. 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. In *Baystate*, the Board also considered whether, independent of these systemic errors, whether Baystate's SSI fractions were understated due to the number of days included in the SSI ratio. *See Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008). The Provider has analyzed Medicare Part A records and has been able to identify patients believed to be entitled to both Medicare Part A and SSI. The Provider has reason to believe that the SSI percentage determined by CMS is incorrect due to the understated days in the SSI ratio. Therefore, the Board should find jurisdiction over the SSI provider specific issue in the instant appeal.[9]

For the Uncompensated Care issue, the Secretary should be required to reconcile her initial estimate of the uninsured patient percentage with actual data when it becomes available after the close of the year. Only "estimates" are subject to the ban on administrative or judicial review. 42 U.S.C. § 1 395ww(r)(3). Therefore, the PRRB has jurisdiction over provider challenges to the uninsured patient percentage computed by the Secretary on the basis that such computation is not supposed to be an "estimate."[10]

The provisions of 42 U.S.C. § 1395ww(r)(3) bar administrative or judicial review over certain "estimates" used by the Secretary. This suggests that Congress intended that administrative review and judicial review should be treated similarly. Thus, administrative review should be available if judicial review is also available. For these reasons, judicial review of the Secretary's estimates is available. Accordingly, administrative review by the Board is also available. Moreover, even if such review by the Board is precluded, the providers desire to channel all of their claims to this tribunal prior to proceeding to the federal courts.[11]

An agency that acts outside of the scope of its lawful authority or in an *ultra vires* manner may not be shielded from judicial review, notwithstanding the existence of a statutory ban on judicial review. For example, an agency's promulgation of a regulation without undertaking the required notice and comment procedures may be grounds for circumventing the preclusion of judicial review on the basis that the agency acted outside of the scope of its authority in issuing the regulation. In such a case, a provider may well be entitled to a writ of mandamus directing the agency to comply with notice and comment procedures, or to injunctive relief prohibiting the application of regulations which are issued by the agency outside of the scope of its lawful authority.[12]

The appeal in this case challenges the Secretary's IPPS final rule as being both procedurally and substantively deficient. In *Bowen v. Michigan Academy of Family Physicians*, 476 U.S. 667 (1986), the Secretary argued that an association was precluded by Section 405(h) of the Social Security Act from challenging the Secretary's regulations implementing Part B of the Medicare Act. Section 405(h) limits judicial review of Social Security and Medicare claims to only

[9] Provider's Response to MAC's Jurisdictional Challenge, at 2 (May 29, 2018).
[10] *Id*. at 3.
[11] *Id*.
[12] *Id*. at 5.

specific types of agency determinations. The Secretary argued that Section 405(h) precluded a challenge to the regulations outside of the context of a challenge to individual payment determinations. The Supreme Court held that the ban on judicial review contained in Section 405(h) applied only to challenges against individual payment determinations. However, the Court held that Section 405(h) did not limit similarly limit the jurisdiction of federal courts to review challenges to the regulations and policies governing those determinations.[13]

Subsequent Supreme Court decisions have narrowed the scope of *Michigan Academy* to only those situations in which there is no alternative avenue for judicial review. *Shalala v. ill. Council on Long Term Care*, 529 U.S. 1 (2000). Thus, under *ill. Council*, a provider may not generally challenge Medicare regulations outside of the appeals process for individual payment determinations, unless there is no avenue for challenging that individual payment determination.[14]

This is precisely the situation in cases involving challenges to the estimates contained in DSH Factors 1-3. The statute appears to preclude appeals of the estimates used by the Secretary to compute DSH Factors 1-3 in connection with individual payment determinations. As such, providers would appear to fit within the *Michigan Academy* exception, authorizing challenges to the regulations themselves when no alternative means of redress are available.[15]

Provider concludes that review by this Board of the uninsured patient percentage is not barred by 42 U.S.C. § 1395ww(r)(3), because such percentages may not be computed on estimates. Moreover, the provisions of 42 U.S.C. § I 395ww(r)(3) reflect intent by Congress to put administrative review on the same footing as judicial review. The ban on judicial review does not apply in connection with mandamus type claims, challenges to regulations, and constitutional challenges. Accordingly, this Board also has jurisdiction over this appeal.[16]

Board Analysis and Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2014), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

A. 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.

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[13] Provider's Response to MAC's Jurisdictional Challenge, at 6.
[14] *Id*.
[15] *Id*.
[16] *Id*. at 6.

1. A. 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 Group Case No. 18-1409G, QRS 2015 DSH SSI Percentage 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. 18-1409G. 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."[17] 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)."[18] 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."[19] The DSH systemic issues filed into Case No. 21-1466GC, 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 $26,000.

Thus, the Board finds that the first aspect of Issue 1 in this appeal is duplicative of the group issue in Case No. 18-1409G, for this same provider and fiscal year. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (Mar. 1, 2013), the Board dismisses this aspect of the DSH/SSI (Provider Specific) issue.

In making this finding, the Board further notes that CMS regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, is pursuing that issue as part of the group under Case 18-1409G. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[20] Provider is misplaced in referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 18-1409G. The Provider's response to the jurisdictional challenge similarly fails to provide any

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

examples or sufficiently explain how the Provider Specific issue is difference from the Provider Systemic issue.

For example, the Provider's response to the jurisdictional challenge states that "the Provider has specifically identified patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS, due to errors that are ***or*** *may be* specific to the Provider, but in any case, are not the systemic errors that have been previously identified in the *Baystate* litigation."[21] Thus, while QRS alleges that it has identified specific patient situations that are *not* systemic, QRS fails to describe those situations, provide any documentation, or otherwise identify the specific patient situations.

Accordingly, consistent with Board Rule 44.4.3 and based on the record before it, the Board must find that Issues 1 and the group issue in Group Case 18-1409G, 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 – Uncompensated Care

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

1. *Bar on Administrative Review*

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

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[21] (Emphasis added and citation omitted.)

(A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).[22]

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

2. Interpretation of Bar on Administrative Review

a) Tampa General v. Sec'y of HHS

In *Florida Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Servs*. ("*Tampa General*"),[23] the U.S. Court of Appeals for the District of Columbia Circuit ("D.C. Circuit") upheld the D.C. District Court's decision[24] that there is no judicial or administrative review of uncompensated care DSH payments. In that case, the provider challenged the calculation of the amount it would receive for uncompensated care for fiscal year 2014. The provider claimed that the Secretary used inappropriate data when she selected the hospital cost data updated in March 2013, instead of data updated in August 2013, when calculating its uncompensated care payments. The provider argued that it was not challenging the estimate of its uncompensated care, but rather the underlying data on which the Secretary relied, judicial review of which is not barred.

The D.C. Circuit found that there was specific language in the statute that precluded administrative or judicial review of the provider's claims because in challenging the use of the March 2013 update data, the hospital was seeking review of an "estimate" used by the Secretary to determine the factors used to calculate additional payments. The D.C. Circuit went on to hold that "the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well."[25] The D.C Circuit also rejected the provider's argument that it could challenge the underlying data, finding that there cannot be judicial review of the underlying data because they are "indispensable" and "integral" to, and "inextricably intertwined" with, the Secretary's estimate of uncompensated care.[26]

The D.C. Circuit went on to address the provider's attempt to reframe its challenge to something other than an estimate of the Secretary. Specifically, it rejected the characterization as a challenge to the "general rules leading to the estimate rather than as a challenge to the estimate itself []" because it was merely an attempt to undo a shielded determination.[27]

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[22] Paragraph (2) is a reference to the three factors that make up the uncompensated care payment: (1) 75 percent of estimated DSH payments that would be paid in absence of § 1395ww(r); (2) 1 minus the percentage of individuals under age 65 who are uninsured in 2013 for the FY 2014 calculation; and (3) the hospital specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital with potential to receive DSH payments, to the amount of uncompensated care for all subsection (d) hospitals that receive payment under 42 U.S.C. § 1395ww(r)(2)(C). 78 Fed. Reg. 50496, 50627, 50631 and 50634.
[23] 830 F.3d 515 (D.C. Cir. 2016).
[24] 89 F. Supp. 3d 121 (D.D.C. 2015).
[25] 830 F.3d 515, 517.
[26] *Id.* at 519.
[27] *Id.* at 521-22.

b) DCH Regional Med. Ctr. v. Azar

The D.C. Circuit Court revisited the judicial and administrative bar on review of uncompensated care DSH payments again in *DCH Regional Med. Ctr. v. Azar* ("*DCH v. Azar*").[28] In *DCH v. Azar*, the provider alleged that it was challenging the methodology adopted and employed by the Secretary to calculate Factor 3 of the DSH payment. Indeed, they stated that the bar on review applied only to the estimates themselves, and not the methodology used to make the estimates. The D.C. Circuit disagreed, stating that "a challenge to the methodology for estimating uncompensated care is unavoidably a challenge to the estimates themselves" and that there is "no way to review the Secretary's method of estimation without reviewing the estimate itself."[29] It continued that allowing an attack on the methodology "would eviscerate the statutory bar, for almost any challenge to an estimate could be recast as a challenge to its underlying methodology." Recalling that it had held in *Tampa General* that the choice of data used to estimate an uncompensated care DSH payment was not reviewable because the data is "inextricably intertwined" with the estimates themselves, the D.C. Circuit found the same relationship existed with regard to the methodology used to generate the estimates.[30]

c) Scranton Quincy Hosp. Co. v. Azar

Recently, in *Scranton Quincy Hosp. Co. v. Azar* ("*Scranton*"),[31] the D.C. District Court considered a similar challenge and held that administrative review was precluded. In *Scranton*, the providers were challenging how the Secretary determined the amount of uncompensated care that would be used in calculating Factor 3 for their FY 2015 DSH adjustments.[32] For 2015 payments, the Secretary announced she would calculate DSH payments based on Medicaid and SSI patient days from 2012 cost reports, unless that cost report was unavailable or was for a period less than twelve months. In that scenario, the Secretary would calculate the FY 2015 DSH payments based on either the 2012 or 2011 cost report that was closest to a full twelve month cost report.[33] Since the providers in *Scranton* changed ownership in FY 2012, each had two cost reports that began in 2012: an initial cost report less than twelve months and a subsequent cost report that was a full twelve months.[34] Nevertheless, the Secretary used each hospital's shorter cost reporting period in calculating the Factor 3 values for their FY 2015 DSH payments.[35]

In *Scranton*, the providers argued that, unlike the providers in *Tampa General* and *DCH v. Azar* who were specifically attacking the methodology and policies adopted by the Secretary, they were simply trying to enforce those policies. The D.C. District Court was not persuaded, finding that the complaint was still about the method used and the particular data the Secretary chose to rely

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[28] 925 F.3d 503 (D.C. Cir. 2019) ("*DCH v. Azar*").
[29] *Id.* at 506.
[30] *Id.* at 507.
[31] 514 F. Supp. 249 (D.D.C. 2021).
[32] *Id.* at 255-56.
[33] *Id.* (quoting 79 Fed. Reg. 49854, 50018 (Aug. 22, 2014)).
[34] *Id.* One provider had a cost report for the six-month period from July 1, 2011 to December 31, 2011 and another for the twelve-month period from July 1, 2012 to June 30, 2013, while the second had a cost report for the nine-month period from October 1, 2011 to June 30, 2012 and another for the twelve-month period from July 1, 2012 to June 30, 2013.
[35] *Id.*

upon when estimating the amount of uncompensated care calculated. Just like in *Tampa General* and *DCH v. Azar*, the selection of one cost report for FY 2012 over another was "inextricably intertwined" with the Secretary's estimate in Factor 3 and not subject to administrative review. Similarly, the challenge to the decision to use one cost report over another was also a challenge to a "period selected by the Secretary," which is also barred from review.[36]

Finally, and perhaps most importantly, the D.C. District Court found that any allegations that the Secretary departed from her own policy and/or acted *ultra vires* did not alter its decision. The D.C. District Court found that, in the context of the bar on review of the Secretary's estimates used and periods chosen for calculating the factors in the UCC payment methodology, "saying that the Secretary wrongly departed from his own policies when he chose the data for the estimate or selected the period involved is fundamentally indistinguishable from a claim that he chose the wrong data or selected the wrong period."[37] While there is some case law to support that claims of *ultra vires* acts may be subject to review in narrow circumstances where such review is precluded by statute, the criteria in *Scranton* were not met.[38] For review to be available in these circumstances, the following criteria must satisfied:

> (i) the statutory preclusion of review is implied rather than express; (ii) there is no alternative procedure for review of the statutory claim; and (iii) the agency plainly acts in excess of its delegated powers and contrary to a specific prohibition in the statute that is clear and mandatory.[39]

The D.C. District Court found that the preclusion of review for this issue was express, not implied, which fails to satisfy the first prong of this test. Second, the departure from the period to be used announced in the Secretary's rulemaking does not satisfy the third prong, which requires a violation of a clear statutory command.[40] The D.C. District Court ultimately upheld the Board's decision that it lacked jurisdiction to consider the providers' appeals.

d) Ascension Borgess Hospital v. Becerra

Even more recently, the D.C. Circuit revisited, once again, the judicial and administrative bar on review of uncompensated care DSH payments again in *Ascension Borgess Hospital v. Becerra* ("*Ascension*").[41] In *Ascension*, the providers sought an order declaring the Worksheet S-10 audit protocol was unlawful, vacating the payments based on the Worksheet S-10 audit, requiring the Secretary to recalculate those payments, and setting aside the Board decisions refusing to exercise jurisdiction over their appeals.[42] Ultimately, the D.C. Circuit found that 42 U.S.C. § 1395ww(r)(3) bars administrative and judicial review of the providers claims. In making this finding, the D.C. Circuit pointed to its earlier decisions in *Tampa General* and *DCH v. Azar* where it "repeatedly applied a "functional approach" focused on whether the challenged action

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

was " 'inextricably intertwined' with the unreviewable estimate itself" and eschewing "categorical distinction between inputs and outputs."[43] The D.C. Circuit further dismissed the applicability of the Supreme Court's 2019 decision in *Azar v. Allina Health Servs*.[44] noting that "[t]he scope of the Medicare Act's notice-and-comment requirement would be relevant in evaluating the merits of plaintiffs' claims—i.e., that the Worksheet S-10 audit protocol establishes or changes a substantive legal standard within the meaning of § 1395hh(a)(2)—***but has no bearing on whether these claims are barred by the Preclusion Provision***."[45]

The Board finds that the same findings are applicable to the Provider's challenge to their FFY 2014 UCC payments. The Providers here are challenging their uncompensated care DSH Payment amounts, as well as the general rules governing the methodology used in calculating those amounts, for FFY 2014. The challenge to CMS' notice and comment procedures focuses on a lack of information and underlying data used by the Secretary to determine the UCC payments, but *Tampa General* held that the underlying data cannot be reviewed or challenged. Likewise, the Provider's arguments centering on the *Allina* decision claim that certain data should recalculated or revised. Again, a challenge to the underlying data used in calculating UCC DSH payments is not subject to administrative or judicial review. Likewise, any challenge to the methodology used to determine the payment amounts was rejected in *DSCH v. Azar*, finding that the methodology was just as "inextricably intertwined" with the actual estimates as the underlying data, and barred from review.

****

In summary, the Board hereby dismisses the SSI Provider Specific issue from this appeal as it is duplicative of the issue in Case No. 18-1409G, there is no final determination from which the Provider can appeal the SSI realignment portion of the issue, and the Provider failed to meet the Board requirements for position papers.. The Board also dismisses Issue 8, DSH Uncompensated Care, as it is precluded from appeal by statute. As there are issues still pending in the appeal, the case will remain open.

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

<u>Board Members Participating</u>:

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

For the Board:

3/1/2023

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

cc: Wilson Leong, Federal Specialized Services

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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RE: ***Board Decision*** **– SSI Percentage (Provider Specific) and Medicaid Eligible Days**
Yakima Regional Medical and Cardiac Center (Prov. No. 50-0012),
FYE 08/31/2017
Case No. 22-0028

Dear Messrs. Summar and Lamprecht:

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the documentation in Case No. 22-0076 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. 22-0028

On October 12, 2021, Yakima Regional Medical and Cardiac Center, appealed a Notice of Program Reimbursement (NPR) dated May 6, 2021, for its fiscal year dating August 31, 2017 ("FY 2017"). The Provider appealed the following issues:[1]

- Issue 1: Supplemental Security Income (SSI) Percentage (Provider Specific)
- Issue 2: SSI Percentage (Systemic Errors)[2]
- Issue 3: Medicaid Eligible Days
- Issue 4: Medicare Managed Care Part C Days[3]
- Issue 5: DSH – Dual Eligible Days[4]

On May 9, 2022, Issues 2, 4, and 5 were transferred to common issue related party ("CIRP") group cases as the Provider is part of Community Health Systems, Inc. ("CHS") and they are issues common to CHS. After all transfers, two issues remain: Issue 1, DSH SSI Percentage (Provider Specific) and Issue 2, DSH Medicaid Eligible Days.[5]

[1] Provider's Request for Hearing, Tab 3, at Issue Statement (Oct. 12, 2021).
[2] The Provider transferred this issue to Group Case No. 20-0997GC on May 9, 2022.
[3] The Provider transferred this issue to Group Case No. 19-2620GC on May 9, 2022.
[4] The Provider transferred this issue to Group Case No. 20-1383GC on May 9, 2022.
[5] MAC's Jurisdictional Challenge, at 1 (Jul. 19, 2022).

The Medicare Contractor filed a Jurisdictional Challenge on July 19, 2022, regarding 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 and the Provider's Participation in Case No. 20-0997GC

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

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

As the Provider is commonly owned by CHS, the Provider was also directly added to the CIRP group under Case No. 20-0997GC entitled "CHS CY 2017 DSH SSI Percentage CIRP Group." This CIRP group has the following issue statement:

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[6] *Id*.
[7] Provider's Request for Hearing, Issue Statement (Oct. 12, 2021).

> **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.[8]

The amount in controversy listed for the Provider as a participant in Case No. 20-0997GC is $5,254.

On May 25, 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 (December 31).

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

> 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).

The only exhibit included with the preliminary position paper that relates to Issue 1 was Exhibit 1, which was listed as an Eligibility Listing, but noted that it would be sent under separate cover. Exhibit 2 shows the amount in controversy as $5,254. This is the same amount that is listed as the amount in controversy for this Provider as a participant in Case No. 20-0997GC.

<u>MAC's Contentions</u>

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 transferred into Group Case No. 20-0997GC, *CHS CY 2018 DSH SSI Percentage CIRP Group*. The Portion of Issue 1 concerning realignment should be dismissed because there was no final determination over SSI realignment and the Provider's appeal is premature as the Provider has not exhausted all available remedies.[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.

Issue 3 – DSH Medicaid Eligible Days

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,

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[9] *Id*. at 2.

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.

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 (2014), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

A. 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 Group Case No. 20-0997GC, CHS 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 directly filed into 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] The DSH systemic issues filed into

[10] Individual Appeal Request, Issue 1.
[11] *Id.*
[12] *Id.*

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). Indeed, the Provider has the same amount in controversy for both Issue 1 and for its participation in the CIRP group, namely $5,254.

Thus, the Board finds that the first aspect of Issue 1 in this appeal is duplicative of the group issue in Case No. 20-0997GC, for this same provider and fiscal year and that Issue 1 was required to be part of the CIRP group since it is common to all CHS providers. Because the issue is duplicative (and subject to the mandatory CIRP group requirements), and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (Mar. 1, 2013), the Board dismisses this aspect of the DSH/SSI (Provider Specific) issue.

In making this finding, the Board further notes that CMS regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, is pursuing that issue as part of the group under Case 20-0997GC. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[13] Provider is misplaced in referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 20-0997GC.

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 20-0997GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with the Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" in its Preliminary Position Paper and include *all* exhibits.

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

> 25.2.2 Unavailable and Omitted Documents If documents necessary to support your position are still unavailable, then provide the following information in the position papers:

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

> 1. Identify the missing documents;
> 2. Explain why the documents remain unavailable;
> 3. State the efforts made to obtain the documents; and
> 4. Explain when the documents will be available.
>
> Once the documents become available, promptly forward them to the Board and the opposing party. Common examples of unavailable documentation include pending discovery requests, pending requests filed under the federal Freedom of Information Act (also known as FOIA requests), or similar requests for information pending with a state Medicaid agency.

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

> https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH.[14] This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows: "DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[15]

Accordingly, the Board must find that Issues 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 4.5 (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.

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[14] (Last accessed Nov. 21, 2022.)
[15] (Emphasis added.)

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 2 as:

> **Statement of the Issue**
>
> Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.
>
> **Statement of the Legal Basis**
>
> The Provider contends 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.[16]

The amount in controversy calculation and protested item documentation for this issue suggests that the number of Medicaid eligible days at issue. However, 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.

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[16] *Id.*

On May 25, 2022, the Provider filed their preliminary position paper in which it indicated that it would be sending the eligibility listing under separate cover.[17] Indeed, the position paper did not even identify how many Medicaid eligible days remained in dispute in this case (*e.g.*, whether there remained the same number of days as suggested in the appeal request or more or less). Specifically, the Provider's complete briefing of this issue in its position paper is as follows:

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

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[17] Provider's Preliminary Position Paper, at 8 (May 25, 2022).

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 $41,369, 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.[18]

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*.[19]

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[18] *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.

[19] (Emphasis added.)

With regard to the filing of an individual appeal, Board Rule 7 (Support for Appealed Final Determination, Issue-Related Information and Claim of Dissatisfaction) (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,[20] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[21]
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.[22]

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

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

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

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

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

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

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

The Board concurs with the Medicare Contractor that the Provider is required to identify and provide documentation to prove what additional Medicaid Eligible days are at issue and to which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rule 25. Further, pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[23] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. 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, due to QRS' failure to identify any days in dispute in the position paper, the Board must find that there are no days in dispute and that there is no actual amount in controversy 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.[24] The Board takes administrative notice that it has made similar dismissal in other cases in which CHS was the designated representative and, notwithstanding, CHS failed to provide the Medicaid eligible days listing with its preliminary position paper.

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In summary, the Board hereby dismisses the SSI Provider Specific issue from this appeal as it is duplicative of the issue in Case No. 20-0997GC, 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

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

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. 22-0028 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.

<u>Board Members Participating</u>:

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

For the Board:

3/1/2023

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Nathan Summar
Community Health Systems, Inc.
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Byron Lamprecht
WPS Government Health Administrators
2525 N 117th Ave., Suite 200
Omaha, NE 68164

RE: ***Board Decision*** **– SSI Percentage (Provider Specific) and Medicaid Eligible Days**
Tennova Healthcare Shelbyville (Prov. No. 44-0137)
FYE 03/31/2018
Case No. 22-0198

Dear Mr. Summar and Mr. Lamprecht:

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the documentation in Case No. 22-0198 pursuant to a jurisdictional challenge filed by the Medicare Contractor ("MAC"). The Board's decision is set forth below.

Background

A. Procedural History for Case No. 22-0198

On December 2, 2021, Tennova Healthcare Shelbyville, appealed a Notice of Program Reimbursement (NPR) dated June 18, 2021, for its fiscal year dating March 31, 2018 ("FY2018"). The Provider appealed the following issues:[1]

- Issue 1: DSH SSI Percentage (Provider Specific)
- Issue 2: DSH SSI Percentage (Systemic Errors)
- Issue 3: DSH Medicaid Eligible Days

Since the Provider is part of Community Health System, Inc. ("CHS") and the issue is common to CHS, the Provider transferred Issue 2, DSH SSI Percentage (Systemic Errors), to a CHS common issue related party ("CIRP") group. As a result, only two issues remain: Issue 1, DSH SSI Percentage (Provider Specific), and Issue 3, DSH – Medicaid Eligible Days.[2]

On October 13, 2022, the Medicare Contractor filed a Jurisdictional Challenge, regarding ***both*** Issue 1, addressing the DSH SSI Percentage (Provider Specific) issue, and Issue 3, DSH – Medicaid Eligible Days.

[1] Provider's Request for Hearing, Tab 3, at Issue Statement (Dec. 2, 2021).
[2] MAC's Jurisdictional Challenge, at 1 (Oct. 13, 2022).

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 Provider contends that the MAC did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the MAC's calculation of how the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations.
>
> The provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both 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.[3]

As the Provider is commonly owned by Community Health Systems, Inc., the Provider also transferred its SSI Provider Systemic issue (issue 2) to the common issue related party ("CIRP") group under Case No. 21-1206GC entitled "CHS CY 2018 DSH SSI Percentage CIRP Group." This CIRP group has the following issue statement:

> **<u>Statement of the Issue:</u>**
>
> Whether the Secretary properly calculated the Provider's [DSH]/[SSI] percentage, and whether CMS should be required to

[3] Provider's Request for Hearing, Issue Statement (Dec. 2, 2021).

> 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?
>
> **<u>Statement of the Legal Basis</u>**
>
> 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.[4]

The amount in controversy listed for the Provider as a participant in 21-1206GC is $6,765.

On July 6, 2022, the Provider filed its preliminary position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **<u>Calculation of the SSI Percentage</u>**
>
> **Provider Specific**
>
> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation based on the Provider's Fiscal Year End (December 31).
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.
>
> Similar to *Loma Linda Community Hospital v. Dept of Health* and Human Services, No. CVT94- 0055 (C.D. Cal. June 2, 1995), the

[4] Group Issue Statement, Case No. 21-1206GC.

> 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).

The only exhibit included with the preliminary position paper that relates to Issue 1 was Exhibit 1, which was listed as an Eligibility Listing, but noted that it would be sent under separate cover. Exhibit 2 shows the amount in controversy as $6,765. 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 transferred into Group Case No. 21-1206GC, *CHS CY 2018 DSH SSI Percentage CIRP Group*. The Portion of Issue 1 concerning realignment should be dismissed because there was no final determination over SSI realignment and the Provider's appeal is premature as the Provider has not exhausted all available remedies.[5]

Lastly, the MAC argues 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.

Issue 3 – DSH Medicaid Eligible Days

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.

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

[5] *Id*. at 2.

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 (2014), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

A. 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 Group 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."[6] 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)."[7] 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."[8] The DSH systemic issues filed into Case No. 21-1466GC, 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 $6,765.

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[6] Individual Appeal Request, Issue 1.
[7] *Id.*
[8] *Id.*

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 4.5 (Mar. 1, 2013), the Board dismisses this aspect of the DSH/SSI (Provider Specific) issue.

In making this finding, the Board further notes that CMS regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, is pursuing that issue as part of the group under Case 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.[9] Provider is misplaced in referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 21-1206GC.

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

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

> 25.2.2 Unavailable and Omitted Documents If documents necessary to support your position are still unavailable, then provide the following information in the position papers:
>
> 1. Identify the missing documents;
> 2. Explain why the documents remain unavailable;
> 3. State the efforts made to obtain the documents; and
> 4. Explain when the documents will be available.
>
> Once the documents become available, promptly forward them to the Board and the opposing party. Common examples of unavailable documentation include pending discovery requests,

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

> 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.[10] 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."[11]

Accordingly, consistent with Board Rule 44.4.3 and based on the record before it,[12] the Board must find 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

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[10] (Last accessed Nov. 21, 2022.)
[11] (Emphasis added.)
[12] Based on the record before it, the Board must find that Issue 1 duplicates Issue 2 which is the common issue that the Provider was required to transfer to the CHS CIRP group.

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 2 as:

> **Statement of the Issue**
>
> Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.
>
> **Statement of the Legal Basis**
>
> The Provider contends 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.[13]

The amount in controversy calculation and protested item documentation for this issue suggests the number of Medicaid eligible days at issue. However, 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 May 25, 2022, the Provider filed their preliminary position paper in which it indicated that it would be sending the eligibility listing under separate cover.[14] Indeed, the position paper did not even identify how many Medicaid eligible days remained in dispute in this case (*e.g.*, whether there remained the same number of days as suggested in the appeal request or more or less). Specifically, the Provider's complete briefing of this issue in its position paper is as follows:

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[13] *Id.*
[14] Provider's Preliminary Position Paper at 8 (May 25, 2022).

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

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 $23,749, 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.[15]

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*.[16]

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.

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[15] *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.

[16] (Emphasis added.)

Similarly, with regard to position papers,[17] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[18]
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.[19]

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,

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

- 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" [20] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. Indeed, even after the Provider filed its position paper, the Medicare Contractor filed with the Board two separate requests on July 6, 2022 and August 23, 2022 that the Provider submit its DSH days listing. However, the Provider failed to do so resulting the Medicare Contractor filing its Jurisdictional Challenge on October 13, 2022. 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, due to the failure of the Provider to identify any days at issue in its position paper filing, the Board must find that there are no days at issue and that the actual amount in controversy is $0.

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.[21] The Board takes administrative notice that it has made similar dismissal in other cases in which CHS was the designated representative and, notwithstanding, CHS failed to provide the Medicaid eligible days listing with its preliminary position paper.

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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. 22-0198 and removes it from the Board's docket.

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[20] (Emphasis added.)
[21] 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.

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:

3/1/2023

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

cc: Wilson Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Dismissal of Duplicate Appeal***
Southwest Consulting Conemaugh Health Sys. 2012 DSH SSI Fract. Part C Days CIRP
Case No. 14-4363GC

Dear Ms. Webster and Mr. Snyder:

The above-referenced common issue related party ("CIRP") group appeal for Conemaugh Health System ("Conemaugh") includes 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* and *after* October 1, 2013. The Provider Reimbursement Review Board ("PRRB" or "Board") has noted that the common owner of this group, Conemaugh, has *already* been granted EJR for the ***same*** issue under appeal, and for this ***same*** specific year. As such, as set forth below, the Board finds the above CIRP group appeal violates the CIRP regulation, is duplicative, and must be dismissed.

Background

The Board received the Group Representative's Request for Hearing dated September 22, 2014, to establish the above mentioned Conemaugh CIRP group. The CIRP group appeal request contained the following issue statement regarding the appealed Part C Days issue:

> [W]hether the Centers for Medicare & Medicare Services ("CMS") has correctly determined the "Medicare Part A/SSI fraction" used in calculating the Providers' disproportionate patient percentage for purposes of the DSH adjustment.[1]

Memorial Medical Center (Prov. No. 39-0110) is the only Provider included in the instant CIRP group appeal.

However, in reviewing the documentation for jurisdiction, it was noted that the common owner of this group had *already* been granted EJR for the ***same*** Part C days issue for this ***same*** specific

[1] Providers' Group Appeal Request, at Issue Statement (Sept. 22, 2014).

year, in another group case. Specifically, it has come to the Board's attention that the sole participant in the instant CIRP group (Memorial Medical Center) was also a participant in the *optional* group under Case No. 17-2014G entitled "Southwest Consulting 2011-2012 DSH Medicaid Fraction Part C Days Group." Notably, prior to join this *optional* group, the Provider was initially a participant in another Conemaugh CIRP group under Case No. 14-436**5**GC entitled "Southwest Consulting Conemaugh Health System 2012 DSH Medicaid Fraction Part C Days CIRP Group."[2] As Memorial Medical Center was the ***only*** participant in the other CIPR group, it requested to be transferred to an *optional* group under Case No. 17-2014G on August 10, 2017, and Case No. 14-4365GC was closed.

In Case No. 17-2014G, the Board granted the EJR request over whether Part C days should be "counted in the Medicare Part A/SSI fraction and excluded from the Medicaid fraction numerator or vice-versa."[3]

Board's Analysis and Decision

Pursuant to 42 C.F.R. § 405.1837(b)(1), hereinafter called the CIRP regulation:

> Two or more providers under common ownership or control that wish to appeal to the Board a specific matter at issue that involves a question of fact or interpretation of law, regulations, or CMS Rulings that is common to the providers, and that arises in cost reporting periods that end in the same calendar year, and for which the amount in controversy is $50,000 or more in the aggregate, must bring the appeal as a group appeal.[4]

Subsection (e) requires that the group provider provide notice that the group is fully formed and complete.[5] Once the group is certified as complete, restrictions are placed on the ability for additional providers under common ownership:

> 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

[2] Case No. 14-4365GC was the companion case to Case No. 14-4363GC where both CIRP groups related to Part C days but the latter CIRP group related to the Medicare fraction and the other to the Medicaid fraction. However, the Board considers these as one issue because, D.C. Circuit explained in In *Allina Health Servs. v. Sebelius* ("*Allina*"), 746 F.3d 1102, 1108 (D.C. Cir. 2014), "*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)." (Emphasis added.) 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 counted in the other).
[3] EJR Determination (Sept. 26, 2018), PRRB Case No. 17-1981G, et al.
[4] 42 C.F.R. § 405.1837(b)(1).
[5] 42 C.F.R. § 405.1837(e)(1).

> reporting period that falls within the calendar year(s) covered by the group appeal.[6]

Accordingly, once a group is fully formed and then closed as a result of EJR, any additional commonly owned or controlled providers outside of this CIRP group for the same issue and year would be part of a duplicate case, violating those same CIRP regulations.[7] Similarly, Board Rule 4.6 prohibits providers from pursuing the same issue for the same year in multiple cases. As Memorial Medical Center (Prov. No. 39-0110) was appealing the ***same*** issue (Part C Days) and for the ***same*** year that it pursued in Case No. 17-2014G, it is clear that Memorial Medical Center's appeal in Case No. 14-4363GC violates § 405.1837(b)(1) and (e) and must be dismissed.

Furthermore, the Board notes that the EJR request for which the Board granted EJR (as well as the Board's EJR decision itself) clearly encompassed the ***complete*** Part C DSH issue, i.e., both the Medicare and Medicaid fractions, as both groups were included in the EJR decision. Per the 2014 holding of the D.C. Circuit in *Allina Health Servs. v. Sebelius* (746 F.3d 1102, 1108 (D.C. Cir. 2014)) ("*Allina*"),[8] the DSH statute at 42 U.S.C. § 1395ww(d)(5)(F)(vi) "*unambiguously requires*" that Part C days be included in either the SSI fraction or Medicaid fraction.[9] This holding is controlling precedent for the interpretation of 42 U.S.C. § 1395ww(r)(3) because the Providers could bring suit in the D.C. Circuit.[10] Thus, the disposition of the DSH Part C Days – Medicare/SSI Fraction issue dictates the disposition of the DSH Part C Days – Medicaid Fraction issue, as *Allina* indicates Part C days must be counted in one fraction or the other.

As such, the Board dismisses the DSH Part C Days issue from PRRB Case No. 14-4363GC because the issue was disposed of through the EJR of Case No. 17-2014G, and because the single participant in Case No. 14-4363GC violated the CIRP regulations at 42 C.F.R. § 405.1837(b)(1) and (e) as well as Board Rule 4.6 prohibiting duplicate appeals.[11]

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[6] *Id*.

[7] *See* 42 C.F.R. § 405.1837(e) ("[w]hen 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.").

[8] 746 F.3d 1102, 1108 (D.C. Cir. 2014).

[9] Specifically, *Allina* states "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)." 746 F.3d at 1108.

[10] The CMS Administrator generally has applied as controlling precedent the law of the Circuit in which the Provider is located. *See, e.g., QRS CHW DSH Labor room Days Groups v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (Apr. 13, 2009), affirming, PRRB Dec. No. 2009-D11 (Feb. 27, 2009); *St. Vincent Mercy Med. Ctr. v. BlueCross BlueShield Ass'n*, Adm'r Dec. (Nov. 17, 2008), *affirming in part and reversing in part*, PRRB Dec. No. 2008-D35 (Sept. 15, 2008). Similarly, in recognizing that providers may file suit with the appropriate District Court either in the Circuit in which they are located or the D.C. Circuit, the Administrator also applies as controlling precedent the law of the D.C. Circuit. *See, e.g., Jordan Hosp. v. Blue Cross Blue Shield Ass'n.*, Adm'r Dec. (Apr. 30, 2007), *vacating*, PRRB Dec. No. 2007-D23 (Feb. 28, 2007).

[11] *See supra* note 2.

The Board hereby closes the group appeal and removes it from the Board's docket. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

3/2/2023

X Clayton J. Nix

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

cc: Wilson Leong, FSS

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Byron Lamprecht
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RE: ***Jurisdictional Determination***
Via Christi Regional Medical Center, Prov. No. 17-0122, FYE 09/30/2013
Case No. 17-1059

Dear Mr. Ravindran and Mr. Lamprecht:

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

Background

The Board received the Provider's Appeal Request on February 16, 2017, related to a Notice of Program Reimbursement ("NPR") dated August 24, 2016.[1] The initial Individual Appeal Request contained nine (9) issues:

1. Disproportionate Share Hospital ("DSH") Payment/Supplemental Security Income ("SSI") Percentage (Provider Specific)[2]
2. DSH/SSI (Systemic Errors)[3]
3. DSH Payment – SSI Fraction/Medicare Managed Care Part C Days[4]
4. DSH Payment – SSI Fraction/Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)[5]
5. DSH Payment – Medicaid Eligible Days[6]
6. DSH Payment – Medicaid Fraction/Medicare Managed Care Part C Days[7]
7. DSH Payment – Medicaid Fraction/Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)[8]
8. Outlier Payments – Fixed Loss Threshold[9]

[1] Provider's Request for Appeal (Feb. 16, 2017).
[2] Issue withdrawn on Oct. 27, 2022.
[3] Issue transferred to PRRB Case No. 16-1472GC on Oct. 19, 2017.
[4] Issue transferred to PRRB Case No. 16-1473GC on Oct. 19, 2017.
[5] Issue transferred to PRRB Case No. 16-1475GC on Oct. 19, 2017.
[6] Issue withdrawn on Oct. 27, 2022.
[7] Issue transferred to PRRB Case No. 16-1474GC on Oct. 19, 2017.
[8] Issue transferred to PRRB Case No. 16-1488GC on Oct. 19, 2017.
[9] Issue transferred to PRRB Case No. 16-1476GC on Oct. 19, 2017.

9. Health Information Technology ("HIT") Payment Adjustment

After the various transfers and withdrawals, the only issue that remains pending in this appeal is the HIT Payment adjustment issue. The Provider's description of the HIT Payment Adjustment issue is, in part:

> The Provider contends that its' HIT Payment was ***incorrectly computed*** because the MAC due to the disallowance of charity care in its HIT Payment. Provider properly followed the charity care policy and contends the MAC improperly disallowed the charity care and resulted in an understated HIT payment.[10]

The MAC filed a Jurisdictional Challenge on April 17, 2018, to which the Provider filed a response on May 16, 2018.

Medicare Contractor's Jurisdictional Challenge

The MAC argues that the HIT incentive payment computations are not appealable.[11] Section 1886(n) of the Social Security Act, which provides for incentives for adoption and meaningful use of certified EHR technology, bars administrative or judicial review under sections 1869 or 1878.[12] The regulations at 42 CFR § 495.110(b) also precludes administrative and judicial review under sections 1869 or 1878 of the Act, or otherwise, of the methodology and standards for determining the incentive payment amounts made to eligible hospitals, including the estimates or proxies for determining discharges, inpatient-bed-days, hospital charges, charity charges, and Medicare share; and the period used to determine such estimate or proxy.[13]

The MAC goes on to contend:

> Inasmuch as the Provider's claimed charity care is a proxy used in the computations of the provider's EHR/HIT incentive payment, it is clear, the Provider does not have appeal rights before the PRRB, with respect to the MAC's and/or CMS's treatment of charity care charges. The Centers for Medicare & Medicaid Services (CMS) has notified providers (eligible professionals, hospitals, and critical access hospitals) of their limited appeal rights. It is clear, appeal options are not available, with respect to payment adjustments.[14]

[10] Provider's appeal request, Issue 9 Issue Statement (emphasis added).
[11] *Id*. at 16.
[12] *Id*. at 15.
[13] *Id*.
[14] *Id*. at 15-16.

Provider's Jurisdictional Response

With respect to the HIT payment issue, the Provider does not address the substantive legal arguments from the MAC's Jurisdictional Challenge. Rather, the Provider argues that:

> The Board does have jurisdiction over [HIT adjustment issue] based on the US Court of Appeals for the Ninth Circuit decision in Loma Linda University Medical Center v. Leavitt.[15] The Ninth Circuit ruled a [sic] that "a Provider which has filed a cost report and is 'dissatisfied' with the Intermediary's final determination… as to the amount of total program reimbursement may obtain a hearing before the PRRB 'with respect to such a cost report.'"[16]

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 HIT 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).

42 U.S.C. § 1395ww(n) provides for incentives for adoption and meaningful use of certified EHR technology. Section 1395ww(n) states the following:

> **(4)Application.—**
>
> (A)Limitations On Review.— There shall be no administrative or judicial review under section 1869, section 1878, 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

[15] 492 F.3d 1065 (9th Cir. 2007) (citation omitted).
[16] 492 F.3d at 1068 (citation omitted).

> 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).

The regulations at 42 C.F.R. § 495.110(b) also precludes administrative and judicial review under sections 1869 or 1878 of the Act, or otherwise, of the following:

> (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.

As the Provider is alleging that the MAC "incorrectly computed" its HIT Payment "due to the disallowance of charity care," The Board concludes that it does not have jurisdiction over the HIT issue in the above referenced appeal because judicial and administrative review of the *calculation* (including, for example, the estimates or proxies used for determining charity charges) is barred by statute and regulation. The Board hereby dismisses this issue.

As the instant case has no issues remaining, the Board dismisses Case No. 17-1059 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.

<u>Board Members</u>:

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

For the Board:

3/2/2023

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

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

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Via Electronic Delivery

Daniel Hettich
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RE: ***Board Decision***
Memorial Hospital West (Prov. No. 10-0281), *as a participant in*
15-0714GC Memorial Healthcare Sys. 2012 DSH SSI Fraction Part C Days CIRP Grp
15-0716GC Memorial Healthcare Sys. 2012 DSH Medicaid Ratio Part C Days CIRP Grp

Dear Mr. Hettich,

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 provider Memorial Hospital West because the issue was not specifically revised in the Revised Notice of Program Reimbursement ("RNPR"), which is the basis for the appeals. The jurisdictional decision of the Board is set forth below.

Pertinent Facts:

The Common Issue Related Parties ("CIRP") Group appeals were established on December 16, 2014, appealing the DSH Payment / SSI Fraction Part C Days issue for PRRB Case No. 15-0714GC and DSH Payment / Medicaid Ratio Part C Days issue for PRRB Case No. 15-0716GC. Memorial Hospital West was directly added to the appeal on December 16, 2014. The Provider has appealed from both an original NPR dated January 16, 2014 and a revised NPR dated August 8, 2014, and directly added both final determinations to the appeal on the same date.

The audit adjustment report associated with the RNPR indicates adjustments, "To reconcile reported days on S-3 against supported amounts submitted by Provider" and "To ensure that the data for the Disproportionate Share Amount is properly reported."

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.

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]

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

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[1] 42 C.F.R. § 405.1889(b).

> 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]

The Board finds that it does not have jurisdiction over the Memorial Hospital West's appeal of the Part C issue from its RNPR, because the RNPR was issued to solely update Medicaid eligible days, not the issue under appeal in the groups. Thus, pursuant to 42 C.F.R. § 405.1889(b) as referenced in § 405.1835(a)(1), the provider does not have the right to appeal the Part C days as used in SSI fraction because Part C days were not adjusted (indeed not even the SSI fraction was adjusted).

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] In these groups, Memorial Hospital West's RNPR was issue to update Medicaid eligible days and there was no adjustment to Part C days. Accordingly, consistent with 42 C.F.R. § 405.1889(b) (as referenced in 42 C.F.R. § 405.1835(a)), the Board finds that it lacks jurisdiction over the Provider's RNPR appeal of this issue. In making this ruling, the Board notes that its application of 42 C.F.R. § 405.1889(b) has been upheld by courts on review.[4]

Notwithstanding the RNPR dismissal, the Board notes that Memorial Hospital West remains a participant in Case Nos. 15-0714GC and 15-0716GC based on its appeal from its original NPR.

Conclusion

The Board finds that it does not have jurisdiction over Memorial Hospital West's RNPR appeal and dismisses the Provider from Case Nos. 15-0714GC and 15-0716GC. Case Nos. 15-0714GC and 15-0716GC remain open for the other providers in the group appeals. The remaining Providers are subject to CMS Ruling 1739-R, and will be addressed under separate cover.

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[2] (Emphasis added).
[3] 42 C.F.R. § 405.1889(b)(1).
[4] *See St. Mary's of Mich. V. Azar*, No. 18-01790, 2020 WL 4049912 (D.D.C. July 20, 2020); *McLaren Flint v. Azar*, No. 18-2005, 2020 WL 2838566 (D.D.C. May 31, 2020), *Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F.Supp.3d 348 (D.D.C. 2014); *HCA Health Servs. of OK v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994).

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

Board Members Participating:

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

For the Board:

3/3/2023

X Clayton J. Nix

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

cc: Geoff Pike, First Coast Service Options, Inc. (J-N)
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RE: ***Board Decision*** **– SSI Percentage (Provider Specific) and Medicaid Eligible Days**
Detar Healthcare System (Prov. No. 45-0147)
FYE 09/30/2016
Case No. 22-0813

Dear Mr. Summar and Mr. Lamprecht:

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the documentation in Case No. 22-0813 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. 22-0813

On February 17, 2022, Detar Healthcare System, appealed a Notice of Program Reimbursement ("NPR") dated August 30, 2021, for its fiscal year ending September 30, 2016 ("FY 2016"). The Provider appealed the following issues:[1]

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

On September 8, 2022, the Provider transferred issues 2, 4, and 5 to common issue related party ("CIRP") group appeals since the Provider is part of CHS. The only remaining issues are Issue 1 – DSH SSI Percentage (Provider Specific) and Issue 3 – DSH Medicaid Eligible Days

[1] Provider's Request for Hearing, Issue Statement (Feb. 17, 2022).
[2] On September 8, 2022, the Provider transferred this issue to Case No. 19-1409GC.
[3] On September 8, 2022, the Provider transferred this issue to Case No. 18-1785GC
[4] On September 8, 2022, the Provider transferred this issue to Case No. 20-1408GC.

On November 29, 2022, the Medicare Contractor filed a Jurisdictional Challenge regarding ***both*** Issues 1 and 2, addressing the DSH Supplemental Security Income ("SSI") Percentage related issue and the DSH Medicaid Eligible Days issue.[5]

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. 19-1409GC

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

> The Provider contends that the MAC did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the MAC's calculation of how the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations.
>
> The Provider contends that its' SSI percentage published by the Center for Medicare and Medicaid Services ("CMS") was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> The Provider contends that the SSI percentage issued by CMS is flawed.
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[6]

The Provider transferred Issue 2 to the common issue related party ("CIRP") group under Case No. 19-1409GC entitled "CHS CY 2016 DSH SSI Percentage CIRP Group." This CIRP group has the following issue statement:

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[5] MAC Jurisdictional Challenge (Nov. 29, 2022).
[6] Provider's Request for Hearing, Issue Statement (Feb. 17, 2022).

> **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/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)(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]

The amount in controversy listed for the Provider as a participant in 19-1409GC is $52,038.

On October 5, 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 Texas

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

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

The 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 $52,038. This is the same amount that is listed as the amount in controversy for this Provider as a participant in 19-1409GC.

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. 19-1409GC, *CHS CY 2016 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.

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[8] MAC Jurisdictional Challenge (Nov. 29, 2022).

[9] *Id*.

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, which the Provider did not do with respect to the Medicaid eligible days issue.[10]

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. 19-1409GC, *CHS CY 2016 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. 19-1409GC. The first aspect of Issue 1 in the present appeal concerns "whether the Medicare Administrative Contractor used the correct [SSI] percentage in the [DSH]

[10] *Id*.

Calculation."[11] The Provider's legal basis for this aspect of Issue 1 is simply that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[12] Similarly, the Provider argues that "it[s] SSI percentage published by [CMS] was incorrectly computed . . ." and it ". . . [s]pecifically . . . disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[13] The DSH systemic issues filed into Case No. 19-1409GC, similarly alleges that the Medicare Contractor and CMS improperly calculated the DSH/SSI Percentage, the DSH/SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F)(vi). Indeed, the Provider has the same amount in controversy for both Issue 1 and for its participation in the CIRP group, namely $52,038.

Thus, the Board finds that the first aspect of Issue 1 in this appeal is duplicative of the group issue in Case No. 19-1409GC, 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 19-1409GC. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[14] Provider is misplaced in referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) in its appeal request of how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 19-1409GC.

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 19-1409GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with the Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue

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[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 may the errors any less systemic. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). *See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).

and explain the nature of the any alleged "errors" in its Preliminary Position Paper and include *all* exhibits.

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

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

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

> https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH.[15] This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows: "DSH is now a self-service application. This

[15] (Last accessed Nov. 21, 2022.)

> ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[16]

Similarly, in the position paper, the Provider claims that it "has worked with the State of Texas and has learned that similar to *Loma Linda Community Hospital v. Dept of Health and Humance Services*, No. CV-94-0055 (D.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records." However, the Provider does not explain how those state records establish SSI entitlement, include in the record any of those records, or explain the significant of such a fact (if true) and how that relates to their claim in this appeal. This is alleged fact that has no foundation and no explanation of how it relates to this appeal (and is not common to the other CHS providers such that it should be part of a CHS CIRP group).

Accordingly, the Board must find that Issues 1 and the group issue in Group Case 19-1409GC, are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (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.

[16] (Emphasis added.)

> **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 October 5, 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

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[17] *Id.*
[18] Provider's Preliminary Position Paper (Oct. 5, 2022).

> *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.

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 $52,982, 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] Indeed, on January 12, 2023, the MAC filed another request for the Medicaid eligible days listing from CHS; however, CHS has again failed to respond.

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

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. *Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board through a schedule applicable to a specific case or through general instructions*.[20]

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

> If the provider, through no fault of its own, does not have access to the underlying information to determine whether the adjustment is correct, describe why the underlying information is unavailable.

Similarly, with regard to position papers,[21] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[22] This requirement is consistent with 42 C.F.R. § 405.1853(b)(3).

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:

[19] *See also* Board's jurisdictional decision in *Lakeland Regional Health* (Case No. 13-2953, 11/20/2019), in which the Board found a Provider essentially abandoned its appeal by filing a position paper that failed to set forth the merits of its claim, explain why the agency's calculation was wrong, and identifying missing documents to support its claim and to explain why those documents remained unavailable.
[20] (Emphasis added.)
[21] The minimum requirements for Final Position Paper narratives and exhibits is the same as those for Preliminary Position Papers. *See* Board Rule 27.2.
[22] (Emphasis added.)

> 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]

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

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

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, it is clear that since CHS failed to include a listing as part of its position paper to identify the days in dispute, the Board must assume that there are no days in disputed and that the actual amount in controversy is $0.

The Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(iii) and Board Rules 25.2.1 and 25.2.2 related to identifying the days in dispute and the submission of documentary evidence required to support its claims or describe why said evidence is unavailable, which the Provider has failed to do.[25]

****

In summary, the Board hereby dismisses the SSI Provider Specific issue from this appeal as it is duplicative of the issue in Case No. 19-1409GC, 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. 22-0813 and removes it from the Board's docket.

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

Board Members Participating:

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

For the Board:

3/6/2023

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.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Expedited Judicial Review Determination***
Kettering Health Network CY 2018 Capital DSH CIRP Group
Case No. 22-1274GC

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 common issue related party ("CIRP") group appeal.[1] The decision with respect to EJR is set forth below.

Issue

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]

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[1] The consolidated EJR request also included Case Nos. 23-0164GC, 22-1089G, 22-1321G and 22-1106G; the EJR determination for those cases was issued under separate cover under lead Case No. 23-0164GC. Relevant to this determination, Kettering Health Network 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 this case. As Kettering Health Network 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]

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[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

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

> 80 percent. Urban hospitals with 100 or more beds that receive 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]

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

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

> *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]

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[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.

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

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

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

> Congress clearly intended hospitals that become rural under section 1886(d)(8)(E) of the Act to receive some benefit as a result. For example, some hospitals currently located in very large urban counties are in fact fairly small, isolated hospitals. Some of these hospitals will now be able to be designated a rural hospital and become eligible to be designated a critical access hospital.
>
> ****
>
> 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

[27] 65 Fed. Reg. 47054, 47087-89 (Aug. 1, 2000).

> Health and Human Services, Health Resources and Services 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]

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

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.

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.

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[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).

(ii) The term *urban area* means—

(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]

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 <u>if either of the following conditions is met</u>:
>
> (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) <u>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</u>.[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

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[34] *Id.* at 49242. *See also id.* at 49103 (discussing implementation of MMA § 401).
[35] (Emphasis added.)
[36] 42 C.F.R. § 412.320 (2004) (underline emphasis added). *See also* 69 Fed. Reg. at 49250.

> 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.
>
> ****
>
> 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

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

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]

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]

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[39] 71 Fed. Reg. 23995, 24122 (Apr. 25, 2006).
[40] *Id.*
[41] *Id.*

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]

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

[42] *Id.*
[43] (Bold emphasis added.)
[44] 2021 WL 4502052 (D.D.C. 2021).

> 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 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:

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[45] *Id.* at *8 (citations omitted).
[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.

- "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 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]

<u>Providers' Request for EJR</u>

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

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

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 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.

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[61] *Id.* at 7.
[62] *Id.*
[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.

A. Jurisdiction

In the November 13, 2015 Final Outpatient Prospective Payment Rule,[69] the Secretary finalized new cost reporting regulations related to the substantive reimbursement requirement of an appropriate cost report claim.[70] 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 the Providers in this case have fiscal years that began after January 1, 2016 (involving fiscal years ending in 2018), the claim-specific dissatisfaction requirement is not applicable.

Based on its review of the record, the Board finds that the Providers filed their appeals within 180 days of the issuance of their respective final determinations as required by 42 C.F.R. § 405.1835. 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).

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—

[69] 80 Fed. Reg. 70298, 70551-70580 (Nov. 13, 2015).
[70] *Id.* at 70555.

> (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.[71]

These regulations are applicable to the cost reporting period for the two Providers in this group case, which both have fiscal year ends ("FYEs") of December 31, 2018. 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*

[71] (Bold emphasis added.)

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"[72] 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.[73] On January 30, 2023, the Medicare Contractor filed a Substantive Claim Challenge for the two Providers in this case, and asserted that an appropriate claim was not made by the Providers. In their response, the Providers acknowledged that they did not protest the specific items under appeal.[74]

Since a party to the appeal has questioned, pursuant to § 405.1873(a), whether an appropriate claim was made,[75] the Board finds that there is a regulatory obligation for the Board to affirmatively, on its own, review the appeal documents to determine whether an appropriate claim was made by the two Providers in this appeal. However, the Providers have conceded that they did not comply with § 413.24(j). Therefore, pursuant to 42 C.F.R. § 405.1873(d)(2), the Board finds in its specific findings of facts and conclusions of law that the two Providers failed to make a substantive claim pursuant to 42 C.F.R. § 413.24(j)(1)-(2), and notes that this is undisputed as the Providers/Group Representative have acknowledged this fact.

C. EJR Request on the Validity of 42 C.F.R. §§ 413.24(j) and 405.1873

While the two Providers admit that they did not protest the capital DSH issue on their cost reports, the Providers assert that the self-disallowance regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 are invalid insofar as these regulations would limit the Board's authority to order payment to providers that have not claimed a particular cost on their cost report as an allowable cost or as a protested amount. The Group Representative requested a second EJR in this particular case over the validity of 42 C.F.R. §§ 413.24(j) and 405.1873 (in addition to the capital DSH issue discussed above).[76]

In the EJR request, the Providers argue that the regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 contravene the Board's authority set forth in 42 U.S.C. § 1395oo. They note that nowhere in the statute is there a requirement that a provider must include a claim for a specific cost on its cost report before payment related to that cost can be addressed by the Board. The Providers recount how the 2008 self-disallowance regulation was held to conflict with the plain

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[72] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."
[73] *See* 42 C.F.R. § 405.1873(a).
[74] Provider's Response to the Substantive Claim Challenge and Second EJR Request at 2 (February 26, 2023) ("Provider's Response and EJR Request").
[75] 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."
[76] Provider's Response and EJR Request.

text of 42 U.S.C. § 1395oo in *Banner Heart Hosp. v. Burwell*, 201 F. Supp. 3d 131, 140 (2016). They argue that the 2016 self-disallowance regulation at 42 C.F.R. § 413.24(j) suffers from the same defects that led the *Banner* court to invalidate the 2008 self-disallowance regulation.[77]

With regard to the Board's jurisdiction, the Providers point to 42 U.S.C. § 1395oo(f)(1), which allows a provider to obtain judicial review "of any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines (on its own motion or at the request of a provider of services . . .) that it is without authority to decide the question." The Providers note that while the validity of these regulatory provisions was not at issue when the Providers filed their appeal, the Medicare Contractor raised this issue in its Substantive Claim Letter, and the Board's rules entitle the Providers to respond, including in the context of an EJR filing, citing Board Rule 44.5.2. Further, the Providers argue that because the Medicare Contractor argues that the substantive claim regulatory provisions prevent the two Providers from receiving additional reimbursement for the capital DSH payment, the validity of these substantive claim regulatory provisions stems from the Providers' appeal of the capital DSH regulation and is integral to the resolution of the capital DSH issue.[78]

Per 42 C.F.R. § 405.1842(a)(1), "a provider [has] the right to seek EJR of a legal question relevant to a specific matter at issue in a Board appeal if there is Board jurisdiction to conduct a hearing on the matter." Here, the Providers' challenge to the validity of 42 C.F.R. §§ 413.24(j) and 405.1873 is relevant to the matter at issue in this group appeal. Since there is no factual dispute regarding the Providers' lack of compliance with 42 C.F.R. § 413.24(j), the Board is able to reach consideration of the Providers' challenge to the validity of 42 C.F.R. §§ 413.24(j) and 405.1873. Further, since 42 C.F.R. § 405.1867 requires that the Board comply with the requirements of the statute and regulations, the Board lacks the authority to eliminate the regulatory provisions that create the self-disallowance requirements in §§ 413.24(j) and 405.1873, which is the remedy the Providers are seeking. Consequently, EJR is appropriate on this issue and the Board grants the Providers' EJR request on this challenge.[79]

D. Board's Decision Regarding the EJR Requests

The Board finds that:

1) It has jurisdiction over both the capital DSH issue and the challenge to the validity of 42 C.F.R. §§ 413.24(j) and 405.1873 for the subject year and that the Providers in this group appeal are entitled to a hearing before the Board;

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[77] *Id.* at 3-8.
[78] *Id.* at 9-11
[79] Compliance with 42 C.F.R. § 413.24(j) is substantive in nature (*i.e.*, directly impacts potential reimbursement), but does not affect the issue that is the subject of the appeal. Similar to jurisdictional review, a provider's compliance with § 413.24(j) relates to the nature of the provider's participation in the group (as set forth in 42 C.F.R. § 405.1873) and is only triggered when, pursuant to § 405.1873(a) as a procedural matter in the proceedings before the Board, a party raises their hand and questions the provider's compliance with § 413.24(j). As a result, the Board finds that potential bifurcation of the § 413.24(j) compliance issue has not been triggered under § 405.1837(f). This situation is akin to the Board denying jurisdiction over one participant in a group but granting EJR relative to the rest of the group.

2) The Providers' appealed cost reports with cost reporting periods beginning after January 1, 2016, and it is undisputed that they failed to include "an appropriate claim for the specific item" that is the subject of the appeal, as required under 42 C.F.R. § 413.24(j);

3) Based upon the Providers' assertions regarding 42 C.F.R. § 412.320(a)(1)(iii), as well as the assertions regarding the validity of 42 C.F.R. §§ 413.24(j) and 405.1873, 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 questions 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 ***and*** whether the regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 are 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 capital DSH issue and the subject year. The Board also finds that the question of the validity of the substantive claim regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for EJR for this issue and the subject year.

The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. As there are no issues remaining in this group appeal, the Board hereby closes it and removes it from the Board's docket.

Board Members Participating:

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

FOR THE BOARD:

3/6/2023

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

Enclosure: Schedule of Providers

cc: Judith Cummings, CGS Administrators (J-15)
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Revised* Expedited Judicial Review Determination**
Bryan Medical Center (Prov. No. 28-0003, FYE 5/31/2010), *as a participant in*
Case No. 16-1174G – Hall Render 2010 Medicare Advantage Days Group III

Dear Ms. Griffin:

The Provider Reimbursement Review Board ("Board") has reopened this optional group appeal pursuant to the Administrator's order dated September 12, 2019. The Administrator ordered the Board's November 14, 2017 jurisdictional decision regarding Bryan Medical Center be dismissed, and also ordered the Board to take action consistent with the District Court order dated August 22, 2019 in this appeal. The Board's revised expedited judicial review ("EJR") determination pertaining to Bryan Medical Center ("Bryan" or "Provider") is set forth below and is hereby incorporated into the November 14, 2017 EJR decision that the Board issued for Case No. 16-1174G.

Administrator's Remand

Bryan previously appealed an original Notice of Program reimbursement dated March 26, 2013 addressing Fiscal Year End ("FYE") May 31, 2010 before the Board. Bryan challenged the treatment of Medicare Part C Days in its Disproportionate Share Hospital ("DSH") payment calculation.

On October 24, 2017, the Providers in this *optional* group appeal requested EJR to seek relief pursuant to *Allina Health Svcs. v. Price,* 863 F. 3d 937 (D.C. Cir. 2017) ("*Allina II"*). The Board issued an EJR Determination on November 14, 2017 which dismissed two Providers from the appeal due to lack of jurisdiction, and granted EJR for the remaining Providers. Bryan was one of the Providers dismissed by the Board. The Board found it lacked jurisdiction over Bryan's Medicare Part C Days challenge as Bryan failed to protest this cost item on its cost report as required by 42 C.F.R § 405.1835(a)(1)(ii).

Subsequently, Bryan filed Civil Action No. 1:18-cv-00078-JDB in the U.S. District Court for the District of Columbia. The U.S. District Court granted the parties Joint Motion for Remand and ordered that Bryan's administrative appeal of its Medicare DSH adjustment for FYE December 31,

2010[1] be remanded to the Secretary. The U.S. District Court ordered the Secretary to vacate the Board's November 14, 2017 jurisdictional decision as it relates to Bryan, and also ordered that *the Board be directed to consider and decide the merits of Bryan Medical Center's claim* ***by issuing an Expedited Judicial Review decision or a hearing decision***.

Pursuant to the U.S. District Court Order, on August 22, 2019, the Acting Principal Deputy Administrator of the Centers for Medicare & Medicaid Services (CMS) ORDERED:

- THAT the Provider Reimbursement Review Board (PRRB) jurisdictional decision in the case of Bryan Medical Center, PRRB Case No. 16-1174G, is hereby dismissed; and
- THAT the PRRB shall take actions *consistent with the Court Order* in this case, and
- THAT the decision of the Board is subject to the provisions of 42 C.F.R. § 405.1875.

Pursuant to the Administrator's Order, the Board has reopened Case No. 16-1174G to revise the EJR decision issued on November 14, 2017 solely as it relates to Bryan (Provider No. 28-0001, FYE May 31, 2010).[2]

Expedited Judicial Review Issue

The issue for which EJR has been requested is:

> The improper inclusion by the [Medicare Contractor] and the Centers for Medicare & Medicaid Services (CMS) of inpatient days attributable to Medicare Advantage patients in the numerator and [denominator] of the Medicare Proxy when calculating the disproportionate share hospital (DSH) eligibility and payments.[3]

Statutory and Regulatory Background: Medicare DSH Payment

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the

[1] The Board notes that there is no evidence in the record of PRRB Case No. 16-1174G of Bryan Medical Center having a Fiscal Year End of December 31, 2010. All documentation in this case, including Bryan Medical Center's appeal request and its cost report indicate a Fiscal Year End of May 31, 2010.
[2] Based on the specific direction given in the U.S. District Court's remand order to either issue an EJR decision or a hearing decision and the fact that this remand order occurred prior to CMS Ruling 1739-R (issued on August 17, 2020), the Board concludes that CMS Ruling 1739-R is outside the parameters of the District Court's remand order. Rather, the Board finds that the remand order directs the Board to reopen its EJR decision and issue a revised EJR decision for the optional group given that Bryan Medical Center is part of the optional group and the remand is occurring for the optional group.
[3] October 23, 2017 EJR Request at 2.

prospective payment system ("PPS").[4] Under PPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[5]

The PPS statute contains a number of provisions that adjust reimbursement based on hospital-specific factors.[6] These cases involve the hospital-specific DSH adjustment, which requires the Secretary to provide increased PPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[7]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[8] 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.[9] The DPP is defined as the sum of two fractions expressed as percentages.[10] Those two fractions are referred to as the "Medicare/SSI" fraction and the "Medicaid" fraction. Both of these fractions consider whether a patient was "entitled to benefits under part A."

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

> [T]he fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter . . . .[11]

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[12]

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

> [T]he fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical

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[4] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[5] *Id.*
[6] *See* 42 U.S.C. § 1395ww(d)(5).
[7] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[8] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[9] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[10] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[11] Emphasis added.
[12] 42 C.F.R. § 412.106(b)(2)-(3).

> assistance under a State plan approved under subchapter XIX [the Medicaid program], but who were *not entitled to benefits under part A of this subchapter,* and the denominator of which is the total number of the hospital's patient days for such period.[13]

The Medicare contractor determines the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period.[14]

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 ("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[15] 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].[16]

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[17]

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[13] Emphasis added.
[14] 42 C.F.R. § 412.106(b)(4).
[15] of Health and Human Services.
[16] 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).
[17] *Id.*

With the creation of Medicare Part C in 1997,[18] 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.[19]

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:

> . . . 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 . . . .*[20]

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."[21] 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*

[18] 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.
[19] 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).
[20] 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).
[21] 69 Fed. Reg. at 49099.

> *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.*[22]

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.[23] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change adopted in the FFY 2005 IPPS final rule. These "technical corrections" are reflected at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).[24] 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."[25]

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[26] 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.[27] However, the Secretary has not acquiesced to that decision.

More recently, in *Allina Health Services v. Price* ("*Allina II*"),[28] 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*.[29] 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.[30] Once again, the Secretary has not acquiesced to this decision.

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[22] *Id.* (emphasis added).
[23] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[24] *Id*. at 47411.
[25] 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).
[26] 746 F. 3d 1102 (D.C. Cir. 2014).
[27] *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.").
[28] 863 F.3d 937 (D.C. Cir. 2017).
[29] *Id.* at 943.
[30] *Id.* at 943-945.

Bryan Medical Center's Request for EJR

Bryan Medical Center asserts that that the Medicare fraction of the DSH calculation is improperly understated due to the Secretary's erroneous inclusion of inpatient days attributable to Medicare Advantage patients in both the numerator and the denominator of the of the Medicare fraction. The failure to include such days in the Medicaid fraction also understated that fraction. The Provider points out that the authority upon which CMS relied to collect Medicare Advantage days information is the DSH regulation at 42 C.F.R. § 412.106, which includes Medicare Advantage days in the description of the days included in the Medicare fraction. However, the enabling statute for this regulation, 42 U.S.C. §1395ww(d)(5)(f), makes no mention of the inclusion of Medicaid Advantage days in the Medicare fraction, only traditional Part A days. The Provider contends that Medicare Advantage beneficiaries are not entitled to benefits under Part A, but instead are entitled to benefits under Part C. As a result, the Provider is challenging the validity of the regulation to the extent that 42 C.F.R. § 412.106 contradicts the enabling statute at 42 U.S.C. § 1395ww(d)(5)(f).[31]

In challenging the validity of the regulation, the Provider asserts that the regulation was adopted in violation of the Administrative Procedures Act (APA). It contends that the Secretary violated the APA when she deprived the public the opportunity to comment on the regulation. This position was upheld in the decisions in both *Allina I* and *Allina II.*[32]

The Provider argues that any Medicare Advantage days that are also dual eligible days cannot be counted in the Medicare ratio for the same reasons as set forth above. Primarily, it believes, the regulation requiring inclusion of dual eligible days in the Medicare ratio is invalid and the days must be counted in numerator of the Medicaid fraction. This allegedly improper treatment resulted in the under payment to Providers as DSH eligible providers of services to indigent patients, and includes any other related adverse impact to DHS payments, such as capital DSH payments.[33]

With respect to EJR, the Provider believes that the Board has jurisdiction over the matter at issue and lacks the legal authority to decide the legal question presented. The Provider posits that the Board is not able to address the legal question of whether CMS correctly followed the statutory mandates for rulemaking set forth in the APA and the statute and is bound by Secretary's actions. The Provider does not believe that the Board has the authority to implement the effect of *Allina I* and *Allina II* decisions until the Secretary instructions it to do so.[34]

Decision of the Board

Pursuant to 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R.§ 405.1842(f)(1) (2017), 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

[31] *Id.* at 2.
[32] *Id.*
[33] *Id.*
[34] *Id.* at 7

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.

Jurisdictional Requirements

Bryan Medical Center has appealed a FYE prior to December 31, 2016.

1. Statutory and Regulatory Background

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending on or after December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming it as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen* ("*Bethesda*").[35] In that case, the Supreme Court concluded that a cost report submitted in full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.[36]

On August 21, 2008, new regulations governing the Board became effective.[37] Among these new regulations was 42 C.F.R. § 405.1835(a)(1)(ii) which added the requirement for cost report periods ending on or after December 31, 2008 that providers who were self-disallowing specific items to do so by following the procedures for filing a cost report under protest.

This new regulatory requirement was litigated in *Banner Heart Hospital v. Burwell* ("*Banner*").[38] In *Banner*, the provider filed its cost report in accordance with the applicable outlier regulations and did not protest the additional outlier payment it was seeking. The provider's request for EJR was denied because the Board found that it lacked jurisdiction over the issue. The District Court concluded that, under *Bethesda,* the 2008 self-disallowance regulation could not be applied to appeals raising a legal challenge to a regulation or other policy that the Medicare Contractor could not address.[39]

The Secretary did not appeal the decision in *Banner* and decided to largely apply the holding to certain similar administrative appeals. Effective April 23, 2018, the CMS Administrator implemented CMS Ruling CMS-1727-R which addresses dissatisfaction with Medicare Contractor determinations for cost report periods which end on or after December 31, 2008 but began before January 1, 2016, Under this Ruling, where the Board determines that the specific

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[35] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).
[36] *Bethesda*, 108 S. Ct. at 1258-59.
[37] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[38] 201 F. Supp. 3d 131 (D.D.C. 2016).
[39] *Id.* at 142.

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) are no longer applicable. However, a provider could elect to self-disallow a specific item deemed non-allowable by filing the matter under protest.

The Board determines that the DSH Part C Days issue in the instant appeal is governed by CMS Ruling CMS-1727-R since the Providers are challenging the DSH regulation at 42 C.F.R. § 412.106, and Board review of the issue is not otherwise precluded by statute or regulation. In addition, the Providers' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal[40] and the appeal was timely filed. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in this case. Accordingly, the Board finds that it has jurisdiction over Bryan's appeal of the Part C Days issue for FYE May 31, 2010 and that Bryan is properly part of Case No. 16-1174G.

Board's Analysis Regarding the Appealed Issue

Bryan is a participant in Case No. 16-1174G and the group's EJR request involves calendar year 2010. As a result, the cost reporting periods at issue for the group (including Bryan's FY 2010 cost report that is at issue) falls squarely within the time frame that covers the Secretary's final rule being challenged.[41] In addition, the Board recognizes that the D.C. Circuit vacated the regulation in *Allina* for the time period at issue in this request. However, the Secretary has not formally acquiesced to that vacatur and, in this regard, has not published any guidance on how the vacatur is being implemented (*e.g.*, only circuit-wide versus nationwide). *See generally Grant Med. Ctr. v. Burwell,* 204 F. Supp. 3d 68, 77-82 (D.D.D. 2016), *appeal filed*, No. 16-5314 (D.C. Cir., Oct 31, 2016). Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit or the circuit within which they are located. *See 42 U.S.C. § 1395oo(f)(1). In addition, within its July 25, 2017 decision in Allina Health Services v. Price*, the D.C. Circuit Court agreed with the Board's determination to grant EJR for the identical issue involved in the instant EJR request.[42]

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[40] *See* 42 C.F.R. § 405.1835(a)(2).
[41] As stated in the FY 2014 IPPS Final Rule, the Secretary "proposed to readopt the policy of counting the days of patients enrolled in MA plans in the Medicare fraction of the DPP[,]" thus "sought public comments from interested parties . . ." following publication of the FY 2014 IPPS Proposed Rule, 78 Fed. Reg. 27578 (May 10, 2013). Ultimately, the Secretary finalized this DSH policy for FFY 2014 and subsequent years on August 19, 2013, in the FY 2014 IPPS Final Rule. *Se*e 78 Fed. Reg. 50496, 50615 (Aug. 19, 2013). The Provider appeals in the instant EJR request are all based upon FY 2013 cost reporting periods and earlier.
[42] *See* 863 Fed. 3d 937 (D.C. Cir. 2017).

Board's Decision Regarding the EJR Request

The Board finds that:

1) It has jurisdiction over the matter for the subject years and that the participant, Bryan Medical Center (FYE May 31, 2010[43]) in Case No. 16-1174G is entitled to a hearing before the Board as part of this optional group;

2) Based upon Bryan Medical Center's assertions regarding 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B), there are no findings of fact for resolution by the Board;

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

4) It is without the authority to decide the legal question of whether 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (2011) codifying the Medicare Part C DSH policy adopted in the FFY 2005 IPPS final rule are valid; and

5) These findings are hereby incorporated into its EJR determination issued on September 14, 2017 consistent with the remand order of the District Court.[44]

Accordingly, the Board finds that the question of the validity of 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (2011) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants Bryan Medical Center's request for EJR for the issue and the subject years. Bryan has 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue and Provider which was subject to the Administrator's and District Courts orders, the Board hereby closes this case.

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

For the Board:

3/6/2023

X Clayton J. Nix

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

cc: Pamela VanArsdale, National Government Services, Inc. (J-6)
Wilson Leong, FSS

[43] *See supra* note 1.
[44] In order to issue an EJR determination, the Board had to do that as part of the optional group since Bryan is a participant in the optional group. Moreover, the Board finds that CMS Ruling 1739-R falls outside the scope of the remand since the Board has been directed to either issue an EJR determination or a decision on the merits of which only an EJR determination is appropriate given that, per 42 C.F.R. § 405.1868, the Board is bound by Medicare regulations (including but not limited to 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (2011)). Moreover, to take action on the merits for Bryan in a manner different from the other participants in the group would have been contrary to the regulations governing groups, 42 C.F.R. § 405.1837.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROVIDER REIMBURSEMENT REVIEW BOARD

Group Name:
HALL RENDER 2010 *
MEDICARE ADVANTAGE DAYS GROUP III
*
Provider: Bryan Medical Center
*
Provider No.: 28-0001
*
v. PRRB Case No. 16-1174G
*
Medicare Contractor:
*
NATIONAL GOVERNMENT SERVICES, INC./
FEDERAL SPECIALIZED SERVICES *

* * * * * * * * * * * * *

NOTICE OF REOPENING PURSUANT TO THE PRINCIPAL DEPUTY ADMINISTRATOR'S ORDER FOR REMAND

AND

PROVIDER REIMBURSMENT REVIEW BOARD ORDER

I
REOPENING

Bryan Medical Center ("Provider") previously appealed an original Notice of Program reimbursement dated March 26, 2013 addressing Fiscal Year End ("FYE") May 31, 2010 before the Provider Reimbursement Review Board ("Board"). The Provider challenged the treatment of Medicare Part C Days in its Disproportionate Share Hospital ("DSH") payment calculation.

On October 24, 2017, the Providers in this optional group appeal requested Expedited Judicial Review to seek relief pursuant to *Allina Health Svcs. v. Price,* 863 F. 3d 937 (D.C. Cir. 2017) ("*Allina II*"). The Board issued an EJR Determination on November 14, 2017 which dismissed two Providers from the appeal due to lack of jurisdiction, and granted EJR for the remaining Providers. Bryan Medical Center was one of the Providers dismissed by the Board. The Board found it lacked jurisdiction over Bryan Medical Center's Medicare Part C Days challenge as the Provider failed to protest this cost item on its cost report as required by 42 C.F.R § 405.1835(a)(1)(ii).

Subsequently, Bryan Medical Center filed Civil Action No. 1:18-cv-00078-JDB in the U.S. District Court for the District of Columbia. The U.S. District Court granted the parties Joint Motion for Remand and ordered that Bryan Medical Center's administrative appeal of its Medicare DSH adjustment for FYE December 31, 2010[1] be remanded to the Secretary. The U.S. District Court ordered the Secretary to vacate the Board's November 14, 2017 jurisdictional decision as it relates to Bryan Medical Center, and also ordered that the Board be directed to consider ***and*** *decide the merits of Bryan Medical Center's claim by* ***issuing an Expedited Judicial Review decision <u>or</u>*** *a hearing decision*.

Pursuant to the U.S. District Court Order, on August 22, 2019, the Acting Principal Deputy Administrator of the Centers for Medicare & Medicaid Services (CMS) ORDERED:

- THAT the Provider Reimbursement Review Board (PRRB) jurisdictional decision in the case of Bryan Medical Center, PRRB Case No. 16-1174G, is hereby dismissed; and

- THAT the PRRB shall take actions *consistent with the Court Order* in this case, and

- THAT the decision of the Board is subject to the provisions of 42 C.F.R. § 405.1875.

Pursuant to the Administrator's Order, the Board has reopened the optional group under Case No. 16-1174G to *revise* the EJR decision issued on November 14, 2017 solely as it relates to the participant, Bryan Medical Center (Prov. No. 28-0001), FYE May 31, 2010.[2]

II
BOARD ORDER

The Board hereby ORDERS that a Revised Expedited Judicial Review decision addressing the participant, Bryan Medical Center, in the optional group under Case No. 16-1174G will be issued to the parties.

SO ORDERED by the Provider Reimbursement Review Board

3/6/2023

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

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[1] The Board notes that there is no evidence in the record of Case No. 16-1174G of Bryan Medical Center having a fiscal year ending ("FYE") December 31, 2010. All documentation in this case, including Bryan Medical Center's appeal request and its cost report indicate an FYE May 31, 2010. As a result, the reference to FYE December 31, 2010 appears to be an error or typo.

[2] The Board's November 14, 2017 EJR decision contained the jurisdictional decision on Bryan Medical Center and the Court has directed the Board to issue an EJR determination. Because the Provider is part of the optional group, the Board must modify the EJR determination of the optional group as it relates to Bryan.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Stephen Price, Sr., Esq.
Wyatt, Tarrant & Combs, LLP
500 West Jefferson St., Ste. 2800
Louisville, KY 40202-2898

RE: ***EJR Determination***
Appalachian Reg'l Healthcare (ARH) 2007 DSH SSI Ratio Dual Elig. Days CIRP Grp
Case No. 13-1910GC

Dear Mr. Price:

The Provider Reimbursement Review Board ("Board") has reviewed Providers' January 6, 2023 request for expedited judicial review ("EJR") in the above-referenced Common Issue Related Party ("CIRP") group appeal. The decision of the Board is set forth below.

Issues in Dispute

The Board received the Providers' Group Appeal Request on May 1, 2013. The group was formed with four (4) providers, but one (1) was withdrawn on December 14, 2022. Each Provider filed its appeal from a revised Notice of Program Reimbursement ("NPR"), and the Board issued a decision on September 21, 2015 finding that it had jurisdiction over each Provider.

The Providers' Statement of the Group Issue describes the issue as follows:

> **ISSUE:** Whether the Fiscal Intermediary's calculation of the Provider's disproportionate patient percent, used for purposes of calculating the Medicare Disproportionate Share ("DSH") Adjustment, was incorrect due to CMS' improper treatment of the Medicare Non-Covered Days, which includes but is not limited to Dual Eligible, Medicare Exhausted and Medicare Secondary Payor days. The improper treatment of these days affects the numerator of the Medicaid fraction and the numerator and the denominator of the Medicare fraction.
>
> ****
>
> According to the interpretation of 42 C.F.R. § 412.106(b), the regulation currently interprets the statutory language "entitled to benefits under [Medicare] Part A" as requiring the inclusion of

> patient days for all Medicare beneficiaries, even if a beneficiary has exhausted his or her Medicare coverage. This interpretation requires the exclusion from the Medicaid fraction of patient days for those individuals who are "eligible" for both Medicare and Medicaid, but who have exhausted their Medicare benefits. Per the ruling from *Metro. Hosp., Inc. v. US. Dep 't of Health & Human Servs*.,702 F. Supp. 2d 808, 825-26 (W.D. Mich. 2010), the district court determined that the interpretation at section 412.106(b) was invalid as contrary to the plain meaning of the DPP statute, reasoning that "entitled" requires payment for hospital services, rather than mere eligibility. Thus, dual-eligible patients with exhausted Medicare benefits would be included in the numerator of the Medicaid fraction.
>
> ****
>
> If Medicare interprets "entitled" to Medicare as "eligible" for Medicare, and thus their basis for including these days in the Medicare fraction, then they also must interpret "entitled" to SSI as "eligible" for SSI and allow Dual Eligible days that are "eligible" for SSI, which includes days where the patient may only be receiving their SSI medical benefit/Medicaid, to be included in the Medicare numerator.[1]

The Board, on its own motion, bifurcated this case on May 7, 2013 – the instant case covering the SSI Ratio/Medicare Fraction, and case 13-1911GC (which is already closed) covering the Medicaid Fraction. As such, the only aspect of the dual eligible days issue is the treatment of dual eligible days as they relate to the numerator and the denominator of the Medicare fraction.

With the Group Appeal Request, each provider submitted an estimated amount in controversy calculation which illustrates the argument that the definition of "entitled to SSI benefits" as used in the numerator of the SSI fraction should be expanded to include days where a patient is eligible for SSI benefits. For each provider, the amount in controversy was estimated to be:

1. Harlan ARH Hospital (Prov. No. 18-0050): $635,977, based on the addition of 777 dual eligible days to the SSI Ratio;
2. Williamson ARH Hospital (Prov. No. 18-0069): $1,149,002, based on the addition of 1,864 dual eligible days to the SSI Ratio; and
3. Hazard ARH Hospital (Prov. No. 18-0029): $1,795,942, based on the addition of 2,251 dual eligible days in the SSI Ratio.

[1] Group Appeal Request, Tab 2 (May 1, 2013).

A request for Expedited Judicial Review was filed on January 6, 2023.[2] The amounts in controversy and number of days added were adjusted in the calculations submitted with the Schedule of Providers which accompany the EJR Request,[3] but the reimbursement impact is still reached through adding dual eligible days to the Medicare Fraction.

Statutory and Regulatory Background:

A. The Secretary's policy on what the phrase "entitled to supplemental security income benefits" in 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I) means for purposes of the numerator of the SSI fraction used in the DSH adjustment calculation

The Medicare program pays inpatient hospital services based on predetermined, standardized amounts subject to certain payment adjustments under Medicare's inpatient prospective payment system ("IPPS").[4] One of these adjustments, the Medicare DSH adjustment, provides additional payments to certain qualifying hospitals that treat a disproportionate share of low income patients.[5] The Medicare DSH adjustment is calculated using two fractions known as the Medicare fraction (also referred to as the SSI fraction or SSI ratio) and the Medicaid fraction. Pursuant to 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I), the Medicare fraction is calculated by using: (a) in the numerator, the "number of such hospital's patient days…which were made up of patients who (for such days) were ***entitled*** to benefits under part A of the subchapter and were ***entitled*** to supplementary security income benefits…under subchapter XVI of this chapter…";[6] and (b) in the denominator, the number of days of care that are furnished to patients who were entitled to Medicare Part A. The Secretary incorporated this statutory provision into the regulations at 42 C.F.R. § 412.106(b)(2)(i)(B) which states:

> (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;

[2] Provider Request for Expedited Judicial Review (Jan 6, 2023) ("EJR Request").
[3] EJR Request, Attachment L.
[4] 42 C.F.R. Part 412.
[5] 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I).
[6] (Emphasis added.)

> (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)).[7]

The dispute in these appeals involves CMS' determination of which patients are "entitled to" both Medicare Part A and SSI benefits for purposes of the Medicare fraction of the DSH calculation.

The SSI program is a federal cash assistance program for low-income individuals who are aged, blind, or disabled,[8] administered by the Social Security Administration ("SSA"). The statutory provisions governing SSI, generally, do not use the term "entitled" to SSI benefits. Rather, the SSI statutory provisions typically refer to whether an individual is "eligible for benefits."[9] In order to be "eligible" for SSI benefits, a person must be: (1) 65 years of age or older, blind or disabled; (2) a lawful resident of the United States; (3) have limited income and resources; (4) not be fleeing to avoid prosecution for a crime or violating a condition of parole; and (5) file an application for benefits.[10]

In contrast, the Medicare program is an insurance program where an individual is automatically "entitled" to Medicare Part A when the person reaches age 65 and is entitled to Social Security benefits or becomes disabled and had been entitled to disability benefits for 24 calendar months.[11] In addition, the Medicare program provides that certain qualifying individuals with end stage renal disease are entitled to Medicare Part A.[12]

Unlike entitlement for Medicare Part A benefits, an individual who is currently eligible for SSI benefits may later become *in*eligible for SSI benefits. In this regard, SSA conducts periodic redeterminations to ensure continued eligibility[13] and may terminate,[14] suspend[15] or stop payments to individuals who are either temporarily or permanently ineligible for payment of SSI benefits.[16] In particular, SSI eligibility may be lost if a person no longer meets the basic

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[7] (Bold emphasis added and italics emphasis in original.) *See also* 42 U.S.C. § 1395w2(d)(5)(F)(vi)(I).
[8] 42 U.S.C. § 1382.
[9] 42 U.S.C. §§ 1381a, 1382(a) (emphasis added).
[10] 20 C.F.R. § 416.202.
[11] 42 U.S.C. § 426.
[12] 42 U.S.C. § 426-1.
[13] 20 C.F.R. § 416.204.
[14] 20 C.F.R. §§ 416.1331-1335.
[15] 20 C.F.R. §§ 416.1320-1330.
[16] 20 C.F.R. § 1320.

requirements. For example, an individual may lose SSI eligibility if the individual is no longer disabled or the individual meets one of the following reasons set forth in §§ 416.207-416.216:

1. The individual fails to give the SSA permission to contact financial institutions;[17]
2. The individual fails to apply for other benefits to which the individual may be entitled;[18]
3. The individual fails to participate in drug or alcohol addiction treatment;[19]
4. The individuals is absent from the United States for more than 30 days;[20] or
5. The individual becomes a resident of a public institutions or prison.[21]

In addition, under certain circumstances, SSA may not pay benefits for administrative reasons, such as removal of a representative payee, an unknown address for the beneficiary, or because of income from a previous month.[22]

After the Medicare DSH statutory provisions were enacted in 1984, CMS (then known as the Health Care Financing Administration ("HCFA")) announced that the Secretary of Health and Human Services, rather than hospitals, would be solely responsible for computation of the Medicare fraction because the data necessary to calculate the Medicare fraction is voluminous and much of this data needed to be obtained from another agency, SSA.[23] CMS noted that, as of 1986, the data sources for the computation of the Medicare fraction included approximately 11 million billing records from the Medicare inpatient discharge file and over 5 million records from the SSI file compiled by SSA.[24] To compute the Medicare fraction, CMS had to match individual Medicare billing records to individual SSI records.[25] Considering the administrative burdens and complexity of the data matching process, CMS concluded that the Secretary would be responsible for the data matching process, which she would conduct retrospectively for every eligible Medicare hospital on a "federal fiscal year" basis—that is, based on discharges occurring in the federal fiscal year.[26] CMS notifies Medicare contractors of the SSI ratios after they are calculated. CMS currently makes this notification by posting the resulting SSI percentages on its website. Medicare contractors then use the posted SSI ratios to calculate the Medicare DSH percentage to determine each qualifying hospital's Medicare DSH payment adjustment.[27]

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[17] 20 C.F.R. § 416.207.
[18] 20 C.F.R. § 416.210.
[19] 20 C.F.R. § 416.214.
[20] 20 C.F.R. § 416.215.
[21] 20 C.F.R. § 416.211.
[22] *See* SSA Program Operations Manual ("POMS") § SI 02301.201 (describing certain SSI post-eligibility events on the internet at https://secure.ssa.gov/apps10/poms.nsf/lnx/0502301201).
[23] 51 Fed. Reg. 31454, 31459 (Sept. 3, 1986).
[24] *Id.*
[25] *Id.*
[26] *Id.* at 31459–31460; 42 C.F.R. § 412.106(b).
[27] 42 C.F.R. § 412.106(b)(5); 42 C.F.R. § 405.1803.

The Medicare DSH payment adjustment has been the subject of much litigation and, from that litigation, the following case is of particular relevance to this appeal: *Baystate v. Leavitt*, 545 F. Supp. 2d 20 *as amended* 587 F. Supp. 2d 37, 44 (D.D.C. 2008) ("*Baystate*"). In *Baystate*, the plaintiff alleged that the Secretary's process to identify and gather the data necessary to calculate each hospital's SSI ratio was deficient and the Court remanded the case to the Administrator for further action. The Board notes that this case discusses the Secretary's historical practice of basing "entitled to . . . SSI" under 42 C.F.R. § 412.106(b)(2) on actual payment of SSI cash benefits.[28]

On April 28, 2010, the Secretary through CMS acted on the *Baystate* remand order and published CMS Ruling CMS-1498-R ("Ruling 1498-R"). Specifically, the Ruling stated that CMS had implemented the *Baystate* remand order by recalculating the plaintiff's SSI fractions and Medicare DSH payment adjustments using a revised data matching process that used "updated and refined SSI eligibility data and Medicare records, and by matching individuals' records with reference to Social Security numbers (SSNs) as well as HICANs and Title II numbers."[29] The Ruling also stated that "in the FY 2011 proposed rule, CMS is proposing to adopt the same revised data matching process" for use with all hospitals and that "[i]n the forthcoming FY 2011 IPPS final rule, CMS expects to respond to public comments filed on the proposed new data matching process, make any changes to such matching process that seem appropriate, and adopt finally a new data matching process."[30] Finally, CMS stated that it would "use that new data matching process in calculating SSI fractions and DSH payments for specific claims that are found to qualify for relief under this Ruling."[31]

Consistent with Ruling 1498-R, the Secretary published the new data matching process in the FY 2011 IPPS proposed rule published on May 4, 2010.[32] The proposed rule includes references to

[28] *Baystate* began with a hearing before the Board. *See Baystate Med. Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006), *modified by*, CMS Adm'r Dec. (May 11, 2006). The Board heard extensive testimony on the Secretary's then-existing data match process. This included testimony from several SSA employees on the data tapes historically sent from SSA to CMS that included "42 monthly indicators (ones and zeros) denoting the payment or non-payment of Federal SSI cash benefits during the period covered by the SSA tape." *Id.* at 11 (citations omitted). Further, this testimony established that SSA's program would "assign a '1' to a month if the CMPH field shows one of two payment codes, C01 (current pay status) or M01 (manual or forced pay), and the FAM field reflects an amount due for the month" and that "[o]therwise, the program assigns a '0' to that month." *Id.* The provider in *Baystate* contested among other things: (1) "the omission of SSI records relating to individuals who received a forced payment from an SSA filed office; (2) "the omission of SSI days associated with individuals whose SSI benefits were temporarily on hold or in suspense when SSA ran each year's SSI tape;" (3) "the omission of SSI days associated with individuals whose benefits were restored or retroactively after SSA ran each year's tape;" and (4) "the omission of individuals who were entitled to non-cash Federal SSI benefits." *Id.* at 23. The Board's discussion of these contentions confirms SSI days were counted when there was actual SSI cash benefits. *See id.* at 26-30. The CMS Administrator's decision and the ensuing decision of the D.C. District Court also contain references to the Secretary's policy. *See, e.g.,* Adm'r Dec. at 5, 16, 39, 41, 48-49; 545 F. Supp. 2d at 28-29 n.13 & n.17, 36-39.
[29] CMS-1498-R at 5.
[30] *Id.*
[31] *Id.* at 5-6.
[32] 85 Fed. Reg. 23852, 24002-24007 (May 4, 2010).

the Secretary's historical practice of basing "entitled to . . . SSI" under 42 C.F.R. § 412.106(b)(2) on actual payment of SSI cash benefits.[33]

The Secretary finalized that data matching process in the FY 2011 IPPS final rule published on August 16, 2010 ("FY 2011 IPPS Final Rule").[34] Significantly, in the preamble to the FY 2011 IPPS Final Rule, CMS acknowledged a public comment that: (1) requested that "CMS include both paid and unpaid days for both SSI entitlement and Medicare entitlement such that there would be consistency between the numerator and denominator of the SSI fraction"; and (2) provided examples of "several SSI codes that represent individuals who were eligible for SSI but not eligible for SSI payments, that should be included as SSI-entitled for purposes of the data match process."[35] CMS responded in detail to this comment and explained that CMS interprets SSI entitlement to correspond with any month for which an individual *receives* payment of SSI benefits. In this regard, CMS stated that the three SSI codes denoted as C01, M01, and M02 "accurately captures all SSI-entitled individuals during the month(s) they are entitled to receive SSI benefits."[36] CMS explicitly rejected the inclusion of other SSA codes because "SSI entitlement can change from time to time" and none of these codes "would be used to describe an individual who was entitled to receive SSI benefits during the month that one of these codes was used."[37] Finally, in the preamble, CMS confirms that "[t]he same data matching process [used for FY 2011 and beyond] will be used to calculate SSI fractions for cost reporting periods covered under the Ruling [1498-R]."[38]

While the new data matching process established in the preamble to the FY 2011 IPPS Final Rule was effective October 1, 2010 (*i.e.*, for FY 2011 and forward), Ruling 1498-R directed that the Medicare contractors apply "the same, unitary relief" consisting of SSI fractions that the Secretary had calculated using the new "suitably revised" data matching process to: (1) any Medicare cost report that had not been settled; and (2) all properly pending Medicare DSH appeals of the SSI fraction data matching process issue.[39] The Ruling noted that hospitals dissatisfied with the initial or revised NPR issued using the new SSI ratios in the Medicare DSH adjustment calculation could seek administrative and judicial review provided they met the

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[33] *See, e.g.,* 75 Fed. Reg. at 24003 (discussing SSI cash payment issues discussed in the *Baystate* decision), 24003-24004 (discussing the proposed matching process where "[t]he SSI eligibility file serves as the system of record for whether or not SSA made a payment of SSI benefits to an individual who applied for SSI"), 24004-06 (discussing the time of the matching process including how "it is important to find an appropriate balance between administrative finality (that is, the final settlement of a hospital's cost report) and the inclusion of retroactive SSI eligibility determinations and the lifting of SSI payment suspensions by using the best and latest available SSI eligibility data at the time of cost report settlement benefits").
[34] 75 Fed. Reg. 50041, 50280-50281. (Aug. 16, 2010).
[35] *Id.* at 50280.
[36] *Id.* at 50280-50281.
[37] *Id.* This include all codes with the "S" prefix indicating a suspension of payment; codes beginning with "N" for nonpayment; code "E01" indicating that the individual had countable income which eliminated the SSI payment; and code "E02" indicating that the patient was not entitled to SSI benefits during that month but became entitled during a subsequent month.
[38] *Id.* at 50285.
[39] CMS-1498-R at 6-7, 31.

jurisdictional and procedural requirements of 42 U.S.C. § 1395oo, the Medicare regulations, and other agency rules and guidelines.[40] In the FY 2011 IPPS Final Rule, the Secretary explicitly recognized that "[t]he data matching process provisions of the Ruling would apply to . . . open cost reports for cost reporting periods beginning prior to October 1, 2010 (that is those preceding the effective date of the FY 2011 IPPS final rule)."[41]

Finally, on April 22, 2015, CMS published Ruling 1498-R2 modifying and amending Ruling 1498-R by allowing hospitals to elect whether to use new Medicare SSI fractions calculated on the basis of "total days" or "covered days" for cost reports involving patient discharges *prior* to October 1, 2004.[42]

However, neither Ruling 1498-R nor Ruling 1498-R2 are applicable to this appeal since the revised NPRs at issue were issued after Ruling 1498-R and since the fiscal year at issue is not covered by Ruling 1498-R2. As a result of the new regulation and new data match process, CMS calculated SSI percentages for the Providers for the fiscal years at issue.[43] The Provider is challenging the adoption of the policy stated therein that only SSI paid days as represented by SSI codes S01, M01 and M02 are included in the numerator of the SSI fraction for purposes of representing days "entitled to [SSI] benefits."

B. FY 2005 IPPS Final Rule

The FY 2005 IPPS Final Rule announced policy changes relative to the treatment of dual eligible days and Medicare Part C days in the SSI fraction.[44] However, it did not address or announce any policy statements or changes relative to what the phrase "entitled to [SSI] benefits as used in 42 U.S.C. § 1395ww(d)(F)(vi)(I).

<u>Providers' Position</u>

In their EJR Request, the Providers acknowledge that, following the Supreme Court's decision in *Empire*, dual eligible days should be excluded from the Medicaid numerator.[45] They argue, however, that there is now an inconsistency between the interpretation of "entitled to benefits under Part A" (which encompasses any patient who satisfies the statutory eligibility criteria whether or not Medicare actually pays), and "entitled to SSI" (which encompasses only patient days where SSI cash payments were actually received).[46] This discrepancy excludes a large number of days from the Medicare fraction numerator.[47] In particular, the Providers are located in Kentucky where a dual eligible patient is entitled to SSI benefits by definition, so the

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[40] *Id.* at 28, 31.
[41] 75 Fed. Reg. at 24006.
[42] CMS-1498-R2 at 2, 6.
[43] SSI ratios are published and can be accessed at https://www.cms.gov/Medicare/ Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.
[44] 69 Fed. Reg. 48916, 49090-99 (Aug. 11, 2004).
[45] EJR Request at 3.
[46] *Id.*
[47] *Id.*

Providers argue all Kentucky dual eligible patient days should be included in the Medicare Fraction's numerator.[48]

Based on the arguments set forth in the EJR Request, and because the applicable regulations[49] only permit group appeals to present a ***single*** question of fact ***or*** interpretation of law, regulations, or CMS Rulings that is common to each provider in the group, the Board issued a Request for Information ("RFI") in this case on February 3, 2023. The RFI sought to clarify the following:

1. Whether the Providers are pursuing a challenge pertaining to dual eligible days in the Medicaid Fraction related to the validity of the FY 2005 IPPS Rule following the decision in *Becerra v. Empire Health Found*.[50];
2. Whether the Providers are challenging the SSI Data Match policy finalized in the FY 2011 IPPS Final Rule;
3. How the discussion of Kentucky Medicaid is relevant to the issue(s) being pursued in this appeal.

On February 15, 2023, the Providers submitted a response to the RFI. They clarified that they are ***not*** pursuing any challenge related to the correct placement of Dual Eligible Medicare Non-Covered Days as they relate to the Medicaid Fraction because they agree that the Supreme Court settled this issue in *Empire Health*. Similarly, the Providers are ***not***, in this case, pursuing a challenge to the SSI Data Match policy finalized in the FY 2011 IPPS Final Rule. In fact, the Providers have separate group cases pursuing this challenge. Similarly, the Providers confirmed that the discussion of Kentucky Medicaid is relevant to the SSI Data Match issue, and thus only tangentially related to the instant case because a favorable ruling in this case would resolve the SSI Data Match cases. As a whole, the Providers' response to the RFI confirmed that, in the instant case, they are ***only*** challenging the interpretation of "entitled to SSI benefits" as set forth in the FY 2011 IPPS Final Rule.

Decision of the Board

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

[48] *Id.* at 2-3.
[49] 42 C.F.R. §§ 405.1837(a)(2), (f).
[50] 142 S.Ct. 2354 (2022).

A. Preliminary Rulings on the Scope of the EJR Request

The Providers have suggested that they are challenging the FY 2005 IPPS Final Rule based on the following finding they included at the end of their EJR request:

> [The Board] is without the authority to decide the legal question of whether 42 C.F.R. § 412.106 codifying the CMS policies adopted in the FY 2005 IPPS Final Rule and the FY 2011 Final Rule are valid.[51]

However, the EJR request only mentions the FY 2005 IPPS Final Rule in one other place as follows:

> In the 2005 Rule construing the Medicare fraction, CMS interpreted the phrase "entitled to benefits under Part A" to encompass any patient who satisfied Part A statutory *eligibility* criteria whether or not Medicare actually pays for the care.[52]

The Providers have recognized that the Supreme Court upheld this policy:

> In *Becerra v. Empire Health Foundation For Valley Hospital Medical Center*, 142 S.Ct. 2354, 2368 (June 24, 2022), the Supreme Court upheld the Secretary's interpretation of the phrase "entitled to benefits" in the numerator of the Medicare fraction to include those individuals qualifying for Medicare regardless of whether that program actually paid for their day of care. The Supreme Court found that the Secretary's reading of "entitled to benefits" comported with the statute's two-population structure because "[a]ll low-income people fit naturally into one or the other box, with the sum of the two leaving no one out." *Id.* at 2367.[53]

Moreover, the Board notes that the FY 2005 IPPS Final Rule does not include any statement regarding the Secretary's interpretation of the phrase "entitled to [SSI] benefits" as used in 42 U.S.C. § 1395ww(d)(F)(vi)(I). Nor do the Providers claim it does.

Accordingly, the Board finds that the EJR request has not laid a sufficient foundation for a challenge to the FY 2005 IPPS Final Rule. In so ruling, it does not mean that it does not have relevance to what is being challenged, namely the FY 2011 IPPS Final Rule as set forth below. However, it is not what is actually being challenged. In this regard, the Provider is maintaining that the term "entitled" should be consistently interpreted across 42 U.S.C. § 1395 and that "entitled to [SSI] benefits" should be broadly interpreted consistent with how the Secretary

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[51] EJR Request at 18.
[52] *Id.* at n.4.
[53] *Id.* at 2 (footnotes omitted).

interpreted "entitled to benefits under [Medicare] Part A" as used in 42 U.S.C. 1395ww(d)(F)(vi)(I) and explained in the FY 2005 IPPS Final Rule and upheld by the Supreme Court in *Empire*, as noted above.

B. Jurisdiction: Appeals of Cost Report Periods Beginning Prior to December 31, 2008

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008 the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming an issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen.*[54] In that case, the Supreme Court concluded that a cost report submitted in full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.[55]

The Board issued a decision on September 21, 2015 determining that it has jurisdiction over the providers in this group appeal and hereby incorporates that decision herein. The appeals were timely, the amount in controversy exceeds $50,000, and the appealed issue is encompassed in the Providers' revised NPRs.

C. Board's Analysis of the Appealed Issue

As noted above, the Secretary revised the SSI data match process in light of the *Baystate* decision through notice and comment in the form of an uncodified regulation. First, the Secretary issued CMS Ruling 1498-R on April 28, 2010, authorizing remands of pending appeals of the SSI data match issue to recalculate the SSI fraction based on a revised data match.[56] The Secretary also stated in the ruling that, where cost reports had not been settled, those providers' SSI fractions would be calculated using the revised data match.[57] Contemporaneous with CMS' issuance of Ruling 1498-R,[58] the Secretary published the FY 2011 IPPS Proposed Rule[59] which, in pertinent part, proposed to adopt the same data match for 2011 and forward. This proposed rule was adopted as the FY 2011 Final IPPS Rule in which the Secretary explained that:

> [W]e used a revised data matching process . . . that comports with the court's decision [in *Baystate* to recalculate the hospitals' SSI fractions]. As the revised data matching process was completed using

[54] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).
[55] *Bethesda at 1258-59.*
[56] CMS Ruling 1498-R at 27.
[57] *Id.* at 31.
[58] *Id.* at 5.
[59] 75 Fed. Reg. 23,852, 24,002-07.

> SSI eligibility data compiled between 13 and 16 years beyond the fiscal years at issue in the *Baystate* case, we believe any issues associated with retroactive determinations of SSI eligibility and the lifting of payment suspensions had been long since resolved. Furthermore, because we believe that the revised match process used to implement the *Baystate* decision addressed all of the concerns found by the court, in the FY 2011 IPPS/LTCH PPS proposed rule we proposed to use the same revised data matching process for calculating hospitals' SSI fractions for FY 2011 and subsequent fiscal years.[60]

Then she announced that:

> We have adopted the proposed data matching process for FY 2011 and beyond as final. The only modification we are making to the proposed matching process is adopting a policy to exclude a record from the data matching process if we find a HICAN in the MedPAR file that we are not able to locate in the EDB[61]which is an extremely unlikely situation as noted in the prior discussion in this final rule. We are adopting this additional step in our validation process to respond to public comment and provide even more assurances that our data matching process will yield accurate SSI fractions and capture all Medicare beneficiaries who were entitled to SSI at the time of their inpatient hospital stay. The same data matching process will be used to calculate SSI fractions for cost reporting periods covered under the ruling.[62]

As part of the adopted data match process, CMS explicitly finalized a policy that SSI codes C01, M01, and M02 would capture all SSI entitled days:

> *Comment*: **One commenter stated that <u>CMS</u>** uses total (that is, "paid and unpaid") Medicare days in the denominator of the SSI fraction, but **<u>uses paid SSI days in the numerator of the SSI fraction</u>**. The commenter requested that CMS interpret the word "entitled" to mean "paid" for both SSI-entitled days used for the numerator and Medicare-entitled days used in the denominator, or alternatively, that CMS include both paid and unpaid days for both SSI entitlement and Medicare entitlement such that there is consistency between the numerator and the denominator of the SSI fraction. **The commenter stated that there were several SSI codes that represent individuals who were eligible for SSI, but not eligible for SSI payments, that should be included as SSI-entitled**

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[60] 75 Fed. Reg. at 50,277.
[61] (Medicare) Enrollment Database.
[62] 75 Fed. Reg. at 50,285.

> **for purposes of the data matching process**. Specifically, the commenter stated that at least the following codes should be considered to be SSI-entitlement:
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> - E01 and E02
> - N06, N10, N11, N18, N35, N39, N42, N43, N46, N50, and N54
> - P01
> - S04, S05, S06, S07, S08, S09, S10, S20, S21, S90, and S91
> - T01, T20, T22, and T31
>
> *Response*: In response to the comment that we are incorrectly applying a different standard in interpreting the word "entitled" with respect to SSI entitlement versus Medicare entitlement, we disagree. The authorizing DSH statute at section 1886(d)(5)(F)(vi)(I) of the Act limits the numerator to individuals entitled to Medicare benefits who are also "*entitled* to supplemental security income benefits (excluding any State supplementation)" (emphasis added).[63] **Consistent with this requirement, we have requested, and are using in the data matching process, those SSA codes that reflect "entitlement to" receive SSI benefits**. Section 1602 of the Act provides that "[e]very aged, blind, or disabled individual who is determined under Part A to be eligible on the basis of his income and resources shall, in accordance with and subject to the provisions of this title, be *paid* benefits by the Commissioner of the Social Security" (emphasis added). However, eligibility for SSI benefits does not automatically mean that an individual will receive SSI benefits for a particular month. For example, section 1611(c)(7) of the Act provides that an application for SSI benefits becomes effective on the later of either the month following the filing of an application for SSI benefits or the month following eligibility for SSI benefits.
>
> On the other hand, section 226 of the Act provides that an individual is automatically "entitled" to Medicare Part A when the person reaches age 65 and is entitled to Social Security benefits under section 202 of the Act (42 U.S.C. 402) or becomes disabled and has been entitled to disability benefits under section 223 of the Act (42 U.S.C. 423) for 24 calendar months. Section 226A of the Act provides that qualifying individuals with end-stage renal disease shall be entitled to Medicare Part A. In addition, section 1818(a)(4)

[63] As a side note, we have used the phrase ''SSI-eligible'' interchangeably with the term ''SSI-entitled'' in the FY 2011 proposed rule as well as prior proposed and final rules, but the statute requires that we include individuals who were entitled to SSI benefits in the SSI fractions. Although we have used these terms interchangeably, we intended no different meaning, and our policy has always been to include only Medicare beneficiaries who are entitled to receive SSI benefits in the numerator of the SSI fraction.

of the Act provides that, "unless otherwise provided, any reference to an individual entitled to benefits under [Part A] includes an individual entitled to benefits under [Part A] pursuant to enrollment under [section 1818] or section 1818A." We believe that Congress used the phrase "entitled to benefits under part A" in section 1886(d)(5)(F)(vi) of the Act to refer individuals who meet the criteria for entitlement under these sections.

Moreover, unlike the SSI program (in which entitlement to receive SSI benefits is based on income and resources and, therefore, can vary from time to time), once a person becomes entitled to Medicare Part A, the individual does not lose such entitlement simply because there was no Medicare Part A coverage of a specific inpatient stay. Entitlement to Medicare Part A reflects an individual's entitlement to Medicare Part A benefits, not the hospital's entitlement or right to receive payment for services provided to such individual. Such Medicare entitlement does not cease to exist simply because Medicare payment for an individual inpatient hospital claim is not made. Again, we are bound by section 1886(d)(5)(F)(vi)(I) of the Act, which defines the SSI fraction numerator as the number of SSI-entitled inpatient days for persons who were "entitled to benefits under [P]art A," and the denominator as the total number of inpatient days for individuals who were "entitled" to Medicare Part A benefits.

In response to the comment about specific SSI status codes, SSA has provided information regarding all of the SSI status codes mentioned by the commenter to assist in the determination of whether <u>any</u> of these codes represent individuals who were entitled to SSI benefits for the purposes of calculating the SSI fraction for Medicare DSH. With respect to the codes that begin with the letter "T," SSA informed us that all of the codes represent individuals whose SSI entitlement was terminated. Code "T01" represents records that were terminated because of the death of the individual, but we confirmed that this code would not be used until the first full month after the death of the individual. That is, for example, if a Medicare individual was entitled to SSI during the month of October, was admitted to the hospital on October 1 and died in the hospital on October 15, the individual would show up as entitled to SSI for the entire month of October on the SSI file (code T01 would not be used on the SSI file until November) and 15 Medicare/SSI inpatient hospital days for that individual would be counted in the numerator and the denominator of the SSI fraction for that hospital.

> Codes beginning with the letter "S" reflect records that are in a "suspended" status and, according to SSA, do not represent individuals who are entitled to SSI benefits.
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> SSA maintains that code "P01" is obsolete and has not been used since the mid-1980s. Therefore, it would not be used on any SSI files reflecting SSI entitlement for FY 2011 and beyond.
>
> Codes that begin with the letter "N" represent records on "nonpayment" and are not used for individuals who are entitled to SSI benefits.
>
> Code "E01" represents an individual who is a resident of a medical treatment facility and is subject to a $30 payment limit, but has countable income of $30 or more. Such an individual is not entitled to receive SSI payment. Alternatively, an individual who is a resident of a medical treatment facility and is subject to a $30 payment limit, but does not have countable income of at least $30, would be reflected on the SSI file as a "C01" (which denotes SSI entitlement) for any month in which the requirements described in this sentence are met. Code "E02" is used to identify a person who is not entitled to SSI payments in the month in which that code is used pursuant to section 1611(c)(7) of the Act, which provides that an application for SSI benefits shall be effective on the later of (1) the first day of the month following the date the application is filed, or (2) the first day of the month following the date the individual becomes eligible for SSI based on that application. Such an individual is not entitled to SSI benefits during the month that his or her application is filed or is determined to be eligible for SSI, but, for the following month, would be coded as a "C01" because he or she would then be entitled to SSI benefits.
>
> Therefore, both codes E01 and E02 represent individuals who are not entitled to SSI benefits and are reflected accordingly on the SSI file. If the individual's entitlement to SSI benefits is initiated the ensuing month, that individual would then be coded as a "C01" on the SSI file and would be included as SSI-entitled for purposes of the data matching process.
>
> As we have described above, **none of the SSI status codes that the commenter mentioned would be used to describe an individual who was entitled to receive SSI benefits during the month that one of those status codes was used**. SSI entitlement can change from time to time, and **we believe that including SSI codes of C01, M01, and M02 accurately captures all SSI-entitled individuals during the month(s) that they are entitled to receive SSI benefits**.

> After consideration of the public comments we received, we are adopting the proposed data matching process for FY 2011 and beyond as final. The only modification we are making to the proposed data matching process is adopting a policy to exclude a record from the data matching process if we find a HICAN in the MedPAR file that we are not able to locate in the EDB, which is an extremely unlikely situation as noted in the prior discussion in this final rule. We are adopting this additional step in our validation process in response to public comments to provide even more assurances that **our data matching process will** yield accurate SSI fractions and **capture all Medicare beneficiaries who were <u>entitled</u> to SSI at the time of their inpatient hospital stay**.[64]

The Secretary did not incorporate, into the Code of Federal Regulations, the above new policy involving the revised data match process (including but not limited to portion of that policy relating to interpreting "entitled to [SSI] benefits" and the use of SSI code C01, M01, and M02 to capture SSI entitled days). However, it is clear from the language in the final IPPS rule, as set forth above, that the Secretary intended to bind the regulated parties and establish a *binding* data match process to be used by the Medicare Contractors in calculating (or recalculating) providers' SSI fractions.

Accordingly, the Board finds that the Secretary intended this policy change for the data match process to be a binding but uncodified regulation and will refer to the portion of that policy as it relates to interpreting "entitled to [SSI] benefits" and the related adoption of the SSI codes C01, M01, and M02 to capture SSI entitled days as the "Uncodified SSI Entitled Days Regulation." Indeed, this finding is consistent with the Secretary's obligations under 42 U.S.C. § 1395hh(a)(2) to promulgate any "substantive legal standard governing . . . the payment of services" as a regulation."[65]

Pursuant to 42 C.F.R. § 405.1867, the Board is bound to apply the statutory and regulatory provisions governing the Medicare program. Consequently, the Board finds that it is bound by the Uncodified SSI Entitled Days Regulation published in the FY 2011 Final Rule and the Board does not have the authority to grant the relief sought by the Provider, namely invalidating the Uncodified SSI Entitled Days Regulation which they allege fails to include all of the SSI codes used by SSA to determine SSI eligibility. As a result, the Board finds that EJR is appropriate for the issue for the calendar year under appeal in this case.

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[64] 75 Fed. Reg. at 50280-81 (footnote in original; bold and underline emphasis added).
[65] 42 U.S.C. § 1395hh(a)(2) states "[n]o rule, requirement, or other statement of policy . . . that establishes or changes a substantive legal standard governing . . . the payment of services . . . shall take effect unless it is promulgated by the Secretary by regulation . . . ."

D. Board's Decision Regarding the EJR Request

The Board finds that:

1) It has jurisdiction over the matter for the subject year and that the Provider is entitled to a hearing before the Board;

2) Based upon the Provider's assertions regarding 42 C.F.R. § 412.106(b)(2)(i) and the Uncodified SSI Entitled Days Regulation as adopted in the preamble to the FY 2011 Final IPPS Rule, there are no findings of fact for resolution by the Board;

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

4) It is without authority to decide the legal question of whether the Uncodified SSI Entitled Days Regulation as adopted in the preamble to the FY 2011 Final IPPS Rule is valid.

Accordingly, the Board finds that the question of the validity of the Uncodified SSI Entitled Days Regulation properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for EJR for that question. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since is the only issue in the appeal, the Board hereby closes the case and removes it from its docket.

<u>Board Members Participating:</u>

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

FOR THE BOARD:

3/7/2023

X Clayton J. Nix

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

Enclosure: Schedule of Providers

cc: Judith Cummings, CGS Administrators (J-15)
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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RE: ***EJR Determination***
ARH 2008 DSH SSI Fraction Dual Eligible Days CIRP Group
Case No. 13-1912GC

Dear Mr. Price:

The Provider Reimbursement Review Board ("Board") has reviewed Providers' January 6, 2023 request for expedited judicial review ("EJR") in the above-referenced Common Issue Related Party ("CIRP") group appeal. The decision of the Board is set forth below.

Issues in Dispute

The Board received the Providers' Group Appeal Request on April 19, 2013. The group was formed with three (3) providers and a fourth was added on April 23, 2013. One (1) provider was withdrawn on December 14, 2022. Each Provider filed its appeal from an original Notice of Program Reimbursement ("NPR") and the stated amount in controversy for this case exceeds $50,000.

The Providers' Statement of the Group Issue describes the issue as follows:

> **ISSUE:** Whether the Fiscal Intermediary's calculation of the Provider's disproportionate patient percent, used or purposes of calculating the Medicare Disproportionate Share ("DSH") Adjustment, was incorrect due to CMS' improper treatment of the Medicare Non-Covered Days, which includes but is not limited to Dual Eligible, Medicare Exhausted and Medicare Secondary Payor days. The improper treatment of these days affects the numerator of the Medicaid fraction and the numerator and the denominator of the Medicare fraction.
>
> ****
>
> According to the interpretation of 42 C.F.R. § 412.106(b), the regulation currently interprets the statutory language "entitled to benefits under [Medicare] Part A" as requiring the inclusion of

> patient days for all Medicare beneficiaries, even if a beneficiary has exhausted his or her Medicare coverage. This interpretation requires the exclusion from the Medicaid fraction of patient days for those individuals who are "eligible" for both Medicare and Medicaid, but who have exhausted their Medicare benefits. Per the ruling from *Metro. Hosp., Inc. v. US. Dep 't of Health & Human Servs*.,702 F. Supp. 2d 808, 825-26 (W.D. Mich. 2010), the district court determined that the interpretation at section 412.106(b) was invalid as contrary to the plain meaning of the DPP statute, reasoning that "entitled" requires payment for hospital services, rather than mere eligibility. Thus, dual-eligible patients with exhausted Medicare benefits would be included in the numerator of the Medicaid fraction.
>
> ****
>
> If Medicare interprets "entitled" to Medicare as "eligible" for Medicare, and thus their basis for including these days in the Medicare fraction, then they also must interpret "entitled" to SSI as "eligible" for SSI and allow Dual Eligible days that are "eligible" for SSI, which includes days where the patient may only be receiving their SSI medical benefit/Medicaid, to be included in the Medicare numerator.[1]

The Board, on its own motion, bifurcated this case on May 7, 2013 – the instant case covering the SSI Ratio/Medicare Fraction, and a separate case covering the Medicaid Fraction. As such, the only aspect of the dual eligible days issue is the treatment of dual eligible days as they relate to the numerator and the denominator of the Medicare fraction.

With the Group Appeal Request, each provider submitted an estimated amount in controversy calculation which illustrates the impact of including dual eligible days in the Medicaid Fraction, and excluding them from the SSI Ratio. In its calculations, the SSI Numerator is unchanged and the SSI Denominator is reduced; the Medicaid days are also increased for the Medicaid Fraction. This calculation appears to illustrate the assertion that no-pay dual eligible days should be removed from the SSI fraction and moved to the numerator of the Medicaid fraction, which is not at issue in this EJR Request.

A request for Expedited Judicial Review was filed on January 6, 2023.[2] The updated amounts in controversy submitted with the Schedule of Providers which accompany the EJR Request differ from those submitted with the original appeal,[3] and these new calculations illustrate the

[1] Group Appeal Request, Tab 2 (Apr. 19, 2013).
[2] Provider Request for Expedited Judicial Review (Jan. 6, 2023) ("EJR Request").
[3] EJR Request, Attachment L.

reimbursement impact based on adding dual eligible days to the Medicare Fraction (the issue in the EJR Request).

Statutory and Regulatory Background:

A. The Secretary's policy on what the phrase "entitled to supplemental security income benefits" in 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I) means for purposes of the numerator of the SSI fraction used in the DSH adjustment calculation

The Medicare program pays inpatient hospital services based on predetermined, standardized amounts subject to certain payment adjustments under Medicare's inpatient prospective payment system ("IPPS").[4] One of these adjustments, the Medicare DSH adjustment, provides additional payments to certain qualifying hospitals that treat a disproportionate share of low income patients.[5] The Medicare DSH adjustment is calculated using two fractions known as the Medicare fraction (also referred to as the SSI fraction or SSI ratio) and the Medicaid fraction. Pursuant to 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I), the Medicare fraction is calculated by using: (a) in the numerator, the "number of such hospital's patient days…which were made up of patients who (for such days) were ***entitled*** to benefits under part A of the subchapter and were ***entitled*** to supplementary security income benefits…under subchapter XVI of this chapter…";[6] and (b) in the denominator, the number of days of care that are furnished to patients who were entitled to Medicare Part A. The Secretary incorporated this statutory provision into the regulations at 42 C.F.R. § 412.106(b)(2)(i)(B) which states:

> (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 –

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[4] 42 C.F.R. Part 412.
[5] 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I).
[6] (Emphasis added.)

> (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)).[7]

The dispute in these appeals involves CMS' determination of which patients are "entitled to" both Medicare Part A and SSI benefits for purposes of the Medicare fraction of the DSH calculation.

The SSI program is a federal cash assistance program for low-income individuals who are aged, blind, or disabled,[8] administered by the Social Security Administration ("SSA"). The statutory provisions governing SSI, generally, do not use the term "entitled" to SSI benefits. Rather, the SSI statutory provisions typically refer to whether an individual is "eligible for benefits."[9] In order to be "eligible" for SSI benefits, a person must be: (1) 65 years of age or older, blind or disabled; (2) a lawful resident of the United States; (3) have limited income and resources; (4) not be fleeing to avoid prosecution for a crime or violating a condition of parole; and (5) file an application for benefits.[10]

In contrast, the Medicare program is an insurance program where an individual is automatically "entitled" to Medicare Part A when the person reaches age 65 and is entitled to Social Security benefits or becomes disabled and had been entitled to disability benefits for 24 calendar months.[11] In addition, the Medicare program provides that certain qualifying individuals with end stage renal disease are entitled to Medicare Part A.[12]

Unlike entitlement for Medicare Part A benefits, an individual who is currently eligible for SSI benefits may later become *in*eligible for SSI benefits. In this regard, SSA conducts periodic redeterminations to ensure continued eligibility[13] and may terminate,[14] suspend[15] or stop payments to individuals who are either temporarily or permanently ineligible for payment of SSI benefits.[16] In particular, SSI eligibility may be lost if a person no longer meets the basic requirements. For example, an individual may lose SSI eligibility if the individual is no longer disabled or the individual meets one of the following reasons set forth in §§ 416.207-416.216:

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[7] (Bold emphasis added and italics emphasis in original.) *See also* 42 U.S.C. § 1395w2(d)(5)(F)(vi)(I).
[8] 42 U.S.C. § 1382.
[9] 42 U.S.C. §§ 1381a, 1382(a) (emphasis added).
[10] 20 C.F.R. § 416.202.
[11] 42 U.S.C. § 426.
[12] 42 U.S.C. § 426-1.
[13] 20 C.F.R. § 416.204.
[14] 20 C.F.R. §§ 416.1331-1335.
[15] 20 C.F.R. §§ 416.1320-1330.
[16] 20 C.F.R. § 1320.

1. The individual fails to give the SSA permission to contact financial institutions;[17]
2. The individual fails to apply for other benefits to which the individual may be entitled;[18]
3. The individual fails to participate in drug or alcohol addiction treatment;[19]
4. The individuals is absent from the United States for more than 30 days;[20] or
5. The individual becomes a resident of a public institutions or prison.[21]

In addition, under certain circumstances, SSA may not pay benefits for administrative reasons, such as removal of a representative payee, an unknown address for the beneficiary, or because of income from a previous month.[22]

After the Medicare DSH statutory provisions were enacted in 1984, CMS (then known as the Health Care Financing Administration ("HCFA")) announced that the Secretary of Health and Human Services, rather than hospitals, would be solely responsible for computation of the Medicare fraction because the data necessary to calculate the Medicare fraction is voluminous and much of this data needed to be obtained from another agency, SSA.[23] CMS noted that, as of 1986, the data sources for the computation of the Medicare fraction included approximately 11 million billing records from the Medicare inpatient discharge file and over 5 million records from the SSI file compiled by SSA.[24] To compute the Medicare fraction, CMS had to match individual Medicare billing records to individual SSI records.[25] Considering the administrative burdens and complexity of the data matching process, CMS concluded that the Secretary would be responsible for the data matching process, which she would conduct retrospectively for every eligible Medicare hospital on a "federal fiscal year" basis—that is, based on discharges occurring in the federal fiscal year.[26] CMS notifies Medicare contractors of the SSI ratios after they are calculated. CMS currently makes this notification by posting the resulting SSI percentages on its website. Medicare contractors then use the posted SSI ratios to calculate the Medicare DSH percentage to determine each qualifying hospital's Medicare DSH payment adjustment.[27]

The Medicare DSH payment adjustment has been the subject of much litigation and, from that litigation, the following case is of particular relevance to this appeal: *Baystate v. Leavitt*, 545 F. Supp. 2d 20 *as amended* 587 F. Supp. 2d 37, 44 (D.D.C. 2008) ("*Baystate*"). In *Baystate*, the

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[17] 20 C.F.R. § 416.207.
[18] 20 C.F.R. § 416.210.
[19] 20 C.F.R. § 416.214.
[20] 20 C.F.R. § 416.215.
[21] 20 C.F.R. § 416.211.
[22] *See* SSA Program Operations Manual ("POMS") § SI 02301.201 (describing certain SSI post-eligibility events on the internet at https://secure.ssa.gov/apps10/poms.nsf/lnx/0502301201).
[23] 51 Fed. Reg. 31454, 31459 (Sept. 3, 1986).
[24] *Id.*
[25] *Id.*
[26] *Id.* at 31459–31460; 42 C.F.R. § 412.106(b).
[27] 42 C.F.R. § 412.106(b)(5); 42 C.F.R. § 405.1803.

plaintiff alleged that the Secretary's process to identify and gather the data necessary to calculate each hospital's SSI ratio was deficient and the Court remanded the case to the Administrator for further action. The Board notes that this case discusses the Secretary's historical practice of basing "entitled to . . . SSI" under 42 C.F.R. § 412.106(b)(2) on actual payment of SSI cash benefits.[28]

On April 28, 2010, the Secretary through CMS acted on the *Baystate* remand order and published CMS Ruling CMS-1498-R ("Ruling 1498-R"). Specifically, the Ruling stated that CMS had implemented the *Baystate* remand order by recalculating the plaintiff's SSI fractions and Medicare DSH payment adjustments using a revised data matching process that used "updated and refined SSI eligibility data and Medicare records, and by matching individuals' records with reference to Social Security numbers (SSNs) as well as HICANs and Title II numbers."[29] The Ruling also stated that "in the FY 2011 proposed rule, CMS is proposing to adopt the same revised data matching process" for use with all hospitals and that "[i]n the forthcoming FY 2011 IPPS final rule, CMS expects to respond to public comments filed on the proposed new data matching process, make any changes to such matching process that seem appropriate, and adopt finally a new data matching process."[30] Finally, CMS stated that it would "use that new data matching process in calculating SSI fractions and DSH payments for specific claims that are found to qualify for relief under this Ruling."[31]

Consistent with Ruling 1498-R, the Secretary published the new data matching process in the FY 2011 IPPS proposed rule published on May 4, 2010.[32] The proposed rule includes references to the Secretary's historical practice of basing "entitled to . . . SSI" under 42 C.F.R. § 412.106(b)(2) on actual payment of SSI cash benefits.[33]

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[28] *Baystate* began with a hearing before the Board. *See Baystate Med. Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006), *modified by*, CMS Adm'r Dec. (May 11, 2006). The Board heard extensive testimony on the Secretary's then-existing data match process. This included testimony from several SSA employees on the data tapes historically sent from SSA to CMS that included "42 monthly indicators (ones and zeros) denoting the payment or non-payment of Federal SSI cash benefits during the period covered by the SSA tape." *Id.* at 11 (citations omitted). Further, this testimony established that SSA's program would "assign a '1' to a month if the CMPH field shows one of two payment codes, C01 (current pay status) or M01 (manual or forced pay), and the FAM field reflects an amount due for the month" and that "[o]therwise, the program assigns a '0' to that month." *Id.* The provider in *Baystate* contested among other things: (1) "the omission of SSI records relating to individuals who received a forced payment from an SSA filed office; (2) "the omission of SSI days associated with individuals whose SSI benefits were temporarily on hold or in suspense when SSA ran each year's SSI tape;" (3) "the omission of SSI days associated with individuals whose benefits were restored or retroactively after SSA ran each year's tape;" and (4) "the omission of individuals who were entitled to non-cash Federal SSI benefits." *Id.* at 23. The Board's discussion of these contentions confirms SSI days were counted when there was actual SSI cash benefits. *See id*. at 26-30. The CMS Administrator's decision and the ensuing decision of the D.C. District Court also contain references to the Secretary's policy. *See, e.g.,* Adm'r Dec. at 5, 16, 39, 41, 48-49; 545 F. Supp. 2d at 28-29 n.13 & n.17, 36-39.

[29] CMS-1498-R at 5.

[30] *Id.*

[31] *Id.* at 5-6.

[32] 85 Fed. Reg. 23852, 24002-24007 (May 4, 2010).

[33] *See, e.g.,* 75 Fed. Reg. at 24003 (discussing SSI cash payment issues discussed in the *Baystate* decision), 24003-24004 (discussing the proposed matching process where "[t]he SSI eligibility file serves as the system of record for whether or not SSA made a payment of SSI benefits to an individual who applied for SSI"), 24004-06 (discussing

The Secretary finalized that data matching process in the FY 2011 IPPS final rule published on August 16, 2010 ("FY 2011 IPPS Final Rule").[34] Significantly, in the preamble to the FY 2011 IPPS Final Rule, CMS acknowledged a public comment that: (1) requested that "CMS include both paid and unpaid days for both SSI entitlement and Medicare entitlement such that there would be consistency between the numerator and denominator of the SSI fraction"; and (2) provided examples of "several SSI codes that represent individuals who were eligible for SSI but not eligible for SSI payments, that should be included as SSI-entitled for purposes of the data match process."[35] CMS responded in detail to this comment and explained that CMS interprets SSI entitlement to correspond with any month for which an individual *receives* payment of SSI benefits. In this regard, CMS stated that the three SSI codes denoted as C01, M01, and M02 "accurately captures all SSI-entitled individuals during the month(s) they are entitled to receive SSI benefits."[36] CMS explicitly rejected the inclusion of other SSA codes because "SSI entitlement can change from time to time" and none of these codes "would be used to describe an individual who was entitled to receive SSI benefits during the month that one of these codes was used."[37] Finally, in the preamble, CMS confirms that "[t]he same data matching process [used for FY 2011 and beyond] will be used to calculate SSI fractions for cost reporting periods covered under the Ruling [1498-R]."[38]

While the new data matching process established in the preamble to the FY 2011 IPPS Final Rule was effective October 1, 2010 (*i.e.*, for FY 2011 and forward), Ruling 1498-R directed that the Medicare contractors apply "the same, unitary relief" consisting of SSI fractions that the Secretary had calculated using the new "suitably revised" data matching process to: (1) any Medicare cost report that had not been settled; and (2) all properly pending Medicare DSH appeals of the SSI fraction data matching process issue.[39] The Ruling noted that hospitals dissatisfied with the initial or revised NPR issued using the new SSI ratios in the Medicare DSH adjustment calculation could seek administrative and judicial review provided they met the jurisdictional and procedural requirements of 42 U.S.C. § 1395oo, the Medicare regulations, and other agency rules and guidelines.[40] In the FY 2011 IPPS Final Rule, the Secretary explicitly recognized that "[t]he data matching process provisions of the Ruling would apply to . . . open

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the time of the matching process including how "it is important to find an appropriate balance between administrative finality (that is, the final settlement of a hospital's cost report) and the inclusion of retroactive SSI eligibility determinations and the lifting of SSI payment suspensions by using the best and latest available SSI eligibility data at the time of cost report settlement benefits").

[34] 75 Fed. Reg. 50041, 50280-50281. (Aug. 16, 2010).

[35] *Id.* at 50280.

[36] *Id.* at 50280-50281.

[37] *Id.* This include all codes with the "S" prefix indicating a suspension of payment; codes beginning with "N" for nonpayment; code "E01" indicating that the individual had countable income which eliminated the SSI payment; and code "E02" indicating that the patient was not entitled to SSI benefits during that month but became entitled during a subsequent month.

[38] *Id.* at 50285.

[39] CMS-1498-R at 6-7, 31.

[40] *Id.* at 28, 31.

cost reports for cost reporting periods beginning prior to October 1, 2010 (that is those preceding the effective date of the FY 2011 IPPS final rule)."[41]

Finally, on April 22, 2015, CMS published Ruling 1498-R2 modifying and amending Ruling 1498-R by allowing hospitals to elect whether to use new Medicare SSI fractions calculated on the basis of "total days" or "covered days" for cost reports involving patient discharges *prior* to October 1, 2004.[42]

However, neither Ruling 1498-R nor Ruling 1498-R2 are applicable to this appeal since the revised NPRs at issue were issued after Ruling 1498-R and since the fiscal year at issue is not covered by Ruling 1498-R2. As a result of the new regulation and new data match process, CMS calculated SSI percentages for the Providers for the fiscal years at issue.[43] The Provider is challenging the adoption of the policy stated therein that only SSI paid days as represented by SSI codes S01, M01 and M02 are included in the numerator of the SSI fraction for purposes of representing days "entitled to [SSI] benefits."

B. FY 2005 IPPS Final Rule

The FY 2005 IPPS Final Rule announced policy changes relative to the treatment of dual eligible days and Medicare Part C days in the SSI fraction.[44] However, it did not address or announce any policy statements or changes relative to what the phrase "entitled to [SSI] benefits as used in 42 U.S.C. § 1395ww(d)(F)(vi)(I).

Providers' Position

In their EJR Request, the Providers acknowledge that, following the Supreme Court's decision in *Empire*, dual eligible days should be excluded from the Medicaid numerator.[45] They argue, however, that there is now an inconsistency between the interpretation of "entitled to benefits under Part A" (which encompasses any patient who satisfies the statutory eligibility criteria whether or not Medicare actually pays), and "entitled to SSI" (which encompasses only patient days where SSI cash payments were actually received).[46] This discrepancy excludes a large number of days from the Medicare fraction numerator.[47] In particular, the Providers are located in Kentucky where a dual eligible patient is entitled to SSI benefits by definition, so the Providers argue all Kentucky dual eligible patient days should be included in the Medicare Fraction's numerator.[48]

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[41] 75 Fed. Reg. at 24006.
[42] CMS-1498-R2 at 2, 6.
[43] SSI ratios are published and can be accessed at https://www.cms.gov/Medicare/ Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.
[44] 69 Fed. Reg. 48916, 49090-99 (Aug. 11, 2004).
[45] EJR Request at 3.
[46] *Id.*
[47] *Id.*
[48] *Id.* at 2-3.

Based on the arguments set forth in the EJR Request, and because the applicable regulations[49] only permit group appeals to present a ***single*** question of fact ***or*** interpretation of law, regulations, or CMS Rulings that is common to each provider in the group, the Board issued a Request for Information ("RFI") in this case on February 3, 2023. The RFI sought to clarify the following:

1. Whether the Providers are pursuing a challenge pertaining to dual eligible days in the Medicaid Fraction related to the validity of the FY 2005 IPPS Rule following the decision in *Becerra v. Empire Health Found.*[50];
2. Whether the Providers are challenging the SSI Data Match policy finalized in the FY 2011 IPPS Final Rule;
3. How the discussion of Kentucky Medicaid is relevant to the issue(s) being pursued in this appeal.

On February 15, 2023, the Providers submitted a response to the RFI. They clarified that they are ***not*** pursuing any challenge related to the correct placement of Dual Eligible Medicare Non-Covered Days as they relate to the Medicaid Fraction because they agree that the Supreme Court settled this issue in *Empire Health*. Similarly, the Providers are ***not***, in this case, pursuing a challenge to the SSI Data Match policy finalized in the FY 2011 IPPS Final Rule. In fact, the Providers have separate group cases pursuing this challenge. Similarly, the Providers confirmed that the discussion of Kentucky Medicaid is relevant to the SSI Data Match issue, and thus only tangentially related to the instant case because a favorable ruling in this case would resolve the SSI Data Match cases. As a whole, the Providers' response to the RFI confirmed that, in the instant case, they are ***only*** challenging the interpretation of "entitled to SSI benefits" as set forth in the FY 2011 IPPS Final Rule.

Decision of the Board

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

A. Preliminary Rulings on the Scope of the EJR Request

The Providers have suggested that they are challenging the FY 2005 IPPS Final Rule based on the following finding they included at the end of their EJR request:

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[49] 42 C.F.R. §§ 405.1837(a)(2), (f).
[50] 142 S.Ct. 2354 (2022).

> [The Board] is without the authority to decide the legal question of whether 42 C.F.R. § 412.106 codifying the CMS policies adopted in the FY 2005 IPPS Final Rule and the FY 2011 Final Rule are valid.[51]

However, the EJR request only mentions the FY 2005 IPPS Final Rule in one other place as follows:

> In the 2005 Rule construing the Medicare fraction, CMS interpreted the phrase "entitled to benefits under Part A" to encompass any patient who satisfied Part A statutory *eligibility* criteria whether or not Medicare actually pays for the care.[52]

The Providers have recognized that the Supreme Court upheld this policy:

> In *Becerra v. Empire Health Foundation For Valley Hospital Medical Center*, 142 S.Ct. 2354, 2368 (June 24, 2022), the Supreme Court upheld the Secretary's interpretation of the phrase "entitled to benefits" in the numerator of the Medicare fraction to include those individuals qualifying for Medicare regardless of whether that program actually paid for their day of care. The Supreme Court found that the Secretary's reading of "entitled to benefits" comported with the statute's two-population structure because "[a]ll low-income people fit naturally into one or the other box, with the sum of the two leaving no one out." *Id.* at 2367.[53]

Moreover, the Board notes that the FY 2005 IPPS Final Rule does not include any statement regarding the Secretary's interpretation of the phrase "entitled to [SSI] benefits" as used in 42 U.S.C. § 1395ww(d)(F)(vi)(I). Nor do the Providers claim it does.

Accordingly, the Board finds that the EJR request has not laid a sufficient foundation for a challenge to the FY 2005 IPPS Final Rule. In so ruling, it does not mean that it does not have relevance to what is being challenged, namely the FY 2011 IPPS Final Rule as set forth below. However, it is not what is actually being challenged. In this regard, the Provider is maintaining that the term "entitled" should be consistently interpreted across 42 U.S.C. § 1395 and that "entitled to [SSI] benefits" should be broadly interpreted consistent with how the Secretary interpreted "entitled to benefits under [Medicare] Part A" as used in 42 U.S.C. 1395ww(d)(F)(vi)(I) and explained in the FY 2005 IPPS Final Rule and upheld by the Supreme Court in *Empire*, as noted above.

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[51] EJR Request at 18.
[52] *Id.* at n.4.
[53] *Id.* at 2 (footnotes omitted).

B. Jurisdiction: Appeals of Cost Report Periods Beginning Prior to December 31, 2008

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008 the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming an issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen.*[54] In that case, the Supreme Court concluded that a cost report submitted in full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.[55]

The Board has determined that the issue in this optional Group as it relates to the meaning of "entitled to [SSI] benefits" is governed by the holding in *Bethesda* since the Providers are challenging the Secretary's interpretation of this phrase as set forth in the FY 2011 IPPS Final Rule and that Board review of this issue is not otherwise precluded by statute or regulation. In addition, the Providers' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal. The appeals were timely filed and no jurisdictional impediments have been identified for the Providers. Based on the above, the Board finds that it has jurisdiction for the above-captioned group appeal.

C. Board's Analysis of the Appealed Issue

As noted above, the Secretary revised the SSI data match process in light of the *Baystate* decision through notice and comment in the form of an uncodified regulation. First, the Secretary issued CMS Ruling 1498-R on April 28, 2010, authorizing remands of pending appeals of the SSI data match issue to recalculate the SSI fraction based on a revised data match.[56] The Secretary also stated in the ruling that, where cost reports had not been settled, those providers' SSI fractions would be calculated using the revised data match.[57] Contemporaneous with CMS' issuance of Ruling 1498-R,[58] the Secretary published the FY 2011 IPPS Proposed Rule[59] which, in pertinent part, proposed to adopt the same data match for 2011 and forward. This proposed rule was adopted as the FY 2011 Final IPPS Rule in which the Secretary explained that:

> [W]e used a revised data matching process . . . that comports with the court's decision [in *Baystate* to recalculate the hospitals' SSI fractions]. As the revised data matching process was completed using

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[54] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).
[55] *Bethesda at 1258-59.*
[56] CMS Ruling 1498-R at 27.
[57] *Id.* at 31.
[58] *Id.* at 5.
[59] 75 Fed. Reg. 23,852, 24,002-07.

> SSI eligibility data compiled between 13 and 16 years beyond the fiscal years at issue in the *Baystate* case, we believe any issues associated with retroactive determinations of SSI eligibility and the lifting of payment suspensions had been long since resolved. Furthermore, because we believe that the revised match process used to implement the *Baystate* decision addressed all of the concerns found by the court, in the FY 2011 IPPS/LTCH PPS proposed rule we proposed to use the same revised data matching process for calculating hospitals' SSI fractions for FY 2011 and subsequent fiscal years.[60]

Then she announced that:

> We have adopted the proposed data matching process for FY 2011 and beyond as final. The only modification we are making to the proposed matching process is adopting a policy to exclude a record from the data matching process if we find a HICAN in the MedPAR file that we are not able to locate in the EDB[61]which is an extremely unlikely situation as noted in the prior discussion in this final rule. We are adopting this additional step in our validation process to respond to public comment and provide even more assurances that our data matching process will yield accurate SSI fractions and capture all Medicare beneficiaries who were entitled to SSI at the time of their inpatient hospital stay. The same data matching process will be used to calculate SSI fractions for cost reporting periods covered under the ruling.[62]

As part of the adopted data match process, CMS explicitly finalized a policy that SSI codes C01, M01, and M02 would capture all SSI entitled days:

> *Comment*: **One commenter stated that <u>CMS</u>** uses total (that is, "paid and unpaid") Medicare days in the denominator of the SSI fraction, but **<u>uses paid SSI days in the numerator of the SSI fraction</u>**. The commenter requested that CMS interpret the word "entitled" to mean "paid" for both SSI-entitled days used for the numerator and Medicare-entitled days used in the denominator, or alternatively, that CMS include both paid and unpaid days for both SSI entitlement and Medicare entitlement such that there is consistency between the numerator and the denominator of the SSI fraction. **The commenter stated that there were several SSI codes that represent individuals who were eligible for SSI, but not eligible for SSI payments, that should be included as SSI-entitled**

[60] 75 Fed. Reg. at 50,277.
[61] (Medicare) Enrollment Database.
[62] 75 Fed. Reg. at 50,285.

> **for purposes of the data matching process**. Specifically, the commenter stated that at least the following codes should be considered to be SSI-entitlement:
>
> - E01 and E02
> - N06, N10, N11, N18, N35, N39, N42, N43, N46, N50, and N54
> - P01
> - S04, S05, S06, S07, S08, S09, S10, S20, S21, S90, and S91
> - T01, T20, T22, and T31
>
> *Response*: In response to the comment that we are incorrectly applying a different standard in interpreting the word "entitled" with respect to SSI entitlement versus Medicare entitlement, we disagree. The authorizing DSH statute at section 1886(d)(5)(F)(vi)(I) of the Act limits the numerator to individuals entitled to Medicare benefits who are also "*entitled* to supplemental security income benefits (excluding any State supplementation)" (emphasis added).[63] **Consistent with this requirement, we have requested, and are using in the data matching process, those SSA codes that reflect "entitlement to" receive SSI benefits**. Section 1602 of the Act provides that "[e]very aged, blind, or disabled individual who is determined under Part A to be eligible on the basis of his income and resources shall, in accordance with and subject to the provisions of this title, be *paid* benefits by the Commissioner of the Social Security" (emphasis added). However, eligibility for SSI benefits does not automatically mean that an individual will receive SSI benefits for a particular month. For example, section 1611(c)(7) of the Act provides that an application for SSI benefits becomes effective on the later of either the month following the filing of an application for SSI benefits or the month following eligibility for SSI benefits.
>
> On the other hand, section 226 of the Act provides that an individual is automatically "entitled" to Medicare Part A when the person reaches age 65 and is entitled to Social Security benefits under section 202 of the Act (42 U.S.C. 402) or becomes disabled and has been entitled to disability benefits under section 223 of the Act (42 U.S.C. 423) for 24 calendar months. Section 226A of the Act provides that qualifying individuals with end-stage renal disease shall be entitled to Medicare Part A. In addition, section 1818(a)(4)

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[63] As a side note, we have used the phrase ''SSI-eligible'' interchangeably with the term ''SSI-entitled'' in the FY 2011 proposed rule as well as prior proposed and final rules, but the statute requires that we include individuals who were entitled to SSI benefits in the SSI fractions. Although we have used these terms interchangeably, we intended no different meaning, and our policy has always been to include only Medicare beneficiaries who are entitled to receive SSI benefits in the numerator of the SSI fraction.

of the Act provides that, "unless otherwise provided, any reference to an individual entitled to benefits under [Part A] includes an individual entitled to benefits under [Part A] pursuant to enrollment under [section 1818] or section 1818A." We believe that Congress used the phrase "entitled to benefits under part A" in section 1886(d)(5)(F)(vi) of the Act to refer individuals who meet the criteria for entitlement under these sections.

Moreover, unlike the SSI program (in which entitlement to receive SSI benefits is based on income and resources and, therefore, can vary from time to time), once a person becomes entitled to Medicare Part A, the individual does not lose such entitlement simply because there was no Medicare Part A coverage of a specific inpatient stay. Entitlement to Medicare Part A reflects an individual's entitlement to Medicare Part A benefits, not the hospital's entitlement or right to receive payment for services provided to such individual. Such Medicare entitlement does not cease to exist simply because Medicare payment for an individual inpatient hospital claim is not made. Again, we are bound by section 1886(d)(5)(F)(vi)(I) of the Act, which defines the SSI fraction numerator as the number of SSI-entitled inpatient days for persons who were "entitled to benefits under [P]art A," and the denominator as the total number of inpatient days for individuals who were "entitled" to Medicare Part A benefits.

In response to the comment about specific SSI status codes, SSA has provided information regarding all of the SSI status codes mentioned by the commenter to assist in the determination of whether <u>any</u> of these codes represent individuals who were entitled to SSI benefits for the purposes of calculating the SSI fraction for Medicare DSH. With respect to the codes that begin with the letter "T," SSA informed us that all of the codes represent individuals whose SSI entitlement was terminated. Code "T01" represents records that were terminated because of the death of the individual, but we confirmed that this code would not be used until the first full month after the death of the individual. That is, for example, if a Medicare individual was entitled to SSI during the month of October, was admitted to the hospital on October 1 and died in the hospital on October 15, the individual would show up as entitled to SSI for the entire month of October on the SSI file (code T01 would not be used on the SSI file until November) and 15 Medicare/SSI inpatient hospital days for that individual would be counted in the numerator and the denominator of the SSI fraction for that hospital.

Codes beginning with the letter "S" reflect records that are in a "suspended" status and, according to SSA, do not represent individuals who are entitled to SSI benefits.

SSA maintains that code "P01" is obsolete and has not been used since the mid-1980s. Therefore, it would not be used on any SSI files reflecting SSI entitlement for FY 2011 and beyond.

Codes that begin with the letter "N" represent records on "nonpayment" and are not used for individuals who are entitled to SSI benefits.

Code "E01" represents an individual who is a resident of a medical treatment facility and is subject to a $30 payment limit, but has countable income of $30 or more. Such an individual is not entitled to receive SSI payment. Alternatively, an individual who is a resident of a medical treatment facility and is subject to a $30 payment limit, but does not have countable income of at least $30, would be reflected on the SSI file as a "C01" (which denotes SSI entitlement) for any month in which the requirements described in this sentence are met. Code "E02" is used to identify a person who is not entitled to SSI payments in the month in which that code is used pursuant to section 1611(c)(7) of the Act, which provides that an application for SSI benefits shall be effective on the later of (1) the first day of the month following the date the application is filed, or (2) the first day of the month following the date the individual becomes eligible for SSI based on that application. Such an individual is not entitled to SSI benefits during the month that his or her application is filed or is determined to be eligible for SSI, but, for the following month, would be coded as a "C01" because he or she would then be entitled to SSI benefits.

Therefore, both codes E01 and E02 represent individuals who are not entitled to SSI benefits and are reflected accordingly on the SSI file. If the individual's entitlement to SSI benefits is initiated the ensuing month, that individual would then be coded as a "C01" on the SSI file and would be included as SSI-entitled for purposes of the data matching process.

As we have described above, **none of the SSI status codes that the commenter mentioned would be used to describe an individual who was entitled to receive SSI benefits during the month that one of those status codes was used**. SSI entitlement can change from time to time, and **we believe that including SSI codes of C01, M01, and M02 accurately captures all SSI-entitled individuals during the month(s) that they are entitled to receive SSI benefits**.

> After consideration of the public comments we received, we are adopting the proposed data matching process for FY 2011 and beyond as final. The only modification we are making to the proposed data matching process is adopting a policy to exclude a record from the data matching process if we find a HICAN in the MedPAR file that we are not able to locate in the EDB, which is an extremely unlikely situation as noted in the prior discussion in this final rule. We are adopting this additional step in our validation process in response to public comments to provide even more assurances that **our data matching process will** yield accurate SSI fractions and **capture all Medicare beneficiaries who were entitled to SSI at the time of their inpatient hospital stay**.[64]

The Secretary did not incorporate, into the Code of Federal Regulations, the above new policy involving the revised data match process (including but not limited to portion of that policy relating to interpreting "entitled to [SSI] benefits" and the use of SSI code C01, M01, and M02 to capture SSI entitled days). However, it is clear from the language in the final IPPS rule, as set forth above, that the Secretary intended to bind the regulated parties and establish a *binding* data match process to be used by the Medicare Contractors in calculating (or recalculating) providers' SSI fractions.

Accordingly, the Board finds that the Secretary intended this policy change for the data match process to be a binding but uncodified regulation and will refer to the portion of that policy as it relates to interpreting "entitled to [SSI] benefits" and the related adoption of the SSI codes C01, M01, and M02 to capture SSI entitled days as the "Uncodified SSI Entitled Days Regulation." Indeed, this finding is consistent with the Secretary's obligations under 42 U.S.C. § 1395hh(a)(2) to promulgate any "substantive legal standard governing . . . the payment of services" as a regulation."[65]

Pursuant to 42 C.F.R. § 405.1867, the Board is bound to apply the statutory and regulatory provisions governing the Medicare program. Consequently, the Board finds that it is bound by the Uncodified SSI Entitled Days Regulation published in the FY 2011 Final Rule and the Board does not have the authority to grant the relief sought by the Provider, namely invalidating the Uncodified SSI Entitled Days Regulation which they allege fails to include all of the SSI codes used by SSA to determine SSI eligibility. As a result, the Board finds that EJR is appropriate for the issue for the calendar year under appeal in this case.

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[64] 75 Fed. Reg. at 50280-81 (footnote in original; bold and underline emphasis added).

[65] 42 U.S.C. § 1395hh(a)(2) states "[n]o rule, requirement, or other statement of policy . . . that establishes or changes a substantive legal standard governing . . . the payment of services . . . shall take effect unless it is promulgated by the Secretary by regulation . . . ."

D. Board's Decision Regarding the EJR Request

The Board finds that:

1) It has jurisdiction over the matter for the subject year and that the Provider is entitled to a hearing before the Board;

2) Based upon the Provider's assertions regarding 42 C.F.R. § 412.106(b)(2)(i) and the Uncodified SSI Entitled Days Regulation as adopted in the preamble to the FY 2011 Final IPPS Rule, there are no findings of fact for resolution by the Board;

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

4) It is without authority to decide the legal question of whether the Uncodified SSI Entitled Days Regulation as adopted in the preamble to the FY 2011 Final IPPS Rule is valid.

Accordingly, the Board finds that the question of the validity of the Uncodified SSI Entitled Days Regulation properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for EJR for that question. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since is the only issue in the appeal, the Board hereby closes the case and removes it from its docket.

Board Members Participating:

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

FOR THE BOARD:

3/7/2023

X Clayton J. Nix

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

Enclosure: Schedule of Providers

cc: Judith Cummings, CGS Administrators (J-15)
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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RE: ***EJR Determination***
Wyatt, Tarrant & Combs 2008 DSH SSI Ratio Dual Eligible Days Group
Case No. 13-1914G

Dear Mr. Price:

The Provider Reimbursement Review Board ("Board") has reviewed Providers' January 9, 2023 request for expedited judicial review ("EJR") in the above-referenced optional group appeal. The decision of the Board is set forth below.

Issues in Dispute

The Board received the Providers' Optional Group Appeal Request on May 1, 2013. The group was formed with two (2) providers and has been deemed complete. Each Provider filed its appeal from an original Notice of Program Reimbursement ("NPR") and the stated amount in controversy for this case exceeds $50,000.

The Providers' Statement of the Group Issue describes the issue as follows:

> **ISSUE:** Whether the Fiscal Intermediary's calculation of the Provider's disproportionate patient percent, used or purposes of calculating the Medicare Disproportionate Share ("DSH") Adjustment, was incorrect due to CMS' improper treatment of the Medicare Non-Covered Days, which includes but is not limited to Dual Eligible, Medicare Exhausted and Medicare Secondary Payor days. The improper treatment of these days affects the numerator of the Medicaid fraction and the numerator and the denominator of the Medicare fraction.
>
> ****
>
> According to the interpretation of 42 C.F.R. § 412.106(b), the regulation currently interprets the statutory language "entitled to benefits under [Medicare] Part A" as requiring the inclusion of patient days for all Medicare beneficiaries, even if a beneficiary

> has exhausted his or her Medicare coverage. This interpretation requires the exclusion from the Medicaid fraction of patient days for those individuals who are "eligible" for both Medicare and Medicaid, but who have exhausted their Medicare benefits. Per the ruling from *Metro. Hosp., Inc. v. US. Dep 't of Health & Human Servs*.,702 F. Supp. 2d 808, 825-26 (W.D. Mich. 2010), the district court determined that the interpretation at section 412.106(b) was invalid as contrary to the plain meaning of the DPP statute, reasoning that "entitled" requires payment for hospital services, rather than mere eligibility. Thus, dual-eligible patients with exhausted Medicare benefits would be included in the numerator of the Medicaid fraction.
>
> ****
>
> If Medicare interprets "entitled" to Medicare as "eligible" for Medicare, and thus their basis for including these days in the Medicare fraction, then they also must interpret "entitled" to SSI as "eligible" for SSI and allow Dual Eligible days that are "eligible" for SSI, which includes days where the patient may only be receiving their SSI medical benefit/Medicaid, to be included in the Medicare numerator.[1]

With the Group Appeal Request, each provider submitted an estimated amount in controversy calculation which illustrates the impact of including dual eligible days in the Medicaid Fraction, and excluding them from the SSI Ratio. In its calculations, the SSI Numerator is unchanged and the SSI Denominator is reduced; the Medicaid days are also increased for the Medicaid Fraction. This calculation appears to illustrate the assertion that no-pay dual eligible days should be removed from the SSI fraction and moved to the numerator of the Medicaid fraction, which is not at issue in this EJR Request.

It also submitted a second calculation which illustrates the alternative argument that the definition of "entitled to SSI benefits" as used in the numerator of the SSI fraction should be expanded to include days where a patient is eligible for SSI benefits. For each provider, the amount in controversy was estimated to be:

1. Murray-Calloway County Hospital (Prov. No. 18-0027): $1,972,895 based on the addition of 2,731 dual eligible days to the SSI Ratio; and
2. TJ Sampson Community Hospital (Prov. No. 18-0017): $1,236,226, based on the addition of 1,451 dual eligible days in the SSI Ratio.

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[1] Group Appeal Request, Tab 2 (May 1, 2013).

A request for Expedited Judicial Review was filed on January 9, 2023.[2] The amounts in controversy and number of days added were adjusted in the calculations submitted with the Schedule of Providers which accompany the EJR Request,[3] but the reimbursement impact is still reached through adding dual eligible days to the Medicare Fraction.

Statutory and Regulatory Background:

A. The Secretary's policy on what the phrase "entitled to supplemental security income benefits" in 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I) means for purposes of the numerator of the SSI fraction used in the DSH adjustment calculation

The Medicare program pays inpatient hospital services based on predetermined, standardized amounts subject to certain payment adjustments under Medicare's inpatient prospective payment system ("IPPS").[4] One of these adjustments, the Medicare DSH adjustment, provides additional payments to certain qualifying hospitals that treat a disproportionate share of low income patients.[5] The Medicare DSH adjustment is calculated using two fractions known as the Medicare fraction (also referred to as the SSI fraction or SSI ratio) and the Medicaid fraction. Pursuant to 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I), the Medicare fraction is calculated by using: (a) in the numerator, the "number of such hospital's patient days…which were made up of patients who (for such days) were ***entitled*** to benefits under part A of the subchapter and were ***entitled*** to supplementary security income benefits…under subchapter XVI of this chapter…";[6] and (b) in the denominator, the number of days of care that are furnished to patients who were entitled to Medicare Part A. The Secretary incorporated this statutory provision into the regulations at 42 C.F.R. § 412.106(b)(2)(i)(B) which states:

> (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;

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[2] Provider Request for Expedited Judicial Review (Jan. 9, 2023) ("EJR Request").
[3] EJR Request, Attachment L.
[4] 42 C.F.R. Part 412.
[5] 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I).
[6] (Emphasis added.)

> (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)).[7]

The dispute in these appeals involves CMS' determination of which patients are "entitled to" both Medicare Part A and SSI benefits for purposes of the Medicare fraction of the DSH calculation.

The SSI program is a federal cash assistance program for low-income individuals who are aged, blind, or disabled,[8] administered by the Social Security Administration ("SSA"). The statutory provisions governing SSI, generally, do not use the term "entitled" to SSI benefits. Rather, the SSI statutory provisions typically refer to whether an individual is "eligible for benefits."[9] In order to be "eligible" for SSI benefits, a person must be: (1) 65 years of age or older, blind or disabled; (2) a lawful resident of the United States; (3) have limited income and resources; (4) not be fleeing to avoid prosecution for a crime or violating a condition of parole; and (5) file an application for benefits.[10]

In contrast, the Medicare program is an insurance program where an individual is automatically "entitled" to Medicare Part A when the person reaches age 65 and is entitled to Social Security benefits or becomes disabled and had been entitled to disability benefits for 24 calendar months.[11] In addition, the Medicare program provides that certain qualifying individuals with end stage renal disease are entitled to Medicare Part A.[12]

Unlike entitlement for Medicare Part A benefits, an individual who is currently eligible for SSI benefits may later become *in*eligible for SSI benefits. In this regard, SSA conducts periodic redeterminations to ensure continued eligibility[13] and may terminate,[14] suspend[15] or stop payments to individuals who are either temporarily or permanently ineligible for payment of SSI benefits.[16] In particular, SSI eligibility may be lost if a person no longer meets the basic

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[7] (Bold emphasis added and italics emphasis in original.) *See also* 42 U.S.C. § 1395w2(d)(5)(F)(vi)(I).
[8] 42 U.S.C. § 1382.
[9] 42 U.S.C. §§ 1381a, 1382(a) (emphasis added).
[10] 20 C.F.R. § 416.202.
[11] 42 U.S.C. § 426.
[12] 42 U.S.C. § 426-1.
[13] 20 C.F.R. § 416.204.
[14] 20 C.F.R. §§ 416.1331-1335.
[15] 20 C.F.R. §§ 416.1320-1330.
[16] 20 C.F.R. § 1320.

requirements. For example, an individual may lose SSI eligibility if the individual is no longer disabled or the individual meets one of the following reasons set forth in §§ 416.207-416.216:

1. The individual fails to give the SSA permission to contact financial institutions;[17]
2. The individual fails to apply for other benefits to which the individual may be entitled;[18]
3. The individual fails to participate in drug or alcohol addiction treatment;[19]
4. The individuals is absent from the United States for more than 30 days;[20] or
5. The individual becomes a resident of a public institutions or prison.[21]

In addition, under certain circumstances, SSA may not pay benefits for administrative reasons, such as removal of a representative payee, an unknown address for the beneficiary, or because of income from a previous month.[22]

After the Medicare DSH statutory provisions were enacted in 1984, CMS (then known as the Health Care Financing Administration ("HCFA")) announced that the Secretary of Health and Human Services, rather than hospitals, would be solely responsible for computation of the Medicare fraction because the data necessary to calculate the Medicare fraction is voluminous and much of this data needed to be obtained from another agency, SSA.[23] CMS noted that, as of 1986, the data sources for the computation of the Medicare fraction included approximately 11 million billing records from the Medicare inpatient discharge file and over 5 million records from the SSI file compiled by SSA.[24] To compute the Medicare fraction, CMS had to match individual Medicare billing records to individual SSI records.[25] Considering the administrative burdens and complexity of the data matching process, CMS concluded that the Secretary would be responsible for the data matching process, which she would conduct retrospectively for every eligible Medicare hospital on a "federal fiscal year" basis—that is, based on discharges occurring in the federal fiscal year.[26] CMS notifies Medicare contractors of the SSI ratios after they are calculated. CMS currently makes this notification by posting the resulting SSI percentages on its website. Medicare contractors then use the posted SSI ratios to calculate the Medicare DSH percentage to determine each qualifying hospital's Medicare DSH payment adjustment.[27]

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[17] 20 C.F.R. § 416.207.
[18] 20 C.F.R. § 416.210.
[19] 20 C.F.R. § 416.214.
[20] 20 C.F.R. § 416.215.
[21] 20 C.F.R. § 416.211.
[22] *See* SSA Program Operations Manual ("POMS") § SI 02301.201 (describing certain SSI post-eligibility events on the internet at https://secure.ssa.gov/apps10/poms.nsf/lnx/0502301201).
[23] 51 Fed. Reg. 31454, 31459 (Sept. 3, 1986).
[24] *Id.*
[25] *Id.*
[26] *Id.* at 31459–31460; 42 C.F.R. § 412.106(b).
[27] 42 C.F.R. § 412.106(b)(5); 42 C.F.R. § 405.1803.

The Medicare DSH payment adjustment has been the subject of much litigation and, from that litigation, the following case is of particular relevance to this appeal: *Baystate v. Leavitt*, 545 F. Supp. 2d 20 *as amended* 587 F. Supp. 2d 37, 44 (D.D.C. 2008) ("*Baystate*"). In *Baystate*, the plaintiff alleged that the Secretary's process to identify and gather the data necessary to calculate each hospital's SSI ratio was deficient and the Court remanded the case to the Administrator for further action. The Board notes that this case discusses the Secretary's historical practice of basing "entitled to . . . SSI" under 42 C.F.R. § 412.106(b)(2) on actual payment of SSI cash benefits.[28]

On April 28, 2010, the Secretary through CMS acted on the *Baystate* remand order and published CMS Ruling CMS-1498-R ("Ruling 1498-R"). Specifically, the Ruling stated that CMS had implemented the *Baystate* remand order by recalculating the plaintiff's SSI fractions and Medicare DSH payment adjustments using a revised data matching process that used "updated and refined SSI eligibility data and Medicare records, and by matching individuals' records with reference to Social Security numbers (SSNs) as well as HICANs and Title II numbers."[29] The Ruling also stated that "in the FY 2011 proposed rule, CMS is proposing to adopt the same revised data matching process" for use with all hospitals and that "[i]n the forthcoming FY 2011 IPPS final rule, CMS expects to respond to public comments filed on the proposed new data matching process, make any changes to such matching process that seem appropriate, and adopt finally a new data matching process."[30] Finally, CMS stated that it would "use that new data matching process in calculating SSI fractions and DSH payments for specific claims that are found to qualify for relief under this Ruling."[31]

Consistent with Ruling 1498-R, the Secretary published the new data matching process in the FY 2011 IPPS proposed rule published on May 4, 2010.[32] The proposed rule includes references to

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[28] *Baystate* began with a hearing before the Board. *See Baystate Med. Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006), *modified by*, CMS Adm'r Dec. (May 11, 2006). The Board heard extensive testimony on the Secretary's then-existing data match process. This included testimony from several SSA employees on the data tapes historically sent from SSA to CMS that included "42 monthly indicators (ones and zeros) denoting the payment or non-payment of Federal SSI cash benefits during the period covered by the SSA tape." *Id.* at 11 (citations omitted). Further, this testimony established that SSA's program would "assign a '1' to a month if the CMPH field shows one of two payment codes, C01 (current pay status) or M01 (manual or forced pay), and the FAM field reflects an amount due for the month" and that "[o]therwise, the program assigns a '0' to that month." *Id.* The provider in *Baystate* contested among other things: (1) "the omission of SSI records relating to individuals who received a forced payment from an SSA filed office; (2) "the omission of SSI days associated with individuals whose SSI benefits were temporarily on hold or in suspense when SSA ran each year's SSI tape;" (3) "the omission of SSI days associated with individuals whose benefits were restored or retroactively after SSA ran each year's tape;" and (4) "the omission of individuals who were entitled to non-cash Federal SSI benefits." *Id.* at 23. The Board's discussion of these contentions confirms SSI days were counted when there was actual SSI cash benefits. *See id.* at 26-30. The CMS Administrator's decision and the ensuing decision of the D.C. District Court also contain references to the Secretary's policy. *See, e.g.,* Adm'r Dec. at 5, 16, 39, 41, 48-49; 545 F. Supp. 2d at 28-29 n.13 & n.17, 36-39.
[29] CMS-1498-R at 5.
[30] *Id.*
[31] *Id.* at 5-6.
[32] 85 Fed. Reg. 23852, 24002-24007 (May 4, 2010).

the Secretary's historical practice of basing "entitled to . . . SSI" under 42 C.F.R. § 412.106(b)(2) on actual payment of SSI cash benefits.[33]

The Secretary finalized that data matching process in the FY 2011 IPPS final rule published on August 16, 2010 ("FY 2011 IPPS Final Rule").[34] Significantly, in the preamble to the FY 2011 IPPS Final Rule, CMS acknowledged a public comment that: (1) requested that "CMS include both paid and unpaid days for both SSI entitlement and Medicare entitlement such that there would be consistency between the numerator and denominator of the SSI fraction"; and (2) provided examples of "several SSI codes that represent individuals who were eligible for SSI but not eligible for SSI payments, that should be included as SSI-entitled for purposes of the data match process."[35] CMS responded in detail to this comment and explained that CMS interprets SSI entitlement to correspond with any month for which an individual *receives* payment of SSI benefits. In this regard, CMS stated that the three SSI codes denoted as C01, M01, and M02 "accurately captures all SSI-entitled individuals during the month(s) they are entitled to receive SSI benefits."[36] CMS explicitly rejected the inclusion of other SSA codes because "SSI entitlement can change from time to time" and none of these codes "would be used to describe an individual who was entitled to receive SSI benefits during the month that one of these codes was used."[37] Finally, in the preamble, CMS confirms that "[t]he same data matching process [used for FY 2011 and beyond] will be used to calculate SSI fractions for cost reporting periods covered under the Ruling [1498-R]."[38]

While the new data matching process established in the preamble to the FY 2011 IPPS Final Rule was effective October 1, 2010 (*i.e.*, for FY 2011 and forward), Ruling 1498-R directed that the Medicare contractors apply "the same, unitary relief" consisting of SSI fractions that the Secretary had calculated using the new "suitably revised" data matching process to: (1) any Medicare cost report that had not been settled; and (2) all properly pending Medicare DSH appeals of the SSI fraction data matching process issue.[39] The Ruling noted that hospitals dissatisfied with the initial or revised NPR issued using the new SSI ratios in the Medicare DSH adjustment calculation could seek administrative and judicial review provided they met the

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[33] *See, e.g.,* 75 Fed. Reg. at 24003 (discussing SSI cash payment issues discussed in the *Baystate* decision), 24003-24004 (discussing the proposed matching process where "[t]he SSI eligibility file serves as the system of record for whether or not SSA made a payment of SSI benefits to an individual who applied for SSI"), 24004-06 (discussing the time of the matching process including how "it is important to find an appropriate balance between administrative finality (that is, the final settlement of a hospital's cost report) and the inclusion of retroactive SSI eligibility determinations and the lifting of SSI payment suspensions by using the best and latest available SSI eligibility data at the time of cost report settlement benefits").
[34] 75 Fed. Reg. 50041, 50280-50281. (Aug. 16, 2010).
[35] *Id.* at 50280.
[36] *Id.* at 50280-50281.
[37] *Id.* This include all codes with the "S" prefix indicating a suspension of payment; codes beginning with "N" for nonpayment; code "E01" indicating that the individual had countable income which eliminated the SSI payment; and code "E02" indicating that the patient was not entitled to SSI benefits during that month but became entitled during a subsequent month.
[38] *Id.* at 50285.
[39] CMS-1498-R at 6-7, 31.

jurisdictional and procedural requirements of 42 U.S.C. § 1395oo, the Medicare regulations, and other agency rules and guidelines.[40] In the FY 2011 IPPS Final Rule, the Secretary explicitly recognized that "[t]he data matching process provisions of the Ruling would apply to . . . open cost reports for cost reporting periods beginning prior to October 1, 2010 (that is those preceding the effective date of the FY 2011 IPPS final rule)."[41]

Finally, on April 22, 2015, CMS published Ruling 1498-R2 modifying and amending Ruling 1498-R by allowing hospitals to elect whether to use new Medicare SSI fractions calculated on the basis of "total days" or "covered days" for cost reports involving patient discharges *prior* to October 1, 2004.[42]

However, neither Ruling 1498-R nor Ruling 1498-R2 are applicable to this appeal since the revised NPRs at issue were issued after Ruling 1498-R and since the fiscal year at issue is not covered by Ruling 1498-R2. As a result of the new regulation and new data match process, CMS calculated SSI percentages for the Providers for the fiscal years at issue.[43] The Provider is challenging the adoption of the policy stated therein that only SSI paid days as represented by SSI codes S01, M01 and M02 are included in the numerator of the SSI fraction for purposes of representing days "entitled to [SSI] benefits."

B. FY 2005 IPPS Final Rule

The FY 2005 IPPS Final Rule announced policy changes relative to the treatment of dual eligible days and Medicare Part C days in the SSI fraction.[44] However, it did not address or announce any policy statements or changes relative to what the phrase "entitled to [SSI] benefits as used in 42 U.S.C. § 1395ww(d)(F)(vi)(I).

Providers' Position

In their EJR Request, the Providers acknowledge that, following the Supreme Court's decision in *Empire*, dual eligible days should be excluded from the Medicaid numerator.[45] They argue, however, that there is now an inconsistency between the interpretation of "entitled to benefits under Part A" (which encompasses any patient who satisfies the statutory eligibility criteria whether or not Medicare actually pays), and "entitled to SSI" (which encompasses only patient days where SSI cash payments were actually received).[46] This discrepancy excludes a large number of days from the Medicare fraction numerator.[47] In particular, the Providers are located in Kentucky where a dual eligible patient is entitled to SSI benefits by definition, so the

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[40] *Id.* at 28, 31.
[41] 75 Fed. Reg. at 24006.
[42] CMS-1498-R2 at 2, 6.
[43] SSI ratios are published and can be accessed at https://www.cms.gov/Medicare/ Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.
[44] 69 Fed. Reg. 48916, 49090-99 (Aug. 11, 2004).
[45] EJR Request at 3.
[46] *Id.*
[47] *Id.*

Providers argue all Kentucky dual eligible patient days should be included in the Medicare Fraction's numerator.[48]

Based on the arguments set forth in the EJR Request, and because the applicable regulations[49] only permit group appeals to present a ***single*** question of fact ***or*** interpretation of law, regulations, or CMS Rulings that is common to each provider in the group, the Board issued a Request for Information ("RFI") in this case on February 7, 2023. The RFI sought to clarify the following:

1. Whether the Providers are pursuing a challenge pertaining to dual eligible days in the Medicaid Fraction related to the validity of the FY 2005 IPPS Rule following the decision in *Becerra v. Empire Health Found*.[50];
2. Whether the Providers are challenging the SSI Data Match policy finalized in the FY 2011 IPPS Final Rule;
3. How the discussion of Kentucky Medicaid is relevant to the issue(s) being pursued in this appeal.

On February 15, 2023, the Providers submitted a response to the RFI. They clarified that they are ***not*** pursuing any challenge related to the correct placement of Dual Eligible Medicare Non-Covered Days as they relate to the Medicaid Fraction because they agree that the Supreme Court settled this issue in *Empire Health*. Similarly, the Providers are ***not***, in this case, pursuing a challenge to the SSI Data Match policy finalized in the FY 2011 IPPS Final Rule. In fact, the Providers have separate group cases pursuing this challenge. Similarly, the Providers confirmed that the discussion of Kentucky Medicaid is relevant to the SSI Data Match issue, and thus only tangentially related to the instant case because a favorable ruling in this case would resolve the SSI Data Match cases. As a whole, the Providers' response to the RFI confirmed that, in the instant case, they are ***only*** challenging the interpretation of "entitled to SSI benefits" as set forth in the FY 2011 IPPS Final Rule.

Decision of the Board

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

[48] *Id.* at 2-3.
[49] 42 C.F.R. §§ 405.1837(a)(2), (f).
[50] 142 S.Ct. 2354 (2022).

A. Preliminary Rulings on the Scope of the EJR Request

The Providers have suggested that they are challenging the FY 2005 IPPS Final Rule based on the following finding they included at the end of their EJR request:

> [The Board] is without the authority to decide the legal question of whether 42 C.F.R. § 412.106 codifying the CMS policies adopted in the FY 2005 IPPS Final Rule and the FY 2011 Final Rule are valid.[51]

However, the EJR request only mentions the FY 2005 IPPS Final Rule in one other place as follows:

> In the 2005 Rule construing the Medicare fraction, CMS interpreted the phrase "entitled to benefits under Part A" to encompass any patient who satisfied Part A statutory *eligibility* criteria whether or not Medicare actually pays for the care.[52]

The Providers have recognized that the Supreme Court upheld this policy:

> In *Becerra v. Empire Health Foundation For Valley Hospital Medical Center*, 142 S.Ct. 2354, 2368 (June 24, 2022), the Supreme Court upheld the Secretary's interpretation of the phrase "entitled to benefits" in the numerator of the Medicare fraction to include those individuals qualifying for Medicare regardless of whether that program actually paid for their day of care. The Supreme Court found that the Secretary's reading of "entitled to benefits" comported with the statute's two-population structure because "[a]ll low-income people fit naturally into one or the other box, with the sum of the two leaving no one out." *Id.* at 2367.[53]

Moreover, the Board notes that the FY 2005 IPPS Final Rule does not include any statement regarding the Secretary's interpretation of the phrase "entitled to [SSI] benefits" as used in 42 U.S.C. § 1395ww(d)(F)(vi)(I). Nor do the Providers claim it does.

Accordingly, the Board finds that the EJR request has not laid a sufficient foundation for a challenge to the FY 2005 IPPS Final Rule. In so ruling, it does not mean that it does not have relevance to what is being challenged, namely the FY 2011 IPPS Final Rule as set forth below. However, it is not what is actually being challenged. In this regard, the Provider is maintaining that the term "entitled" should be consistently interpreted across 42 U.S.C. § 1395 and that "entitled to [SSI] benefits" should be broadly interpreted consistent with how the Secretary

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[51] EJR Request at 18.
[52] *Id.* at n.4.
[53] *Id.* at 2 (footnotes omitted).

interpreted "entitled to benefits under [Medicare] Part A" as used in 42 U.S.C. 1395ww(d)(F)(vi)(I) and explained in the FY 2005 IPPS Final Rule and upheld by the Supreme Court in *Empire*, as noted above.

B. Jurisdiction: Appeals of Cost Report Periods Beginning Prior to December 31, 2008

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008 the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming an issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen.*[54] In that case, the Supreme Court concluded that a cost report submitted in full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.[55]

The Board has determined that the issue in this optional Group as it relates to the meaning of "entitled to [SSI] benefits" is governed by the holding in *Bethesda* since the Providers are challenging the Secretary's interpretation of this phrase as set forth in the FY 2011 IPPS Final Rule and that Board review of this issue is not otherwise precluded by statute or regulation. In addition, the Providers' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal. The appeals were timely filed and no jurisdictional impediments have been identified for the Providers. Based on the above, the Board finds that it has jurisdiction for the above-captioned group appeal.

C. Board's Analysis of the Appealed Issue

As noted above, the Secretary revised the SSI data match process in light of the *Baystate* decision through notice and comment in the form of an uncodified regulation. First, the Secretary issued CMS Ruling 1498-R on April 28, 2010, authorizing remands of pending appeals of the SSI data match issue to recalculate the SSI fraction based on a revised data match.[56] The Secretary also stated in the ruling that, where cost reports had not been settled, those providers' SSI fractions would be calculated using the revised data match.[57] Contemporaneous with CMS' issuance of Ruling 1498-R,[58] the Secretary published the FY 2011 IPPS Proposed Rule[59] which, in pertinent part, proposed to adopt the same data match for 2011 and forward. This proposed rule was adopted as the FY 2011 Final IPPS Rule in which the Secretary explained that:

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[54] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).
[55] *Bethesda at 1258-59.*
[56] CMS Ruling 1498-R at 27.
[57] *Id.* at 31.
[58] *Id.* at 5.
[59] 75 Fed. Reg. 23,852, 24,002-07.

> [W]e used a revised data matching process . . . that comports with the court's decision [in *Baystate* to recalculate the hospitals' SSI fractions]. As the revised data matching process was completed using SSI eligibility data compiled between 13 and 16 years beyond the fiscal years at issue in the *Baystate* case, we believe any issues associated with retroactive determinations of SSI eligibility and the lifting of payment suspensions had been long since resolved. Furthermore, because we believe that the revised match process used to implement the *Baystate* decision addressed all of the concerns found by the court, in the FY 2011 IPPS/LTCH PPS proposed rule we proposed to use the same revised data matching process for calculating hospitals' SSI fractions for FY 2011 and subsequent fiscal years.[60]

Then she announced that:

> We have adopted the proposed data matching process for FY 2011 and beyond as final. The only modification we are making to the proposed matching process is adopting a policy to exclude a record from the data matching process if we find a HICAN in the MedPAR file that we are not able to locate in the EDB[61]which is an extremely unlikely situation as noted in the prior discussion in this final rule. We are adopting this additional step in our validation process to respond to public comment and provide even more assurances that our data matching process will yield accurate SSI fractions and capture all Medicare beneficiaries who were entitled to SSI at the time of their inpatient hospital stay. The same data matching process will be used to calculate SSI fractions for cost reporting periods covered under the ruling.[62]

As part of the adopted data match process, CMS explicitly finalized a policy that SSI codes C01, M01, and M02 would capture all SSI entitled days:

> *Comment*: **One commenter stated that <u>CMS</u>** uses total (that is, "paid and unpaid") Medicare days in the denominator of the SSI fraction, but **<u>uses paid SSI days in the numerator of the SSI fraction</u>**. The commenter requested that CMS interpret the word "entitled" to mean "paid" for both SSI-entitled days used for the numerator and Medicare-entitled days used in the denominator, or alternatively, that CMS include both paid and unpaid days for both SSI entitlement and Medicare entitlement such that there is

[60] 75 Fed. Reg. at 50,277.
[61] (Medicare) Enrollment Database.
[62] 75 Fed. Reg. at 50,285.

consistency between the numerator and the denominator of the SSI fraction. **The commenter stated that there were several SSI codes that represent individuals who were eligible for SSI, but not eligible for SSI payments, that should be included as SSI-entitled for purposes of the data matching process**. Specifically, the commenter stated that at least the following codes should be considered to be SSI-entitlement:

- E01 and E02
- N06, N10, N11, N18, N35, N39, N42, N43, N46, N50, and N54
- P01
- S04, S05, S06, S07, S08, S09, S10, S20, S21, S90, and S91
- T01, T20, T22, and T31

Response: In response to the comment that we are incorrectly applying a different standard in interpreting the word "entitled" with respect to SSI entitlement versus Medicare entitlement, we disagree. The authorizing DSH statute at section 1886(d)(5)(F)(vi)(I) of the Act limits the numerator to individuals entitled to Medicare benefits who are also "*entitled* to supplemental security income benefits (excluding any State supplementation)" (emphasis added).[63] **Consistent with this requirement, we have requested, and are using in the data matching process, those SSA codes that reflect "entitlement to" receive SSI benefits**. Section 1602 of the Act provides that "[e]very aged, blind, or disabled individual who is determined under Part A to be eligible on the basis of his income and resources shall, in accordance with and subject to the provisions of this title, be *paid* benefits by the Commissioner of the Social Security" (emphasis added). However, eligibility for SSI benefits does not automatically mean that an individual will receive SSI benefits for a particular month. For example, section 1611(c)(7) of the Act provides that an application for SSI benefits becomes effective on the later of either the month following the filing of an application for SSI benefits or the month following eligibility for SSI benefits.

On the other hand, section 226 of the Act provides that an individual is automatically "entitled" to Medicare Part A when the person reaches age 65 and is entitled to Social Security benefits under section 202 of the Act (42 U.S.C. 402) or becomes disabled and has

[63] As a side note, we have used the phrase ''SSI-eligible'' interchangeably with the term ''SSI-entitled'' in the FY 2011 proposed rule as well as prior proposed and final rules, but the statute requires that we include individuals who were entitled to SSI benefits in the SSI fractions. Although we have used these terms interchangeably, we intended no different meaning, and our policy has always been to include only Medicare beneficiaries who are entitled to receive SSI benefits in the numerator of the SSI fraction.

> been entitled to disability benefits under section 223 of the Act (42 U.S.C. 423) for 24 calendar months. Section 226A of the Act provides that qualifying individuals with end-stage renal disease shall be entitled to Medicare Part A. In addition, section 1818(a)(4) of the Act provides that, "unless otherwise provided, any reference to an individual entitled to benefits under [Part A] includes an individual entitled to benefits under [Part A] pursuant to enrollment under [section 1818] or section 1818A." We believe that Congress used the phrase "entitled to benefits under part A" in section 1886(d)(5)(F)(vi) of the Act to refer individuals who meet the criteria for entitlement under these sections.
>
> Moreover, unlike the SSI program (in which entitlement to receive SSI benefits is based on income and resources and, therefore, can vary from time to time), once a person becomes entitled to Medicare Part A, the individual does not lose such entitlement simply because there was no Medicare Part A coverage of a specific inpatient stay. Entitlement to Medicare Part A reflects an individual's entitlement to Medicare Part A benefits, not the hospital's entitlement or right to receive payment for services provided to such individual. Such Medicare entitlement does not cease to exist simply because Medicare payment for an individual inpatient hospital claim is not made. Again, we are bound by section 1886(d)(5)(F)(vi)(I) of the Act, which defines the SSI fraction numerator as the number of SSI-entitled inpatient days for persons who were "entitled to benefits under [P]art A," and the denominator as the total number of inpatient days for individuals who were "entitled" to Medicare Part A benefits.
>
> **In response to the comment about specific SSI status codes, SSA has provided information regarding all of the SSI status codes mentioned by the commenter to assist in the determination of whether <u>any</u> of these codes represent individuals who were entitled to SSI benefits for the purposes of calculating the SSI fraction for Medicare DSH**. With respect to the codes that begin with the letter "T," SSA informed us that all of the codes represent individuals whose SSI entitlement was terminated. Code "T01" represents records that were terminated because of the death of the individual, but we confirmed that this code would not be used until the first full month after the death of the individual. That is, for example, if a Medicare individual was entitled to SSI during the month of October, was admitted to the hospital on October 1 and died in the hospital on October 15, the individual would show up as entitled to SSI for the entire month of October on the SSI file (code T01 would not be used on the SSI file until November) and 15 Medicare/SSI inpatient hospital

days for that individual would be counted in the numerator and the denominator of the SSI fraction for that hospital.

Codes beginning with the letter "S" reflect records that are in a "suspended" status and, according to SSA, do not represent individuals who are entitled to SSI benefits.

SSA maintains that code "P01" is obsolete and has not been used since the mid-1980s. Therefore, it would not be used on any SSI files reflecting SSI entitlement for FY 2011 and beyond.

Codes that begin with the letter "N" represent records on "nonpayment" and are not used for individuals who are entitled to SSI benefits.

Code "E01" represents an individual who is a resident of a medical treatment facility and is subject to a $30 payment limit, but has countable income of $30 or more. Such an individual is not entitled to receive SSI payment. Alternatively, an individual who is a resident of a medical treatment facility and is subject to a $30 payment limit, but does not have countable income of at least $30, would be reflected on the SSI file as a "C01" (which denotes SSI entitlement) for any month in which the requirements described in this sentence are met. Code "E02" is used to identify a person who is not entitled to SSI payments in the month in which that code is used pursuant to section 1611(c)(7) of the Act, which provides that an application for SSI benefits shall be effective on the later of (1) the first day of the month following the date the application is filed, or (2) the first day of the month following the date the individual becomes eligible for SSI based on that application. Such an individual is not entitled to SSI benefits during the month that his or her application is filed or is determined to be eligible for SSI, but, for the following month, would be coded as a "C01" because he or she would then be entitled to SSI benefits.

Therefore, both codes E01 and E02 represent individuals who are not entitled to SSI benefits and are reflected accordingly on the SSI file. If the individual's entitlement to SSI benefits is initiated the ensuing month, that individual would then be coded as a "C01" on the SSI file and would be included as SSI-entitled for purposes of the data matching process.

As we have described above, **none of the SSI status codes that the commenter mentioned would be used to describe an individual who was entitled to receive SSI benefits during the month that one of those status codes was used**. SSI entitlement can change

> from time to time, and **we believe that including SSI codes of C01, M01, and M02 accurately captures all SSI-entitled individuals during the month(s) that they are entitled to receive SSI benefits**.
>
> After consideration of the public comments we received, we are adopting the proposed data matching process for FY 2011 and beyond as final. The only modification we are making to the proposed data matching process is adopting a policy to exclude a record from the data matching process if we find a HICAN in the MedPAR file that we are not able to locate in the EDB, which is an extremely unlikely situation as noted in the prior discussion in this final rule. We are adopting this additional step in our validation process in response to public comments to provide even more assurances that **our data matching process will** yield accurate SSI fractions and **capture all Medicare beneficiaries who were <u>entitled</u> to SSI at the time of their inpatient hospital stay**.[64]

The Secretary did not incorporate, into the Code of Federal Regulations, the above new policy involving the revised data match process (including but not limited to portion of that policy relating to interpreting "entitled to [SSI] benefits" and the use of SSI code C01, M01, and M02 to capture SSI entitled days). However, it is clear from the language in the final IPPS rule, as set forth above, that the Secretary intended to bind the regulated parties and establish a *binding* data match process to be used by the Medicare Contractors in calculating (or recalculating) providers' SSI fractions.

Accordingly, the Board finds that the Secretary intended this policy change for the data match process to be a binding but uncodified regulation and will refer to the portion of that policy as it relates to interpreting "entitled to [SSI] benefits" and the related adoption of the SSI codes C01, M01, and M02 to capture SSI entitled days as the "Uncodified SSI Entitled Days Regulation." Indeed, this finding is consistent with the Secretary's obligations under 42 U.S.C. § 1395hh(a)(2) to promulgate any "substantive legal standard governing . . . the payment of services" as a regulation."[65]

Pursuant to 42 C.F.R. § 405.1867, the Board is bound to apply the statutory and regulatory provisions governing the Medicare program. Consequently, the Board finds that it is bound by the Uncodified SSI Entitled Days Regulation published in the FY 2011 Final Rule and the Board does not have the authority to grant the relief sought by the Provider, namely invalidating the Uncodified SSI Entitled Days Regulation which they allege fails to include all of the SSI codes

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[64] 75 Fed. Reg. at 50280-81 (footnote in original; bold and underline emphasis added).

[65] 42 U.S.C. § 1395hh(a)(2) states "[n]o rule, requirement, or other statement of policy . . . that establishes or changes a substantive legal standard governing . . . the payment of services . . . shall take effect unless it is promulgated by the Secretary by regulation . . . ."

used by SSA to determine SSI eligibility. As a result, the Board finds that EJR is appropriate for the issue for the calendar year under appeal in this case.

D. Board's Decision Regarding the EJR Request

The Board finds that:

1) It has jurisdiction over the matter for the subject year and that the Provider is entitled to a hearing before the Board;

2) Based upon the Provider's assertions regarding 42 C.F.R. § 412.106(b)(2)(i) and the Uncodified SSI Entitled Days Regulation as adopted in the preamble to the FY 2011 Final IPPS Rule, there are no findings of fact for resolution by the Board;

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

4) It is without authority to decide the legal question of whether the Uncodified SSI Entitled Days Regulation as adopted in the preamble to the FY 2011 Final IPPS Rule is valid.

Accordingly, the Board finds that the question of the validity of the Uncodified SSI Entitled Days Regulation properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for EJR for that question. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since is the only issue in the appeal, the Board hereby closes the case and removes it from its docket.

Board Members Participating:

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

FOR THE BOARD:

3/7/2023

X Clayton J. Nix

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

Enclosure: Schedule of Providers

cc: Judith Cummings, CGS Administrators (J-15)
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***EJR Determination***
KDMC/Murray-Calloway 2009 DSH SSI Fract. Dual Elig. Medicare Non-Covered Days Grp
Case No. 14-2320G

Dear Mr. Price:

The Provider Reimbursement Review Board ("Board") has reviewed Providers' January 6, 2023 request for expedited judicial review ("EJR") in the above-referenced optional group appeal. The decision of the Board is set forth below.

Issues in Dispute

The Board received the Providers' Optional Group Appeal Request on February 7, 2014. The group was formed with two (2) providers and has been deemed complete. Each Provider filed its appeal from an original Notice of Program Reimbursement ("NPR") and the stated amount in controversy for this case exceeds $50,000.

The Providers' Statement of the Group Issue describes the issue as follows:

> **ISSUE:** Whether the Fiscal Intermediary's calculation of the Provider's disproportionate patient percent, used or purposes of calculating the Medicare Disproportionate Share ("DSH") Adjustment, was incorrect due to CMS' improper treatment of the Medicare Non-Covered Days, which includes but is not limited to Dual Eligible, Medicare Exhausted and Medicare Secondary Payor days. The improper treatment of these days affects the numerator of the Medicaid fraction and the numerator and the denominator of the Medicare fraction.
>
> ****
>
> If Medicare interprets "entitled" to Medicare as "eligible" for Medicare, and thus their basis for including these days in the Medicare fraction, then they also must interpret "entitled" to SSI as "eligible" for SSI and allow Dual Eligible days that are "eligible"

> for SSI, which includes days where the patient may only be receiving their SSI medical benefit/Medicaid, to be included in the Medicare numerator.[1]

With the Group Appeal Request, each provider submitted an estimated amount in controversy calculation which illustrates the impact of including dual eligible days in the Medicaid Fraction, and excluding them from the SSI Ratio. In its calculations, the SSI Numerator is unchanged and the SSI Denominator is reduced; the Medicaid days are also increased for the Medicaid Fraction. This calculation appears to illustrate the assertion that no-pay dual eligible days should be removed from the SSI fraction and moved to the numerator of the Medicaid fraction, which is not at issue in this EJR Request.

A request for Expedited Judicial Review was filed on January 9, 2023.[2] The updated amounts in controversy submitted with the Schedule of Providers which accompany the EJR Request differ from those submitted with the original appeal,[3] and these new calculations illustrate the reimbursement impact based on adding dual eligible days to the Medicare Fraction (the issue in the EJR Request).

<u>Statutory and Regulatory Background:</u>

A. The Secretary's policy on what the phrase "entitled to supplemental security income benefits" in 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I) means for purposes of the numerator of the SSI fraction used in the DSH adjustment calculation

The Medicare program pays inpatient hospital services based on predetermined, standardized amounts subject to certain payment adjustments under Medicare's inpatient prospective payment system ("IPPS").[4] One of these adjustments, the Medicare DSH adjustment, provides additional payments to certain qualifying hospitals that treat a disproportionate share of low income patients.[5] The Medicare DSH adjustment is calculated using two fractions known as the Medicare fraction (also referred to as the SSI fraction or SSI ratio) and the Medicaid fraction. Pursuant to 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I), the Medicare fraction is calculated by using: (a) in the numerator, the "number of such hospital's patient days…which were made up of patients who (for such days) were ***entitled*** to benefits under part A of the subchapter and were ***entitled*** to supplementary security income benefits…under subchapter XVI of this chapter…";[6] and (b) in the denominator, the number of days of care that are furnished to patients who were entitled to Medicare Part A. The Secretary incorporated this statutory provision into the regulations at 42 C.F.R. § 412.106(b)(2)(i)(B) which states:

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[1] Group Appeal Request, Tab 2 (Feb. 7, 2014).
[2] Provider Request for Expedited Judicial Review (Jan. 9, 2023) ("EJR Request").
[3] EJR Request, Attachment L.
[4] 42 C.F.R. Part 412.
[5] 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I).
[6] (Emphasis added.)

> (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)).[7]

The dispute in these appeals involves CMS' determination of which patients are "entitled to" both Medicare Part A and SSI benefits for purposes of the Medicare fraction of the DSH calculation.

The SSI program is a federal cash assistance program for low-income individuals who are aged, blind, or disabled,[8] administered by the Social Security Administration ("SSA"). The statutory provisions governing SSI, generally, do not use the term "entitled" to SSI benefits. Rather, the SSI statutory provisions typically refer to whether an individual is "eligible for benefits."[9] In order to be "eligible" for SSI benefits, a person must be: (1) 65 years of age or older, blind or disabled; (2) a lawful resident of the United States; (3) have limited income and resources; (4) not be fleeing to avoid prosecution for a crime or violating a condition of parole; and (5) file an application for benefits.[10]

In contrast, the Medicare program is an insurance program where an individual is automatically "entitled" to Medicare Part A when the person reaches age 65 and is entitled to Social Security benefits or becomes disabled and had been entitled to disability benefits for 24 calendar

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[7] (Bold emphasis added and italics emphasis in original.) *See also* 42 U.S.C. § 1395w2(d)(5)(F)(vi)(I).
[8] 42 U.S.C. § 1382.
[9] 42 U.S.C. §§ 1381a, 1382(a) (emphasis added).
[10] 20 C.F.R. § 416.202.

months.[11] In addition, the Medicare program provides that certain qualifying individuals with end stage renal disease are entitled to Medicare Part A.[12]

Unlike entitlement for Medicare Part A benefits, an individual who is currently eligible for SSI benefits may later become *in*eligible for SSI benefits. In this regard, SSA conducts periodic redeterminations to ensure continued eligibility[13] and may terminate,[14] suspend[15] or stop payments to individuals who are either temporarily or permanently ineligible for payment of SSI benefits.[16] In particular, SSI eligibility may be lost if a person no longer meets the basic requirements. For example, an individual may lose SSI eligibility if the individual is no longer disabled or the individual meets one of the following reasons set forth in §§ 416.207-416.216:

1. The individual fails to give the SSA permission to contact financial institutions;[17]
2. The individual fails to apply for other benefits to which the individual may be entitled;[18]
3. The individual fails to participate in drug or alcohol addiction treatment;[19]
4. The individuals is absent from the United States for more than 30 days;[20] or
5. The individual becomes a resident of a public institutions or prison.[21]

In addition, under certain circumstances, SSA may not pay benefits for administrative reasons, such as removal of a representative payee, an unknown address for the beneficiary, or because of income from a previous month.[22]

After the Medicare DSH statutory provisions were enacted in 1984, CMS (then known as the Health Care Financing Administration ("HCFA")) announced that the Secretary of Health and Human Services, rather than hospitals, would be solely responsible for computation of the Medicare fraction because the data necessary to calculate the Medicare fraction is voluminous and much of this data needed to be obtained from another agency, SSA.[23] CMS noted that, as of 1986, the data sources for the computation of the Medicare fraction included approximately 11 million billing records from the Medicare inpatient discharge file and over 5 million records

[11] 42 U.S.C. § 426.
[12] 42 U.S.C. § 426-1.
[13] 20 C.F.R. § 416.204.
[14] 20 C.F.R. §§ 416.1331-1335.
[15] 20 C.F.R. §§ 416.1320-1330.
[16] 20 C.F.R. § 1320.
[17] 20 C.F.R. § 416.207.
[18] 20 C.F.R. § 416.210.
[19] 20 C.F.R. § 416.214.
[20] 20 C.F.R. § 416.215.
[21] 20 C.F.R. § 416.211.
[22] *See* SSA Program Operations Manual ("POMS") § SI 02301.201 (describing certain SSI post-eligibility events on the internet at https://secure.ssa.gov/apps10/poms.nsf/lnx/0502301201).
[23] 51 Fed. Reg. 31454, 31459 (Sept. 3, 1986).

from the SSI file compiled by SSA.[24] To compute the Medicare fraction, CMS had to match individual Medicare billing records to individual SSI records.[25] Considering the administrative burdens and complexity of the data matching process, CMS concluded that the Secretary would be responsible for the data matching process, which she would conduct retrospectively for every eligible Medicare hospital on a "federal fiscal year" basis—that is, based on discharges occurring in the federal fiscal year.[26] CMS notifies Medicare contractors of the SSI ratios after they are calculated. CMS currently makes this notification by posting the resulting SSI percentages on its website. Medicare contractors then use the posted SSI ratios to calculate the Medicare DSH percentage to determine each qualifying hospital's Medicare DSH payment adjustment.[27]

The Medicare DSH payment adjustment has been the subject of much litigation and, from that litigation, the following case is of particular relevance to this appeal: *Baystate v. Leavitt*, 545 F. Supp. 2d 20 *as amended* 587 F. Supp. 2d 37, 44 (D.D.C. 2008) ("*Baystate*"). In *Baystate*, the plaintiff alleged that the Secretary's process to identify and gather the data necessary to calculate each hospital's SSI ratio was deficient and the Court remanded the case to the Administrator for further action. The Board notes that this case discusses the Secretary's historical practice of basing "entitled to . . . SSI" under 42 C.F.R. § 412.106(b)(2) on actual payment of SSI cash benefits.[28]

On April 28, 2010, the Secretary through CMS acted on the *Baystate* remand order and published CMS Ruling CMS-1498-R ("Ruling 1498-R"). Specifically, the Ruling stated that CMS had implemented the *Baystate* remand order by recalculating the plaintiff's SSI fractions and Medicare DSH payment adjustments using a revised data matching process that used "updated and refined SSI eligibility data and Medicare records, and by matching individuals' records with reference to Social Security numbers (SSNs) as well as HICANs and Title II numbers."[29] The Ruling also stated that "in the FY 2011 proposed rule, CMS is proposing to

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[24] *Id.*
[25] *Id.*
[26] *Id.* at 31459–31460; 42 C.F.R. § 412.106(b).
[27] 42 C.F.R. § 412.106(b)(5); 42 C.F.R. § 405.1803.
[28] *Baystate* began with a hearing before the Board. *See Baystate Med. Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006), *modified by*, CMS Adm'r Dec. (May 11, 2006). The Board heard extensive testimony on the Secretary's then-existing data match process. This included testimony from several SSA employees on the data tapes historically sent from SSA to CMS that included "42 monthly indicators (ones and zeros) denoting the payment or non-payment of Federal SSI cash benefits during the period covered by the SSA tape." *Id.* at 11 (citations omitted). Further, this testimony established that SSA's program would "assign a '1' to a month if the CMPH field shows one of two payment codes, C01 (current pay status) or M01 (manual or forced pay), and the FAM field reflects an amount due for the month" and that "[o]therwise, the program assigns a '0' to that month." *Id.* The provider in *Baystate* contested among other things: (1) "the omission of SSI records relating to individuals who received a forced payment from an SSA filed office; (2) "the omission of SSI days associated with individuals whose SSI benefits were temporarily on hold or in suspense when SSA ran each year's SSI tape;" (3) "the omission of SSI days associated with individuals whose benefits were restored or retroactively after SSA ran each year's tape;" and (4) "the omission of individuals who were entitled to non-cash Federal SSI benefits." *Id.* at 23. The Board's discussion of these contentions confirms SSI days were counted when there was actual SSI cash benefits. *See id*. at 26-30. The CMS Administrator's decision and the ensuing decision of the D.C. District Court also contain references to the Secretary's policy. *See, e.g.,* Adm'r Dec. at 5, 16, 39, 41, 48-49; 545 F. Supp. 2d at 28-29 n.13 & n.17, 36-39.
[29] CMS-1498-R at 5.

adopt the same revised data matching process" for use with all hospitals and that "[i]n the forthcoming FY 2011 IPPS final rule, CMS expects to respond to public comments filed on the proposed new data matching process, make any changes to such matching process that seem appropriate, and adopt finally a new data matching process."[30] Finally, CMS stated that it would "use that new data matching process in calculating SSI fractions and DSH payments for specific claims that are found to qualify for relief under this Ruling."[31]

Consistent with Ruling 1498-R, the Secretary published the new data matching process in the FY 2011 IPPS proposed rule published on May 4, 2010.[32] The proposed rule includes references to the Secretary's historical practice of basing "entitled to . . . SSI" under 42 C.F.R. § 412.106(b)(2) on actual payment of SSI cash benefits.[33]

The Secretary finalized that data matching process in the FY 2011 IPPS final rule published on August 16, 2010 ("FY 2011 IPPS Final Rule").[34] Significantly, in the preamble to the FY 2011 IPPS Final Rule, CMS acknowledged a public comment that: (1) requested that "CMS include both paid and unpaid days for both SSI entitlement and Medicare entitlement such that there would be consistency between the numerator and denominator of the SSI fraction"; and (2) provided examples of "several SSI codes that represent individuals who were eligible for SSI but not eligible for SSI payments, that should be included as SSI-entitled for purposes of the data match process."[35] CMS responded in detail to this comment and explained that CMS interprets SSI entitlement to correspond with any month for which an individual *receives* payment of SSI benefits. In this regard, CMS stated that the three SSI codes denoted as C01, M01, and M02 "accurately captures all SSI-entitled individuals during the month(s) they are entitled to receive SSI benefits."[36] CMS explicitly rejected the inclusion of other SSA codes because "SSI entitlement can change from time to time" and none of these codes "would be used to describe an individual who was entitled to receive SSI benefits during the month that one of these codes was used."[37] Finally, in the preamble, CMS confirms that "[t]he same data matching process

[30] *Id.*
[31] *Id.* at 5-6.
[32] 85 Fed. Reg. 23852, 24002-24007 (May 4, 2010).
[33] *See, e.g.,* 75 Fed. Reg. at 24003 (discussing SSI cash payment issues discussed in the *Baystate* decision), 24003-24004 (discussing the proposed matching process where "[t]he SSI eligibility file serves as the system of record for whether or not SSA made a payment of SSI benefits to an individual who applied for SSI"), 24004-06 (discussing the time of the matching process including how "it is important to find an appropriate balance between administrative finality (that is, the final settlement of a hospital's cost report) and the inclusion of retroactive SSI eligibility determinations and the lifting of SSI payment suspensions by using the best and latest available SSI eligibility data at the time of cost report settlement benefits").
[34] 75 Fed. Reg. 50041, 50280-50281. (Aug. 16, 2010).
[35] *Id.* at 50280.
[36] *Id.* at 50280-50281.
[37] *Id.* This include all codes with the "S" prefix indicating a suspension of payment; codes beginning with "N" for nonpayment; code "E01" indicating that the individual had countable income which eliminated the SSI payment; and code "E02" indicating that the patient was not entitled to SSI benefits during that month but became entitled during a subsequent month.

[used for FY 2011 and beyond] will be used to calculate SSI fractions for cost reporting periods covered under the Ruling [1498-R]."[38]

While the new data matching process established in the preamble to the FY 2011 IPPS Final Rule was effective October 1, 2010 (*i.e*., for FY 2011 and forward), Ruling 1498-R directed that the Medicare contractors apply "the same, unitary relief" consisting of SSI fractions that the Secretary had calculated using the new "suitably revised" data matching process to: (1) any Medicare cost report that had not been settled; and (2) all properly pending Medicare DSH appeals of the SSI fraction data matching process issue.[39] The Ruling noted that hospitals dissatisfied with the initial or revised NPR issued using the new SSI ratios in the Medicare DSH adjustment calculation could seek administrative and judicial review provided they met the jurisdictional and procedural requirements of 42 U.S.C. § 1395oo, the Medicare regulations, and other agency rules and guidelines.[40] In the FY 2011 IPPS Final Rule, the Secretary explicitly recognized that "[t]he data matching process provisions of the Ruling would apply to . . . open cost reports for cost reporting periods beginning prior to October 1, 2010 (that is those preceding the effective date of the FY 2011 IPPS final rule)."[41]

Finally, on April 22, 2015, CMS published Ruling 1498-R2 modifying and amending Ruling 1498-R by allowing hospitals to elect whether to use new Medicare SSI fractions calculated on the basis of "total days" or "covered days" for cost reports involving patient discharges *prior* to October 1, 2004.[42]

However, neither Ruling 1498-R nor Ruling 1498-R2 are applicable to this appeal since the revised NPRs at issue were issued after Ruling 1498-R and since the fiscal year at issue is not covered by Ruling 1498-R2. As a result of the new regulation and new data match process, CMS calculated SSI percentages for the Providers for the fiscal years at issue.[43] The Provider is challenging the adoption of the policy stated therein that only SSI paid days as represented by SSI codes S01, M01 and M02 are included in the numerator of the SSI fraction for purposes of representing days "entitled to [SSI] benefits."

B. FY 2005 IPPS Final Rule

The FY 2005 IPPS Final Rule announced policy changes relative to the treatment of dual eligible days and Medicare Part C days in the SSI fraction.[44] However, it did not address or announce

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[38] *Id.* at 50285.
[39] CMS-1498-R at 6-7, 31.
[40] *Id.* at 28, 31.
[41] 75 Fed. Reg. at 24006.
[42] CMS-1498-R2 at 2, 6.
[43] SSI ratios are published and can be accessed at https://www.cms.gov/Medicare/ Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.
[44] 69 Fed. Reg. 48916, 49090-99 (Aug. 11, 2004).

any policy statements or changes relative to what the phrase "entitled to [SSI] benefits as used in 42 U.S.C. § 1395ww(d)(F)(vi)(I).

Providers' Position

In their EJR Request, the Providers acknowledge that, following the Supreme Court's decision in *Empire*, dual eligible days should be excluded from the Medicaid numerator.[45] They argue, however, that there is now an inconsistency between the interpretation of "entitled to benefits under Part A" (which encompasses any patient who satisfies the statutory eligibility criteria whether or not Medicare actually pays), and "entitled to SSI" (which encompasses only patient days where SSI cash payments were actually received).[46] This discrepancy excludes a large number of days from the Medicare fraction numerator.[47] In particular, the Providers are located in Kentucky where a dual eligible patient is entitled to SSI benefits by definition, so the Providers argue all Kentucky dual eligible patient days should be included in the Medicare Fraction's numerator.[48]

Based on the arguments set forth in the EJR Request, and because the applicable regulations[49] only permit group appeals to present a ***single*** question of fact ***or*** interpretation of law, regulations, or CMS Rulings that is common to each provider in the group, the Board issued a Request for Information ("RFI") in this case on February 7, 2023. The RFI sought to clarify the following:

1. Whether the Providers are pursuing a challenge pertaining to dual eligible days in the Medicaid Fraction related to the validity of the FY 2005 IPPS Rule following the decision in *Becerra v. Empire Health Found.*[50];
2. Whether the Providers are challenging the SSI Data Match policy finalized in the FY 2011 IPPS Final Rule;
3. How the discussion of Kentucky Medicaid is relevant to the issue(s) being pursued in this appeal.

On February 15, 2023, the Providers submitted a response to the RFI. They clarified that they are ***not*** pursuing any challenge related to the correct placement of Dual Eligible Medicare Non-Covered Days as they relate to the Medicaid Fraction because they agree that the Supreme Court settled this issue in *Empire Health*. Similarly, the Providers are ***not***, in this case, pursuing a challenge to the SSI Data Match policy finalized in the FY 2011 IPPS Final Rule. In fact, the Providers have separate group cases pursuing this challenge. Similarly, the Providers confirmed that the discussion of Kentucky Medicaid is relevant to the SSI Data Match issue, and thus only tangentially related to the instant case because a favorable ruling in this case would resolve the

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[45] EJR Request at 3.
[46] *Id.*
[47] *Id.*
[48] *Id.* at 2-3.
[49] 42 C.F.R. §§ 405.1837(a)(2), (f).
[50] 142 S.Ct. 2354 (2022).

SSI Data Match cases. As a whole, the Providers' response to the RFI confirmed that, in the instant case, they are ***only*** challenging the interpretation of "entitled to SSI benefits" as set forth in the FY 2011 IPPS Final Rule.

Decision of the Board

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

A. Preliminary Rulings on the Scope of the EJR Request

The Providers have suggested that they are challenging the FY 2005 IPPS Final Rule based on the following finding they included at the end of their EJR request:

> [The Board] is without the authority to decide the legal question of whether 42 C.F.R. § 412.106 codifying the CMS policies adopted in the FY 2005 IPPS Final Rule and the FY 2011 Final Rule are valid.[51]

However, the EJR request only mentions the FY 2005 IPPS Final Rule in one other place as follows:

> In the 2005 Rule construing the Medicare fraction, CMS interpreted the phrase "entitled to benefits under Part A" to encompass any patient who satisfied Part A statutory *eligibility* criteria whether or not Medicare actually pays for the care.[52]

The Providers have recognized that the Supreme Court upheld this policy:

> In *Becerra v. Empire Health Foundation For Valley Hospital Medical Center*, 142 S.Ct. 2354, 2368 (June 24, 2022), the Supreme Court upheld the Secretary's interpretation of the phrase "entitled to benefits" in the numerator of the Medicare fraction to include those individuals qualifying for Medicare regardless of whether that program actually paid for their day of care. The Supreme Court found that the Secretary's reading of "entitled to benefits" comported with the statute's two-population structure

[51] EJR Request at 18.
[52] *Id.* at n.4.

> because "[a]ll low-income people fit naturally into one or the other box, with the sum of the two leaving no one out." *Id.* at 2367.[53]

Moreover, the Board notes that the FY 2005 IPPS Final Rule does not include any statement regarding the Secretary's interpretation of the phrase "entitled to [SSI] benefits" as used in 42 U.S.C. § 1395ww(d)(F)(vi)(I). Nor do the Providers claim it does.

Accordingly, the Board finds that the EJR request has not laid a sufficient foundation for a challenge to the FY 2005 IPPS Final Rule. In so ruling, it does not mean that it does not have relevance to what is being challenged, namely the FY 2011 IPPS Final Rule as set forth below. However, it is not what is actually being challenged. In this regard, the Provider is maintaining that the term "entitled" should be consistently interpreted across 42 U.S.C. § 1395 and that "entitled to [SSI] benefits" should be broadly interpreted consistent with how the Secretary interpreted "entitled to benefits under [Medicare] Part A" as used in 42 U.S.C. 1395ww(d)(F)(vi)(I) and explained in the FY 2005 IPPS Final Rule and upheld by the Supreme Court in *Empire*, as noted above.

B. Jurisdiction: Appeals of Cost Report Periods Beginning After December 31, 2008 and Before January 1, 2016

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008 the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming an issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen.*[54] In that case, the Supreme Court concluded that a cost report submitted in full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.[55]

On August 21, 2008, new regulations governing the Board were effective.[56] Among the new regulations implemented in the Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hospital v. Burwell* ("*Banner*").[57] In *Banner*, the provider filed its cost report in accordance with the applicable

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[53] *Id.* at 2 (footnotes omitted).
[54] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).
[55] *Bethesda at 1258-59.*
[56] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[57] 201 F. Supp. 3d 131 (D.D.C. 2016).

outlier regulations and did not protest the additional outlier payment it was seeking. The provider's request for EJR was denied because the Board found that it lacked jurisdiction over the issue. The District Court concluded that, under *Bethesda,* the 2008 self-disallowance regulation could not be applied to appeals raising a legal challenge to a regulation or other policy that the Medicare Contractor could not address.[58]

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

The Board has determined that the issue in this CIRP Group as it relates to the meaning of "entitled to [SSI] benefits" is governed by CMS Ruling CMS-1727-R since the Providers are challenging the Secretary's interpretation of this phrase as set forth in the FY 2011 IPPS Final Rule and that Board review of this issue is not otherwise precluded by statute or regulation. In addition, the Providers' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal. The appeals were timely filed and no jurisdictional impediments have been identified for the Providers. Based on the above, the Board finds that it has jurisdiction for the above-captioned group appeal.

C. Board's Analysis of the Appealed Issue

As noted above, the Secretary revised the SSI data match process in light of the *Baystate* decision through notice and comment in the form of an uncodified regulation. First, the Secretary issued CMS Ruling 1498-R on April 28, 2010, authorizing remands of pending appeals of the SSI data match issue to recalculate the SSI fraction based on a revised data match.[59] The Secretary also stated in the ruling that, where cost reports had not been settled, those providers' SSI fractions would be calculated using the revised data match.[60] Contemporaneous with CMS' issuance of Ruling 1498-R,[61] the Secretary published the FY 2011 IPPS Proposed Rule[62] which, in pertinent part, proposed to adopt the same data match for 2011 and forward. This proposed rule was adopted as the FY 2011 Final IPPS Rule in which the Secretary explained that:

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[58] *Id.* at 142.
[59] CMS Ruling 1498-R at 27.
[60] *Id.* at 31.
[61] *Id.* at 5.
[62] 75 Fed. Reg. 23,852, 24,002-07.

> [W]e used a revised data matching process . . . that comports with the court's decision [in *Baystate* to recalculate the hospitals' SSI fractions]. As the revised data matching process was completed using SSI eligibility data compiled between 13 and 16 years beyond the fiscal years at issue in the *Baystate* case, we believe any issues associated with retroactive determinations of SSI eligibility and the lifting of payment suspensions had been long since resolved. Furthermore, because we believe that the revised match process used to implement the *Baystate* decision addressed all of the concerns found by the court, in the FY 2011 IPPS/LTCH PPS proposed rule we proposed to use the same revised data matching process for calculating hospitals' SSI fractions for FY 2011 and subsequent fiscal years.[63]

Then she announced that:

> We have adopted the proposed data matching process for FY 2011 and beyond as final. The only modification we are making to the proposed matching process is adopting a policy to exclude a record from the data matching process if we find a HICAN in the MedPAR file that we are not able to locate in the EDB[64]which is an extremely unlikely situation as noted in the prior discussion in this final rule. We are adopting this additional step in our validation process to respond to public comment and provide even more assurances that our data matching process will yield accurate SSI fractions and capture all Medicare beneficiaries who were entitled to SSI at the time of their inpatient hospital stay. The same data matching process will be used to calculate SSI fractions for cost reporting periods covered under the ruling.[65]

As part of the adopted data match process, CMS explicitly finalized a policy that SSI codes C01, M01, and M02 would capture all SSI entitled days:

> *Comment*: **One commenter stated that <u>CMS</u>** uses total (that is, "paid and unpaid") Medicare days in the denominator of the SSI fraction, but **<u>uses paid SSI days in the numerator of the SSI fraction</u>**. The commenter requested that CMS interpret the word "entitled" to mean "paid" for both SSI-entitled days used for the numerator and Medicare-entitled days used in the denominator, or alternatively, that CMS include both paid and unpaid days for both SSI entitlement and Medicare entitlement such that there is consistency between the numerator and the denominator of the SSI

63 75 Fed. Reg. at 50,277.
64 (Medicare) Enrollment Database.
65 75 Fed. Reg. at 50,285.

> fraction. **The commenter stated that there were several SSI codes that represent individuals who were eligible for SSI, but not eligible for SSI payments, that should be included as SSI-entitled for purposes of the data matching process**. Specifically, the commenter stated that at least the following codes should be considered to be SSI-entitlement:
>
> - E01 and E02
> - N06, N10, N11, N18, N35, N39, N42, N43, N46, N50, and N54
> - P01
> - S04, S05, S06, S07, S08, S09, S10, S20, S21, S90, and S91
> - T01, T20, T22, and T31
>
> *Response*: In response to the comment that we are incorrectly applying a different standard in interpreting the word "entitled" with respect to SSI entitlement versus Medicare entitlement, we disagree. The authorizing DSH statute at section 1886(d)(5)(F)(vi)(I) of the Act limits the numerator to individuals entitled to Medicare benefits who are also "*entitled* to supplemental security income benefits (excluding any State supplementation)" (emphasis added).[66] **Consistent with this requirement, we have requested, and are using in the data matching process, those SSA codes that reflect "entitlement to" receive SSI benefits**. Section 1602 of the Act provides that "[e]very aged, blind, or disabled individual who is determined under Part A to be eligible on the basis of his income and resources shall, in accordance with and subject to the provisions of this title, be *paid* benefits by the Commissioner of the Social Security" (emphasis added). However, eligibility for SSI benefits does not automatically mean that an individual will receive SSI benefits for a particular month. For example, section 1611(c)(7) of the Act provides that an application for SSI benefits becomes effective on the later of either the month following the filing of an application for SSI benefits or the month following eligibility for SSI benefits.
>
> On the other hand, section 226 of the Act provides that an individual is automatically "entitled" to Medicare Part A when the person reaches age 65 and is entitled to Social Security benefits under section 202 of the Act (42 U.S.C. 402) or becomes disabled and has been entitled to disability benefits under section 223 of the Act (42

[66] As a side note, we have used the phrase ''SSI-eligible'' interchangeably with the term ''SSI-entitled'' in the FY 2011 proposed rule as well as prior proposed and final rules, but the statute requires that we include individuals who were entitled to SSI benefits in the SSI fractions. Although we have used these terms interchangeably, we intended no different meaning, and our policy has always been to include only Medicare beneficiaries who are entitled to receive SSI benefits in the numerator of the SSI fraction.

U.S.C. 423) for 24 calendar months. Section 226A of the Act provides that qualifying individuals with end-stage renal disease shall be entitled to Medicare Part A. In addition, section 1818(a)(4) of the Act provides that, "unless otherwise provided, any reference to an individual entitled to benefits under [Part A] includes an individual entitled to benefits under [Part A] pursuant to enrollment under [section 1818] or section 1818A." We believe that Congress used the phrase "entitled to benefits under part A" in section 1886(d)(5)(F)(vi) of the Act to refer individuals who meet the criteria for entitlement under these sections.

Moreover, unlike the SSI program (in which entitlement to receive SSI benefits is based on income and resources and, therefore, can vary from time to time), once a person becomes entitled to Medicare Part A, the individual does not lose such entitlement simply because there was no Medicare Part A coverage of a specific inpatient stay. Entitlement to Medicare Part A reflects an individual's entitlement to Medicare Part A benefits, not the hospital's entitlement or right to receive payment for services provided to such individual. Such Medicare entitlement does not cease to exist simply because Medicare payment for an individual inpatient hospital claim is not made. Again, we are bound by section 1886(d)(5)(F)(vi)(I) of the Act, which defines the SSI fraction numerator as the number of SSI-entitled inpatient days for persons who were "entitled to benefits under [P]art A," and the denominator as the total number of inpatient days for individuals who were "entitled" to Medicare Part A benefits.

In response to the comment about specific SSI status codes, SSA has provided information regarding all of the SSI status codes mentioned by the commenter to assist in the determination of whether any of these codes represent individuals who were entitled to SSI benefits for the purposes of calculating the SSI fraction for Medicare DSH. With respect to the codes that begin with the letter "T," SSA informed us that all of the codes represent individuals whose SSI entitlement was terminated. Code "T01" represents records that were terminated because of the death of the individual, but we confirmed that this code would not be used until the first full month after the death of the individual. That is, for example, if a Medicare individual was entitled to SSI during the month of October, was admitted to the hospital on October 1 and died in the hospital on October 15, the individual would show up as entitled to SSI for the entire month of October on the SSI file (code T01 would not be used on the SSI file until November) and 15 Medicare/SSI inpatient hospital

days for that individual would be counted in the numerator and the denominator of the SSI fraction for that hospital.

Codes beginning with the letter "S" reflect records that are in a "suspended" status and, according to SSA, do not represent individuals who are entitled to SSI benefits.

SSA maintains that code "P01" is obsolete and has not been used since the mid-1980s. Therefore, it would not be used on any SSI files reflecting SSI entitlement for FY 2011 and beyond.

Codes that begin with the letter "N" represent records on "nonpayment" and are not used for individuals who are entitled to SSI benefits.

Code "E01" represents an individual who is a resident of a medical treatment facility and is subject to a $30 payment limit, but has countable income of $30 or more. Such an individual is not entitled to receive SSI payment. Alternatively, an individual who is a resident of a medical treatment facility and is subject to a $30 payment limit, but does not have countable income of at least $30, would be reflected on the SSI file as a "C01" (which denotes SSI entitlement) for any month in which the requirements described in this sentence are met. Code "E02" is used to identify a person who is not entitled to SSI payments in the month in which that code is used pursuant to section 1611(c)(7) of the Act, which provides that an application for SSI benefits shall be effective on the later of (1) the first day of the month following the date the application is filed, or (2) the first day of the month following the date the individual becomes eligible for SSI based on that application. Such an individual is not entitled to SSI benefits during the month that his or her application is filed or is determined to be eligible for SSI, but, for the following month, would be coded as a "C01" because he or she would then be entitled to SSI benefits.

Therefore, both codes E01 and E02 represent individuals who are not entitled to SSI benefits and are reflected accordingly on the SSI file. If the individual's entitlement to SSI benefits is initiated the ensuing month, that individual would then be coded as a "C01" on the SSI file and would be included as SSI-entitled for purposes of the data matching process.

As we have described above, **none of the SSI status codes that the commenter mentioned would be used to describe an individual who was entitled to receive SSI benefits during the month that one of those status codes was used**. SSI entitlement can change

> from time to time, and **we believe that including SSI codes of C01, M01, and M02 accurately captures all SSI-entitled individuals during the month(s) that they are entitled to receive SSI benefits**.
>
> After consideration of the public comments we received, we are adopting the proposed data matching process for FY 2011 and beyond as final. The only modification we are making to the proposed data matching process is adopting a policy to exclude a record from the data matching process if we find a HICAN in the MedPAR file that we are not able to locate in the EDB, which is an extremely unlikely situation as noted in the prior discussion in this final rule. We are adopting this additional step in our validation process in response to public comments to provide even more assurances that **our data matching process will** yield accurate SSI fractions and **capture all Medicare beneficiaries who were <u>entitled</u> to SSI at the time of their inpatient hospital stay**.[67]

The Secretary did not incorporate, into the Code of Federal Regulations, the above new policy involving the revised data match process (including but not limited to portion of that policy relating to interpreting "entitled to [SSI] benefits" and the use of SSI code C01, M01, and M02 to capture SSI entitled days). However, it is clear from the language in the final IPPS rule, as set forth above, that the Secretary intended to bind the regulated parties and establish a *binding* data match process to be used by the Medicare Contractors in calculating (or recalculating) providers' SSI fractions.

Accordingly, the Board finds that the Secretary intended this policy change for the data match process to be a binding but uncodified regulation and will refer to the portion of that policy as it relates to interpreting "entitled to [SSI] benefits" and the related adoption of the SSI codes C01, M01, and M02 to capture SSI entitled days as the "Uncodified SSI Entitled Days Regulation." Indeed, this finding is consistent with the Secretary's obligations under 42 U.S.C. § 1395hh(a)(2) to promulgate any "substantive legal standard governing . . . the payment of services" as a regulation."[68]

Pursuant to 42 C.F.R. § 405.1867, the Board is bound to apply the statutory and regulatory provisions governing the Medicare program. Consequently, the Board finds that it is bound by the Uncodified SSI Entitled Days Regulation published in the FY 2011 Final Rule and the Board does not have the authority to grant the relief sought by the Provider, namely invalidating the Uncodified SSI Entitled Days Regulation which they allege fails to include all of the SSI codes

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[67] 75 Fed. Reg. at 50280-81 (footnote in original; bold and underline emphasis added).
[68] 42 U.S.C. § 1395hh(a)(2) states "[n]o rule, requirement, or other statement of policy . . . that establishes or changes a substantive legal standard governing . . . the payment of services . . . shall take effect unless it is promulgated by the Secretary by regulation . . . ."

used by SSA to determine SSI eligibility. As a result, the Board finds that EJR is appropriate for the issue for the calendar year under appeal in this case.

D. Board's Decision Regarding the EJR Request

The Board finds that:

1) It has jurisdiction over the matter for the subject year and that the Provider is entitled to a hearing before the Board;

2) Based upon the Provider's assertions regarding 42 C.F.R. § 412.106(b)(2)(i) and the Uncodified SSI Entitled Days Regulation as adopted in the preamble to the FY 2011 Final IPPS Rule, there are no findings of fact for resolution by the Board;

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

4) It is without authority to decide the legal question of whether the Uncodified SSI Entitled Days Regulation as adopted in the preamble to the FY 2011 Final IPPS Rule is valid.

Accordingly, the Board finds that the question of the validity of the Uncodified SSI Entitled Days Regulation properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for EJR for that question. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since is the only issue in the appeal, the Board hereby closes the case and removes it from its docket.

<u>Board Members Participating:</u>

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

FOR THE BOARD:

3/7/2023

X Clayton J. Nix

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

Enclosure: Schedule of Providers

cc: Judith Cummings, CGS Administrators (J-15)
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***EJR Determination***
ARH DSH - SSI Ratio Dual Eligible Medicare Non-Covered Days CIRP Group
Case No. 14-2481GC

Dear Mr. Price:

The Provider Reimbursement Review Board ("Board") has reviewed Providers' January 6, 2023 request for expedited judicial review ("EJR") in the above-referenced Common Issue Related Party ("CIRP") group appeal. The decision of the Board is set forth below.

Issues in Dispute

The Board received the Providers' Group Appeal Request on February 18, 2014. The group was formed with four (4) providers but one (1) provider was withdrawn on December 14, 2022. Each Provider filed its appeal from an original Notice of Program Reimbursement ("NPR") and the stated amount in controversy for this case exceeds $50,000.

The Providers' Statement of the Group Issue describes the issue as follows:

> **ISSUE:** Whether the Fiscal Intermediary's calculation of the Provider's disproportionate patient percent, used or purposes of calculating the Medicare Disproportionate Share ("DSH") Adjustment, was incorrect due to CMS' improper treatment of the Medicare Non-Covered Days, which includes but is not limited to Dual Eligible, Medicare Exhausted and Medicare Secondary Payor days. The improper treatment of these days affects the numerator of the Medicaid fraction and the numerator and the denominator of the Medicare fraction.
>
> ****
>
> According to the interpretation of 42 C.F.R. § 412.106(b), the regulation currently interprets the statutory language "entitled to benefits under [Medicare] Part A" as requiring the inclusion of patient days for all Medicare beneficiaries, even if a beneficiary has exhausted his or her Medicare coverage. This interpretation requires

> the exclusion from the Medicaid fraction of patient days for those individuals who are "eligible" for both Medicare and Medicaid, but who have exhausted their Medicare benefits. Per the ruling from *Metro. Hosp., Inc. v. US. Dep 't of Health & Human Servs*.,702 F. Supp. 2d 808, 825-26 (W.D. Mich. 2010), the district court determined that the interpretation at section 412.106(b) was invalid as contrary to the plain meaning of the DPP statute, reasoning that "entitled" requires payment for hospital services, rather than mere eligibility. Thus, dual-eligible patients with exhausted Medicare benefits would be included in the numerator of the Medicaid fraction.
>
> ****
>
> If Medicare interprets "entitled" to Medicare as "eligible" for Medicare, and thus their basis for including these days in the Medicare fraction, then they also must interpret "entitled" to SSI as "eligible" for SSI and allow Dual Eligible days that are "eligible" for SSI, which includes days where the patient may only be receiving their SSI medical benefit/Medicaid, to be included in the Medicare numerator.[1]

With the Group Appeal Request, each provider submitted two estimated amount in controversy calculations. One illustrates the impact of including dual eligible days in the Medicaid Fraction, and excluding them from the SSI Ratio. In its calculations, the SSI Numerator is unchanged and the SSI Denominator is reduced; the Medicaid days are also increased for the Medicaid Fraction. This calculation appears to illustrate the assertion that no-pay dual eligible days should be removed from the SSI fraction and moved to the numerator of the Medicaid fraction, which is not at issue in this EJR Request.

The Providers also included separate calculations which illustrate the alternative argument that the definition of "entitled to SSI benefits" as used in the numerator of the SSI fraction should be expanded to include days where a patient is eligible for SSI benefits. For each provider, the amount in controversy was estimated to be:

1. Harlan ARH Hospital (Prov. No. 18-0050): $693,212, based on the addition of 736 dual eligible days to the SSI Ratio;
2. Williamson ARH Hospital (Prov. No. 18-0069): $753,191, based on the addition of 1,282 dual eligible days to the SSI Ratio; and
3. Hazard ARH Hospital (Prov. No. 18-0029): $1,994,930, based on the addition of 2,046 dual eligible days in the SSI Ratio.

A request for Expedited Judicial Review was filed on January 6, 2023.[2]

[1] Group Appeal Request, Tab 2 (Feb. 18, 2014).
[2] Provider Request for Expedited Judicial Review (Jan 6, 2023) ("EJR Request").

Statutory and Regulatory Background:

A. The Secretary's policy on what the phrase "entitled to supplemental security income benefits" in 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I) means for purposes of the numerator of the SSI fraction used in the DSH adjustment calculation

The Medicare program pays inpatient hospital services based on predetermined, standardized amounts subject to certain payment adjustments under Medicare's inpatient prospective payment system ("IPPS").[3] One of these adjustments, the Medicare DSH adjustment, provides additional payments to certain qualifying hospitals that treat a disproportionate share of low income patients.[4] The Medicare DSH adjustment is calculated using two fractions known as the Medicare fraction (also referred to as the SSI fraction or SSI ratio) and the Medicaid fraction. Pursuant to 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I), the Medicare fraction is calculated by using: (a) in the numerator, the "number of such hospital's patient days…which were made up of patients who (for such days) were ***entitled*** to benefits under part A of the subchapter and were ***entitled*** to supplementary security income benefits…under subchapter XVI of this chapter…";[5] and (b) in the denominator, the number of days of care that are furnished to patients who were entitled to Medicare Part A. The Secretary incorporated this statutory provision into the regulations at 42 C.F.R. § 412.106(b)(2)(i)(B) which states:

> (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

[3] 42 C.F.R. Part 412.
[4] 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I).
[5] (Emphasis added.)

> (B) Are furnished to patients entitled to Medicare Part A (including Medicare Advantage (Part C)).[6]

The dispute in these appeals involves CMS' determination of which patients are "entitled to" both Medicare Part A and SSI benefits for purposes of the Medicare fraction of the DSH calculation.

The SSI program is a federal cash assistance program for low-income individuals who are aged, blind, or disabled,[7] administered by the Social Security Administration ("SSA"). The statutory provisions governing SSI, generally, do not use the term "entitled" to SSI benefits. Rather, the SSI statutory provisions typically refer to whether an individual is "eligible for benefits."[8] In order to be "eligible" for SSI benefits, a person must be: (1) 65 years of age or older, blind or disabled; (2) a lawful resident of the United States; (3) have limited income and resources; (4) not be fleeing to avoid prosecution for a crime or violating a condition of parole; and (5) file an application for benefits.[9]

In contrast, the Medicare program is an insurance program where an individual is automatically "entitled" to Medicare Part A when the person reaches age 65 and is entitled to Social Security benefits or becomes disabled and had been entitled to disability benefits for 24 calendar months.[10] In addition, the Medicare program provides that certain qualifying individuals with end stage renal disease are entitled to Medicare Part A.[11]

Unlike entitlement for Medicare Part A benefits, an individual who is currently eligible for SSI benefits may later become *in*eligible for SSI benefits. In this regard, SSA conducts periodic redeterminations to ensure continued eligibility[12] and may terminate,[13] suspend[14] or stop payments to individuals who are either temporarily or permanently ineligible for payment of SSI benefits.[15] In particular, SSI eligibility may be lost if a person no longer meets the basic requirements. For example, an individual may lose SSI eligibility if the individual is no longer disabled or the individual meets one of the following reasons set forth in §§ 416.207-416.216:

1. The individual fails to give the SSA permission to contact financial institutions;[16]
2. The individual fails to apply for other benefits to which the individual may be entitled;[17]

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[6] (Bold emphasis added and italics emphasis in original.) *See also* 42 U.S.C. § 1395w2(d)(5)(F)(vi)(I).
[7] 42 U.S.C. § 1382.
[8] 42 U.S.C. §§ 1381a, 1382(a) (emphasis added).
[9] 20 C.F.R. § 416.202.
[10] 42 U.S.C. § 426.
[11] 42 U.S.C. § 426-1.
[12] 20 C.F.R. § 416.204.
[13] 20 C.F.R. §§ 416.1331-1335.
[14] 20 C.F.R. §§ 416.1320-1330.
[15] 20 C.F.R. § 1320.
[16] 20 C.F.R. § 416.207.
[17] 20 C.F.R. § 416.210.

3. The individual fails to participate in drug or alcohol addiction treatment;[18]
4. The individuals is absent from the United States for more than 30 days;[19] or
5. The individual becomes a resident of a public institutions or prison.[20]

In addition, under certain circumstances, SSA may not pay benefits for administrative reasons, such as removal of a representative payee, an unknown address for the beneficiary, or because of income from a previous month.[21]

After the Medicare DSH statutory provisions were enacted in 1984, CMS (then known as the Health Care Financing Administration ("HCFA")) announced that the Secretary of Health and Human Services, rather than hospitals, would be solely responsible for computation of the Medicare fraction because the data necessary to calculate the Medicare fraction is voluminous and much of this data needed to be obtained from another agency, SSA.[22] CMS noted that, as of 1986, the data sources for the computation of the Medicare fraction included approximately 11 million billing records from the Medicare inpatient discharge file and over 5 million records from the SSI file compiled by SSA.[23] To compute the Medicare fraction, CMS had to match individual Medicare billing records to individual SSI records.[24] Considering the administrative burdens and complexity of the data matching process, CMS concluded that the Secretary would be responsible for the data matching process, which she would conduct retrospectively for every eligible Medicare hospital on a "federal fiscal year" basis—that is, based on discharges occurring in the federal fiscal year.[25] CMS notifies Medicare contractors of the SSI ratios after they are calculated. CMS currently makes this notification by posting the resulting SSI percentages on its website. Medicare contractors then use the posted SSI ratios to calculate the Medicare DSH percentage to determine each qualifying hospital's Medicare DSH payment adjustment.[26]

The Medicare DSH payment adjustment has been the subject of much litigation and, from that litigation, the following case is of particular relevance to this appeal: *Baystate v. Leavitt*, 545 F. Supp. 2d 20 *as amended* 587 F. Supp. 2d 37, 44 (D.D.C. 2008) ("*Baystate*"). In *Baystate*, the plaintiff alleged that the Secretary's process to identify and gather the data necessary to calculate each hospital's SSI ratio was deficient and the Court remanded the case to the Administrator for further action. The Board notes that this case discusses the Secretary's historical practice of basing "entitled to . . . SSI" under 42 C.F.R. § 412.106(b)(2) on actual payment of SSI cash benefits.[27]

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[18] 20 C.F.R. § 416.214.
[19] 20 C.F.R. § 416.215.
[20] 20 C.F.R. § 416.211.
[21] *See* SSA Program Operations Manual ("POMS") § SI 02301.201 (describing certain SSI post-eligibility events on the internet at https://secure.ssa.gov/apps10/poms.nsf/lnx/0502301201).
[22] 51 Fed. Reg. 31454, 31459 (Sept. 3, 1986).
[23] *Id.*
[24] *Id.*
[25] *Id.* at 31459–31460; 42 C.F.R. § 412.106(b).
[26] 42 C.F.R. § 412.106(b)(5); 42 C.F.R. § 405.1803.
[27] *Baystate* began with a hearing before the Board. *See Baystate Med. Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006), *modified by*, CMS Adm'r Dec. (May 11, 2006). The Board heard extensive

On April 28, 2010, the Secretary through CMS acted on the *Baystate* remand order and published CMS Ruling CMS-1498-R ("Ruling 1498-R"). Specifically, the Ruling stated that CMS had implemented the *Baystate* remand order by recalculating the plaintiff's SSI fractions and Medicare DSH payment adjustments using a revised data matching process that used "updated and refined SSI eligibility data and Medicare records, and by matching individuals' records with reference to Social Security numbers (SSNs) as well as HICANs and Title II numbers."[28] The Ruling also stated that "in the FY 2011 proposed rule, CMS is proposing to adopt the same revised data matching process" for use with all hospitals and that "[i]n the forthcoming FY 2011 IPPS final rule, CMS expects to respond to public comments filed on the proposed new data matching process, make any changes to such matching process that seem appropriate, and adopt finally a new data matching process."[29] Finally, CMS stated that it would "use that new data matching process in calculating SSI fractions and DSH payments for specific claims that are found to qualify for relief under this Ruling."[30]

Consistent with Ruling 1498-R, the Secretary published the new data matching process in the FY 2011 IPPS proposed rule published on May 4, 2010.[31] The proposed rule includes references to the Secretary's historical practice of basing "entitled to . . . SSI" under 42 C.F.R. § 412.106(b)(2) on actual payment of SSI cash benefits.[32]

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testimony on the Secretary's then-existing data match process. This included testimony from several SSA employees on the data tapes historically sent from SSA to CMS that included "42 monthly indicators (ones and zeros) denoting the payment or non-payment of Federal SSI cash benefits during the period covered by the SSA tape." *Id.* at 11 (citations omitted). Further, this testimony established that SSA's program would "assign a '1' to a month if the CMPH field shows one of two payment codes, C01 (current pay status) or M01 (manual or forced pay), and the FAM field reflects an amount due for the month" and that "[o]therwise, the program assigns a '0' to that month." *Id.* The provider in *Baystate* contested among other things: (1) "the omission of SSI records relating to individuals who received a forced payment from an SSA filed office; (2) "the omission of SSI days associated with individuals whose SSI benefits were temporarily on hold or in suspense when SSA ran each year's SSI tape;" (3) "the omission of SSI days associated with individuals whose benefits were restored or retroactively after SSA ran each year's tape;" and (4) "the omission of individuals who were entitled to non-cash Federal SSI benefits." *Id.* at 23. The Board's discussion of these contentions confirms SSI days were counted when there was actual SSI cash benefits. *See id.* at 26-30. The CMS Administrator's decision and the ensuing decision of the D.C. District Court also contain references to the Secretary's policy. *See, e.g.,* Adm'r Dec. at 5, 16, 39, 41, 48-49; 545 F. Supp. 2d at 28-29 n.13 & n.17, 36-39.

[28] CMS-1498-R at 5.

[29] *Id.*

[30] *Id.* at 5-6.

[31] 85 Fed. Reg. 23852, 24002-24007 (May 4, 2010).

[32] *See, e.g.,* 75 Fed. Reg. at 24003 (discussing SSI cash payment issues discussed in the *Baystate* decision), 24003-24004 (discussing the proposed matching process where "[t]he SSI eligibility file serves as the system of record for whether or not SSA made a payment of SSI benefits to an individual who applied for SSI"), 24004-06 (discussing the time of the matching process including how "it is important to find an appropriate balance between administrative finality (that is, the final settlement of a hospital's cost report) and the inclusion of retroactive SSI eligibility determinations and the lifting of SSI payment suspensions by using the best and latest available SSI eligibility data at the time of cost report settlement benefits").

The Secretary finalized that data matching process in the FY 2011 IPPS final rule published on August 16, 2010 ("FY 2011 IPPS Final Rule").[33] Significantly, in the preamble to the FY 2011 IPPS Final Rule, CMS acknowledged a public comment that: (1) requested that "CMS include both paid and unpaid days for both SSI entitlement and Medicare entitlement such that there would be consistency between the numerator and denominator of the SSI fraction"; and (2) provided examples of "several SSI codes that represent individuals who were eligible for SSI but not eligible for SSI payments, that should be included as SSI-entitled for purposes of the data match process."[34] CMS responded in detail to this comment and explained that CMS interprets SSI entitlement to correspond with any month for which an individual *receives* payment of SSI benefits. In this regard, CMS stated that the three SSI codes denoted as C01, M01, and M02 "accurately captures all SSI-entitled individuals during the month(s) they are entitled to receive SSI benefits."[35] CMS explicitly rejected the inclusion of other SSA codes because "SSI entitlement can change from time to time" and none of these codes "would be used to describe an individual who was entitled to receive SSI benefits during the month that one of these codes was used."[36] Finally, in the preamble, CMS confirms that "[t]he same data matching process [used for FY 2011 and beyond] will be used to calculate SSI fractions for cost reporting periods covered under the Ruling [1498-R]."[37]

While the new data matching process established in the preamble to the FY 2011 IPPS Final Rule was effective October 1, 2010 (*i.e.*, for FY 2011 and forward), Ruling 1498-R directed that the Medicare contractors apply "the same, unitary relief" consisting of SSI fractions that the Secretary had calculated using the new "suitably revised" data matching process to: (1) any Medicare cost report that had not been settled; and (2) all properly pending Medicare DSH appeals of the SSI fraction data matching process issue.[38] The Ruling noted that hospitals dissatisfied with the initial or revised NPR issued using the new SSI ratios in the Medicare DSH adjustment calculation could seek administrative and judicial review provided they met the jurisdictional and procedural requirements of 42 U.S.C. § 1395oo, the Medicare regulations, and other agency rules and guidelines.[39] In the FY 2011 IPPS Final Rule, the Secretary explicitly recognized that "[t]he data matching process provisions of the Ruling would apply to . . . open cost reports for cost reporting periods beginning prior to October 1, 2010 (that is those preceding the effective date of the FY 2011 IPPS final rule)."[40]

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[33] 75 Fed. Reg. 50041, 50280-50281. (Aug. 16, 2010).
[34] *Id.* at 50280.
[35] *Id.* at 50280-50281.
[36] *Id.* This include all codes with the "S" prefix indicating a suspension of payment; codes beginning with "N" for nonpayment; code "E01" indicating that the individual had countable income which eliminated the SSI payment; and code "E02" indicating that the patient was not entitled to SSI benefits during that month but became entitled during a subsequent month.
[37] *Id.* at 50285.
[38] CMS-1498-R at 6-7, 31.
[39] *Id.* at 28, 31.
[40] 75 Fed. Reg. at 24006.

Finally, on April 22, 2015, CMS published Ruling 1498-R2 modifying and amending Ruling 1498-R by allowing hospitals to elect whether to use new Medicare SSI fractions calculated on the basis of "total days" or "covered days" for cost reports involving patient discharges *prior* to October 1, 2004.[41]

However, neither Ruling 1498-R nor Ruling 1498-R2 are applicable to this appeal since the revised NPRs at issue were issued after Ruling 1498-R and since the fiscal year at issue is not covered by Ruling 1498-R2. As a result of the new regulation and new data match process, CMS calculated SSI percentages for the Providers for the fiscal years at issue.[42] The Provider is challenging the adoption of the policy stated therein that only SSI paid days as represented by SSI codes S01, M01 and M02 are included in the numerator of the SSI fraction for purposes of representing days "entitled to [SSI] benefits."

B. FY 2005 IPPS Final Rule

The FY 2005 IPPS Final Rule announced policy changes relative to the treatment of dual eligible days and Medicare Part C days in the SSI fraction.[43] However, it did not address or announce any policy statements or changes relative to what the phrase "entitled to [SSI] benefits as used in 42 U.S.C. § 1395ww(d)(F)(vi)(I).

Providers' Position

In their EJR Request, the Providers acknowledge that, following the Supreme Court's decision in *Empire*, dual eligible days should be excluded from the Medicaid numerator.[44] They argue, however, that there is now an inconsistency between the interpretation of "entitled to benefits under Part A" (which encompasses any patient who satisfies the statutory eligibility criteria whether or not Medicare actually pays), and "entitled to SSI" (which encompasses only patient days where SSI cash payments were actually received).[45] This discrepancy excludes a large number of days from the Medicare fraction numerator.[46] In particular, the Providers are located in Kentucky where a dual eligible patient is entitled to SSI benefits by definition, so the Providers argue all Kentucky dual eligible patient days should be included in the Medicare Fraction's numerator.[47]

Based on the arguments set forth in the EJR Request, and because the applicable regulations[48] only permit group appeals to present a ***single*** question of fact ***or*** interpretation of law, regulations, or CMS Rulings that is common to each provider in the group, the Board issued a

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[41] CMS-1498-R2 at 2, 6.
[42] SSI ratios are published and can be accessed at https://www.cms.gov/Medicare/ Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.
[43] 69 Fed. Reg. 48916, 49090-99 (Aug. 11, 2004).
[44] EJR Request at 3.
[45] *Id.*
[46] *Id.*
[47] *Id.* at 2-3.
[48] 42 C.F.R. §§ 405.1837(a)(2), (f).

Request for Information ("RFI") in this case on February 3, 2023. The RFI sought to clarify the following:

1. Whether the Providers are pursuing a challenge pertaining to dual eligible days in the Medicaid Fraction related to the validity of the FY 2005 IPPS Rule following the decision in *Becerra v. Empire Health Found.*[49];
2. Whether the Providers are challenging the SSI Data Match policy finalized in the FY 2011 IPPS Final Rule;
3. How the discussion of Kentucky Medicaid is relevant to the issue(s) being pursued in this appeal.

On February 15, 2023, the Providers submitted a response to the RFI. They clarified that they are ***not*** pursuing any challenge related to the correct placement of Dual Eligible Medicare Non-Covered Days as they relate to the Medicaid Fraction because they agree that the Supreme Court settled this issue in *Empire Health*. Similarly, the Providers are ***not***, in this case, pursuing a challenge to the SSI Data Match policy finalized in the FY 2011 IPPS Final Rule. In fact, the Providers have separate group cases pursuing this challenge. Similarly, the Providers confirmed that the discussion of Kentucky Medicaid is relevant to the SSI Data Match issue, and thus only tangentially related to the instant case because a favorable ruling in this case would resolve the SSI Data Match cases. As a whole, the Providers' response to the RFI confirmed that, in the instant case, they are ***only*** challenging the interpretation of "entitled to SSI benefits" as set forth in the FY 2011 IPPS Final Rule.

Decision of the Board

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

A. Preliminary Rulings on the Scope of the EJR Request

The Providers have suggested that they are challenging the FY 2005 IPPS Final Rule based on the following finding they included at the end of their EJR request:

> [The Board] is without the authority to decide the legal question of whether 42 C.F.R. § 412.106 codifying the CMS policies adopted in the FY 2005 IPPS Final Rule and the FY 2011 Final Rule are valid.[50]

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[49] 142 S.Ct. 2354 (2022).
[50] EJR Request at 18.

However, the EJR request only mentions the FY 2005 IPPS Final Rule in one other place as follows:

> In the 2005 Rule construing the Medicare fraction, CMS interpreted the phrase "entitled to benefits under Part A" to encompass any patient who satisfied Part A statutory *eligibility* criteria whether or not Medicare actually pays for the care.[51]

The Providers have recognized that the Supreme Court upheld this policy:

> In *Becerra v. Empire Health Foundation For Valley Hospital Medical Center*, 142 S.Ct. 2354, 2368 (June 24, 2022), the Supreme Court upheld the Secretary's interpretation of the phrase "entitled to benefits" in the numerator of the Medicare fraction to include those individuals qualifying for Medicare regardless of whether that program actually paid for their day of care. The Supreme Court found that the Secretary's reading of "entitled to benefits" comported with the statute's two-population structure because "[a]ll low-income people fit naturally into one or the other box, with the sum of the two leaving no one out." *Id.* at 2367.[52]

Moreover, the Board notes that the FY 2005 IPPS Final Rule does not include any statement regarding the Secretary's interpretation of the phrase "entitled to [SSI] benefits" as used in 42 U.S.C. § 1395ww(d)(F)(vi)(I). Nor do the Providers claim it does.

Accordingly, the Board finds that the EJR request has not laid a sufficient foundation for a challenge to the FY 2005 IPPS Final Rule. In so ruling, it does not mean that it does not have relevance to what is being challenged, namely the FY 2011 IPPS Final Rule as set forth below. However, it is not what is actually being challenged. In this regard, the Provider is maintaining that the term "entitled" should be consistently interpreted across 42 U.S.C. § 1395 and that "entitled to [SSI] benefits" should be broadly interpreted consistent with how the Secretary interpreted "entitled to benefits under [Medicare] Part A" as used in 42 U.S.C. 1395ww(d)(F)(vi)(I) and explained in the FY 2005 IPPS Final Rule and upheld by the Supreme Court in *Empire*, as noted above.

B. Jurisdiction: Appeals of Cost Report Periods Beginning After December 31, 2008 and Before January 1, 2016

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008 the participant may demonstrate dissatisfaction with the amount of

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[51] *Id.* at n.4.
[52] *Id.* at 2 (footnotes omitted).

Medicare reimbursement for the appealed issue by claiming an issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen.*[53] In that case, the Supreme Court concluded that a cost report submitted in full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.[54]

On August 21, 2008, new regulations governing the Board were effective.[55] Among the new regulations implemented in the Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hospital v. Burwell* ("*Banner*").[56] In *Banner*, the provider filed its cost report in accordance with the applicable outlier regulations and did not protest the additional outlier payment it was seeking. The provider's request for EJR was denied because the Board found that it lacked jurisdiction over the issue. The District Court concluded that, under *Bethesda,* the 2008 self-disallowance regulation could not be applied to appeals raising a legal challenge to a regulation or other policy that the Medicare Contractor could not address.[57]

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

The Board has determined that the issue in this CIRP Group as it relates to the meaning of "entitled to [SSI] benefits" is governed by CMS Ruling CMS-1727-R since the Providers are challenging the Secretary's interpretation of this phrase as set forth in the FY 2011 IPPS Final Rule and that Board review of this issue is not otherwise precluded by statute or regulation. In addition, the Providers' documentation shows that the estimated amount in controversy exceeds $50,000, as

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[53] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).
[54] *Bethesda at 1258-59.*
[55] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[56] 201 F. Supp. 3d 131 (D.D.C. 2016).
[57] *Id.* at 142.

required for a group appeal. The appeals were timely filed and no jurisdictional impediments have been identified for the Providers. Based on the above, the Board finds that it has jurisdiction for the above-captioned group appeal.

C. Board's Analysis of the Appealed Issue

As noted above, the Secretary revised the SSI data match process in light of the *Baystate* decision through notice and comment in the form of an uncodified regulation. First, the Secretary issued CMS Ruling 1498-R on April 28, 2010, authorizing remands of pending appeals of the SSI data match issue to recalculate the SSI fraction based on a revised data match.[58] The Secretary also stated in the ruling that, where cost reports had not been settled, those providers' SSI fractions would be calculated using the revised data match.[59] Contemporaneous with CMS' issuance of Ruling 1498-R,[60] the Secretary published the FY 2011 IPPS Proposed Rule[61] which, in pertinent part, proposed to adopt the same data match for 2011 and forward. This proposed rule was adopted as the FY 2011 Final IPPS Rule in which the Secretary explained that:

> [W]e used a revised data matching process . . . that comports with the court's decision [in *Baystate* to recalculate the hospitals' SSI fractions]. As the revised data matching process was completed using SSI eligibility data compiled between 13 and 16 years beyond the fiscal years at issue in the *Baystate* case, we believe any issues associated with retroactive determinations of SSI eligibility and the lifting of payment suspensions had been long since resolved. Furthermore, because we believe that the revised match process used to implement the *Baystate* decision addressed all of the concerns found by the court, in the FY 2011 IPPS/LTCH PPS proposed rule we proposed to use the same revised data matching process for calculating hospitals' SSI fractions for FY 2011 and subsequent fiscal years.[62]

Then she announced that:

> We have adopted the proposed data matching process for FY 2011 and beyond as final. The only modification we are making to the proposed matching process is adopting a policy to exclude a record from the data matching process if we find a HICAN in the MedPAR file that we are not able to locate in the EDB[63]which is an extremely unlikely situation as noted in the prior discussion in this final rule. We are adopting this additional step in our

[58] CMS Ruling 1498-R at 27.
[59] *Id.* at 31.
[60] *Id.* at 5.
[61] 75 Fed. Reg. 23,852, 24,002-07.
[62] 75 Fed. Reg. at 50,277.
[63] (Medicare) Enrollment Database.

> validation process to respond to public comment and provide even more assurances that our data matching process will yield accurate SSI fractions and capture all Medicare beneficiaries who were entitled to SSI at the time of their inpatient hospital stay. The same data matching process will be used to calculate SSI fractions for cost reporting periods covered under the ruling.[64]

As part of the adopted data match process, CMS explicitly finalized a policy that SSI codes C01, M01, and M02 would capture all SSI entitled days:

> *Comment*: **One commenter stated that <u>CMS</u>** uses total (that is, "paid and unpaid") Medicare days in the denominator of the SSI fraction, but **<u>uses paid SSI days in the numerator of the SSI fraction</u>**. The commenter requested that CMS interpret the word "entitled" to mean "paid" for both SSI-entitled days used for the numerator and Medicare-entitled days used in the denominator, or alternatively, that CMS include both paid and unpaid days for both SSI entitlement and Medicare entitlement such that there is consistency between the numerator and the denominator of the SSI fraction. **The commenter stated that there were several SSI codes that represent individuals who were eligible for SSI, but not eligible for SSI payments, that should be included as SSI-entitled for purposes of the data matching process**. Specifically, the commenter stated that at least the following codes should be considered to be SSI-entitlement:
>
> - E01 and E02
> - N06, N10, N11, N18, N35, N39, N42, N43, N46, N50, and N54
> - P01
> - S04, S05, S06, S07, S08, S09, S10, S20, S21, S90, and S91
> - T01, T20, T22, and T31
>
> *Response*: In response to the comment that we are incorrectly applying a different standard in interpreting the word "entitled" with respect to SSI entitlement versus Medicare entitlement, we disagree. The authorizing DSH statute at section 1886(d)(5)(F)(vi)(I) of the Act limits the numerator to individuals entitled to Medicare benefits who are also "*entitled* to supplemental security income benefits (excluding any State supplementation)" (emphasis added).[65] **Consistent with**

[64] 75 Fed. Reg. at 50,285.
[65] As a side note, we have used the phrase ''SSI-eligible'' interchangeably with the term ''SSI-entitled'' in the FY 2011 proposed rule as well as prior proposed and final rules, but the statute requires that we include individuals who were entitled to SSI benefits in the SSI fractions. Although we have used these terms interchangeably, we intended

> **this requirement, we have requested, and are using in the data matching process, those SSA codes that reflect "entitlement to" receive SSI benefits**. Section 1602 of the Act provides that "[e]very aged, blind, or disabled individual who is determined under Part A to be eligible on the basis of his income and resources shall, in accordance with and subject to the provisions of this title, be *paid* benefits by the Commissioner of the Social Security" (emphasis added). However, eligibility for SSI benefits does not automatically mean that an individual will receive SSI benefits for a particular month. For example, section 1611(c)(7) of the Act provides that an application for SSI benefits becomes effective on the later of either the month following the filing of an application for SSI benefits or the month following eligibility for SSI benefits.
>
> On the other hand, section 226 of the Act provides that an individual is automatically "entitled" to Medicare Part A when the person reaches age 65 and is entitled to Social Security benefits under section 202 of the Act (42 U.S.C. 402) or becomes disabled and has been entitled to disability benefits under section 223 of the Act (42 U.S.C. 423) for 24 calendar months. Section 226A of the Act provides that qualifying individuals with end-stage renal disease shall be entitled to Medicare Part A. In addition, section 1818(a)(4) of the Act provides that, "unless otherwise provided, any reference to an individual entitled to benefits under [Part A] includes an individual entitled to benefits under [Part A] pursuant to enrollment under [section 1818] or section 1818A." We believe that Congress used the phrase "entitled to benefits under part A" in section 1886(d)(5)(F)(vi) of the Act to refer individuals who meet the criteria for entitlement under these sections.
>
> Moreover, unlike the SSI program (in which entitlement to receive SSI benefits is based on income and resources and, therefore, can vary from time to time), once a person becomes entitled to Medicare Part A, the individual does not lose such entitlement simply because there was no Medicare Part A coverage of a specific inpatient stay. Entitlement to Medicare Part A reflects an individual's entitlement to Medicare Part A benefits, not the hospital's entitlement or right to receive payment for services provided to such individual. Such Medicare entitlement does not cease to exist simply because Medicare payment for an individual inpatient hospital claim is not made. Again, we are bound by section 1886(d)(5)(F)(vi)(I) of the

no different meaning, and our policy has always been to include only Medicare beneficiaries who are entitled to receive SSI benefits in the numerator of the SSI fraction.

Act, which defines the SSI fraction numerator as the number of SSI-entitled inpatient days for persons who were "entitled to benefits under [P]art A," and the denominator as the total number of inpatient days for individuals who were "entitled" to Medicare Part A benefits.

In response to the comment about specific SSI status codes, SSA has provided information regarding all of the SSI status codes mentioned by the commenter to assist in the determination of whether any of these codes represent individuals who were entitled to SSI benefits for the purposes of calculating the SSI fraction for Medicare DSH. With respect to the codes that begin with the letter "T," SSA informed us that all of the codes represent individuals whose SSI entitlement was terminated. Code "T01" represents records that were terminated because of the death of the individual, but we confirmed that this code would not be used until the first full month after the death of the individual. That is, for example, if a Medicare individual was entitled to SSI during the month of October, was admitted to the hospital on October 1 and died in the hospital on October 15, the individual would show up as entitled to SSI for the entire month of October on the SSI file (code T01 would not be used on the SSI file until November) and 15 Medicare/SSI inpatient hospital days for that individual would be counted in the numerator and the denominator of the SSI fraction for that hospital.

Codes beginning with the letter "S" reflect records that are in a "suspended" status and, according to SSA, do not represent individuals who are entitled to SSI benefits.

SSA maintains that code "P01" is obsolete and has not been used since the mid-1980s. Therefore, it would not be used on any SSI files reflecting SSI entitlement for FY 2011 and beyond.

Codes that begin with the letter "N" represent records on "nonpayment" and are not used for individuals who are entitled to SSI benefits.

Code "E01" represents an individual who is a resident of a medical treatment facility and is subject to a $30 payment limit, but has countable income of $30 or more. Such an individual is not entitled to receive SSI payment. Alternatively, an individual who is a resident of a medical treatment facility and is subject to a $30 payment limit, but does not have countable income of at least $30, would be reflected on the SSI file as a "C01" (which denotes SSI entitlement) for any month in which the requirements described in this sentence are met. Code "E02" is used to identify a person who is not entitled to SSI payments

> in the month in which that code is used pursuant to section 1611(c)(7) of the Act, which provides that an application for SSI benefits shall be effective on the later of (1) the first day of the month following the date the application is filed, or (2) the first day of the month following the date the individual becomes eligible for SSI based on that application. Such an individual is not entitled to SSI benefits during the month that his or her application is filed or is determined to be eligible for SSI, but, for the following month, would be coded as a "C01" because he or she would then be entitled to SSI benefits.
>
> Therefore, both codes E01 and E02 represent individuals who are not entitled to SSI benefits and are reflected accordingly on the SSI file. If the individual's entitlement to SSI benefits is initiated the ensuing month, that individual would then be coded as a "C01" on the SSI file and would be included as SSI-entitled for purposes of the data matching process.
>
> As we have described above, **none of the SSI status codes that the commenter mentioned would be used to describe an individual who was entitled to receive SSI benefits during the month that one of those status codes was used**. SSI entitlement can change from time to time, and **we believe that including SSI codes of C01, M01, and M02 accurately captures all SSI-entitled individuals during the month(s) that they are entitled to receive SSI benefits**.
>
> After consideration of the public comments we received, we are adopting the proposed data matching process for FY 2011 and beyond as final. The only modification we are making to the proposed data matching process is adopting a policy to exclude a record from the data matching process if we find a HICAN in the MedPAR file that we are not able to locate in the EDB, which is an extremely unlikely situation as noted in the prior discussion in this final rule. We are adopting this additional step in our validation process in response to public comments to provide even more assurances that **our data matching process will** yield accurate SSI fractions and **capture all Medicare beneficiaries who were <u>entitled</u> to SSI at the time of their inpatient hospital stay**.[66]

The Secretary did not incorporate, into the Code of Federal Regulations, the above new policy involving the revised data match process (including but not limited to portion of that policy relating to interpreting "entitled to [SSI] benefits" and the use of SSI code C01, M01, and M02 to capture SSI entitled days). However, it is clear from the language in the final IPPS rule, as set

[66] 75 Fed. Reg. at 50280-81 (footnote in original; bold and underline emphasis added).

forth above, that the Secretary intended to bind the regulated parties and establish a *binding* data match process to be used by the Medicare Contractors in calculating (or recalculating) providers' SSI fractions.

Accordingly, the Board finds that the Secretary intended this policy change for the data match process to be a binding but uncodified regulation and will refer to the portion of that policy as it relates to interpreting "entitled to [SSI] benefits" and the related adoption of the SSI codes C01, M01, and M02 to capture SSI entitled days as the "Uncodified SSI Entitled Days Regulation." Indeed, this finding is consistent with the Secretary's obligations under 42 U.S.C. § 1395hh(a)(2) to promulgate any "substantive legal standard governing . . . the payment of services" as a regulation."[67]

Pursuant to 42 C.F.R. § 405.1867, the Board is bound to apply the statutory and regulatory provisions governing the Medicare program. Consequently, the Board finds that it is bound by the Uncodified SSI Entitled Days Regulation published in the FY 2011 Final Rule and the Board does not have the authority to grant the relief sought by the Provider, namely invalidating the Uncodified SSI Entitled Days Regulation which they allege fails to include all of the SSI codes used by SSA to determine SSI eligibility. As a result, the Board finds that EJR is appropriate for the issue for the calendar year under appeal in this case.

D. Board's Decision Regarding the EJR Request

The Board finds that:

1) It has jurisdiction over the matter for the subject year and that the Provider is entitled to a hearing before the Board;

2) Based upon the Provider's assertions regarding 42 C.F.R. § 412.106(b)(2)(i) and the Uncodified SSI Entitled Days Regulation as adopted in the preamble to the FY 2011 Final IPPS Rule, there are no findings of fact for resolution by the Board;

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

4) It is without authority to decide the legal question of whether the Uncodified SSI Entitled Days Regulation as adopted in the preamble to the FY 2011 Final IPPS Rule is valid.

Accordingly, the Board finds that the question of the validity of the Uncodified SSI Entitled Days Regulation properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for EJR for that question. The Providers have 60 days from the

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[67] 42 U.S.C. § 1395hh(a)(2) states "[n]o rule, requirement, or other statement of policy . . . that establishes or changes a substantive legal standard governing . . . the payment of services . . . shall take effect unless it is promulgated by the Secretary by regulation . . . ."

receipt of this decision to institute the appropriate action for judicial review. Since is the only issue in the appeal, the Board hereby closes the case and removes it from its docket.

Board Members Participating:

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

FOR THE BOARD:

3/7/2023

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

Enclosure: Schedule of Providers

cc: Judith Cummings, CGS Administrators (J-15)
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***EJR Determination***
Appalachian Reg'l Healthcare 2011 SSI Fract. Dual Eligible Non-Covered Days CIRP
Case No. 15-1612GC

Dear Mr. Price:

The Provider Reimbursement Review Board ("Board") has reviewed Providers' January 6, 2023 request for expedited judicial review ("EJR") in the above-referenced Common Issue Related Party ("CIRP") group appeal. The decision of the Board is set forth below.

Issues in Dispute

The Board received the Providers' Group Appeal Request on February 24, 2015. The group was formed with three (3) providers, but one (1) provider was withdrawn on December 14, 2022. Each Provider filed its appeal from an original Notice of Program Reimbursement ("NPR") and the stated amount in controversy for this case exceeds $50,000.

The Providers' Statement of the Group Issue describes the issue as follows:

> **ISSUE:** Whether the Fiscal Intermediary's calculation of the Provider's disproportionate patient percent, used or purposes of calculating the Medicare Disproportionate Share ("DSH") Adjustment, was incorrect due to CMS' improper treatment of the Medicare Non-Covered Days, which includes but is not limited to Dual Eligible, Medicare Exhausted and Medicare Secondary Payor days. The improper treatment of these days affects numerator and the denominator of the Medicare fraction.
>
> ****
>
> If Medicare interprets "entitled" to Medicare as "eligible" for Medicare, and thus their basis for including these days in the Medicare fraction, then they also must interpret "entitled" to SSI as "eligible" for SSI and allow Dual Eligible days that are "eligible" for SSI, which includes days where the patient may only be

> receiving their SSI medical benefit/Medicaid, to be included in the Medicare numerator.[1]

With the Group Appeal Request, each provider submitted two estimated amount in controversy calculations. One illustrates the impact of including dual eligible days in the Medicaid Fraction, and excluding them from the SSI Ratio. In its calculations, the SSI Numerator is unchanged and the SSI Denominator is reduced; the Medicaid days are also increased for the Medicaid Fraction. This calculation appears to illustrate the assertion that no-pay dual eligible days should be removed from the SSI fraction and moved to the numerator of the Medicaid fraction, which is not at issue in this EJR Request.

The Providers also included separate calculations which illustrate the alternative argument that the definition of "entitled to SSI benefits" as used in the numerator of the SSI fraction should be expanded to include days where a patient is eligible for SSI benefits. For each provider, the amount in controversy was estimated to be:

1. Harlan ARH Hospital (Prov. No. 18-0050): $2,245,337, based on the addition of 2,280 dual eligible days to the SSI Ratio; and
2. Hazard ARH Hospital (Prov. No. 18-0029): $6,345,654, based on the addition of 7,528 dual eligible days in the SSI Ratio.

A request for Expedited Judicial Review was filed on January 6, 2023.[2]

Statutory and Regulatory Background:

A. The Secretary's policy on what the phrase "entitled to supplemental security income benefits" in 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I) means for purposes of the numerator of the SSI fraction used in the DSH adjustment calculation

The Medicare program pays inpatient hospital services based on predetermined, standardized amounts subject to certain payment adjustments under Medicare's inpatient prospective payment system ("IPPS").[3] One of these adjustments, the Medicare DSH adjustment, provides additional payments to certain qualifying hospitals that treat a disproportionate share of low income patients.[4] The Medicare DSH adjustment is calculated using two fractions known as the Medicare fraction (also referred to as the SSI fraction or SSI ratio) and the Medicaid fraction. Pursuant to 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I), the Medicare fraction is calculated by using: (a) in the numerator, the "number of such hospital's patient days…which were made up of patients who (for such days) were ***entitled*** to benefits under part A of the subchapter and were ***entitled*** to supplementary security income benefits…under subchapter XVI of this chapter…";[5]

[1] Group Appeal Request, Tab 2 (Feb. 24, 2015).
[2] Provider Request for Expedited Judicial Review (Jan. 6, 2023) ("EJR Request").
[3] 42 C.F.R. Part 412.
[4] 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I).
[5] (Emphasis added.)

and (b) in the denominator, the number of days of care that are furnished to patients who were entitled to Medicare Part A. The Secretary incorporated this statutory provision into the regulations at 42 C.F.R. § 412.106(b)(2)(i)(B) which states:

> (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)).[6]

The dispute in these appeals involves CMS' determination of which patients are "entitled to" both Medicare Part A and SSI benefits for purposes of the Medicare fraction of the DSH calculation.

The SSI program is a federal cash assistance program for low-income individuals who are aged, blind, or disabled,[7] administered by the Social Security Administration ("SSA"). The statutory provisions governing SSI, generally, do not use the term "entitled" to SSI benefits. Rather, the SSI statutory provisions typically refer to whether an individual is "eligible for benefits."[8] In order to be "eligible" for SSI benefits, a person must be: (1) 65 years of age or older, blind or disabled; (2) a lawful resident of the United States; (3) have limited income and resources; (4) not be fleeing to avoid prosecution for a crime or violating a condition of parole; and (5) file an application for benefits.[9]

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[6] (Bold emphasis added and italics emphasis in original.) *See also* 42 U.S.C. § 1395w2(d)(5)(F)(vi)(I).
[7] 42 U.S.C. § 1382.
[8] 42 U.S.C. §§ 1381a, 1382(a) (emphasis added).
[9] 20 C.F.R. § 416.202.

In contrast, the Medicare program is an insurance program where an individual is automatically "entitled" to Medicare Part A when the person reaches age 65 and is entitled to Social Security benefits or becomes disabled and had been entitled to disability benefits for 24 calendar months.[10] In addition, the Medicare program provides that certain qualifying individuals with end stage renal disease are entitled to Medicare Part A.[11]

Unlike entitlement for Medicare Part A benefits, an individual who is currently eligible for SSI benefits may later become *in*eligible for SSI benefits. In this regard, SSA conducts periodic redeterminations to ensure continued eligibility[12] and may terminate,[13] suspend[14] or stop payments to individuals who are either temporarily or permanently ineligible for payment of SSI benefits.[15] In particular, SSI eligibility may be lost if a person no longer meets the basic requirements. For example, an individual may lose SSI eligibility if the individual is no longer disabled or the individual meets one of the following reasons set forth in §§ 416.207-416.216:

1. The individual fails to give the SSA permission to contact financial institutions;[16]
2. The individual fails to apply for other benefits to which the individual may be entitled;[17]
3. The individual fails to participate in drug or alcohol addiction treatment;[18]
4. The individuals is absent from the United States for more than 30 days;[19] or
5. The individual becomes a resident of a public institutions or prison.[20]

In addition, under certain circumstances, SSA may not pay benefits for administrative reasons, such as removal of a representative payee, an unknown address for the beneficiary, or because of income from a previous month.[21]

After the Medicare DSH statutory provisions were enacted in 1984, CMS (then known as the Health Care Financing Administration ("HCFA")) announced that the Secretary of Health and Human Services, rather than hospitals, would be solely responsible for computation of the Medicare fraction because the data necessary to calculate the Medicare fraction is voluminous

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[10] 42 U.S.C. § 426.
[11] 42 U.S.C. § 426-1.
[12] 20 C.F.R. § 416.204.
[13] 20 C.F.R. §§ 416.1331-1335.
[14] 20 C.F.R. §§ 416.1320-1330.
[15] 20 C.F.R. § 1320.
[16] 20 C.F.R. § 416.207.
[17] 20 C.F.R. § 416.210.
[18] 20 C.F.R. § 416.214.
[19] 20 C.F.R. § 416.215.
[20] 20 C.F.R. § 416.211.
[21] *See* SSA Program Operations Manual ("POMS") § SI 02301.201 (describing certain SSI post-eligibility events on the internet at https://secure.ssa.gov/apps10/poms.nsf/lnx/0502301201).

and much of this data needed to be obtained from another agency, SSA.[22] CMS noted that, as of 1986, the data sources for the computation of the Medicare fraction included approximately 11 million billing records from the Medicare inpatient discharge file and over 5 million records from the SSI file compiled by SSA.[23] To compute the Medicare fraction, CMS had to match individual Medicare billing records to individual SSI records.[24] Considering the administrative burdens and complexity of the data matching process, CMS concluded that the Secretary would be responsible for the data matching process, which she would conduct retrospectively for every eligible Medicare hospital on a "federal fiscal year" basis—that is, based on discharges occurring in the federal fiscal year.[25] CMS notifies Medicare contractors of the SSI ratios after they are calculated. CMS currently makes this notification by posting the resulting SSI percentages on its website. Medicare contractors then use the posted SSI ratios to calculate the Medicare DSH percentage to determine each qualifying hospital's Medicare DSH payment adjustment.[26]

The Medicare DSH payment adjustment has been the subject of much litigation and, from that litigation, the following case is of particular relevance to this appeal: *Baystate v. Leavitt*, 545 F. Supp. 2d 20 *as amended* 587 F. Supp. 2d 37, 44 (D.D.C. 2008) ("*Baystate*"). In *Baystate*, the plaintiff alleged that the Secretary's process to identify and gather the data necessary to calculate each hospital's SSI ratio was deficient and the Court remanded the case to the Administrator for further action. The Board notes that this case discusses the Secretary's historical practice of basing "entitled to . . . SSI" under 42 C.F.R. § 412.106(b)(2) on actual payment of SSI cash benefits.[27]

On April 28, 2010, the Secretary through CMS acted on the *Baystate* remand order and published CMS Ruling CMS-1498-R ("Ruling 1498-R"). Specifically, the Ruling stated that CMS had implemented the *Baystate* remand order by recalculating the plaintiff's SSI fractions and Medicare DSH payment adjustments using a revised data matching process that used

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[22] 51 Fed. Reg. 31454, 31459 (Sept. 3, 1986).
[23] *Id.*
[24] *Id.*
[25] *Id.* at 31459–31460; 42 C.F.R. § 412.106(b).
[26] 42 C.F.R. § 412.106(b)(5); 42 C.F.R. § 405.1803.
[27] *Baystate* began with a hearing before the Board. *See Baystate Med. Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006), *modified by*, CMS Adm'r Dec. (May 11, 2006). The Board heard extensive testimony on the Secretary's then-existing data match process. This included testimony from several SSA employees on the data tapes historically sent from SSA to CMS that included "42 monthly indicators (ones and zeros) denoting the payment or non-payment of Federal SSI cash benefits during the period covered by the SSA tape." *Id.* at 11 (citations omitted). Further, this testimony established that SSA's program would "assign a '1' to a month if the CMPH field shows one of two payment codes, C01 (current pay status) or M01 (manual or forced pay), and the FAM field reflects an amount due for the month" and that "[o]therwise, the program assigns a '0' to that month." *Id.* The provider in *Baystate* contested among other things: (1) "the omission of SSI records relating to individuals who received a forced payment from an SSA filed office; (2) "the omission of SSI days associated with individuals whose SSI benefits were temporarily on hold or in suspense when SSA ran each year's SSI tape;" (3) "the omission of SSI days associated with individuals whose benefits were restored or retroactively after SSA ran each year's tape;" and (4) "the omission of individuals who were entitled to non-cash Federal SSI benefits." *Id.* at 23. The Board's discussion of these contentions confirms SSI days were counted when there was actual SSI cash benefits. *See id*. at 26-30. The CMS Administrator's decision and the ensuing decision of the D.C. District Court also contain references to the Secretary's policy. *See, e.g.,* Adm'r Dec. at 5, 16, 39, 41, 48-49; 545 F. Supp. 2d at 28-29 n.13 & n.17, 36-39.

"updated and refined SSI eligibility data and Medicare records, and by matching individuals' records with reference to Social Security numbers (SSNs) as well as HICANs and Title II numbers."[28] The Ruling also stated that "in the FY 2011 proposed rule, CMS is proposing to adopt the same revised data matching process" for use with all hospitals and that "[i]n the forthcoming FY 2011 IPPS final rule, CMS expects to respond to public comments filed on the proposed new data matching process, make any changes to such matching process that seem appropriate, and adopt finally a new data matching process."[29] Finally, CMS stated that it would "use that new data matching process in calculating SSI fractions and DSH payments for specific claims that are found to qualify for relief under this Ruling."[30]

Consistent with Ruling 1498-R, the Secretary published the new data matching process in the FY 2011 IPPS proposed rule published on May 4, 2010.[31] The proposed rule includes references to the Secretary's historical practice of basing "entitled to . . . SSI" under 42 C.F.R. § 412.106(b)(2) on actual payment of SSI cash benefits.[32]

The Secretary finalized that data matching process in the FY 2011 IPPS final rule published on August 16, 2010 ("FY 2011 IPPS Final Rule").[33] Significantly, in the preamble to the FY 2011 IPPS Final Rule, CMS acknowledged a public comment that: (1) requested that "CMS include both paid and unpaid days for both SSI entitlement and Medicare entitlement such that there would be consistency between the numerator and denominator of the SSI fraction"; and (2) provided examples of "several SSI codes that represent individuals who were eligible for SSI but not eligible for SSI payments, that should be included as SSI-entitled for purposes of the data match process."[34] CMS responded in detail to this comment and explained that CMS interprets SSI entitlement to correspond with any month for which an individual *receives* payment of SSI benefits. In this regard, CMS stated that the three SSI codes denoted as C01, M01, and M02 "accurately captures all SSI-entitled individuals during the month(s) they are entitled to receive SSI benefits."[35] CMS explicitly rejected the inclusion of other SSA codes because "SSI entitlement can change from time to time" and none of these codes "would be used to describe an individual who was entitled to receive SSI benefits during the month that one of these codes was used."[36] Finally, in the preamble, CMS confirms that "[t]he same data matching process

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[28] CMS-1498-R at 5.
[29] *Id.*
[30] *Id.* at 5-6.
[31] 85 Fed. Reg. 23852, 24002-24007 (May 4, 2010).
[32] *See, e.g.,* 75 Fed. Reg. at 24003 (discussing SSI cash payment issues discussed in the *Baystate* decision), 24003-24004 (discussing the proposed matching process where "[t]he SSI eligibility file serves as the system of record for whether or not SSA made a payment of SSI benefits to an individual who applied for SSI"), 24004-06 (discussing the time of the matching process including how "it is important to find an appropriate balance between administrative finality (that is, the final settlement of a hospital's cost report) and the inclusion of retroactive SSI eligibility determinations and the lifting of SSI payment suspensions by using the best and latest available SSI eligibility data at the time of cost report settlement benefits").
[33] 75 Fed. Reg. 50041, 50280-50281. (Aug. 16, 2010).
[34] *Id.* at 50280.
[35] *Id.* at 50280-50281.
[36] *Id.* This include all codes with the "S" prefix indicating a suspension of payment; codes beginning with "N" for nonpayment; code "E01" indicating that the individual had countable income which eliminated the SSI payment;

[used for FY 2011 and beyond] will be used to calculate SSI fractions for cost reporting periods covered under the Ruling [1498-R]."[37]

While the new data matching process established in the preamble to the FY 2011 IPPS Final Rule was effective October 1, 2010 (*i.e.*, for FY 2011 and forward), Ruling 1498-R directed that the Medicare contractors apply "the same, unitary relief" consisting of SSI fractions that the Secretary had calculated using the new "suitably revised" data matching process to: (1) any Medicare cost report that had not been settled; and (2) all properly pending Medicare DSH appeals of the SSI fraction data matching process issue.[38] The Ruling noted that hospitals dissatisfied with the initial or revised NPR issued using the new SSI ratios in the Medicare DSH adjustment calculation could seek administrative and judicial review provided they met the jurisdictional and procedural requirements of 42 U.S.C. § 1395oo, the Medicare regulations, and other agency rules and guidelines.[39] In the FY 2011 IPPS Final Rule, the Secretary explicitly recognized that "[t]he data matching process provisions of the Ruling would apply to . . . open cost reports for cost reporting periods beginning prior to October 1, 2010 (that is those preceding the effective date of the FY 2011 IPPS final rule)."[40]

Finally, on April 22, 2015, CMS published Ruling 1498-R2 modifying and amending Ruling 1498-R by allowing hospitals to elect whether to use new Medicare SSI fractions calculated on the basis of "total days" or "covered days" for cost reports involving patient discharges *prior* to October 1, 2004.[41]

However, neither Ruling 1498-R nor Ruling 1498-R2 are applicable to this appeal since the revised NPRs at issue were issued after Ruling 1498-R and since the fiscal year at issue is not covered by Ruling 1498-R2. As a result of the new regulation and new data match process, CMS calculated SSI percentages for the Providers for the fiscal years at issue.[42] The Provider is challenging the adoption of the policy stated therein that only SSI paid days as represented by SSI codes S01, M01 and M02 are included in the numerator of the SSI fraction for purposes of representing days "entitled to [SSI] benefits."

B. FY 2005 IPPS Final Rule

The FY 2005 IPPS Final Rule announced policy changes relative to the treatment of dual eligible days and Medicare Part C days in the SSI fraction.[43] However, it did not address or announce

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and code "E02" indicating that the patient was not entitled to SSI benefits during that month but became entitled during a subsequent month.

[37] *Id.* at 50285.

[38] CMS-1498-R at 6-7, 31.

[39] *Id.* at 28, 31.

[40] 75 Fed. Reg. at 24006.

[41] CMS-1498-R2 at 2, 6.

[42] SSI ratios are published and can be accessed at https://www.cms.gov/Medicare/ Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.

[43] 69 Fed. Reg. 48916, 49090-99 (Aug. 11, 2004).

any policy statements or changes relative to what the phrase "entitled to [SSI] benefits as used in 42 U.S.C. § 1395ww(d)(F)(vi)(I).

Providers' Position

In their EJR Request, the Providers acknowledge that, following the Supreme Court's decision in *Empire*, dual eligible days should be excluded from the Medicaid numerator.[44] They argue, however, that there is now an inconsistency between the interpretation of "entitled to benefits under Part A" (which encompasses any patient who satisfies the statutory eligibility criteria whether or not Medicare actually pays), and "entitled to SSI" (which encompasses only patient days where SSI cash payments were actually received).[45] This discrepancy excludes a large number of days from the Medicare fraction numerator.[46] In particular, the Providers are located in Kentucky where a dual eligible patient is entitled to SSI benefits by definition, so the Providers argue all Kentucky dual eligible patient days should be included in the Medicare Fraction's numerator.[47]

Based on the arguments set forth in the EJR Request, and because the applicable regulations[48] only permit group appeals to present a ***single*** question of fact ***or*** interpretation of law, regulations, or CMS Rulings that is common to each provider in the group, the Board issued a Request for Information ("RFI") in this case on February 3, 2023. The RFI sought to clarify the following:

1. Whether the Providers are pursuing a challenge pertaining to dual eligible days in the Medicaid Fraction related to the validity of the FY 2005 IPPS Rule following the decision in *Becerra v. Empire Health Found.*[49];
2. Whether the Providers are challenging the SSI Data Match policy finalized in the FY 2011 IPPS Final Rule;
3. How the discussion of Kentucky Medicaid is relevant to the issue(s) being pursued in this appeal.

On February 15, 2023, the Providers submitted a response to the RFI. They clarified that they are ***not*** pursuing any challenge related to the correct placement of Dual Eligible Medicare Non-Covered Days as they relate to the Medicaid Fraction because they agree that the Supreme Court settled this issue in *Empire Health*. Similarly, the Providers are ***not***, in this case, pursuing a challenge to the SSI Data Match policy finalized in the FY 2011 IPPS Final Rule. In fact, the Providers have separate group cases pursuing this challenge. Similarly, the Providers confirmed that the discussion of Kentucky Medicaid is relevant to the SSI Data Match issue, and thus only tangentially related to the instant case because a favorable ruling in this case would resolve the

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[44] EJR Request at 3.
[45] *Id.*
[46] *Id.*
[47] *Id.* at 2-3.
[48] 42 C.F.R. §§ 405.1837(a)(2), (f).
[49] 142 S.Ct. 2354 (2022).

SSI Data Match cases. As a whole, the Providers' response to the RFI confirmed that, in the instant case, they are ***only*** challenging the interpretation of "entitled to SSI benefits" as set forth in the FY 2011 IPPS Final Rule.

Decision of the Board

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

A. Preliminary Rulings on the Scope of the EJR Request

The Providers have suggested that they are challenging the FY 2005 IPPS Final Rule based on the following finding they included at the end of their EJR request:

> [The Board] is without the authority to decide the legal question of whether 42 C.F.R. § 412.106 codifying the CMS policies adopted in the FY 2005 IPPS Final Rule and the FY 2011 Final Rule are valid.[50]

However, the EJR request only mentions the FY 2005 IPPS Final Rule in one other place as follows:

> In the 2005 Rule construing the Medicare fraction, CMS interpreted the phrase "entitled to benefits under Part A" to encompass any patient who satisfied Part A statutory *eligibility* criteria whether or not Medicare actually pays for the care.[51]

The Providers have recognized that the Supreme Court upheld this policy:

> In *Becerra v. Empire Health Foundation For Valley Hospital Medical Center*, 142 S.Ct. 2354, 2368 (June 24, 2022), the Supreme Court upheld the Secretary's interpretation of the phrase "entitled to benefits" in the numerator of the Medicare fraction to include those individuals qualifying for Medicare regardless of whether that program actually paid for their day of care. The Supreme Court found that the Secretary's reading of "entitled to benefits" comported with the statute's two-population structure

[50] EJR Request at 18.
[51] *Id.* at n.4.

> because "[a]ll low-income people fit naturally into one or the other box, with the sum of the two leaving no one out." *Id.* at 2367.[52]

Moreover, the Board notes that the FY 2005 IPPS Final Rule does not include any statement regarding the Secretary's interpretation of the phrase "entitled to [SSI] benefits" as used in 42 U.S.C. § 1395ww(d)(F)(vi)(I). Nor do the Providers claim it does.

Accordingly, the Board finds that the EJR request has not laid a sufficient foundation for a challenge to the FY 2005 IPPS Final Rule. In so ruling, it does not mean that it does not have relevance to what is being challenged, namely the FY 2011 IPPS Final Rule as set forth below. However, it is not what is actually being challenged. In this regard, the Provider is maintaining that the term "entitled" should be consistently interpreted across 42 U.S.C. § 1395 and that "entitled to [SSI] benefits" should be broadly interpreted consistent with how the Secretary interpreted "entitled to benefits under [Medicare] Part A" as used in 42 U.S.C. 1395ww(d)(F)(vi)(I) and explained in the FY 2005 IPPS Final Rule and upheld by the Supreme Court in *Empire*, as noted above.

B. Jurisdiction: Appeals of Cost Report Periods Beginning After December 31, 2008 and Before January 1, 2016

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008 the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming an issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen.*[53] In that case, the Supreme Court concluded that a cost report submitted in full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.[54]

On August 21, 2008, new regulations governing the Board were effective.[55] Among the new regulations implemented in the Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hospital v. Burwell* ("*Banner*").[56] In *Banner*, the provider filed its cost report in accordance with the applicable

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[52] *Id.* at 2 (footnotes omitted).
[53] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).
[54] *Bethesda at 1258-59.*
[55] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[56] 201 F. Supp. 3d 131 (D.D.C. 2016).

outlier regulations and did not protest the additional outlier payment it was seeking. The provider's request for EJR was denied because the Board found that it lacked jurisdiction over the issue. The District Court concluded that, under *Bethesda,* the 2008 self-disallowance regulation could not be applied to appeals raising a legal challenge to a regulation or other policy that the Medicare Contractor could not address.[57]

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

The Board has determined that the issue in this CIRP Group as it relates to the meaning of "entitled to [SSI] benefits" is governed by CMS Ruling CMS-1727-R since the Providers are challenging the Secretary's interpretation of this phrase as set forth in the FY 2011 IPPS Final Rule and that Board review of this issue is not otherwise precluded by statute or regulation. In addition, the Providers' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal. The appeals were timely filed and no jurisdictional impediments have been identified for the Providers. Based on the above, the Board finds that it has jurisdiction for the above-captioned group appeal.

C. Board's Analysis of the Appealed Issue

As noted above, the Secretary revised the SSI data match process in light of the *Baystate* decision through notice and comment in the form of an uncodified regulation. First, the Secretary issued CMS Ruling 1498-R on April 28, 2010, authorizing remands of pending appeals of the SSI data match issue to recalculate the SSI fraction based on a revised data match.[58] The Secretary also stated in the ruling that, where cost reports had not been settled, those providers' SSI fractions would be calculated using the revised data match.[59] Contemporaneous with CMS' issuance of Ruling 1498-R,[60] the Secretary published the FY 2011 IPPS Proposed Rule[61] which, in pertinent part, proposed to adopt the same data match for 2011 and forward. This proposed rule was adopted as the FY 2011 Final IPPS Rule in which the Secretary explained that:

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[57] *Id.* at 142.
[58] CMS Ruling 1498-R at 27.
[59] *Id.* at 31.
[60] *Id.* at 5.
[61] 75 Fed. Reg. 23,852, 24,002-07.

> [W]e used a revised data matching process . . . that comports with the court's decision [in *Baystate* to recalculate the hospitals' SSI fractions]. As the revised data matching process was completed using SSI eligibility data compiled between 13 and 16 years beyond the fiscal years at issue in the *Baystate* case, we believe any issues associated with retroactive determinations of SSI eligibility and the lifting of payment suspensions had been long since resolved. Furthermore, because we believe that the revised match process used to implement the *Baystate* decision addressed all of the concerns found by the court, in the FY 2011 IPPS/LTCH PPS proposed rule we proposed to use the same revised data matching process for calculating hospitals' SSI fractions for FY 2011 and subsequent fiscal years.[62]

Then she announced that:

> We have adopted the proposed data matching process for FY 2011 and beyond as final. The only modification we are making to the proposed matching process is adopting a policy to exclude a record from the data matching process if we find a HICAN in the MedPAR file that we are not able to locate in the EDB[63]which is an extremely unlikely situation as noted in the prior discussion in this final rule. We are adopting this additional step in our validation process to respond to public comment and provide even more assurances that our data matching process will yield accurate SSI fractions and capture all Medicare beneficiaries who were entitled to SSI at the time of their inpatient hospital stay. The same data matching process will be used to calculate SSI fractions for cost reporting periods covered under the ruling.[64]

As part of the adopted data match process, CMS explicitly finalized a policy that SSI codes C01, M01, and M02 would capture all SSI entitled days:

> *Comment*: **One commenter stated that <u>CMS</u>** uses total (that is, "paid and unpaid") Medicare days in the denominator of the SSI fraction, but **<u>uses paid SSI days in the numerator of the SSI fraction</u>**. The commenter requested that CMS interpret the word "entitled" to mean "paid" for both SSI-entitled days used for the numerator and Medicare-entitled days used in the denominator, or alternatively, that CMS include both paid and unpaid days for both SSI entitlement and Medicare entitlement such that there is consistency between the numerator and the denominator of the SSI

[62] 75 Fed. Reg. at 50,277.
[63] (Medicare) Enrollment Database.
[64] 75 Fed. Reg. at 50,285.

> fraction. **The commenter stated that there were several SSI codes that represent individuals who were eligible for SSI, but not eligible for SSI payments, that should be included as SSI-entitled for purposes of the data matching process**. Specifically, the commenter stated that at least the following codes should be considered to be SSI-entitlement:
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> - E01 and E02
> - N06, N10, N11, N18, N35, N39, N42, N43, N46, N50, and N54
> - P01
> - S04, S05, S06, S07, S08, S09, S10, S20, S21, S90, and S91
> - T01, T20, T22, and T31
>
> *Response*: In response to the comment that we are incorrectly applying a different standard in interpreting the word "entitled" with respect to SSI entitlement versus Medicare entitlement, we disagree. The authorizing DSH statute at section 1886(d)(5)(F)(vi)(I) of the Act limits the numerator to individuals entitled to Medicare benefits who are also "*entitled* to supplemental security income benefits (excluding any State supplementation)" (emphasis added).[65] **Consistent with this requirement, we have requested, and are using in the data matching process, those SSA codes that reflect "entitlement to" receive SSI benefits**. Section 1602 of the Act provides that "[e]very aged, blind, or disabled individual who is determined under Part A to be eligible on the basis of his income and resources shall, in accordance with and subject to the provisions of this title, be *paid* benefits by the Commissioner of the Social Security" (emphasis added). However, eligibility for SSI benefits does not automatically mean that an individual will receive SSI benefits for a particular month. For example, section 1611(c)(7) of the Act provides that an application for SSI benefits becomes effective on the later of either the month following the filing of an application for SSI benefits or the month following eligibility for SSI benefits.
>
> On the other hand, section 226 of the Act provides that an individual is automatically "entitled" to Medicare Part A when the person reaches age 65 and is entitled to Social Security benefits under section 202 of the Act (42 U.S.C. 402) or becomes disabled and has been entitled to disability benefits under section 223 of the Act (42

[65] As a side note, we have used the phrase ''SSI-eligible'' interchangeably with the term ''SSI-entitled'' in the FY 2011 proposed rule as well as prior proposed and final rules, but the statute requires that we include individuals who were entitled to SSI benefits in the SSI fractions. Although we have used these terms interchangeably, we intended no different meaning, and our policy has always been to include only Medicare beneficiaries who are entitled to receive SSI benefits in the numerator of the SSI fraction.

U.S.C. 423) for 24 calendar months. Section 226A of the Act provides that qualifying individuals with end-stage renal disease shall be entitled to Medicare Part A. In addition, section 1818(a)(4) of the Act provides that, "unless otherwise provided, any reference to an individual entitled to benefits under [Part A] includes an individual entitled to benefits under [Part A] pursuant to enrollment under [section 1818] or section 1818A." We believe that Congress used the phrase "entitled to benefits under part A" in section 1886(d)(5)(F)(vi) of the Act to refer individuals who meet the criteria for entitlement under these sections.

Moreover, unlike the SSI program (in which entitlement to receive SSI benefits is based on income and resources and, therefore, can vary from time to time), once a person becomes entitled to Medicare Part A, the individual does not lose such entitlement simply because there was no Medicare Part A coverage of a specific inpatient stay. Entitlement to Medicare Part A reflects an individual's entitlement to Medicare Part A benefits, not the hospital's entitlement or right to receive payment for services provided to such individual. Such Medicare entitlement does not cease to exist simply because Medicare payment for an individual inpatient hospital claim is not made. Again, we are bound by section 1886(d)(5)(F)(vi)(I) of the Act, which defines the SSI fraction numerator as the number of SSI-entitled inpatient days for persons who were "entitled to benefits under [P]art A," and the denominator as the total number of inpatient days for individuals who were "entitled" to Medicare Part A benefits.

In response to the comment about specific SSI status codes, SSA has provided information regarding all of the SSI status codes mentioned by the commenter to assist in the determination of whether any of these codes represent individuals who were entitled to SSI benefits for the purposes of calculating the SSI fraction for Medicare DSH. With respect to the codes that begin with the letter "T," SSA informed us that all of the codes represent individuals whose SSI entitlement was terminated. Code "T01" represents records that were terminated because of the death of the individual, but we confirmed that this code would not be used until the first full month after the death of the individual. That is, for example, if a Medicare individual was entitled to SSI during the month of October, was admitted to the hospital on October 1 and died in the hospital on October 15, the individual would show up as entitled to SSI for the entire month of October on the SSI file (code T01 would not be used on the SSI file until November) and 15 Medicare/SSI inpatient hospital

days for that individual would be counted in the numerator and the denominator of the SSI fraction for that hospital.

Codes beginning with the letter "S" reflect records that are in a "suspended" status and, according to SSA, do not represent individuals who are entitled to SSI benefits.

SSA maintains that code "P01" is obsolete and has not been used since the mid-1980s. Therefore, it would not be used on any SSI files reflecting SSI entitlement for FY 2011 and beyond.

Codes that begin with the letter "N" represent records on "nonpayment" and are not used for individuals who are entitled to SSI benefits.

Code "E01" represents an individual who is a resident of a medical treatment facility and is subject to a $30 payment limit, but has countable income of $30 or more. Such an individual is not entitled to receive SSI payment. Alternatively, an individual who is a resident of a medical treatment facility and is subject to a $30 payment limit, but does not have countable income of at least $30, would be reflected on the SSI file as a "C01" (which denotes SSI entitlement) for any month in which the requirements described in this sentence are met. Code "E02" is used to identify a person who is not entitled to SSI payments in the month in which that code is used pursuant to section 1611(c)(7) of the Act, which provides that an application for SSI benefits shall be effective on the later of (1) the first day of the month following the date the application is filed, or (2) the first day of the month following the date the individual becomes eligible for SSI based on that application. Such an individual is not entitled to SSI benefits during the month that his or her application is filed or is determined to be eligible for SSI, but, for the following month, would be coded as a "C01" because he or she would then be entitled to SSI benefits.

Therefore, both codes E01 and E02 represent individuals who are not entitled to SSI benefits and are reflected accordingly on the SSI file. If the individual's entitlement to SSI benefits is initiated the ensuing month, that individual would then be coded as a "C01" on the SSI file and would be included as SSI-entitled for purposes of the data matching process.

As we have described above, **none of the SSI status codes that the commenter mentioned would be used to describe an individual who was entitled to receive SSI benefits during the month that one of those status codes was used**. SSI entitlement can change

> from time to time, and **we believe that including SSI codes of C01, M01, and M02 accurately captures all SSI-entitled individuals during the month(s) that they are entitled to receive SSI benefits**.
>
> After consideration of the public comments we received, we are adopting the proposed data matching process for FY 2011 and beyond as final. The only modification we are making to the proposed data matching process is adopting a policy to exclude a record from the data matching process if we find a HICAN in the MedPAR file that we are not able to locate in the EDB, which is an extremely unlikely situation as noted in the prior discussion in this final rule. We are adopting this additional step in our validation process in response to public comments to provide even more assurances that **our data matching process will** yield accurate SSI fractions and **capture all Medicare beneficiaries who were <u>entitled</u> to SSI at the time of their inpatient hospital stay**.[66]

The Secretary did not incorporate, into the Code of Federal Regulations, the above new policy involving the revised data match process (including but not limited to portion of that policy relating to interpreting "entitled to [SSI] benefits" and the use of SSI code C01, M01, and M02 to capture SSI entitled days). However, it is clear from the language in the final IPPS rule, as set forth above, that the Secretary intended to bind the regulated parties and establish a *binding* data match process to be used by the Medicare Contractors in calculating (or recalculating) providers' SSI fractions.

Accordingly, the Board finds that the Secretary intended this policy change for the data match process to be a binding but uncodified regulation and will refer to the portion of that policy as it relates to interpreting "entitled to [SSI] benefits" and the related adoption of the SSI codes C01, M01, and M02 to capture SSI entitled days as the "Uncodified SSI Entitled Days Regulation." Indeed, this finding is consistent with the Secretary's obligations under 42 U.S.C. § 1395hh(a)(2) to promulgate any "substantive legal standard governing . . . the payment of services" as a regulation."[67]

Pursuant to 42 C.F.R. § 405.1867, the Board is bound to apply the statutory and regulatory provisions governing the Medicare program. Consequently, the Board finds that it is bound by the Uncodified SSI Entitled Days Regulation published in the FY 2011 Final Rule and the Board does not have the authority to grant the relief sought by the Provider, namely invalidating the Uncodified SSI Entitled Days Regulation which they allege fails to include all of the SSI codes

[66] 75 Fed. Reg. at 50280-81 (footnote in original; bold and underline emphasis added).
[67] 42 U.S.C. § 1395hh(a)(2) states "[n]o rule, requirement, or other statement of policy . . . that establishes or changes a substantive legal standard governing . . . the payment of services . . . shall take effect unless it is promulgated by the Secretary by regulation . . . ."

used by SSA to determine SSI eligibility. As a result, the Board finds that EJR is appropriate for the issue for the calendar year under appeal in this case.

D. Board's Decision Regarding the EJR Request

The Board finds that:

1) It has jurisdiction over the matter for the subject year and that the Provider is entitled to a hearing before the Board;

2) Based upon the Provider's assertions regarding 42 C.F.R. § 412.106(b)(2)(i) and the Uncodified SSI Entitled Days Regulation as adopted in the preamble to the FY 2011 Final IPPS Rule, there are no findings of fact for resolution by the Board;

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

4) It is without authority to decide the legal question of whether the Uncodified SSI Entitled Days Regulation as adopted in the preamble to the FY 2011 Final IPPS Rule is valid.

Accordingly, the Board finds that the question of the validity of the Uncodified SSI Entitled Days Regulation properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for EJR for that question. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since is the only issue in the appeal, the Board hereby closes the case and removes it from its docket.

Board Members Participating:

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

FOR THE BOARD:

3/7/2023

X Clayton J. Nix

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

Enclosure: Schedule of Providers

cc: Judith Cummings, CGS Administrators (J-15)
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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RE: ***EJR Determination***
Wyatt 2011 DSH SSI Ratio Dual Eligible Non-Covered Days Group
Case No. 15-2312G

Dear Mr. Price:

The Provider Reimbursement Review Board ("Board") has reviewed Providers' January 9, 2023 request for expedited judicial review ("EJR") in the above-referenced optional group appeal. The decision of the Board is set forth below.

Issues in Dispute

The Board received the Providers' Optional Group Appeal Request on April 1, 2015. The group was formed with two (2) providers and has been deemed complete. Each Provider filed its appeal from an original Notice of Program Reimbursement ("NPR") and the stated amount in controversy for this case exceeds $50,000.

The Providers' Statement of the Group Issue describes the issue as follows:

> **ISSUE:** Whether the Fiscal Intermediary's calculation of the Provider's disproportionate patient percent, used or purposes of calculating the Medicare Disproportionate Share ("DSH") Adjustment, was incorrect due to CMS' improper treatment of the Medicare Non-Covered Days, which includes but is not limited to Dual Eligible, Medicare Exhausted and Medicare Secondary Payor days. The improper treatment of these days affects the numerator of the Medicaid fraction and the numerator and the denominator of the Medicare fraction.
>
> ****
>
> If Medicare interprets "entitled" to Medicare as "eligible" for Medicare, and thus their basis for including these days in the Medicare fraction, then they also must interpret "entitled" to SSI as "eligible" for SSI and allow Dual Eligible days that are "eligible" for SSI, which includes days where the patient may only be

> receiving their SSI medical benefit/Medicaid, to be included in the Medicare numerator.[1]

With the Group Appeal Request, one provider submitted an estimated amount in controversy calculation which illustrates the alternative argument that the definition of "entitled to SSI benefits" as used in the numerator of the SSI fraction should be expanded to include days where a patient is eligible for SSI benefits:

1. King's Daughter's Medical Center (Prov. No. 18-0009): $5,018,991 based on the addition of 12,129 dual eligible days to the SSI Ratio.

The second Provider (TJ Sampson Community Hospital (Prov. No. 18-0017)) was transferred from an individual appeal. The issue statement is the same but its estimated amount in controversy calculation appears to illustrates the impact of including dual eligible days in the Medicaid Fraction, and excluding them from the SSI Ratio. In its calculation, the SSI Numerator is unchanged and the SSI Denominator is reduced; the Medicaid days are also increased for the Medicaid Fraction. This calculation appears to illustrate the assertion that no-pay dual eligible days should be removed from the SSI fraction and moved to the numerator of the Medicaid fraction, which is not at issue in this EJR Request.[2]

A request for Expedited Judicial Review was filed on January 9, 2023.[3] The updated amounts in controversy submitted with the Schedule of Providers which accompany the EJR Request differ from those submitted with the original appeal,[4] and these new calculations illustrate the reimbursement impact based on adding dual eligible days to the Medicare Fraction (the issue in the EJR Request).

Statutory and Regulatory Background:

A. The Secretary's policy on what the phrase "entitled to supplemental security income benefits" in 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I) means for purposes of the numerator of the SSI fraction used in the DSH adjustment calculation

The Medicare program pays inpatient hospital services based on predetermined, standardized amounts subject to certain payment adjustments under Medicare's inpatient prospective payment system ("IPPS").[5] One of these adjustments, the Medicare DSH adjustment, provides additional payments to certain qualifying hospitals that treat a disproportionate share of low income patients.[6] The Medicare DSH adjustment is calculated using two fractions known as the Medicare fraction (also referred to as the SSI fraction or SSI ratio) and the Medicaid fraction.

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[1] Group Appeal Request, Tab 2 (Apr. 1, 2015).
[2] *See* Provider's Preliminary Position Paper, Schedule of Providers, Tab 1E (Aug. 1, 2016).
[3] Provider Request for Expedited Judicial Review (Jan. 9, 2023) ("EJR Request").
[4] EJR Request, Attachment L.
[5] 42 C.F.R. Part 412.
[6] 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I).

Pursuant to 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I), the Medicare fraction is calculated by using: (a) in the numerator, the "number of such hospital's patient days…which were made up of patients who (for such days) were ***entitled*** to benefits under part A of the subchapter and were ***entitled*** to supplementary security income benefits…under subchapter XVI of this chapter…";[7] and (b) in the denominator, the number of days of care that are furnished to patients who were entitled to Medicare Part A. The Secretary incorporated this statutory provision into the regulations at 42 C.F.R. § 412.106(b)(2)(i)(B) which states:

> (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)).[8]

The dispute in these appeals involves CMS' determination of which patients are "entitled to" both Medicare Part A and SSI benefits for purposes of the Medicare fraction of the DSH calculation.

The SSI program is a federal cash assistance program for low-income individuals who are aged, blind, or disabled,[9] administered by the Social Security Administration ("SSA"). The statutory provisions governing SSI, generally, do not use the term "entitled" to SSI benefits. Rather, the SSI statutory provisions typically refer to whether an individual is "eligible for benefits."[10] In order to be "eligible" for SSI benefits, a person must be: (1) 65 years of age or older, blind or disabled; (2) a lawful resident of the United States; (3) have limited income and resources; (4)

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[7] (Emphasis added.)
[8] (Bold emphasis added and italics emphasis in original.) *See also* 42 U.S.C. § 1395w2(d)(5)(F)(vi)(I).
[9] 42 U.S.C. § 1382.
[10] 42 U.S.C. §§ 1381a, 1382(a) (emphasis added).

not be fleeing to avoid prosecution for a crime or violating a condition of parole; and (5) file an application for benefits.[11]

In contrast, the Medicare program is an insurance program where an individual is automatically "entitled" to Medicare Part A when the person reaches age 65 and is entitled to Social Security benefits or becomes disabled and had been entitled to disability benefits for 24 calendar months.[12] In addition, the Medicare program provides that certain qualifying individuals with end stage renal disease are entitled to Medicare Part A.[13]

Unlike entitlement for Medicare Part A benefits, an individual who is currently eligible for SSI benefits may later become *in*eligible for SSI benefits. In this regard, SSA conducts periodic redeterminations to ensure continued eligibility[14] and may terminate,[15] suspend[16] or stop payments to individuals who are either temporarily or permanently ineligible for payment of SSI benefits.[17] In particular, SSI eligibility may be lost if a person no longer meets the basic requirements. For example, an individual may lose SSI eligibility if the individual is no longer disabled or the individual meets one of the following reasons set forth in §§ 416.207-416.216:

1. The individual fails to give the SSA permission to contact financial institutions;[18]
2. The individual fails to apply for other benefits to which the individual may be entitled;[19]
3. The individual fails to participate in drug or alcohol addiction treatment;[20]
4. The individuals is absent from the United States for more than 30 days;[21] or
5. The individual becomes a resident of a public institutions or prison.[22]

In addition, under certain circumstances, SSA may not pay benefits for administrative reasons, such as removal of a representative payee, an unknown address for the beneficiary, or because of income from a previous month.[23]

After the Medicare DSH statutory provisions were enacted in 1984, CMS (then known as the Health Care Financing Administration ("HCFA")) announced that the Secretary of Health and Human Services, rather than hospitals, would be solely responsible for computation of the

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[11] 20 C.F.R. § 416.202.
[12] 42 U.S.C. § 426.
[13] 42 U.S.C. § 426-1.
[14] 20 C.F.R. § 416.204.
[15] 20 C.F.R. §§ 416.1331-1335.
[16] 20 C.F.R. §§ 416.1320-1330.
[17] 20 C.F.R. § 1320.
[18] 20 C.F.R. § 416.207.
[19] 20 C.F.R. § 416.210.
[20] 20 C.F.R. § 416.214.
[21] 20 C.F.R. § 416.215.
[22] 20 C.F.R. § 416.211.
[23] *See* SSA Program Operations Manual ("POMS") § SI 02301.201 (describing certain SSI post-eligibility events on the internet at https://secure.ssa.gov/apps10/poms.nsf/lnx/0502301201).

Medicare fraction because the data necessary to calculate the Medicare fraction is voluminous and much of this data needed to be obtained from another agency, SSA.[24] CMS noted that, as of 1986, the data sources for the computation of the Medicare fraction included approximately 11 million billing records from the Medicare inpatient discharge file and over 5 million records from the SSI file compiled by SSA.[25] To compute the Medicare fraction, CMS had to match individual Medicare billing records to individual SSI records.[26] Considering the administrative burdens and complexity of the data matching process, CMS concluded that the Secretary would be responsible for the data matching process, which she would conduct retrospectively for every eligible Medicare hospital on a "federal fiscal year" basis—that is, based on discharges occurring in the federal fiscal year.[27] CMS notifies Medicare contractors of the SSI ratios after they are calculated. CMS currently makes this notification by posting the resulting SSI percentages on its website. Medicare contractors then use the posted SSI ratios to calculate the Medicare DSH percentage to determine each qualifying hospital's Medicare DSH payment adjustment.[28]

The Medicare DSH payment adjustment has been the subject of much litigation and, from that litigation, the following case is of particular relevance to this appeal: *Baystate v. Leavitt*, 545 F. Supp. 2d 20 *as amended* 587 F. Supp. 2d 37, 44 (D.D.C. 2008) ("*Baystate*"). In *Baystate*, the plaintiff alleged that the Secretary's process to identify and gather the data necessary to calculate each hospital's SSI ratio was deficient and the Court remanded the case to the Administrator for further action. The Board notes that this case discusses the Secretary's historical practice of basing "entitled to . . . SSI" under 42 C.F.R. § 412.106(b)(2) on actual payment of SSI cash benefits.[29]

On April 28, 2010, the Secretary through CMS acted on the *Baystate* remand order and published CMS Ruling CMS-1498-R ("Ruling 1498-R"). Specifically, the Ruling stated that CMS had implemented the *Baystate* remand order by recalculating the plaintiff's SSI fractions and Medicare DSH payment adjustments using a revised data matching process that used

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[24] 51 Fed. Reg. 31454, 31459 (Sept. 3, 1986).
[25] *Id.*
[26] *Id.*
[27] *Id.* at 31459–31460; 42 C.F.R. § 412.106(b).
[28] 42 C.F.R. § 412.106(b)(5); 42 C.F.R. § 405.1803.
[29] *Baystate* began with a hearing before the Board. *See Baystate Med. Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006), *modified by*, CMS Adm'r Dec. (May 11, 2006). The Board heard extensive testimony on the Secretary's then-existing data match process. This included testimony from several SSA employees on the data tapes historically sent from SSA to CMS that included "42 monthly indicators (ones and zeros) denoting the payment or non-payment of Federal SSI cash benefits during the period covered by the SSA tape." *Id.* at 11 (citations omitted). Further, this testimony established that SSA's program would "assign a '1' to a month if the CMPH field shows one of two payment codes, C01 (current pay status) or M01 (manual or forced pay), and the FAM field reflects an amount due for the month" and that "[o]therwise, the program assigns a '0' to that month." *Id.* The provider in *Baystate* contested among other things: (1) "the omission of SSI records relating to individuals who received a forced payment from an SSA filed office; (2) "the omission of SSI days associated with individuals whose SSI benefits were temporarily on hold or in suspense when SSA ran each year's SSI tape;" (3) "the omission of SSI days associated with individuals whose benefits were restored or retroactively after SSA ran each year's tape;" and (4) "the omission of individuals who were entitled to non-cash Federal SSI benefits." *Id.* at 23. The Board's discussion of these contentions confirms SSI days were counted when there was actual SSI cash benefits. *See id*. at 26-30. The CMS Administrator's decision and the ensuing decision of the D.C. District Court also contain references to the Secretary's policy. *See, e.g.,* Adm'r Dec. at 5, 16, 39, 41, 48-49; 545 F. Supp. 2d at 28-29 n.13 & n.17, 36-39.

"updated and refined SSI eligibility data and Medicare records, and by matching individuals' records with reference to Social Security numbers (SSNs) as well as HICANs and Title II numbers."[30] The Ruling also stated that "in the FY 2011 proposed rule, CMS is proposing to adopt the same revised data matching process" for use with all hospitals and that "[i]n the forthcoming FY 2011 IPPS final rule, CMS expects to respond to public comments filed on the proposed new data matching process, make any changes to such matching process that seem appropriate, and adopt finally a new data matching process."[31] Finally, CMS stated that it would "use that new data matching process in calculating SSI fractions and DSH payments for specific claims that are found to qualify for relief under this Ruling."[32]

Consistent with Ruling 1498-R, the Secretary published the new data matching process in the FY 2011 IPPS proposed rule published on May 4, 2010.[33] The proposed rule includes references to the Secretary's historical practice of basing "entitled to . . . SSI" under 42 C.F.R. § 412.106(b)(2) on actual payment of SSI cash benefits.[34]

The Secretary finalized that data matching process in the FY 2011 IPPS final rule published on August 16, 2010 ("FY 2011 IPPS Final Rule").[35] Significantly, in the preamble to the FY 2011 IPPS Final Rule, CMS acknowledged a public comment that: (1) requested that "CMS include both paid and unpaid days for both SSI entitlement and Medicare entitlement such that there would be consistency between the numerator and denominator of the SSI fraction"; and (2) provided examples of "several SSI codes that represent individuals who were eligible for SSI but not eligible for SSI payments, that should be included as SSI-entitled for purposes of the data match process."[36] CMS responded in detail to this comment and explained that CMS interprets SSI entitlement to correspond with any month for which an individual *receives* payment of SSI benefits. In this regard, CMS stated that the three SSI codes denoted as C01, M01, and M02 "accurately captures all SSI-entitled individuals during the month(s) they are entitled to receive SSI benefits."[37] CMS explicitly rejected the inclusion of other SSA codes because "SSI entitlement can change from time to time" and none of these codes "would be used to describe an individual who was entitled to receive SSI benefits during the month that one of these codes was used."[38] Finally, in the preamble, CMS confirms that "[t]he same data matching process

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[30] CMS-1498-R at 5.
[31] *Id.*
[32] *Id.* at 5-6.
[33] 85 Fed. Reg. 23852, 24002-24007 (May 4, 2010).
[34] *See, e.g.,* 75 Fed. Reg. at 24003 (discussing SSI cash payment issues discussed in the *Baystate* decision), 24003-24004 (discussing the proposed matching process where "[t]he SSI eligibility file serves as the system of record for whether or not SSA made a payment of SSI benefits to an individual who applied for SSI"), 24004-06 (discussing the time of the matching process including how "it is important to find an appropriate balance between administrative finality (that is, the final settlement of a hospital's cost report) and the inclusion of retroactive SSI eligibility determinations and the lifting of SSI payment suspensions by using the best and latest available SSI eligibility data at the time of cost report settlement benefits").
[35] 75 Fed. Reg. 50041, 50280-50281. (Aug. 16, 2010).
[36] *Id.* at 50280.
[37] *Id.* at 50280-50281.
[38] *Id.* This include all codes with the "S" prefix indicating a suspension of payment; codes beginning with "N" for nonpayment; code "E01" indicating that the individual had countable income which eliminated the SSI payment; and

[used for FY 2011 and beyond] will be used to calculate SSI fractions for cost reporting periods covered under the Ruling [1498-R]."[39]

While the new data matching process established in the preamble to the FY 2011 IPPS Final Rule was effective October 1, 2010 (*i.e.*, for FY 2011 and forward), Ruling 1498-R directed that the Medicare contractors apply "the same, unitary relief" consisting of SSI fractions that the Secretary had calculated using the new "suitably revised" data matching process to: (1) any Medicare cost report that had not been settled; and (2) all properly pending Medicare DSH appeals of the SSI fraction data matching process issue.[40] The Ruling noted that hospitals dissatisfied with the initial or revised NPR issued using the new SSI ratios in the Medicare DSH adjustment calculation could seek administrative and judicial review provided they met the jurisdictional and procedural requirements of 42 U.S.C. § 1395oo, the Medicare regulations, and other agency rules and guidelines.[41] In the FY 2011 IPPS Final Rule, the Secretary explicitly recognized that "[t]he data matching process provisions of the Ruling would apply to . . . open cost reports for cost reporting periods beginning prior to October 1, 2010 (that is those preceding the effective date of the FY 2011 IPPS final rule)."[42]

Finally, on April 22, 2015, CMS published Ruling 1498-R2 modifying and amending Ruling 1498-R by allowing hospitals to elect whether to use new Medicare SSI fractions calculated on the basis of "total days" or "covered days" for cost reports involving patient discharges *prior* to October 1, 2004.[43]

However, neither Ruling 1498-R nor Ruling 1498-R2 are applicable to this appeal since the revised NPRs at issue were issued after Ruling 1498-R and since the fiscal year at issue is not covered by Ruling 1498-R2. As a result of the new regulation and new data match process, CMS calculated SSI percentages for the Providers for the fiscal years at issue.[44] The Provider is challenging the adoption of the policy stated therein that only SSI paid days as represented by SSI codes S01, M01 and M02 are included in the numerator of the SSI fraction for purposes of representing days "entitled to [SSI] benefits."

B. FY 2005 IPPS Final Rule

The FY 2005 IPPS Final Rule announced policy changes relative to the treatment of dual eligible days and Medicare Part C days in the SSI fraction.[45] However, it did not address or announce

code "E02" indicating that the patient was not entitled to SSI benefits during that month but became entitled during a subsequent month.

[39] *Id.* at 50285.

[40] CMS-1498-R at 6-7, 31.

[41] *Id.* at 28, 31.

[42] 75 Fed. Reg. at 24006.

[43] CMS-1498-R2 at 2, 6.

[44] SSI ratios are published and can be accessed at https://www.cms.gov/Medicare/ Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.

[45] 69 Fed. Reg. 48916, 49090-99 (Aug. 11, 2004).

any policy statements or changes relative to what the phrase "entitled to [SSI] benefits as used in 42 U.S.C. § 1395ww(d)(F)(vi)(I).

Providers' Position

In their EJR Request, the Providers acknowledge that, following the Supreme Court's decision in *Empire*, dual eligible days should be excluded from the Medicaid numerator.[46] They argue, however, that there is now an inconsistency between the interpretation of "entitled to benefits under Part A" (which encompasses any patient who satisfies the statutory eligibility criteria whether or not Medicare actually pays), and "entitled to SSI" (which encompasses only patient days where SSI cash payments were actually received).[47] This discrepancy excludes a large number of days from the Medicare fraction numerator.[48] In particular, the Providers are located in Kentucky where a dual eligible patient is entitled to SSI benefits by definition, so the Providers argue all Kentucky dual eligible patient days should be included in the Medicare Fraction's numerator.[49]

Based on the arguments set forth in the EJR Request, and because the applicable regulations[50] only permit group appeals to present a ***single*** question of fact ***or*** interpretation of law, regulations, or CMS Rulings that is common to each provider in the group, the Board issued a Request for Information ("RFI") in this case on February 7, 2023. The RFI sought to clarify the following:

1. Whether the Providers are pursuing a challenge pertaining to dual eligible days in the Medicaid Fraction related to the validity of the FY 2005 IPPS Rule following the decision in *Becerra v. Empire Health Found*.[51];
2. Whether the Providers are challenging the SSI Data Match policy finalized in the FY 2011 IPPS Final Rule;
3. How the discussion of Kentucky Medicaid is relevant to the issue(s) being pursued in this appeal.

On February 15, 2023, the Providers submitted a response to the RFI. They clarified that they are ***not*** pursuing any challenge related to the correct placement of Dual Eligible Medicare Non-Covered Days as they relate to the Medicaid Fraction because they agree that the Supreme Court settled this issue in *Empire Health*. Similarly, the Providers are ***not***, in this case, pursuing a challenge to the SSI Data Match policy finalized in the FY 2011 IPPS Final Rule. In fact, the Providers have separate group cases pursuing this challenge. Similarly, the Providers confirmed that the discussion of Kentucky Medicaid is relevant to the SSI Data Match issue, and thus only tangentially related to the instant case because a favorable ruling in this case would resolve the SSI Data Match cases. As a whole, the Providers' response to the RFI confirmed that, in the

[46] EJR Request at 3.
[47] *Id.*
[48] *Id.*
[49] *Id.* at 2-3.
[50] 42 C.F.R. §§ 405.1837(a)(2), (f).
[51] 142 S.Ct. 2354 (2022).

instant case, they are ***only*** challenging the interpretation of "entitled to SSI benefits" as set forth in the FY 2011 IPPS Final Rule.

Decision of the Board

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

A. Preliminary Rulings on the Scope of the EJR Request

The Providers have suggested that they are challenging the FY 2005 IPPS Final Rule based on the following finding they included at the end of their EJR request:

> [The Board] is without the authority to decide the legal question of whether 42 C.F.R. § 412.106 codifying the CMS policies adopted in the FY 2005 IPPS Final Rule and the FY 2011 Final Rule are valid.[52]

However, the EJR request only mentions the FY 2005 IPPS Final Rule in one other place as follows:

> In the 2005 Rule construing the Medicare fraction, CMS interpreted the phrase "entitled to benefits under Part A" to encompass any patient who satisfied Part A statutory *eligibility* criteria whether or not Medicare actually pays for the care.[53]

The Providers have recognized that the Supreme Court upheld this policy:

> In *Becerra v. Empire Health Foundation For Valley Hospital Medical Center*, 142 S.Ct. 2354, 2368 (June 24, 2022), the Supreme Court upheld the Secretary's interpretation of the phrase "entitled to benefits" in the numerator of the Medicare fraction to include those individuals qualifying for Medicare regardless of whether that program actually paid for their day of care. The Supreme Court found that the Secretary's reading of "entitled to benefits" comported with the statute's two-population structure because "[a]ll low-income people fit naturally into one or the other box, with the sum of the two leaving no one out." *Id.* at 2367.[54]

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[52] EJR Request at 18.
[53] *Id.* at n.4.
[54] *Id.* at 2 (footnotes omitted).

Moreover, the Board notes that the FY 2005 IPPS Final Rule does not include any statement regarding the Secretary's interpretation of the phrase "entitled to [SSI] benefits" as used in 42 U.S.C. § 1395ww(d)(F)(vi)(I). Nor do the Providers claim it does.

Accordingly, the Board finds that the EJR request has not laid a sufficient foundation for a challenge to the FY 2005 IPPS Final Rule. In so ruling, it does not mean that it does not have relevance to what is being challenged, namely the FY 2011 IPPS Final Rule as set forth below. However, it is not what is actually being challenged. In this regard, the Provider is maintaining that the term "entitled" should be consistently interpreted across 42 U.S.C. § 1395 and that "entitled to [SSI] benefits" should be broadly interpreted consistent with how the Secretary interpreted "entitled to benefits under [Medicare] Part A" as used in 42 U.S.C. 1395ww(d)(F)(vi)(I) and explained in the FY 2005 IPPS Final Rule and upheld by the Supreme Court in *Empire*, as noted above.

B. Jurisdiction: Appeals of Cost Report Periods Beginning After December 31, 2008 and Before January 1, 2016

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008 the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming an issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen.*[55] In that case, the Supreme Court concluded that a cost report submitted in full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.[56]

On August 21, 2008, new regulations governing the Board were effective.[57] Among the new regulations implemented in the Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hospital v. Burwell* ("*Banner*").[58] In *Banner*, the provider filed its cost report in accordance with the applicable outlier regulations and did not protest the additional outlier payment it was seeking. The provider's request for EJR was denied because the Board found that it lacked jurisdiction over the issue. The District Court concluded that, under *Bethesda,* the 2008 self-disallowance regulation could not be applied to appeals raising a legal challenge to a regulation or other policy that the Medicare Contractor could not address.[59]

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[55] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R.
[56] *Bethesda* at 1258-59.
[57] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[58] 201 F. Supp. 3d 131 (D.D.C. 2016).
[59] *Id.* at 142.

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

The Board has determined that the issue in this CIRP Group as it relates to the meaning of "entitled to [SSI] benefits" is governed by CMS Ruling CMS-1727-R since the Providers are challenging the Secretary's interpretation of this phrase as set forth in the FY 2011 IPPS Final Rule and that Board review of this issue is not otherwise precluded by statute or regulation. In addition, the Providers' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal. The appeals were timely filed and no jurisdictional impediments have been identified for the Providers. Based on the above, the Board finds that it has jurisdiction for the above-captioned group appeal.

C. Board's Analysis of the Appealed Issue

As noted above, the Secretary revised the SSI data match process in light of the *Baystate* decision through notice and comment in the form of an uncodified regulation. First, the Secretary issued CMS Ruling 1498-R on April 28, 2010, authorizing remands of pending appeals of the SSI data match issue to recalculate the SSI fraction based on a revised data match.[60] The Secretary also stated in the ruling that, where cost reports had not been settled, those providers' SSI fractions would be calculated using the revised data match.[61] Contemporaneous with CMS' issuance of Ruling 1498-R,[62] the Secretary published the FY 2011 IPPS Proposed Rule[63] which, in pertinent part, proposed to adopt the same data match for 2011 and forward. This proposed rule was adopted as the FY 2011 Final IPPS Rule in which the Secretary explained that:

> [W]e used a revised data matching process . . . that comports with the court's decision [in *Baystate* to recalculate the hospitals' SSI fractions]. As the revised data matching process was completed using SSI eligibility data compiled between 13 and 16 years beyond the fiscal years at issue in the *Baystate* case, we believe any issues associated with retroactive determinations of SSI eligibility and the lifting of payment suspensions had been long since resolved. Furthermore, because we believe that the revised match process used

[60] CMS Ruling 1498-R at 27.
[61] *Id.* at 31.
[62] *Id.* at 5.
[63] 75 Fed. Reg. 23,852, 24,002-07.

> to implement the *Baystate* decision addressed all of the concerns found by the court, in the FY 2011 IPPS/LTCH PPS proposed rule we proposed to use the same revised data matching process for calculating hospitals' SSI fractions for FY 2011 and subsequent fiscal years.[64]

Then she announced that:

> We have adopted the proposed data matching process for FY 2011 and beyond as final. The only modification we are making to the proposed matching process is adopting a policy to exclude a record from the data matching process if we find a HICAN in the MedPAR file that we are not able to locate in the EDB[65]which is an extremely unlikely situation as noted in the prior discussion in this final rule. We are adopting this additional step in our validation process to respond to public comment and provide even more assurances that our data matching process will yield accurate SSI fractions and capture all Medicare beneficiaries who were entitled to SSI at the time of their inpatient hospital stay. The same data matching process will be used to calculate SSI fractions for cost reporting periods covered under the ruling.[66]

As part of the adopted data match process, CMS explicitly finalized a policy that SSI codes C01, M01, and M02 would capture all SSI entitled days:

> *Comment*: **One commenter stated that <u>CMS</u>** uses total (that is, "paid and unpaid") Medicare days in the denominator of the SSI fraction, but **<u>uses paid SSI days in the numerator of the SSI fraction</u>**. The commenter requested that CMS interpret the word "entitled" to mean "paid" for both SSI-entitled days used for the numerator and Medicare-entitled days used in the denominator, or alternatively, that CMS include both paid and unpaid days for both SSI entitlement and Medicare entitlement such that there is consistency between the numerator and the denominator of the SSI fraction. **The commenter stated that there were several SSI codes that represent individuals who were eligible for SSI, but not eligible for SSI payments, that should be included as SSI-entitled for purposes of the data matching process**. Specifically, the commenter stated that at least the following codes should be considered to be SSI-entitlement:

[64] 75 Fed. Reg. at 50,277.
[65] (Medicare) Enrollment Database.
[66] 75 Fed. Reg. at 50,285.

- E01 and E02
- N06, N10, N11, N18, N35, N39, N42, N43, N46, N50, and N54
- P01
- S04, S05, S06, S07, S08, S09, S10, S20, S21, S90, and S91
- T01, T20, T22, and T31

Response: In response to the comment that we are incorrectly applying a different standard in interpreting the word "entitled" with respect to SSI entitlement versus Medicare entitlement, we disagree. The authorizing DSH statute at section 1886(d)(5)(F)(vi)(I) of the Act limits the numerator to individuals entitled to Medicare benefits who are also "*entitled* to supplemental security income benefits (excluding any State supplementation)" (emphasis added).[67] **Consistent with this requirement, we have requested, and are using in the data matching process, those SSA codes that reflect "entitlement to" receive SSI benefits**. Section 1602 of the Act provides that "[e]very aged, blind, or disabled individual who is determined under Part A to be eligible on the basis of his income and resources shall, in accordance with and subject to the provisions of this title, be *paid* benefits by the Commissioner of the Social Security" (emphasis added). However, eligibility for SSI benefits does not automatically mean that an individual will receive SSI benefits for a particular month. For example, section 1611(c)(7) of the Act provides that an application for SSI benefits becomes effective on the later of either the month following the filing of an application for SSI benefits or the month following eligibility for SSI benefits.

On the other hand, section 226 of the Act provides that an individual is automatically "entitled" to Medicare Part A when the person reaches age 65 and is entitled to Social Security benefits under section 202 of the Act (42 U.S.C. 402) or becomes disabled and has been entitled to disability benefits under section 223 of the Act (42 U.S.C. 423) for 24 calendar months. Section 226A of the Act provides that qualifying individuals with end-stage renal disease shall be entitled to Medicare Part A. In addition, section 1818(a)(4) of the Act provides that, "unless otherwise provided, any reference to an individual entitled to benefits under [Part A] includes an individual entitled to benefits under [Part A] pursuant to enrollment under [section 1818] or section 1818A." We believe that Congress

[67] As a side note, we have used the phrase ''SSI-eligible'' interchangeably with the term ''SSI-entitled'' in the FY 2011 proposed rule as well as prior proposed and final rules, but the statute requires that we include individuals who were entitled to SSI benefits in the SSI fractions. Although we have used these terms interchangeably, we intended no different meaning, and our policy has always been to include only Medicare beneficiaries who are entitled to receive SSI benefits in the numerator of the SSI fraction.

> used the phrase "entitled to benefits under part A" in section 1886(d)(5)(F)(vi) of the Act to refer individuals who meet the criteria for entitlement under these sections.
>
> Moreover, unlike the SSI program (in which entitlement to receive SSI benefits is based on income and resources and, therefore, can vary from time to time), once a person becomes entitled to Medicare Part A, the individual does not lose such entitlement simply because there was no Medicare Part A coverage of a specific inpatient stay. Entitlement to Medicare Part A reflects an individual's entitlement to Medicare Part A benefits, not the hospital's entitlement or right to receive payment for services provided to such individual. Such Medicare entitlement does not cease to exist simply because Medicare payment for an individual inpatient hospital claim is not made. Again, we are bound by section 1886(d)(5)(F)(vi)(I) of the Act, which defines the SSI fraction numerator as the number of SSI-entitled inpatient days for persons who were "entitled to benefits under [P]art A," and the denominator as the total number of inpatient days for individuals who were "entitled" to Medicare Part A benefits.
>
> **In response to the comment about specific SSI status codes, SSA has provided information regarding all of the SSI status codes mentioned by the commenter to assist in the determination of whether <u>any</u> of these codes represent individuals who were entitled to SSI benefits for the purposes of calculating the SSI fraction for Medicare DSH**. With respect to the codes that begin with the letter "T," SSA informed us that all of the codes represent individuals whose SSI entitlement was terminated. Code "T01" represents records that were terminated because of the death of the individual, but we confirmed that this code would not be used until the first full month after the death of the individual. That is, for example, if a Medicare individual was entitled to SSI during the month of October, was admitted to the hospital on October 1 and died in the hospital on October 15, the individual would show up as entitled to SSI for the entire month of October on the SSI file (code T01 would not be used on the SSI file until November) and 15 Medicare/SSI inpatient hospital days for that individual would be counted in the numerator and the denominator of the SSI fraction for that hospital.
>
> Codes beginning with the letter "S" reflect records that are in a "suspended" status and, according to SSA, do not represent individuals who are entitled to SSI benefits.

> SSA maintains that code "P01" is obsolete and has not been used since the mid-1980s. Therefore, it would not be used on any SSI files reflecting SSI entitlement for FY 2011 and beyond.
>
> Codes that begin with the letter "N" represent records on "nonpayment" and are not used for individuals who are entitled to SSI benefits.
>
> Code "E01" represents an individual who is a resident of a medical treatment facility and is subject to a $30 payment limit, but has countable income of $30 or more. Such an individual is not entitled to receive SSI payment. Alternatively, an individual who is a resident of a medical treatment facility and is subject to a $30 payment limit, but does not have countable income of at least $30, would be reflected on the SSI file as a "C01" (which denotes SSI entitlement) for any month in which the requirements described in this sentence are met. Code "E02" is used to identify a person who is not entitled to SSI payments in the month in which that code is used pursuant to section 1611(c)(7) of the Act, which provides that an application for SSI benefits shall be effective on the later of (1) the first day of the month following the date the application is filed, or (2) the first day of the month following the date the individual becomes eligible for SSI based on that application. Such an individual is not entitled to SSI benefits during the month that his or her application is filed or is determined to be eligible for SSI, but, for the following month, would be coded as a "C01" because he or she would then be entitled to SSI benefits.
>
> Therefore, both codes E01 and E02 represent individuals who are not entitled to SSI benefits and are reflected accordingly on the SSI file. If the individual's entitlement to SSI benefits is initiated the ensuing month, that individual would then be coded as a "C01" on the SSI file and would be included as SSI-entitled for purposes of the data matching process.
>
> As we have described above, **none of the SSI status codes that the commenter mentioned would be used to describe an individual who was entitled to receive SSI benefits during the month that one of those status codes was used**. SSI entitlement can change from time to time, and **we believe that including SSI codes of C01, M01, and M02 accurately captures all SSI-entitled individuals during the month(s) that they are entitled to receive SSI benefits**.
>
> After consideration of the public comments we received, we are adopting the proposed data matching process for FY 2011 and beyond as final. The only modification we are making to the proposed data

> matching process is adopting a policy to exclude a record from the data matching process if we find a HICAN in the MedPAR file that we are not able to locate in the EDB, which is an extremely unlikely situation as noted in the prior discussion in this final rule. We are adopting this additional step in our validation process in response to public comments to provide even more assurances that **our data matching process will** yield accurate SSI fractions and **capture all Medicare beneficiaries who were entitled to SSI at the time of their inpatient hospital stay**.[68]

The Secretary did not incorporate, into the Code of Federal Regulations, the above new policy involving the revised data match process (including but not limited to portion of that policy relating to interpreting "entitled to [SSI] benefits" and the use of SSI code C01, M01, and M02 to capture SSI entitled days). However, it is clear from the language in the final IPPS rule, as set forth above, that the Secretary intended to bind the regulated parties and establish a *binding* data match process to be used by the Medicare Contractors in calculating (or recalculating) providers' SSI fractions.

Accordingly, the Board finds that the Secretary intended this policy change for the data match process to be a binding but uncodified regulation and will refer to the portion of that policy as it relates to interpreting "entitled to [SSI] benefits" and the related adoption of the SSI codes C01, M01, and M02 to capture SSI entitled days as the "Uncodified SSI Entitled Days Regulation." Indeed, this finding is consistent with the Secretary's obligations under 42 U.S.C. § 1395hh(a)(2) to promulgate any "substantive legal standard governing . . . the payment of services" as a regulation."[69]

Pursuant to 42 C.F.R. § 405.1867, the Board is bound to apply the statutory and regulatory provisions governing the Medicare program. Consequently, the Board finds that it is bound by the Uncodified SSI Entitled Days Regulation published in the FY 2011 Final Rule and the Board does not have the authority to grant the relief sought by the Provider, namely invalidating the Uncodified SSI Entitled Days Regulation which they allege fails to include all of the SSI codes used by SSA to determine SSI eligibility. As a result, the Board finds that EJR is appropriate for the issue for the calendar year under appeal in this case.

D. Board's Decision Regarding the EJR Request

The Board finds that:

1) It has jurisdiction over the matter for the subject year and that the Provider is entitled to a hearing before the Board;

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[68] 75 Fed. Reg. at 50280-81 (footnote in original; bold and underline emphasis added).

[69] 42 U.S.C. § 1395hh(a)(2) states "[n]o rule, requirement, or other statement of policy . . . that establishes or changes a substantive legal standard governing . . . the payment of services . . . shall take effect unless it is promulgated by the Secretary by regulation . . . ."

2) Based upon the Provider's assertions regarding 42 C.F.R. § 412.106(b)(2)(i) and the Uncodified SSI Entitled Days Regulation as adopted in the preamble to the FY 2011 Final IPPS Rule, there are no findings of fact for resolution by the Board;

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

4) It is without authority to decide the legal question of whether the Uncodified SSI Entitled Days Regulation as adopted in the preamble to the FY 2011 Final IPPS Rule is valid.

Accordingly, the Board finds that the question of the validity of the Uncodified SSI Entitled Days Regulation properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for EJR for that question. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since is the only issue in the appeal, the Board hereby closes the case and removes it from its docket.

Board Members Participating:

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

FOR THE BOARD:

3/7/2023

X Clayton J. Nix

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

Enclosure: Schedule of Providers

cc: Judith Cummings, CGS Administrators (J-15)
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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RE: ***EJR Determination***
Appalachian Reg'l Healthcare (ARH) 2012 Dual Eligible Medicare Non-Covered Days CIRP Grp
Case No. 16-0062GC

Dear Mr. Price:

The Provider Reimbursement Review Board ("Board") has reviewed Providers' January 6, 2023 request for expedited judicial review ("EJR") in the above-referenced Common Issue Related Party ("CIRP") group appeal. The decision of the Board is set forth below.

Issues in Dispute

The Board received the Providers' Group Appeal Request on October 6, 2015. The group was formed with two (2) providers and has since been deemed complete. Each Provider filed its appeal from an original Notice of Program Reimbursement ("NPR") and the stated amount in controversy for this case exceeds $50,000.

The Providers' Statement of the Group Issue describes the issue as follows:

> **ISSUE:** Whether the Fiscal Intermediary's calculation of the Provider's disproportionate patient percent, used or purposes of calculating the Medicare Disproportionate Share ("DSH") Adjustment, was incorrect due to CMS' improper treatment of the Medicare Non-Covered Days, which includes but is not limited to Dual Eligible, Medicare Exhausted and Medicare Secondary Payor days. The improper treatment of these days affects numerator and the denominator of the Medicare fraction.
>
> ****
>
> According to the interpretation of 42 C.F.R. § 412.106(b), the regulation currently interprets the statutory language "entitled to benefits under [Medicare] Part A" as requiring the inclusion of patient days for all Medicare beneficiaries, even if a beneficiary has exhausted his or her Medicare coverage. This interpretation

> requires the exclusion from the Medicaid fraction of patient days for those individuals who are "eligible" for both Medicare and Medicaid, but who have exhausted their Medicare benefits. Per the ruling from *Metro. Hosp., Inc. v. US. Dep 't of Health & Human Servs*.,702 F. Supp. 2d 808, 825-26 (W.D. Mich. 2010), the district court determined that the interpretation at section 412.106(b) was invalid as contrary to the plain meaning of the DPP statute, reasoning that "entitled" requires payment for hospital services, rather than mere eligibility. Thus, dual-eligible patients with exhausted Medicare benefits would be included in the numerator of the Medicaid fraction.
>
> ****
>
> If Medicare interprets "entitled" to Medicare as "eligible" for Medicare, and thus their basis for including these days in the Medicare fraction, then they also must interpret "entitled" to SSI as "eligible" for SSI and allow Dual Eligible days that are "eligible" for SSI, which includes days where the patient may only be receiving their SSI medical benefit/Medicaid, to be included in the Medicare numerator.[1]

With the Group Appeal Request, each provider submitted an estimated amount in controversy calculation which illustrates the alternative argument that the definition of "entitled to SSI benefits" as used in the numerator of the SSI fraction should be expanded to include days where a patient is eligible for SSI benefits. For each provider, the amount in controversy was estimated to be:

1. Harlan ARH Hospital (Prov. No. 18-0050): $2,924,853, based on the addition of 2,970 dual eligible days to the SSI Ratio; and
2. Hazard ARH Hospital (Prov. No. 18-0029): $8,751,158, based on the addition of 10,146 dual eligible days in the SSI Ratio.

A request for Expedited Judicial Review was filed on January 6, 2023.[2] The amounts in controversy and number of days added were adjusted in the calculations submitted with the Schedule of Providers which accompany the EJR Request,[3] but the reimbursement impact is still reached through adding dual eligible days to the Medicare Fraction.

[1] Group Appeal Request, Tab 2 (Oct. 6, 2015).
[2] Provider Request for Expedited Judicial Review (Jan. 6, 2023) ("EJR Request").
[3] EJR Request, Attachment L.

Statutory and Regulatory Background:

A. The Secretary's policy on what the phrase "entitled to supplemental security income benefits" in 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I) means for purposes of the numerator of the SSI fraction used in the DSH adjustment calculation

The Medicare program pays inpatient hospital services based on predetermined, standardized amounts subject to certain payment adjustments under Medicare's inpatient prospective payment system ("IPPS").[4] One of these adjustments, the Medicare DSH adjustment, provides additional payments to certain qualifying hospitals that treat a disproportionate share of low income patients.[5] The Medicare DSH adjustment is calculated using two fractions known as the Medicare fraction (also referred to as the SSI fraction or SSI ratio) and the Medicaid fraction. Pursuant to 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I), the Medicare fraction is calculated by using: (a) in the numerator, the "number of such hospital's patient days…which were made up of patients who (for such days) were ***entitled*** to benefits under part A of the subchapter and were ***entitled*** to supplementary security income benefits…under subchapter XVI of this chapter…";[6] and (b) in the denominator, the number of days of care that are furnished to patients who were entitled to Medicare Part A. The Secretary incorporated this statutory provision into the regulations at 42 C.F.R. § 412.106(b)(2)(i)(B) which states:

> (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

[4] 42 C.F.R. Part 412.
[5] 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I).
[6] (Emphasis added.)

> (B) Are furnished to patients entitled to Medicare Part A (including Medicare Advantage (Part C)).[7]

The dispute in these appeals involves CMS' determination of which patients are "entitled to" both Medicare Part A and SSI benefits for purposes of the Medicare fraction of the DSH calculation.

The SSI program is a federal cash assistance program for low-income individuals who are aged, blind, or disabled,[8] administered by the Social Security Administration ("SSA"). The statutory provisions governing SSI, generally, do not use the term "entitled" to SSI benefits. Rather, the SSI statutory provisions typically refer to whether an individual is "eligible for benefits."[9] In order to be "eligible" for SSI benefits, a person must be: (1) 65 years of age or older, blind or disabled; (2) a lawful resident of the United States; (3) have limited income and resources; (4) not be fleeing to avoid prosecution for a crime or violating a condition of parole; and (5) file an application for benefits.[10]

In contrast, the Medicare program is an insurance program where an individual is automatically "entitled" to Medicare Part A when the person reaches age 65 and is entitled to Social Security benefits or becomes disabled and had been entitled to disability benefits for 24 calendar months.[11] In addition, the Medicare program provides that certain qualifying individuals with end stage renal disease are entitled to Medicare Part A.[12]

Unlike entitlement for Medicare Part A benefits, an individual who is currently eligible for SSI benefits may later become *in*eligible for SSI benefits. In this regard, SSA conducts periodic redeterminations to ensure continued eligibility[13] and may terminate,[14] suspend[15] or stop payments to individuals who are either temporarily or permanently ineligible for payment of SSI benefits.[16] In particular, SSI eligibility may be lost if a person no longer meets the basic requirements. For example, an individual may lose SSI eligibility if the individual is no longer disabled or the individual meets one of the following reasons set forth in §§ 416.207-416.216:

1. The individual fails to give the SSA permission to contact financial institutions;[17]
2. The individual fails to apply for other benefits to which the individual may be entitled;[18]

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7 (Bold emphasis added and italics emphasis in original.) *See also* 42 U.S.C. § 1395w2(d)(5)(F)(vi)(I).
8 42 U.S.C. § 1382.
9 42 U.S.C. §§ 1381a, 1382(a) (emphasis added).
10 20 C.F.R. § 416.202.
11 42 U.S.C. § 426.
12 42 U.S.C. § 426-1.
13 20 C.F.R. § 416.204.
14 20 C.F.R. §§ 416.1331-1335.
15 20 C.F.R. §§ 416.1320-1330.
16 20 C.F.R. § 1320.
17 20 C.F.R. § 416.207.
18 20 C.F.R. § 416.210.

3. The individual fails to participate in drug or alcohol addiction treatment;[19]
4. The individuals is absent from the United States for more than 30 days;[20] or
5. The individual becomes a resident of a public institutions or prison.[21]

In addition, under certain circumstances, SSA may not pay benefits for administrative reasons, such as removal of a representative payee, an unknown address for the beneficiary, or because of income from a previous month.[22]

After the Medicare DSH statutory provisions were enacted in 1984, CMS (then known as the Health Care Financing Administration ("HCFA")) announced that the Secretary of Health and Human Services, rather than hospitals, would be solely responsible for computation of the Medicare fraction because the data necessary to calculate the Medicare fraction is voluminous and much of this data needed to be obtained from another agency, SSA.[23] CMS noted that, as of 1986, the data sources for the computation of the Medicare fraction included approximately 11 million billing records from the Medicare inpatient discharge file and over 5 million records from the SSI file compiled by SSA.[24] To compute the Medicare fraction, CMS had to match individual Medicare billing records to individual SSI records.[25] Considering the administrative burdens and complexity of the data matching process, CMS concluded that the Secretary would be responsible for the data matching process, which she would conduct retrospectively for every eligible Medicare hospital on a "federal fiscal year" basis—that is, based on discharges occurring in the federal fiscal year.[26] CMS notifies Medicare contractors of the SSI ratios after they are calculated. CMS currently makes this notification by posting the resulting SSI percentages on its website. Medicare contractors then use the posted SSI ratios to calculate the Medicare DSH percentage to determine each qualifying hospital's Medicare DSH payment adjustment.[27]

The Medicare DSH payment adjustment has been the subject of much litigation and, from that litigation, the following case is of particular relevance to this appeal: *Baystate v. Leavitt*, 545 F. Supp. 2d 20 *as amended* 587 F. Supp. 2d 37, 44 (D.D.C. 2008) ("*Baystate*"). In *Baystate*, the plaintiff alleged that the Secretary's process to identify and gather the data necessary to calculate each hospital's SSI ratio was deficient and the Court remanded the case to the Administrator for further action. The Board notes that this case discusses the Secretary's historical practice of basing "entitled to . . . SSI" under 42 C.F.R. § 412.106(b)(2) on actual payment of SSI cash benefits.[28]

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[19] 20 C.F.R. § 416.214.
[20] 20 C.F.R. § 416.215.
[21] 20 C.F.R. § 416.211.
[22] *See* SSA Program Operations Manual ("POMS") § SI 02301.201 (describing certain SSI post-eligibility events on the internet at https://secure.ssa.gov/apps10/poms.nsf/lnx/0502301201).
[23] 51 Fed. Reg. 31454, 31459 (Sept. 3, 1986).
[24] *Id.*
[25] *Id.*
[26] *Id.* at 31459–31460; 42 C.F.R. § 412.106(b).
[27] 42 C.F.R. § 412.106(b)(5); 42 C.F.R. § 405.1803.
[28] *Baystate* began with a hearing before the Board. *See Baystate Med. Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006), *modified by*, CMS Adm'r Dec. (May 11, 2006). The Board heard extensive

On April 28, 2010, the Secretary through CMS acted on the *Baystate* remand order and published CMS Ruling CMS-1498-R ("Ruling 1498-R"). Specifically, the Ruling stated that CMS had implemented the *Baystate* remand order by recalculating the plaintiff's SSI fractions and Medicare DSH payment adjustments using a revised data matching process that used "updated and refined SSI eligibility data and Medicare records, and by matching individuals' records with reference to Social Security numbers (SSNs) as well as HICANs and Title II numbers."[29] The Ruling also stated that "in the FY 2011 proposed rule, CMS is proposing to adopt the same revised data matching process" for use with all hospitals and that "[i]n the forthcoming FY 2011 IPPS final rule, CMS expects to respond to public comments filed on the proposed new data matching process, make any changes to such matching process that seem appropriate, and adopt finally a new data matching process."[30] Finally, CMS stated that it would "use that new data matching process in calculating SSI fractions and DSH payments for specific claims that are found to qualify for relief under this Ruling."[31]

Consistent with Ruling 1498-R, the Secretary published the new data matching process in the FY 2011 IPPS proposed rule published on May 4, 2010.[32] The proposed rule includes references to the Secretary's historical practice of basing "entitled to . . . SSI" under 42 C.F.R. § 412.106(b)(2) on actual payment of SSI cash benefits.[33]

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testimony on the Secretary's then-existing data match process. This included testimony from several SSA employees on the data tapes historically sent from SSA to CMS that included "42 monthly indicators (ones and zeros) denoting the payment or non-payment of Federal SSI cash benefits during the period covered by the SSA tape." *Id.* at 11 (citations omitted). Further, this testimony established that SSA's program would "assign a '1' to a month if the CMPH field shows one of two payment codes, C01 (current pay status) or M01 (manual or forced pay), and the FAM field reflects an amount due for the month" and that "[o]therwise, the program assigns a '0' to that month." *Id.* The provider in *Baystate* contested among other things: (1) "the omission of SSI records relating to individuals who received a forced payment from an SSA filed office; (2) "the omission of SSI days associated with individuals whose SSI benefits were temporarily on hold or in suspense when SSA ran each year's SSI tape;" (3) "the omission of SSI days associated with individuals whose benefits were restored or retroactively after SSA ran each year's tape;" and (4) "the omission of individuals who were entitled to non-cash Federal SSI benefits." *Id.* at 23. The Board's discussion of these contentions confirms SSI days were counted when there was actual SSI cash benefits. *See id.* at 26-30. The CMS Administrator's decision and the ensuing decision of the D.C. District Court also contain references to the Secretary's policy. *See, e.g.,* Adm'r Dec. at 5, 16, 39, 41, 48-49; 545 F. Supp. 2d at 28-29 n.13 & n.17, 36-39.

[29] CMS-1498-R at 5.

[30] *Id.*

[31] *Id.* at 5-6.

[32] 85 Fed. Reg. 23852, 24002-24007 (May 4, 2010).

[33] *See, e.g.,* 75 Fed. Reg. at 24003 (discussing SSI cash payment issues discussed in the *Baystate* decision), 24003-24004 (discussing the proposed matching process where "[t]he SSI eligibility file serves as the system of record for whether or not SSA made a payment of SSI benefits to an individual who applied for SSI"), 24004-06 (discussing the time of the matching process including how "it is important to find an appropriate balance between administrative finality (that is, the final settlement of a hospital's cost report) and the inclusion of retroactive SSI eligibility determinations and the lifting of SSI payment suspensions by using the best and latest available SSI eligibility data at the time of cost report settlement benefits").

The Secretary finalized that data matching process in the FY 2011 IPPS final rule published on August 16, 2010 ("FY 2011 IPPS Final Rule").[34] Significantly, in the preamble to the FY 2011 IPPS Final Rule, CMS acknowledged a public comment that: (1) requested that "CMS include both paid and unpaid days for both SSI entitlement and Medicare entitlement such that there would be consistency between the numerator and denominator of the SSI fraction"; and (2) provided examples of "several SSI codes that represent individuals who were eligible for SSI but not eligible for SSI payments, that should be included as SSI-entitled for purposes of the data match process."[35] CMS responded in detail to this comment and explained that CMS interprets SSI entitlement to correspond with any month for which an individual *receives* payment of SSI benefits. In this regard, CMS stated that the three SSI codes denoted as C01, M01, and M02 "accurately captures all SSI-entitled individuals during the month(s) they are entitled to receive SSI benefits."[36] CMS explicitly rejected the inclusion of other SSA codes because "SSI entitlement can change from time to time" and none of these codes "would be used to describe an individual who was entitled to receive SSI benefits during the month that one of these codes was used."[37] Finally, in the preamble, CMS confirms that "[t]he same data matching process [used for FY 2011 and beyond] will be used to calculate SSI fractions for cost reporting periods covered under the Ruling [1498-R]."[38]

While the new data matching process established in the preamble to the FY 2011 IPPS Final Rule was effective October 1, 2010 (*i.e.*, for FY 2011 and forward), Ruling 1498-R directed that the Medicare contractors apply "the same, unitary relief" consisting of SSI fractions that the Secretary had calculated using the new "suitably revised" data matching process to: (1) any Medicare cost report that had not been settled; and (2) all properly pending Medicare DSH appeals of the SSI fraction data matching process issue.[39] The Ruling noted that hospitals dissatisfied with the initial or revised NPR issued using the new SSI ratios in the Medicare DSH adjustment calculation could seek administrative and judicial review provided they met the jurisdictional and procedural requirements of 42 U.S.C. § 1395oo, the Medicare regulations, and other agency rules and guidelines.[40] In the FY 2011 IPPS Final Rule, the Secretary explicitly recognized that "[t]he data matching process provisions of the Ruling would apply to . . . open cost reports for cost reporting periods beginning prior to October 1, 2010 (that is those preceding the effective date of the FY 2011 IPPS final rule)."[41]

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[34] 75 Fed. Reg. 50041, 50280-50281. (Aug. 16, 2010).
[35] *Id.* at 50280.
[36] *Id.* at 50280-50281.
[37] *Id.* This include all codes with the "S" prefix indicating a suspension of payment; codes beginning with "N" for nonpayment; code "E01" indicating that the individual had countable income which eliminated the SSI payment; and code "E02" indicating that the patient was not entitled to SSI benefits during that month but became entitled during a subsequent month.
[38] *Id.* at 50285.
[39] CMS-1498-R at 6-7, 31.
[40] *Id.* at 28, 31.
[41] 75 Fed. Reg. at 24006.

Finally, on April 22, 2015, CMS published Ruling 1498-R2 modifying and amending Ruling 1498-R by allowing hospitals to elect whether to use new Medicare SSI fractions calculated on the basis of "total days" or "covered days" for cost reports involving patient discharges *prior* to October 1, 2004.[42]

However, neither Ruling 1498-R nor Ruling 1498-R2 are applicable to this appeal since the revised NPRs at issue were issued after Ruling 1498-R and since the fiscal year at issue is not covered by Ruling 1498-R2. As a result of the new regulation and new data match process, CMS calculated SSI percentages for the Providers for the fiscal years at issue.[43] The Provider is challenging the adoption of the policy stated therein that only SSI paid days as represented by SSI codes S01, M01 and M02 are included in the numerator of the SSI fraction for purposes of representing days "entitled to [SSI] benefits."

B. FY 2005 IPPS Final Rule

The FY 2005 IPPS Final Rule announced policy changes relative to the treatment of dual eligible days and Medicare Part C days in the SSI fraction.[44] However, it did not address or announce any policy statements or changes relative to what the phrase "entitled to [SSI] benefits as used in 42 U.S.C. § 1395ww(d)(F)(vi)(I).

Providers' Position

In their EJR Request, the Providers acknowledge that, following the Supreme Court's decision in *Empire*, dual eligible days should be excluded from the Medicaid numerator.[45] They argue, however, that there is now an inconsistency between the interpretation of "entitled to benefits under Part A" (which encompasses any patient who satisfies the statutory eligibility criteria whether or not Medicare actually pays), and "entitled to SSI" (which encompasses only patient days where SSI cash payments were actually received).[46] This discrepancy excludes a large number of days from the Medicare fraction numerator.[47] In particular, the Providers are located in Kentucky where a dual eligible patient is entitled to SSI benefits by definition, so the Providers argue all Kentucky dual eligible patient days should be included in the Medicare Fraction's numerator.[48]

Based on the arguments set forth in the EJR Request, and because the applicable regulations[49] only permit group appeals to present a ***single*** question of fact ***or*** interpretation of law, regulations, or CMS Rulings that is common to each provider in the group, the Board issued a

[42] CMS-1498-R2 at 2, 6.
[43] SSI ratios are published and can be accessed at https://www.cms.gov/Medicare/ Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.
[44] 69 Fed. Reg. 48916, 49090-99 (Aug. 11, 2004).
[45] EJR Request at 3.
[46] *Id.*
[47] *Id.*
[48] *Id.* at 2-3.
[49] 42 C.F.R. §§ 405.1837(a)(2), (f).

Request for Information ("RFI") in this case on February 3, 2023. The RFI sought to clarify the following:

1. Whether the Providers are pursuing a challenge pertaining to dual eligible days in the Medicaid Fraction related to the validity of the FY 2005 IPPS Rule following the decision in *Becerra v. Empire Health Found.*[50];
2. Whether the Providers are challenging the SSI Data Match policy finalized in the FY 2011 IPPS Final Rule;
3. How the discussion of Kentucky Medicaid is relevant to the issue(s) being pursued in this appeal.

On February 15, 2023, the Providers submitted a response to the RFI. They clarified that they are ***not*** pursuing any challenge related to the correct placement of Dual Eligible Medicare Non-Covered Days as they relate to the Medicaid Fraction because they agree that the Supreme Court settled this issue in *Empire Health*. Similarly, the Providers are ***not***, in this case, pursuing a challenge to the SSI Data Match policy finalized in the FY 2011 IPPS Final Rule. In fact, the Providers have separate group cases pursuing this challenge. Similarly, the Providers confirmed that the discussion of Kentucky Medicaid is relevant to the SSI Data Match issue, and thus only tangentially related to the instant case because a favorable ruling in this case would resolve the SSI Data Match cases. As a whole, the Providers' response to the RFI confirmed that, in the instant case, they are ***only*** challenging the interpretation of "entitled to SSI benefits" as set forth in the FY 2011 IPPS Final Rule.

Decision of the Board

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

A. Preliminary Rulings on the Scope of the EJR Request

The Providers have suggested that they are challenging the FY 2005 IPPS Final Rule based on the following finding they included at the end of their EJR request:

> [The Board] is without the authority to decide the legal question of whether 42 C.F.R. § 412.106 codifying the CMS policies adopted in the FY 2005 IPPS Final Rule and the FY 2011 Final Rule are valid.[51]

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[50] 142 S.Ct. 2354 (2022).
[51] EJR Request at 18.

However, the EJR request only mentions the FY 2005 IPPS Final Rule in one other place as follows:

> In the 2005 Rule construing the Medicare fraction, CMS interpreted the phrase "entitled to benefits under Part A" to encompass any patient who satisfied Part A statutory *eligibility* criteria whether or not Medicare actually pays for the care.[52]

The Providers have recognized that the Supreme Court upheld this policy:

> In *Becerra v. Empire Health Foundation For Valley Hospital Medical Center*, 142 S.Ct. 2354, 2368 (June 24, 2022), the Supreme Court upheld the Secretary's interpretation of the phrase "entitled to benefits" in the numerator of the Medicare fraction to include those individuals qualifying for Medicare regardless of whether that program actually paid for their day of care. The Supreme Court found that the Secretary's reading of "entitled to benefits" comported with the statute's two-population structure because "[a]ll low-income people fit naturally into one or the other box, with the sum of the two leaving no one out." *Id.* at 2367.[53]

Moreover, the Board notes that the FY 2005 IPPS Final Rule does not include any statement regarding the Secretary's interpretation of the phrase "entitled to [SSI] benefits" as used in 42 U.S.C. § 1395ww(d)(F)(vi)(I). Nor do the Providers claim it does.

Accordingly, the Board finds that the EJR request has not laid a sufficient foundation for a challenge to the FY 2005 IPPS Final Rule. In so ruling, it does not mean that it does not have relevance to what is being challenged, namely the FY 2011 IPPS Final Rule as set forth below. However, it is not what is actually being challenged. In this regard, the Provider is maintaining that the term "entitled" should be consistently interpreted across 42 U.S.C. § 1395 and that "entitled to [SSI] benefits" should be broadly interpreted consistent with how the Secretary interpreted "entitled to benefits under [Medicare] Part A" as used in 42 U.S.C. 1395ww(d)(F)(vi)(I) and explained in the FY 2005 IPPS Final Rule and upheld by the Supreme Court in *Empire*, as noted above.

B. Jurisdiction: Appeals of Cost Report Periods Beginning After December 31, 2008 and Before January 1, 2016

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008 the participant may demonstrate dissatisfaction with the amount of

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[52] *Id.* at n.4.
[53] *Id.* at 2 (footnotes omitted).

Medicare reimbursement for the appealed issue by claiming an issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen.*[54] In that case, the Supreme Court concluded that a cost report submitted in full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.[55]

On August 21, 2008, new regulations governing the Board were effective.[56] Among the new regulations implemented in the Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hospital v. Burwell* ("*Banner*").[57] In *Banner*, the provider filed its cost report in accordance with the applicable outlier regulations and did not protest the additional outlier payment it was seeking. The provider's request for EJR was denied because the Board found that it lacked jurisdiction over the issue. The District Court concluded that, under *Bethesda,* the 2008 self-disallowance regulation could not be applied to appeals raising a legal challenge to a regulation or other policy that the Medicare Contractor could not address.[58]

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

The Board has determined that the issue in this CIRP Group as it relates to the meaning of "entitled to [SSI] benefits" is governed by CMS Ruling CMS-1727-R since the Providers are challenging the Secretary's interpretation of this phrase as set forth in the FY 2011 IPPS Final Rule and that Board review of this issue is not otherwise precluded by statute or regulation. In addition, the Providers' documentation shows that the estimated amount in controversy exceeds $50,000, as

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[54] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).
[55] *Bethesda at 1258-59.*
[56] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[57] 201 F. Supp. 3d 131 (D.D.C. 2016).
[58] *Id.* at 142.

required for a group appeal. The appeals were timely filed and no jurisdictional impediments have been identified for the Providers. Based on the above, the Board finds that it has jurisdiction for the above-captioned group appeal.

C. Board's Analysis of the Appealed Issue

As noted above, the Secretary revised the SSI data match process in light of the *Baystate* decision through notice and comment in the form of an uncodified regulation. First, the Secretary issued CMS Ruling 1498-R on April 28, 2010, authorizing remands of pending appeals of the SSI data match issue to recalculate the SSI fraction based on a revised data match.[59] The Secretary also stated in the ruling that, where cost reports had not been settled, those providers' SSI fractions would be calculated using the revised data match.[60] Contemporaneous with CMS' issuance of Ruling 1498-R,[61] the Secretary published the FY 2011 IPPS Proposed Rule[62] which, in pertinent part, proposed to adopt the same data match for 2011 and forward. This proposed rule was adopted as the FY 2011 Final IPPS Rule in which the Secretary explained that:

> [W]e used a revised data matching process . . . that comports with the court's decision [in *Baystate* to recalculate the hospitals' SSI fractions]. As the revised data matching process was completed using SSI eligibility data compiled between 13 and 16 years beyond the fiscal years at issue in the *Baystate* case, we believe any issues associated with retroactive determinations of SSI eligibility and the lifting of payment suspensions had been long since resolved. Furthermore, because we believe that the revised match process used to implement the *Baystate* decision addressed all of the concerns found by the court, in the FY 2011 IPPS/LTCH PPS proposed rule we proposed to use the same revised data matching process for calculating hospitals' SSI fractions for FY 2011 and subsequent fiscal years.[63]

Then she announced that:

> We have adopted the proposed data matching process for FY 2011 and beyond as final. The only modification we are making to the proposed matching process is adopting a policy to exclude a record from the data matching process if we find a HICAN in the MedPAR file that we are not able to locate in the EDB[64]which is an extremely unlikely situation as noted in the prior discussion in this final rule. We are adopting this additional step in our

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[59] CMS Ruling 1498-R at 27.
[60] *Id.* at 31.
[61] *Id.* at 5.
[62] 75 Fed. Reg. 23,852, 24,002-07.
[63] 75 Fed. Reg. at 50,277.
[64] (Medicare) Enrollment Database.

> validation process to respond to public comment and provide even more assurances that our data matching process will yield accurate SSI fractions and capture all Medicare beneficiaries who were entitled to SSI at the time of their inpatient hospital stay. The same data matching process will be used to calculate SSI fractions for cost reporting periods covered under the ruling.[65]

As part of the adopted data match process, CMS explicitly finalized a policy that SSI codes C01, M01, and M02 would capture all SSI entitled days:

> *Comment*: **One commenter stated that <u>CMS</u>** uses total (that is, "paid and unpaid") Medicare days in the denominator of the SSI fraction, but **<u>uses paid SSI days in the numerator of the SSI fraction</u>**. The commenter requested that CMS interpret the word "entitled" to mean "paid" for both SSI-entitled days used for the numerator and Medicare-entitled days used in the denominator, or alternatively, that CMS include both paid and unpaid days for both SSI entitlement and Medicare entitlement such that there is consistency between the numerator and the denominator of the SSI fraction. **The commenter stated that there were several SSI codes that represent individuals who were eligible for SSI, but not eligible for SSI payments, that should be included as SSI-entitled for purposes of the data matching process**. Specifically, the commenter stated that at least the following codes should be considered to be SSI-entitlement:
>
> - E01 and E02
> - N06, N10, N11, N18, N35, N39, N42, N43, N46, N50, and N54
> - P01
> - S04, S05, S06, S07, S08, S09, S10, S20, S21, S90, and S91
> - T01, T20, T22, and T31
>
> *Response*: In response to the comment that we are incorrectly applying a different standard in interpreting the word "entitled" with respect to SSI entitlement versus Medicare entitlement, we disagree. The authorizing DSH statute at section 1886(d)(5)(F)(vi)(I) of the Act limits the numerator to individuals entitled to Medicare benefits who are also "*entitled* to supplemental security income benefits (excluding any State supplementation)" (emphasis added).[66] **Consistent with**

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[65] 75 Fed. Reg. at 50,285.

[66] As a side note, we have used the phrase ''SSI-eligible'' interchangeably with the term ''SSI-entitled'' in the FY 2011 proposed rule as well as prior proposed and final rules, but the statute requires that we include individuals who were entitled to SSI benefits in the SSI fractions. Although we have used these terms interchangeably, we intended

> **this requirement, we have requested, and are using in the data matching process, those SSA codes that reflect "entitlement to" receive SSI benefits**. Section 1602 of the Act provides that "[e]very aged, blind, or disabled individual who is determined under Part A to be eligible on the basis of his income and resources shall, in accordance with and subject to the provisions of this title, be *paid* benefits by the Commissioner of the Social Security" (emphasis added). However, eligibility for SSI benefits does not automatically mean that an individual will receive SSI benefits for a particular month. For example, section 1611(c)(7) of the Act provides that an application for SSI benefits becomes effective on the later of either the month following the filing of an application for SSI benefits or the month following eligibility for SSI benefits.
>
> On the other hand, section 226 of the Act provides that an individual is automatically "entitled" to Medicare Part A when the person reaches age 65 and is entitled to Social Security benefits under section 202 of the Act (42 U.S.C. 402) or becomes disabled and has been entitled to disability benefits under section 223 of the Act (42 U.S.C. 423) for 24 calendar months. Section 226A of the Act provides that qualifying individuals with end-stage renal disease shall be entitled to Medicare Part A. In addition, section 1818(a)(4) of the Act provides that, "unless otherwise provided, any reference to an individual entitled to benefits under [Part A] includes an individual entitled to benefits under [Part A] pursuant to enrollment under [section 1818] or section 1818A." We believe that Congress used the phrase "entitled to benefits under part A" in section 1886(d)(5)(F)(vi) of the Act to refer individuals who meet the criteria for entitlement under these sections.
>
> Moreover, unlike the SSI program (in which entitlement to receive SSI benefits is based on income and resources and, therefore, can vary from time to time), once a person becomes entitled to Medicare Part A, the individual does not lose such entitlement simply because there was no Medicare Part A coverage of a specific inpatient stay. Entitlement to Medicare Part A reflects an individual's entitlement to Medicare Part A benefits, not the hospital's entitlement or right to receive payment for services provided to such individual. Such Medicare entitlement does not cease to exist simply because Medicare payment for an individual inpatient hospital claim is not made. Again, we are bound by section 1886(d)(5)(F)(vi)(I) of the

no different meaning, and our policy has always been to include only Medicare beneficiaries who are entitled to receive SSI benefits in the numerator of the SSI fraction.

Act, which defines the SSI fraction numerator as the number of SSI-entitled inpatient days for persons who were "entitled to benefits under [P]art A," and the denominator as the total number of inpatient days for individuals who were "entitled" to Medicare Part A benefits.

In response to the comment about specific SSI status codes, SSA has provided information regarding all of the SSI status codes mentioned by the commenter to assist in the determination of whether <u>any</u> of these codes represent individuals who were entitled to SSI benefits for the purposes of calculating the SSI fraction for Medicare DSH. With respect to the codes that begin with the letter "T," SSA informed us that all of the codes represent individuals whose SSI entitlement was terminated. Code "T01" represents records that were terminated because of the death of the individual, but we confirmed that this code would not be used until the first full month after the death of the individual. That is, for example, if a Medicare individual was entitled to SSI during the month of October, was admitted to the hospital on October 1 and died in the hospital on October 15, the individual would show up as entitled to SSI for the entire month of October on the SSI file (code T01 would not be used on the SSI file until November) and 15 Medicare/SSI inpatient hospital days for that individual would be counted in the numerator and the denominator of the SSI fraction for that hospital.

Codes beginning with the letter "S" reflect records that are in a "suspended" status and, according to SSA, do not represent individuals who are entitled to SSI benefits.

SSA maintains that code "P01" is obsolete and has not been used since the mid-1980s. Therefore, it would not be used on any SSI files reflecting SSI entitlement for FY 2011 and beyond.

Codes that begin with the letter "N" represent records on "nonpayment" and are not used for individuals who are entitled to SSI benefits.

Code "E01" represents an individual who is a resident of a medical treatment facility and is subject to a $30 payment limit, but has countable income of $30 or more. Such an individual is not entitled to receive SSI payment. Alternatively, an individual who is a resident of a medical treatment facility and is subject to a $30 payment limit, but does not have countable income of at least $30, would be reflected on the SSI file as a "C01" (which denotes SSI entitlement) for any month in which the requirements described in this sentence are met. Code "E02" is used to identify a person who is not entitled to SSI payments

> in the month in which that code is used pursuant to section 1611(c)(7) of the Act, which provides that an application for SSI benefits shall be effective on the later of (1) the first day of the month following the date the application is filed, or (2) the first day of the month following the date the individual becomes eligible for SSI based on that application. Such an individual is not entitled to SSI benefits during the month that his or her application is filed or is determined to be eligible for SSI, but, for the following month, would be coded as a "C01" because he or she would then be entitled to SSI benefits.
>
> Therefore, both codes E01 and E02 represent individuals who are not entitled to SSI benefits and are reflected accordingly on the SSI file. If the individual's entitlement to SSI benefits is initiated the ensuing month, that individual would then be coded as a "C01" on the SSI file and would be included as SSI-entitled for purposes of the data matching process.
>
> As we have described above, **none of the SSI status codes that the commenter mentioned would be used to describe an individual who was entitled to receive SSI benefits during the month that one of those status codes was used**. SSI entitlement can change from time to time, and **we believe that including SSI codes of C01, M01, and M02 accurately captures all SSI-entitled individuals during the month(s) that they are entitled to receive SSI benefits**.
>
> After consideration of the public comments we received, we are adopting the proposed data matching process for FY 2011 and beyond as final. The only modification we are making to the proposed data matching process is adopting a policy to exclude a record from the data matching process if we find a HICAN in the MedPAR file that we are not able to locate in the EDB, which is an extremely unlikely situation as noted in the prior discussion in this final rule. We are adopting this additional step in our validation process in response to public comments to provide even more assurances that **our data matching process will** yield accurate SSI fractions and **capture all Medicare beneficiaries who were <u>entitled</u> to SSI at the time of their inpatient hospital stay**.[67]

The Secretary did not incorporate, into the Code of Federal Regulations, the above new policy involving the revised data match process (including but not limited to portion of that policy relating to interpreting "entitled to [SSI] benefits" and the use of SSI code C01, M01, and M02 to capture SSI entitled days). However, it is clear from the language in the final IPPS rule, as set

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[67] 75 Fed. Reg. at 50280-81 (footnote in original; bold and underline emphasis added).

forth above, that the Secretary intended to bind the regulated parties and establish a *binding* data match process to be used by the Medicare Contractors in calculating (or recalculating) providers' SSI fractions.

Accordingly, the Board finds that the Secretary intended this policy change for the data match process to be a binding but uncodified regulation and will refer to the portion of that policy as it relates to interpreting "entitled to [SSI] benefits" and the related adoption of the SSI codes C01, M01, and M02 to capture SSI entitled days as the "Uncodified SSI Entitled Days Regulation." Indeed, this finding is consistent with the Secretary's obligations under 42 U.S.C. § 1395hh(a)(2) to promulgate any "substantive legal standard governing . . . the payment of services" as a regulation."[68]

Pursuant to 42 C.F.R. § 405.1867, the Board is bound to apply the statutory and regulatory provisions governing the Medicare program. Consequently, the Board finds that it is bound by the Uncodified SSI Entitled Days Regulation published in the FY 2011 Final Rule and the Board does not have the authority to grant the relief sought by the Provider, namely invalidating the Uncodified SSI Entitled Days Regulation which they allege fails to include all of the SSI codes used by SSA to determine SSI eligibility. As a result, the Board finds that EJR is appropriate for the issue for the calendar year under appeal in this case.

D. Board's Decision Regarding the EJR Request

The Board finds that:

1) It has jurisdiction over the matter for the subject year and that the Provider is entitled to a hearing before the Board;

2) Based upon the Provider's assertions regarding 42 C.F.R. § 412.106(b)(2)(i) and the Uncodified SSI Entitled Days Regulation as adopted in the preamble to the FY 2011 Final IPPS Rule, there are no findings of fact for resolution by the Board;

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

4) It is without authority to decide the legal question of whether the Uncodified SSI Entitled Days Regulation as adopted in the preamble to the FY 2011 Final IPPS Rule is valid.

Accordingly, the Board finds that the question of the validity of the Uncodified SSI Entitled Days Regulation properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for EJR for that question. The Providers have 60 days from the

[68] 42 U.S.C. § 1395hh(a)(2) states "[n]o rule, requirement, or other statement of policy . . . that establishes or changes a substantive legal standard governing . . . the payment of services . . . shall take effect unless it is promulgated by the Secretary by regulation . . . ."

receipt of this decision to institute the appropriate action for judicial review. Since is the only issue in the appeal, the Board hereby closes the case and removes it from its docket.

Board Members Participating:

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

FOR THE BOARD:

3/7/2023

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

Enclosure: Schedule of Providers

cc: Judith Cummings, CGS Administrators (J-15)
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Board Decision to Dismiss LIP Medicaid Days Sub-Issue***
SRI Summa FY 2008 Medicaid Fraction Unmatched Days Group
Case No. 14-1568GC

Dear Mr. Putnam and Ms. Cummings:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Group Representative's documentation pursuant to a pending jurisdictional challenge filed by the Medicare Contractor ("MAC") on July 8, 2022. As set forth below, the Board finds that it does not have jurisdiction to hear the Inpatient Rehab Facilities – Low Income Payment ("IRF-LIP") related sub-issue and dismisses that sub-issue from the instant appeal. The Board's decision is set forth below.

Pertinent Facts

The group appeal was established on December 6, 2013, with two Providers: Summa Akron City and St. Thomas Hospitals (Prov. No. 36-0020) and Summa Barberton Hospital (Prov. No. 36-0019). On April 25, 2014, Summa Cuyahoga Falls General Hospital (Prov. No. 36-0150) was transferred to the group appeal from Case No. 13-3318.

In the Statement of Group Issues, the Providers' representative summarizes its DSH Unmatched Medicaid Eligible Days issue as follows:

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

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

MAC Jurisdictional Challenge

On July 8, 2022, the MAC filed a Jurisdictional Challenge regarding the IRF-LIP sub-issue.[2] The MAC contends that the Board does not have subject matter jurisdiction over the LIP calculation. The IRF-LIP adjustment is a component of the IRF prospective payment rate established under 42 U.S.C. § 1395ww(j)(3)(A)(v). In accordance with § 1395ww(j)(8), there is no administrative or judicial review of the IRF-LIP adjustment.

The MAC argues that in this appeal, the Provider challenges the accuracy of the IRF-LIP adjustment. The IRF-LIP adjustment is a facility-level adjustment for low income patients that takes into account both the percentage of Medicare patients who are receiving Supplemental Security Income and the percentage of Medicaid patients who are not entitled to Medicare. The purpose of the LIP adjustment is to pay IRFs more accurately for the incremental increase in Medicare costs associated with the facility's percentage of low-income patients. 42 U.S.C. § 1395ww(8) specifically prohibits and precludes administrative and judicial review of prospective payment rates established under § 1395ww(j)(3).[3]

They add, that in responding to comments made in response to the Secretary's final rule in the Federal Register regarding IRF-LIP adjustments, the Secretary specifically noted that the LIP adjustment was an adjustment under § 1395ww(j)(3)(A)(v). Because the LIP adjustment is a component of the IRF prospective payment rate established under § 1395ww(j)(3), administrative and judicial review of the LIP adjustment are statutorily precluded by § 1395ww(j)(8). 42 C.F.R. § 405.1867 mandates that the Board must comply with all of the provisions of the Medicare Act and the regulations issued thereunder. Accordingly, § 1395ww(j)(8)(B) precludes administrative review of the IRF-LIP adjustment, and thereby divests the Board of jurisdiction to the IRF-LIP sub-issue of the instant appeal.[4]

Provider 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.[5] The Provider has not filed a response in this case and the time for doing so has elapsed.

Board's Analysis and Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2012), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if

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[1] Statement of Group Issues (Dec. 6, 2013).
[2] Jurisdictional Challenge at 2 (July 8, 2022).
[3] *Id*.
[4] *Id*. at 2-3.
[5] Board Rule 44.3, v. 3.1. (Nov. 2021).

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. Under 42 C.F.R. § 405.1835(a)(1) (2012), a provider has preserved its right to claim dissatisfaction from the amount of Medicare payment for a specific item at issue by either (i) including a claim for the specific item on its cost report for the period where the provider seeks payment that it believes to be in accordance with Medicare policy; or (ii) effective with cost reporting periods that end on or after December 31, 2008, self-disallowing the specific item by following the applicable procedures for filing a cost report under protest where the provider seeks payment that it believes may not be in accordance with Medicare policy.

Under 42 U.S.C. § 1395ww(j)(8)(B), Congress specifically precludes administrative or judicial review of the prospective payment rates under the IRF-PPS. Although providers have attempted to dispute exactly what rate-setting "steps" Congress intended to shield from review under the statute, the D.C. Circuit's decision in *Mercy Hosp., Inc. v. Azar,* 891 F. 3d 1062 (June 8, 2018) ("*Mercy*"*)* answers this question and clarifies what is shielded from review in its analysis of this issue.

In *Mercy*, the Court describes CMS' two-step rate-setting process for Medicare reimbursement for IRFs. The first step takes place prior to the beginning of the fiscal year and involves CMS' establishment of a standardized reimbursement rate, while the second step involves CMS' adjustments (calculated by the Medicare contractor) to "the standardized rates to reflect the particular circumstances of each hospital for that year."[6] One of the ways in which CMS adjusts ahospital's IRF Medicare payment is by taking into account the number of low-income patients ("LIP") served by the hospital, also known as the LIP adjustment. The Court in *Mercy* affirmed the District Court's decision, wherein the District Court concluded that 42 U.S.C. § 1395ww(j)(8) prohibits administrative or judicial review of the Medicare Contractor's determination of the LIP adjustment, because such review amounts to review of the establishment of the hospital's prospective payment rates.[7] The D.C. Circuit concluded that the Statute's plain language prohibits administrative and judicial review of not only the statutory adjustments, but also the "step two rates" utilized by the Medicare Contractor when adjusting the standardized reimbursement rate and then calculating a hospital's final payment.[8]

In the instant appeal, the Provider seeks Board review of a number of the components utilized by the Medicare Contractor to determine the Providers' LIP adjustments. Because, pursuant to 42 U.S.C. § 1395ww(j)(8)(B), Congress has prohibited administrative and judicial review of the prospective payment rates for IRFs, including the LIP adjustment, the Board lacks the jurisdiction to hear the Provider's appeal of the LIP adjustment and dismisses the issue in the instant appeal that challenge this adjustment. In making this finding, the Board relied on the *Mercy* decision in determining the scope and applicability of the preclusion provisions in 42 U.S.C. § 1395ww(j)(8) and notes that, consistent with the Administrator's practice, the D.C.

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[6] *Mercy*, 891 F.3d at 1064.
[7] *Mercy Hosp., Inc. v. Burwell*, 206 F. Supp. 3d 93, 102 (D.D.C. 2016).
[8] *Mercy*, 891 F.3d at 1068.

Circuit's decision in *Mercy* is controlling precedent for the interpretation of 42 U.S.C. § 1395ww(j)(8) because the Provider could bring suit in the D.C. Circuit.[9] Accordingly, the Board hereby dismisses the IRF-LIP Adjustment sub-issue from the instant appeal.

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

Board Members:

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

For the Board:

3/7/2023

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

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

[9] The CMS Administrator generally has applied as controlling precedent the law of the Circuit in which the Provider is located. *See, e.g., QRS CHW DSH Labor room Days Groups v. Blue Cross Blue Shield Ass'n,* Adm'r Dec. (Apr. 13, 2009), affirming, PRRB Dec. No. 2009-D11 (Feb. 27, 2009); *St. Vincent Mercy Med. Ctr. v. BlueCross BlueShield Ass'n*, Adm'r Dec. (Nov. 17, 2008), *affirming in part and reversing in part*, PRRB Dec. No. 2008-D35 (Sept. 15, 2008). Further, in recognizing that providers may file suit with the appropriate District Court either in the Circuit in which they are located or the D.C. Circuit, the Administrator also applies as controlling precedent the law of the D.C. Circuit. *See, e.g., Jordan Hosp. v. Blue Cross Blue Shield Ass'n.*, Adm'r Dec. (Apr. 30, 2007), *vacating*, PRRB Dec. No. 2007-D23 (Feb. 28, 2007).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Nan Chi
Houston Methodist Hospital System
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Houston, TX 77054

RE: ***Board Decision* – Jurisdictional Challenge**
Houston Methodist Hospital (Prov. No. 45-0358)
FYE 12/30/2010
Case No. 16-2263

Dear Ms. Chi,

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. 16-2263*

On February 26, 2016, the Provider was issued a final Notice of Program Reimbursement ("NPR") for fiscal year end December 31, 2010.

On August 23, 2016, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained ten (10) issues:

1. DSH Payment/SSI Percentage – Provider Specific
2. DSH/SSI Percentage – Systemic Errors[1]
3. DSH Payment - SSI Fraction/Medicare Managed Care Part C Days[2]
4. DSH Payment - SSI Fraction/Dual Eligible Days[3]
5. DSH Payment – Medicaid Eligible Days[4]
6. DSH Payment – Medicaid Fraction/Medicare Managed Care Part C Days[5]
7. DSH Payment – Medicaid Fraction/Dual Eligible Days[6]
8. Capital IME and DSH

[1] On April 11, 2017, this issue was transferred to PRRB Case No. 15-2917GC.
[2] On April 11, 2017, this issue was transferred to PRRB Case No. 15-2920GC.
[3] On April 11, 2017, this issue was transferred to PRRB Case No. 15-2918GC.
[4] Issue withdrawn by the Provider on May 8, 2018.
[5] On April 11, 2017, this issue was transferred to PRRB Case No. 15-2921GC.
[6] On April 11, 2017, this issue was transferred to PRRB Case No. 15-2919GC.

9. LIP Amount Calculation
10. LIP SSI Percentage

The Provider is part of the Houston Methodist Health System and is subject to the mandatory CIRP group rules. Consistent with the CIRP group rules, the Provider transferred Issues 2, 3, 4, 6 and 7 to CIRP groups. The Provider also withdrew Issue 5. As a result of these transfers and withdrawal, the remaining issues are Issue 1 (the DSH Payment/SSI Percentage – Provider Specific), Issue 8 (Capital IME and DSH), Issue 9 (LIP Amount Calculation), and Issue 10 (LIP SSI Percentage).

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 15-2917GC

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

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

The Provider's appeal request described Issue 2: DSH/SSI as follows:

> The Providers [*sic*] contend that the Lead MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute at 42 U.S.C. § 1395ww(d)(5)(F)(i). The Providers [*sic*] further contend that the SSI percentages calculated by [CMS] and used by the Lead MAC to settle their Cost Reports does not address all the deficiencies as described in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37, 44 (D.D.C. 2008) and incorporates a new methodology inconsistent with the Medicare statute.
>
> The Providers [*sic*] challenge their SSI percentages based on the following reasons:
>
> 1. Availability of MEDPAR and SSA Records

[7] Individual Appeal Request at Tab 3.

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

The Provider also transferred its Issue 2 – DSH/SSI to the CIRP group under Case No. 15-2917GC, *QRS Houston Methodist 2010 DSH SSI Percentage (Systemic Errors) CIRP Group*, on April 11, 2017. The Group Issue Statement for that case is ***identical*** to the DSH/SSI issue in Case No. 16-2263.

C. Description of Issues 9 & 10 in the Appeal Request

The Provider's appeal request described Issue 9: LIP Amount Calculation as:

> We pose the same arguments presented regarding operating DHS in Issue 5 above, as they apply to patients residing in our Rehab unit during FY 2010 and the determination of LIP reimbursement due Provider.[9]

The Provider's appeal request described Issue 10: LIP SSI Percentage as:

> The Provider has a separately licensed Rehabilitation unit (i.e. Provider Number 45-T358). In the August 7, 2001 Federal Register, beginning on page 41359, [CMS] initiated an adjustment for facilities serving low-income patients. This adjustment is known as the Low-Income Patient ("LIP") adjustment. This measure used to compute an Inpatient Rehabilitation Facilities ("IRFs") percentage of low-income patients is the same measure used to measure low-income patients in acute care hospitals (i.e. [DSH]). All IRFs are eligible to receive a LIP adjustment. There is not a required threshold for a minimum number of beds or a minimum amount of DSH in order to receive the adjustment.
>
> The Provider contends that the MAC did not determine IRF LIP reimbursement in accordance with the 42 C.F.R. § 412.624.
>
> The Provider contends that the SSI percentage published by CMS was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the IRF LIP adjustment.[10]

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[8] *Id.* at Issue 2.
[9] *Id*. at Issue 9.
[10] *Id*. at Issue 10.

MAC'S Contentions:

The Medicare Contractor filed a Jurisdictional Challenge on May 4, 2018 arguing the DSH Provider Specific and DSH/SSI issues are identical. Since the issues are identical the Medicare Contractor requests that the Board dismiss the DSH Provider Specific Issue be dismissed. The MAC also contended that the Board lacks jurisdiction on Issues 9 and 10 because the LIP adjustment is not subject to appeal.

Provider's Response:

The Board received a Jurisdictional Response filed on behalf of the Provider on May 14, 2018, which argued that the Board has jurisdiction over the DSH/SSI issues which includes both the "provider specific" and realignment sub-issues.[11] The Provider stated that it is "not only addressing a realignment of the SSI percentage, but also addressing the various errors of omission and commission that do not fit into the 'systemic errors' category."[12] They go on to argue that the two appeal issues "represent different aspects/components of the SSI issue."[13]

The Provider also argued the IRF-LIP calculations are hospital-specific components, like SSI percentage and Medicaid percentage, have administrative and judicial review rights.[14] Preclusion of review, would apply only to the formulas used in the IRF-PPS payments and adjustments and uniform Federal rates, not individual hospital-specific rates.[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.

[11] Provider's Jurisdictional Response at 7 (May 14, 2018).
[12] *Id*. at 8.
[13] *Id.* at 7.
[14] *Id*. at 16.
[15] *Id*.

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 issue that was appealed in Group Case No. 15-2917GC.

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 issue) that was appealed in Case No. 15-2917GC. 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. 15-2917GC, 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).

Thus, the Board finds that the first aspect of Issue 1 in this appeal is duplicative of the appealed issue in Case No. 15-2917GC. 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 aspect of the DSH/SSI (Provider Specific) issue from the instant case.

In making this finding, the Board further notes that CMS regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, is pursuing that issue as part of the group under Case No. 15-2917GC. 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] Provider is misplaced in referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 15-2917GC.

To this end, the Board also reviewed the Provider's Final Position Paper (as filed on February 1, 2023) to see if it further clarified Issue 1. However, it did not provide any basis upon which to

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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 may the errors any less systemic. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). *See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).

distinguish Issue 1 from the SSI issue in Case No. 15-2917GC or confirm that the issue is not common to other Houston Methodist providers such that it required transfer to a CIRP group.[20] Moreover, the Board finds that the Provider's Final Position Paper failed to comply with the Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" in its Final Position Paper and include *all* exhibits.

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 there have been issuances since the 2000 Federal Register addressing the availability of data underlying the SSI fraction, such MEDPAR data. 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

[20] Board Rule 12.11 address "Timeliness of Transferring Issues to a Group Appeal" and specifies that provider under common ownership or control must transfer to the mandatory group no later than the filing of the preliminary position paper.

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.[21] 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."[22]

Similarly, the Board notes that, in its response to the Jurisdictional Challenge, the asserted that it: (1) "has analyzed Medicare Part A records and has been able to identify patients believed to be entitled to both Medicare Part A and SSI"; (2) "has reason to believe that the SSI percentage determined by CMS is incorrect due to the understate days in the SSI ratio"; and (3) ""the Provider has specifically identified patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS, due to errors that are or may be specific to the Provider, but in any case, are not the systemic errors that have been previously identified in the *Baystate* litigation." However, the Provider failed both as part of that filing as well as the final position paper to include that data/specific patient documents, explain what that data shows, and in particular, explain how the alleged errors are provider specific rather than systemic.

Accordingly, the Board must find that Issues 1 and the group issue in Group Case 15-3037G, 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.

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

B. Issue 9 – IRF LIP and Issue 10 – LIP SSI

Under 42 U.S.C. § 1395ww(j)(8)(B), Congress specifically precludes administrative or judicial review of the prospective payment rates ("PPS") for inpatient rehabilitation facilities ("IRFs"). Although providers have attempted to dispute exactly what rate-setting "steps" Congress intended to shield from review under the statute, the United States Court of Appeals, District of Columbia Circuit's decision in *Mercy Hospital, Inc. v. Azar*, answers this question and clarifies what is shielded from review in its analysis of this issue.[23]

In *Mercy*, the D.C. Circuit describes CMS' two-step rate-setting process for Medicare reimbursement for IRFs. The first step takes place prior to the beginning of the fiscal year and involves CMS' establishment of a standardized reimbursement rate, while the second step involves CMS' adjustments (calculated by the Medicare contractor) to "the standardized rates to reflect the particular circumstances of each hospital for that year."[24] One of the ways in which CMS adjusts a hospital's IRF Medicare payment is by taking into account the number of low income patients ("LIP") served by the hospital, also known as the LIP adjustment. The D.C. Circuit in *Mercy* affirmed the U.S. District Court, wherein the District Court concluded that 42 U.S.C. § 1395ww(j)(8) prohibits administrative or judicial review of the Medicare Contractor's determination of the LIP adjustment, because such review amounts to review of the establishment of the hospital's prospective payment rates.[25] The D.C. Circuit concluded that the Statute's plain language prohibits administrative and judicial review of not only the statutory adjustments, but also the "step two rates" utilized by the Medicare Contractor when adjusting the standardized reimbursement rate and then calculating a hospital's final payment.[26]

In the instant appeal, the Provider seeks Board review the IRF LIP calculation utilized by the Medicare Contractor to determine the Providers' LIP adjustments. Because, pursuant to 42 U.S.C. § 1395ww(j)(8)(B), Congress has prohibited administrative and judicial review of the prospective payment rates for IRFs, including the LIP adjustment, the Board lacks the jurisdiction to hear the Provider's appeal of the LIP adjustment and dismisses the issues in the instant appeal that challenge this adjustment. In making this finding, the Board relied on the *Mercy* decision and notes that the D.C. Circuit's decision in *Mercy* is controlling precedent for the interpretation of 42 U.S.C. § 1395ww(j)(8)(B) because the Provider could bring suit in the D.C. Circuit.[27] Accordingly, the Board hereby dismisses issues 9 and 10, as it does not have jurisdiction to hear those issues.

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[23] 891 F.3d 1062 (D.C. Cir. 2019).
[24] *Id.* at 1064.
[25] *Mercy Hosp., Inc. v. Burwell,* 206 F. Supp. 3d 93, 102 (D.D.C. 2016).
[26] *Mercy*, 891 F.3d at 1068.
[27] The CMS Administrator generally has applied as controlling precedent the law of the Circuit in which the Provider is located. *See, e.g., QRS CHW DSH Labor room Days Groups v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (Apr. 13, 2009), affirming, PRRB Dec. No. 2009-D11 (Feb. 27, 2009); *St. Vincent Mercy Med. Ctr. v. BlueCross BlueShield Ass'n*, Adm'r Dec. (Nov. 17, 2008), *affirming in part and reversing in part*, PRRB Dec. No. 2008-D35 (Sept. 15, 2008). Further, in recognizing that providers may file suit with the appropriate District Court either in the Circuit in which they are located or the D.C. Circuit, the Administrator also applies as controlling precedent the law of the D.C. Circuit. *See, e.g., Jordan Hosp. v. Blue Cross Blue Shield Ass'n.*, Adm'r Dec. (Apr. 30, 2007), *vacating*, PRRB Dec. No. 2007-D23 (Feb. 28, 2007).

Conclusion:

The Board dismisses Issue 1, the DSH/SSI (Provider Specific) issue, in its entirety from this appeal. The Board also dismisses Issues 9 and 10. Since the Capital IME and DSH issue remains open in the appeal, Case No. 16-2263 will remain open on 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 upon final disposition of the appeal.

Board Members Participating:

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

For the Board:

3/7/2023

X Clayton J. Nix

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

cc: Wilson C. Leong, Esq., Federal Specialized Services
Bill Tisdale, Novitas Solutions, Inc. (J-H)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Stephanie Webster, Esq.
Ropes & Gray
2099 Pennsylvania Ave, NW
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RE: ***Board Jurisdictional Decision***
University of Louisville Hospital (Provider No. 18-0141)
FYE 12/31/10
Case No. 16-1367

Dear Ms. Webster:

The Provider Reimbursement Review Board ("Board") has reviewed the documents in the above-referenced appeal for fiscal year ("FY") 2010 and finds that it does not have jurisdiction over the additional Labor and Delivery Room ("LDR") days. The decision of the Board is set forth below.

Background:

On March 31, 2016, the Provider timely filed its Individual Appeal Request appealing their October 21, 2015 Notice of Program Reimbursement ("NPR") for FY 2010 to establish the instant case. The appeal request included ***only*** one issue: the inclusion of additional Medicaid eligible days in the numerator of the Medicaid fraction of the disproportionate share hospital ("DSH") adjustment.

On June 9, 2016, the Provider *timely* filed an Add-Issue Request to exclude certain LDR days from the total days used in the denominator of the Medicaid fraction of the DSH adjustment. In its add-issue request, the Provider described the LDR days issue as follows:

> The issue is whether the MAC properly determined the Provider's Total Days in regards to computing the Medicare DSH calculation. *The Provider* ***mistakenly*** *reported* 1,731 [LDR] Days in both line 12 and in line 29 on Worksheet S-3 of the as-filed cost report. This resulted in the LDR days being counted twice. Accordingly, the Provider requests that the MAC revise the Provider's Total Days by removing 1,731 LDR Days from the Total Days reported in Column 6, line 12 of Worksheet S-3.[1]

On May 15, 2018, the Medicare Contractor filed a Jurisdictional Challenge over the LDR Days issue. On June 13, 2018, the Provider timely filed a response to the Medicare Contractor's Jurisdictional Challenge.

[1] (Emphasis added.)

On October 24, 2018, the Provider withdrew the DSH Medicaid eligible days issue pursuant to an agreement from the Medicare Contactor to reopen the cost report for that issue. The 3-year period to request reinstatement of that issue expired on October 24, 2021. As a result of that withdrawal, *the **sole** remaining issue* in this case is the LDR Days issue.

Medicare Contractor's Jurisdictional Challenge:

The Medicare Contractor contends that it did not render a final determination over the disputed LDR days and the Provider failed to show how the disputed days were claimed on the cost report then disallowed by the Medicare Contractor.

According to the Medicare Contractor, *the Provider **mistakenly*** included the LDR days in the cost report twice, but an adjustment was never proposed for this issue. The Medicare Contractor states, "*The Provider **mistakenly*** reported 1,731 [LDR] Days in both 12 and in line 29 on Worksheet S-3 of the as-filed cost report. This resulted in LDR days being counted twice."[2]

Next, the Medicare Contractor argues that the Provider has not preserved the right to claim dissatisfaction for this issue as a self-disallowed item in accordance with 42 C.F.R. §405.1835(a)(1)(ii). The Provider's as filed cost report included these protested items: a) Title XIX and related days, b) SSI days, and c) Budget Neutrality State Rural Floor Index. The Provider did not establish a self-disallowed item for the LDR days and, thus, did not preserve its right to claim dissatisfaction for this issue in accordance with 42 C.F.R. § 405.1835(a) (2010). Further, according to the Medicare Contractor, the Supreme Court's holding in *Bethesda Hospital* is ***not*** applicable in the instant case because the self-disallowance item at issue was a result from the, "Provider's negligence and failure to properly handle the L&D days in the total days."[3]

Provider's Response to Jurisdictional Challenge:

The Provider maintains it *properly* claimed a DSH payment and listed the LDR days on its as-filed cost report and that "[t]his is not a case in in [*sic*] which a hospital omitted a claim for reimbursable amount."[4] The Provider contends that:

1. CMS changed the instructions for reporting LDR patient days on cost report Worksheet S-3 pursuant to Provider Reimbursement Manual, CMS Pub. 15-2 ("PRM 15-2"), Transmittal 21 (Jan. 2010). (NOTE – Per Transmittal 21, these changes were effective for cost reporting periods beginning on or after October 1, 2009.)

2. Before that revision, LDR patient days were in the "Total" patient days listed on Line 12 of Worksheet S-3.

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[2] Medicare Contractor's Jurisdictional Challenge at 2 (emphasis added).
[3] *Id.* at 8.
[4] Provider's Response at 1.

3. The revised instructions otherwise conflict with the cost report form because, after that revision, the cost report form itself continued to call for "Total" patient days on Line 12. Specifically, "the revised instructions effectively redefined 'Total' to mean something else, paradoxically directing hospitals to carve out [LDR] days on line 29."[5]

Accordingly, the Provider asserts that, per the revised form and instructions, it listed its LDR patient days both on Line 29, and then also in the "Total" patient days on Line 12 "as it always had in the past" (significantly, the Provider did not include any support for its position that "it always in the past" had reported LDR days in Line 12). As a result, the LDR days were double counted in the denominator of the DSH Medicaid fraction and, as such, "the Provider is plainly dissatisfied with the contractor's final DSH payment determination."[6]

The Provider interprets 42 U.S.C. § 1395oo(a)(1)(A)(i), as indicating that hospitals are not required to have "perfectly listed each and every particular cost report entry, data element or statistic in order to be 'dissatisfied' with and have the right to appeal a matter at issue before [*sic*] Board."[7] The Provider argues that it did not omit any claim for payment rather, "it was the MAC's job to review carefully the hospital's cost report filing to identify and correct any mistakenly listed statistics prior to settlement."[8] Accordingly, the Provider asserts that "the MAC erred in finalizing the cost report by including the 1,731 [LDR] days twice in the denominator of the Medicaid fraction . . . ."[9]

In addition to the dissatisfaction requirement, the Provider contends that the Board has jurisdiction over the entire DSH issue for the total patient days in question based on long-standing agency precedents.

Lastly, the Provider concludes that the Board should exercise its discretion under 42 U.S.C. § 1395oo(d) to find jurisdiction because this statutory provision allows the Board to review and revise all aspects of a cost report even with issues not considered by the Medicare Contractor, so long as the issue was covered by the cost report.[10]

Board Decision:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2016), a provider has a right to a hearing before the Board with respect to *specific items* 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] In this case, the Provider

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[5] *Id.* at 5 (citations omitted).
[6] *Id.* at 1.
[7] *Id*. at 7.
[8] *Id*. at 11.
[9] *Id.* at 6.
[10] *Id*. at 15.
[11] Board Rule 4.4.1 (Aug. 29, 2018); 42 CFR §405.1835.

appealed from an NPR, the amount exceeds $10,000, and the Provider timely filed its appeal. In addition, the Provider timely added the LDR issue pursuant to 42 C.F.R. § 405.1835(c) (2011).

42 C.F.R. § 405.1835(a) (2011) sets forth the jurisdictional requirements for a provider appeal to the Board. In particular, it specifies that, for cost report periods ending on or after December 31, 2008, a provider must preserve its right to claim dissatisfaction with the amount of Medicare payment for the specific items at issue by either claiming the specific item on the cost report or self-disallowing the specific item on the cost report. Specifically, § 405.1835(a) (2011) states:

> (a) *Criteria*. A provider (but no other individual, entity, or party) has a right to a Board hearing, as a single provider appeal, for specific items claimed for a cost reporting period covered by an intermediary or Secretary determination, only if –
>
> (1) The provider has preserved its right to claim dissatisfaction with the amount of Medicare payment for the specific item(s) at issue by either –
>
> (i) Including a claim for specific item(s) on its cost report for the period where the provider seeks payment that it believes to be in accordance with Medicare policy; or
>
> (ii) Effective with cost reporting periods that end on or after December 31, 2008, self-disallowing the specific item(s) by following the applicable procedures for filing a cost report under protest, where the provider seeks payment that it believes may not be allowable or may not be in accordance with Medicare policy (for example, if the intermediary lacks discretion to award the reimbursement the provider seeks for the item(s)).

The cost reporting period at issue ended on December 31, 2010 and therefore 42 C.F.R § 405.1835(a)(1)(ii) is applicable as it was effective for cost reporting periods that ended on or after December 31, 2008.[12]

The Board finds that it does not have jurisdiction over the LDR days issue because the Provider failed to meet the dissatisfaction requirement. First, the Provider's appeal is not about a claim it made that was then disallowed or adjusted by the Medicare Contractor. Rather, the Provider is seeking to remove certain LDR days that it improperly claimed twice on the cost report and where the duplication was not otherwise adjusted/removed. Indeed, in its add-issue request establishing its appeal of the LDR days issue, the Provider concedes that its dissatisfaction was the result of its

[12] The Board notes that subsequent revisions were made to 42 C.F.R. § 405.1835(a) as part of the final rule published on November 13, 2015; however, those revisions were effective for cost reporting periods beginning on or after January 1, 2016. As a result, these 2015 revisions are not applicable to this case. *See* 80 Fed Reg. 70298, 70551-80, 70599-600 (Nov. 13, 2015).

own error: "the Provider ***mistakenly*** *reported* 1,731 [LDR] Days in both line 12 and line 29 on Worksheet S-3 of the as-filed cost report."[13] There was no regulation or other payment policy that prevented the Medicare Contractor from making payment in the manner now being sought by the Provider on appeal because there was nothing preventing the Provider from properly reporting the LDR Days at issue in compliance with the cost reporting instructions for Worksheet S-3 (including for Lines 12 and 29). Similarly, there is no indication that the Medicare Contractor could have even known that LDR days had been improperly included in Line 12 because the "Total Days" included in that Line are exclusively from the Provider's records and, without audit, the Medicare Contractor could not know (or be expected to know) whether the Provider had improperly included LDR days in that Line.

As noted above, the changes that Transmittal 21 made to Worksheet S-3 were effective for cost reporting periods beginning on or after October 1, 2009 and, as such, were clearly applicable to the Provider's FY 2010 which began January 1, 2010. The Provider's argument that the revisions to the cost report Worksheet S-3 for Lines 12 and 29 were conflicting[14] is refuted by a review of the revised cost reporting form for Worksheet S-3, as well as the revised cost reporting instructions for these lines. Transmittal 21 for PRM 15-2, Ch. 36, which the Provider notes was published in January 2010,[15] made changes to the cost report almost 12 months ***before** the end of the Provider's cost reporting period*, ***and*** almost 17 months before their FY 2010 cost report was due.[16] The revisions to Worksheet S-3 included the addition of Line 29, specifically for the reporting of LDR days. In prior years (*i.e.*, for years prior to the effective date of Transmittal 21), these days were not reported separately. Further, the revisions to the cost reporting form included the directive "see instructions" on both Line 12 (Total Days) and Line 29 (LRD Days). An analysis of the cost reporting instructions included in the PRM 15-2 § 3605.1 (also revised in January 2010 as a result of Transmittal 21) reveals the following instructions:

> Line 12 – Enter the sum of lines 5 – 11 for columns 1-6, and for columns 12-15, enter the amount from line 1. For columns 7-11, enter the total for each from your records.
>
> ***Labor and delivery days (as defined in the instructions for line 29 of Worksheet S-3, Part I) must not be included on this line."***
>
> * * * *
>
> Line 29 – Effective for cost reporting periods beginning on or after October 1, 2009, indicate in column 5 the count of labor/delivery

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[13] Provider's Add Issue Statement (June 8, 2016). *See also* Medicare Contractor's Exhibit I-3.
[14] Provider's Response at 5.
[15] PRM 15-2, Ch. 36, Transmittal 21 is available at the following link which also states that January 15, 2010 is the issue date for this transmittal: https://www.hhs.gov/guidance/document/provider-reimbursement-manual-part-2-provider-cost-reporting-forms-and-instructions-22 (last accessed on Feb. 2, 2023).
[16] Since FY 2010 ended on December 31, 2010, the cost report was due at the end of the 5th month following the close of the FY, *i.e.*, by May 31, 2011. *See* 42 C.F.R. § 413.24(f)(2).

> days for Title XIX and in column 6 the total count of labor/delivery days for the entire facility.
>
> For the purposes of reporting on this line, labor and delivery days are defined as days during which a maternity patient is in the labor/delivery room ancillary area at midnight at the time of census taking, and is not included in the census of the inpatient routine care area because the patient has not occupied an inpatient routine bed at some time before admission....***These days must <u>not</u> be reported on Worksheet S-3, Part I, line 1 or line 12***.[17]

The above instructions for Lines 12 and 29 are clear that LDR days should ***not*** be included on Line 12, and ***should*** be included on Line 29. Further, the cost reporting form was altered to direct the cost report preparer to refer to the cost reporting instructions for both of these Lines. The Provider's failure to do so is not the failure of the Medicare Contractor and, mistakenly or not, the error is the Provider's. Again, as noted above, this was not an error that the Medicare Contractor could have known without specifically scoping Line 12 for review/audit.

It is important to note that the Provider could also have identified the overstatement of days if they had chosen to reconcile the DSH Adjustment calculated on their as-filed cost report. This would have made it clear that the denominator of the Medicaid ratio was 102,413 days. If the Provider's Total Days (as reported on S-3, Line 12) were only 100,211, it could have questioned this difference and reviewed the instructions for Worksheet S-3 at that time. However, the Provider did not discover the issue until June 2016, when it added the issue to the appeal, over 5 years after the cost report was filed. Indeed, the Provider's as-filed protested items workpaper, included with the appeal request, uses the ***incorrectly*** *overstated* Total Days of 102,413 in all of its calculations. No mention is made of an overstatement of Total Days in the protested amount calculations.

Second, the Provider did not protest or self-disallow the LDR days issue on its as-filed FY 2010 cost report. The above regulation makes clear that providers who are self-disallowing specific items must do so by following the procedures for filing a cost report under protest. Here, as documented in the Provider's appeal request,[18] the Provider's as-filed cost report identified three issues under protest:

A) Title XIX and Related Days – This relates to certain days that the Provider "*did **not** include* . . . in our DSH factor calculation" such as exhausted Part A Medicare days, certain Medicare/Medicaid dual-eligible days, QCCT State Plan days, and "inpatient Medicaid eligible stays that will become retrospectively eligible."[19]

[17] The quoted text was added to the instructions by Transmittal 21 and, as such, is in red italicized font. The red italicized font was removed and the italics, underline, and bold emphasis was added.
[18] The Provider's appeal request included a copy of the "protested workpaper" filed with its FY 2010 cost report.
[19] (Emphasis added.)

B) SSI Days – This relates to certain days that the Provider "did not include in the DSH calculation," namely days not already included in the published SSI fraction that are for patients who were entitled to SSI and to either Medicare Part A or Medicare+Choice.

C) Budget Neutrality State Rural Floor Index.

However, none of these protested items pertain to or encompass errors in "total days" as used in the Medicaid fraction of the DSH adjustment, much less LDR days as used in the "total days." As such, it is clear that the Provider did ***not*** self-disallow for the LDR days issue. Indeed, as explained below, it would not have made sense for the Provider to protest LDR days issue because, rather than protesting the issue, the Provider could have filed a correct cost report without including LDR days in Line 12 of Worksheet S-12.[20] Therefore, in accordance with 42 C.F.R. § 405.1835(a)(1)(ii), the Provider has ***not*** preserved its right to claim dissatisfaction as a self-disallowed item.

Third, the Board notes that the LDR issue does not meet the single exception to the dissatisfaction requirement for Board jurisdiction. On April 23, 2018, the CMS Administrator issued CMS Ruling CMS-1727-R ("Ruling 1727-R") to provide for an exception to the dissatisfaction requirement for Board jurisdiction set forth in § 405.1835(a)(1) in connection with then-pending or subsequent Board appeals of Medicare contractor determinations for cost report periods ending on or after December 31, 2008 but beginning before January 1, 2016. Pursuant to this Ruling, "the self-disallowance requirement for PRRB jurisdiction in 42 CFR 405.1835(a)(1)(ii) shall not be applied to a provider's appeal of a specific item if the provider had a good faith belief that claiming reimbursement for such item in the cost report would be futile *because the item was subject to a regulation or other payment policy that* ***bound the Medicare contractor and left the contractor with no authority or discretion*** *to make payment in the manner sought by the provider*."[21]

Here, the Provider's cost report ended December 31, 2010 and its appeal was filed after April 23, 2018. Accordingly, it is clear that the Provider's appeal of the LDR issue is subject to Ruling 1727-R. However, the Board finds that it is not applicable to the Provider's appeal of the LDR days issue because the LDR issue exists as a result of the Provider's own error. As explained above, the Provider did not have "a good faith belief that claiming reimbursement for such item in the cost report would be futile *because the item was subject to a regulation or other payment policy that* ***bound the Medicare contractor and left the contractor with no authority or discretion*** *to make payment in the manner sought by the provider*"[22] because the cost reporting instructions and form were clear about how to report "Total" days on Line 12 of Worksheet S-3 and this statistic is one that the Medicare Contractor could ***not*** determine outside of the Provider.

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[20] To this end, the Board notes that the purpose of the self-disallowance provision in 42 C.F.R. § 405.1835(a)(ii) to the Provider to include items on the cost report that it could not otherwise properly claim in accordance with the applicable Medicare regulations, instructions and policies. In other words, protested items are intended to cover items that are non-allowable under those regulations/instructions/policies. Here, had the Provider properly followed them, there would be no LDR issue.
[21] CMS Ruling 1727-R at 8 (emphasis added).
[22] *Id.* (emphasis added).

Finally, the Board notes that it does not have discretion under 42 U.S.C. § 1395oo(d) to consider the Provider's appeal of the LDR days issue. As part of the final rule issued on May 23, 2008, the Secretary issued the following regulations interpreting the scope of that statutory provision at 42 C.F.R. § 405.1869(a) addressing the "Scope of Board's authority in a hearing decision":

> (a) If the Board has jurisdiction to conduct a hearing on a specific matter at issue under section 1878(a) or (b) of the Act and §405.1840 of this subpart, and the legal authority to fully resolve the matter in a hearing decision (as described in §§405.1842(f), 405.1867, and 405.1871 of this subpart), section 1878 of the Act, and paragraph (a) of this section give the Board the power to affirm, modify, or reverse the intermediary's findings on each specific matter at issue in the intermediary determination for the cost reporting period under appeal, and to make additional revisions on specific matters regardless of whether the intermediary considered the matters in issuing the intermediary determination. *The Board's power to make additional revisions in a hearing decision does* ***not*** *authorize the Board to consider or decide a specific matter at issue for which it lacks jurisdiction (as described in §405.1840(b) of this subpart)* or which was not timely raised in the provider's hearing request. The Board's power under section 1878(d) of the Act and paragraph (a) of this section to make additional revisions is ***limited*** *to those revisions necessary to resolve fully a specific matter at issue if—*
>
> (1) *The Board has jurisdiction to grant a hearing on the specific matter at issue* ***under section 1878(a)*** or (b) of the Act and §405.1840 of this subpart; and
>
> (2) The specific matter at issue was timely raised in an initial request for a Board hearing filed in accordance with §405.1835 or §405.1837 of this subpart, as applicable, or in a timely request to add issues to a single provider appeal submitted in accordance with §405.1835(c) of this subpart.

Thus, pursuant to § 405.1869(a), the Board's discretionary authority under 42 U.S.C. § 1395oo(d) can only encompass an issue for which the Board has jurisdiction to grant a hearing under § 1395oo(a) or (b). However, as explained above, the Board does not have jurisdiction under § 1395oo(a) because the Provider did not meet the dissatisfaction requirement for Board jurisdiction. Further, § 1395oo(b) is not applicable since this is an individual appeal and § 1395oo(b) only pertains to group appeals.

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In summary, the Board finds that it does not have jurisdiction over this issue and dismisses it from the case. As there are no remaining issues pending, the Board closes the case and removes it from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

3/8/2023

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

cc: Wilson C. Leong, Esq., Federal Specialized Services
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DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Board Decision* – SSI Percentage (Provider Specific) and Medicaid Eligible Days**
Physicians Regional Medical Center (Prov. No. 10-0286)
FYE 09/30/2017
Case No. 22-0364

Dear Mr. Summar and Mr. Pike:

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the documentation in Case No. 22-0364 pursuant to a jurisdictional challenge filed by the Medicare Contractor ("MAC"). The Board's decision is set forth below.

Background

A. Procedural History for Case No. 22-0364

On January 5, 2022, Physicians Regional Medical Center, appealed a Notice of Program Reimbursement (NPR) dated July 16, 2021, for its fiscal year dating September 30, 2017 ("FY 2017"). The Provider appealed the following five issues:[1]

- Issue 1: DSH SSI Percentage (Provider Specific)
- Issue 2: DSH SSI Percentage (Systemic Errors)[2]
- Issue 3: DSH Medicaid Eligible Days
- Issue 4: DSH Part C Days – SSI & Medicaid Fraction[3]
- Issue 5: DSH Dual Eligible Days – SSI & Medicaid Fraction[4]

The Provider is commonly owned by Community Health Systems, Inc. ("CHS") and, as such, is subject to the mandatory common issue related party ("CIRP") group regulations at 42 C.F.R. § 405.1837(b)(1). On August 15, 2022, consistent with the CIRP group regulations, the Provider transferred Issues 2, 4 and 5 to CHS CIRP group cases. As a result, only 2 issues remain in this

[1] Provider's Request for Hearing, Tab 3, at Issue Statement (Jan. 5, 2022).
[2] The Provider transferred this issue to Group Case No. 20-0997GC on August 15, 2022.
[3] The Provider transferred this issue to Group Case No. 19-2620GC on August 15, 2022.
[4] The Provider transferred this issue to Group Case No. 20-1383GC on August 15, 2022.

case: Issue 1, DSH SSI Percentage (Provider Specific), and Issue 3, DSH – Medicaid Eligible Days.[5]

On August 24, 2022, the Provider filed its preliminary position paper.

On October 27, 2022, the Medicare Contractor filed a Jurisdictional Challenge, regarding ***both*** Issue 1, and 3, addressing the DSH Supplemental Security Income ("SSI") Percentage and the DSH Medicaid Eligible Days issues.

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."

On December 2, 2022, the Medicare Contactor filed its preliminary position paper.

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

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

> The Provider contends that the MAC did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the MAC's calculation of how the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations.
>
> The provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both 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.[6]

[5] MAC's Jurisdictional Challenge, at 1 (Oct. 27, 2022).
[6] Provider's Request for Hearing, Issue Statement (Jan. 5, 2022).

As the Provider is commonly owned by CHS, the Provider transferred issue #2, DSH SSI Percentage (Systemic Errors) to the CIRP group under Case No. 20-0997GC entitled "CHS CY 2017 DSH SSI Percentage CIRP Group." This CIRP group has the following issue statement:

> **<u>Statement of the Issue:</u>**
>
> 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?
>
> **<u>Statement of the Legal Basis</u>**
>
> 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.[7]

The amount in controversy listed for the Provider as a participant in 20-0997GC is $82,931.

On August 24, 2022, the Provider filed its preliminary position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **<u>Calculation of the SSI Percentage</u>**
>
> The Provider contends that the 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 the Centers for Medicare and Medicaid Services ("CMS") and used by the MAC

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

> to settle their Cost Report was incorrectly computed because of the following reasons:
>
> **Provider Specific**
>
> The Provider contends that its' SSI percentage published by the Centers for Medicare and Medicaid Services ("CMS") was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation. This is based on certain data from the State of Florida and the Provider that does not support the SSI percentage issued by CMS.
>
> The Provider has worked with the State of Florida and has learned that similar to *Loma Linda Community Hospital v. Dept of Health* and Human Services, No. CVT94- 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. *See* 65 Fed. Reg. 50,548 (2000). The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare Fraction.[8]

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 $82,931. This is the same amount that is listed as the amount in controversy for this Provider as a participant in Case No. 20-0997GC.

<u>MAC's Contentions</u>

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 transferred into Group Case No. 20-0997GC, *CHS CY 2017 DSH SSI Percentage CIRP Group*. The Portion of Issue 1 concerning realignment should be dismissed because there was no final determination over SSI realignment and the Provider's appeal is premature as the Provider has not exhausted all available remedies.[9]

With respect to SSI realignment, the MAC contends that this issue has been abandoned. The Provider did not brief the issue of SSI realignment within its preliminary position paper. As a result, it should be considered withdrawn in accordance with Board Rule 25.3. Alternatively, the

[8] Provider's Preliminary Position Paper at 8 (August 24, 2022).
[9] MAC's Jurisdictional Challenge, at 2.

MAC asserts that the Board does not have jurisdiction over realignment. There was no final determination over the SSI realignment and the appeal is premature as the Provider has not exhausted all available remedies. This issue should be dismissed. It should also be noted that the Provider's fiscal year end is the same as the federal fiscal year end (September 30). The result of the Medicare computation based on the Provider's fiscal year end would therefore be the same as the Medicare computation based on the federal fiscal year end.[10]

Issue 3 – DSH – Medicaid Eligible Days

The MAC also argues that the Provider 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.[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 (2014), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

A. 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 Group Case No. 20-0997GC, CHS CY 2017 DSH SSI Percentage CIRP Group.

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[10] *Id.*
[11] *Id.*

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. 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."[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. 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). Indeed, the Provider has the same amount in controversy for both Issue 1 and for its participation in the CIRP group, namely $82,931.

Thus, the Board finds that the first aspect of Issue 1 in this appeal is duplicative of the group issue in Case No. 20-0997GC, for this same provider and fiscal year. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (Mar. 1, 2013), the Board dismisses this aspect of the DSH/SSI (Provider Specific) issue.

In making this finding, the Board further notes that CMS regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, is pursuing that issue as part of the group under Case 20-0997GC. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[15] Provider is misplaced in referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 20-0997GC.

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 20-0997GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with the Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" in its Preliminary Position Paper and include *all* exhibits.

[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.*, 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.

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

> https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH.[16] This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows: "DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[17]

[16] (Last accessed Nov. 21, 2022.)
[17] (Emphasis added.)

Similarly, the Provider claims that it "has worked with the State of Florida and has learned that similar to *Loma Linda Community Hospital v. Dept of Health* and Human Services, No. CVT94-0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records." However, the Provider fails to explain how SSI entitlement can be ascertained from State records, much less provide those State records or even identify what State records it is referring to. All of this information should have been included in the position paper filing as confirmed by 42 C.F.R. 405.1853(b)(2)-(3) and Board Rule 25. More importantly, the Provider fails to show how the alleged State record information is a provider specific issue and not common to other CHS providers (including other CHS provider in the same State). Establish that issue provider specific rather than *systemic* is critical because the Provider is commonly owned by CHS and subject to the mandatory CIRP group regulations which require transfer of issues common to CHS.

Accordingly, based on the record before it,[18] the Board must find that Issues 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 4.5 (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.

[18] The Board again notes that the Provider failed to respond to the Jurisdictional Challenge. As noted in Board Rule 44.4.3: "Failure to respond will result in the Board making a jurisdictional determination *with the information contained in the record*." (Emphasis added.)

> **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.[19]

The amount in controversy calculation and protested item documentation for this issue suggests the number of Medicaid eligible days at issue. However, 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.

While the Calculation Support filed with their appeal notes a net impact of $88,478, 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.

On August 24, 2022, the Provider filed their PPP in which it indicated that it would be sending the eligibility listing under separate cover. [20] Indeed, the position paper did not even identify how many Medicaid eligible days remained in dispute in this case (e.g., whether there remained the same number of days as suggested in the appeal request or more or less). 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

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[19] *Id*.
[20] Provider's Preliminary Position Paper at 8 (August 24, 2022).

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

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 $88,478, 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.[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, regarding position papers,[23] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[24] This requirement is consistent with 42 C.F.R. § 405.1853(b)(3).

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

> *If documents necessary to support your position are still unavailable,* then provide the following information in the position papers:
>
> 1. Identify the missing documents;

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

[22] (Emphasis added.)

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

[24] (Emphasis added.)

> 2. Explain why the documents remain unavailable;
> 3. State the efforts made to obtain the documents; and
> 4. Explain when the documents will be available.
>
> Once the documents become available, promptly forward them to the Board and the opposing party.[25]

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

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

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

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

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

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

The Board concurs with the Medicare Contractor that the Provider is required to identify and provide documentation to prove what additional Medicaid Eligible days are at issue and to which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rule 25. Further, pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[26] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. Based on the record before the Board, the Board finds that the Provider has failed to provide a listing or other supporting documentation for the

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

Medicaid Eligible Days issue as required by the controlling regulations and Board Rules. Nor has the Provider provided any explanation as to why the documentation was absent or what is being done to obtain it consistent with Board Rule 25.2.2. Indeed, as no specific days were identified as being in dispute in the position paper filing, the Board must assume that no days are in dispute and that the *actual* amount in controversy is $0.

The Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of Board Rules 25.2.1 and 25.2.2 related to identifying the days in dispute and the submission of documentary evidence required to support its claims or describe why said evidence is unavailable, which the Provider has failed to do.[27] The Board takes administrative notice that it has made similar dismissal in other cases in which CHS was the designated representative and, notwithstanding, CHS failed to provide the Medicaid eligible days listing with its preliminary position paper.

****

In summary, the Board hereby dismisses the SSI Provider Specific issue from this appeal as it is duplicative of the issue in Case No. 20-0997GC, 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. 22-0364 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.

<u>Board Members Participating</u>:

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

For the Board:

3/8/2023

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Board Decision* – SSI Percentage (Provider Specific) and Medicaid Eligible Days**
City Hospital, Inc. (Prov. No. 51-0008)
FYE 12/31/2017
Case No. 22-0719

Dear Mr. Ravindran and Ms. Johnson:

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the documentation in Case No. 22-0719 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. 22-0719

City Hospital appealed a Notice of Program Reimbursement ("NPR") dated August 15, 2021 for fiscal year end December 31, 2017. On February 9, 2022, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained seven (7) issues[1]:

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

As the Provider is part of West Virginia University Health System ("WVUHS"), the Provider transferred 5 issues to common issue related party ("CIRP") groups for WVUHS. On January 20,

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[1] **Note:** Issue Nos. 5 & 7 were initially submitted as one issue. However, the Board granted the Provider's request to bifurcate these issues on September 27, 2022.
[2] On September 27, 2022, this issue was transferred to PRRB Case No. 22-1450GC.
[3] On September 27, 2022, this issue was transferred to PRRB Case No. 22-1452GC.
[4] On September 27, 2022, this issue was transferred to PRRB Case No. 22-1454GC.
[5] On September 27, 2022, this issue was transferred to PRRB Case No. 22-1451GC.
[6] On September 27, 2022, this issue was transferred to PRRB Case No. 22-1453GC.

2023, 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.

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 (3) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record.

The Provider did file an untimely response on March 8, 2023 and did not recognize that it was filed late nor provide any good cause to justify its late filing.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 22-1450GC

In their Individual Appeal Request, Provider summarizes its DSH/SSI – Provider Specific issue as follows:

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

Provider described its DSH/SSI – Systemic Errors issue, which has been transferred to a group appeal, as whether the Medicare/SSI Fraction used to calculate their DSH payment accurately and correctly counted the number of patient days to be included therein. More specifically, Provider lists the following reasons for challenging its SSI percentage:

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

[7] Issue Statement at 1 (Feb. 9, 2022).

6. Covered days vs. Total days[8]

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

> **Provider Specific**
>
> The Provider contends that its' [sic] SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation based on the Provider's Fiscal Year End (December 31).
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to 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).[9]

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 $44,150. This is the same amount that is listed as the amount in controversy for this Provider as a participant in 22-1450GC.

<u>MAC's Contentions</u>:

Issue 1 – DSH SSI Percentage (Provider Specific)

The MAC argues that the Board lacks jurisdiction over the DHS SSI% - Provider Specific issue for two reasons. First, the MAC argues that the appeal is premature:

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[8] *Id*. at 2.
[9] Provider's Preliminary Position Paper at 8-9 (Oct. 1, 2022).

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

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.[11]

Lastly, the MAC contends 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 and 27.1.[12]

Issue 3 – Medicaid Eligible Days

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

> The MAC contends that the Provider was in violation of Board Rule 25.3 when it failed to sufficiently develop and set forth the relevant facts and arguments regarding the merits of its claim in its preliminary position paper. Moreover, the Provider neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2. Accordingly, the DSH – Medicaid Eligible Days issue should be dismissed.
>
> Within its preliminary position paper, the Provider makes the broad allegation, "[t]he [sic] Provider contends that the total number of days reflected in its' [sic] 2017 cost report does not

[10] Jurisdictional Challenge at 7 (Jan. 20, 2023).
[11] *Id*. at 6.
[12] *Id*. at 8-10.

> reflect an accurate number of Medicaid eligible days. . ." The Provider has failed to include any evidence to establish the material facts in this case relating to inaccuracies in the Medicaid Percentage calculation at issue. The Provider merely repeats its appeal request.[13]

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."

The Provider did file an untimely response on March 8, 2023 and did not recognize that it was filed late nor provide any good cause to justify its late filing. For the DSH Percentage, QRS simply asserts that the SSI data supporting its position is not available because CMS will not release the data:

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

For the Medicaid eligible days issue, QRS does not provide a Medicaid eligible days listing or even the exact number of days at issue but simply asserts that the Provider has not abandoned the issue and that the Provider's operations were disrupted due to the COVID-19 pandemic:

> The MAC relies on Board rule 25.3. It is unclear, however, whether the MAC relies on the current Board rules version 3.1 or the Board Rules Version 2.0 (8/29/2018), which was in effect in 2019 when the Preliminary Position Paper was filed. Under Board Rules Version 2.0, a Final Position Paper is required for appeals filed prior to the effective date of Version 2.0. Rule 27.1.1 It was the reasonable understanding and expectation of the Provider, therefore, that the outside date for submission of the listing of

[13] *Id*. at 12.

> additional Medicaid eligible days was the Final Position Paper deadline.
>
> . . . Just as the operations of the Board and the MAC were disrupted by the COVID pandemic, as witnessed by the issuance of Alert 19, the operations of the Provider likewise were disrupted. Indeed, the Provider faced, and continues to face, the challenge of providing lifesaving health services to patients suffering from COVID (and, more recently, children suffering from life-threatening respiratory disease).

Board Analysis and Decision:

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

A. DSH SSI Percentage (Provider Specific)

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

1. First Aspect of Issue 1

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH SSI Percentage - Systemic Error issue that was appealed in PRRB Case No. 22-1450GC.

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

---

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

The Provider's DSH SSI Percentage - Systemic Errors issue in group Case No. 22-1450GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds the DSH SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH SSI Percentage - Systemic Errors issue in Case No. 22-1450GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[17], the Board dismisses this aspect of the DSH/SSI Percentage - Provider Specific issue.

In making this finding, the Board further notes that CMS regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, is pursuing that issue as part of the group under Case 22-1450GC. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[18] Provider is misplaced in referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 22-1450GC.

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 22-1450GC, 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;

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

> 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.[19]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."[20]

Similarly, QRS asserts in the position paper that "[s]imilar 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" but that "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." However, QRS fails to provide any information what "State records" its referring to, much less

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

provide those "State records" (unlike the provider in *Loma Linda*) or explain what they show or establish relative to the "***provider specific***" issue they are alleging here.

The Board recognizes that, on March 8, 2023, the Provider filed a response to the Jurisdictional Challenge. However, that response was not timely filed and the Board declines to give it any weight. Moreover, even if the response had been timely filed, it is clear that it was ***wholly*** *inadequate*. In this regard, the Board notes that the Provider asserts that CMS will not release "the SSI data" but then recognizes that "CMS *does make certain SSI data available*" which it claims is "inadequate and does not provide all patient payment status codes and other necessary information required to fully support this issue." However, this explanation is wholly inadequate in that it is contradictory saying on one hand that CMS will not release "the SSI data" and then on the other hand recognizing that some data is available without even confirming that it has received that data. QRS fails to explain what the available data shows and what the state records show relative to this provide for the specific fiscal year at issue. All of this information should have been included in the position paper filing as confirmed by 42 C.F.R. 405.1853(b)(2)-(3) and Board Rule 25.[21] However, neither the position paper nor the untimely response to the jurisdictional challenge include this important information. Finally, the Board notes that QRS' jurisdictional response fails to address the major point of the Medicare Contractor's filing, namely that the issue is duplicative of the common issue that it transferred to Case No. 22-1450GC. In this regard, QRS fails to establish in its response that the issue is provider specific rather than *systemic*. This is critical because the Provider is commonly owned by WVUHS and subject to the mandatory CIRP group regulations which require transfer of issues common to WVUHS.

Accordingly, based on the record before it, the Board finds that the remaining issue in the instant appeal and the group issue from Group Case 22-1450GC are the same issue and is a systemic rather than provider specific issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH/SSI (Provider Specific) issue. 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—is dismissed by the Board.

The Board finds that, under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal

[21] To further highlight the wholly inadequate position paper filing, the Board notes that QRS asserts in its jurisdictional response that "the refusal of CMS to release SSI data is currently being litigated before the United States Court of Appeals for the District of Columbia. See Pomona Valley Hospital Medical Center v. Becerra, No. 20-5350, 20- 5351." However, it is unclear why QRS failed to mention this litigation and its relevance in its position paper failing.

fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." Without this written request, the Medicare Contractor cannot issue a final determination from which the Provider can be dissatisfied with for appealing purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding DSH SSI Percentage realignment. Therefore, the Board finds that it lacks jurisdiction in this aspect of the appeal and Issue 1 should be dismissed.

B. Medicaid Eligible Days

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

> **Statement of the Issue**
>
> Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.
>
> **Statement of the Legal Basis**
>
> The Provider contends that the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees [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.[22]

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

On October 1, 2022, the Provider filed their preliminary position paper in which it indicated that it could be sending the eligibility listing under separate cover.[23] As of the filing of the jurisdictional challenge in January 2023, 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 $50,239, 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.

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[22] Individual Appeal Request, Issue 3.
[23] Provider's Preliminary Position Paper at Exhibit 1.

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, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage when the DSH adjustment is calculated. Similar decisions were rendered by the Fourth, Eighth and Ninth Circuits: *Cabell Huntington Hospital, Inc. v. Shalala*, 101 F.3d 984 (4th Cir. 1996); *Deaconess Health Services Corp. v. Shalala*, 83 F.3d 1041 (8th Cir. 1996), *aff'g* 912 F. Supp. 478 (E.D. Mo. 1995); and *Legacy Emanuel Hospital and Health Center v. Shalala*, 97 F.3d 1261 (9th Cir. 1996).
>
> The Centers for Medicare and Medicaid Services ("CMS", formerly HCFA) acquiesced in the above decisions and issued HCFA Ruling 97-2, which in pertinent part reads as follows:
>
>> [T]he Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to include all inpatient hospital days of service for patients who were eligible on that day for medical assistance under a state Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for these inpatient hospital services.
>
> Based on the Listing of Medicaid Eligible Days being sent under separate cover, the Provider contends that the total number of days reflected in its' [*sic*] 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.[24]

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 $50,239, it is unclear whether this amount continues to be in dispute as of the Provider's filing of the position paper.

---

[24] *Id.* at 7-8.

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.[25]

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*.[26]

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:

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[25] *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.

[26] (Emphasis added).

> 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,[27] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[28] 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.[29]

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.

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

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"[30] 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 did the Provider provide any explanation as to why the documentation was absent or what is being done to obtain it consistent with Board Rule 25.2.2. Indeed, without any days identified in the position paper filing, the Board must assume that there are no days and that the actual amount in dispute for this issue is $0.

The Board recognizes that, on March 8, 2023, the Provider filed a response to the Jurisdictional Challenge. However, that response was not timely filed and the Board declines to give it any weight. Moreover, even if the response had been timely filed, it is clear that it was ***wholly*** *inadequate*. QRS suggests that the Provider was not required to include the Medicaid eligible days listing with the position paper filing and generally states COVID-19 affected Provider operations without explaining how that relates to the inability of QRS as the Provider's representative from including information on the Medicaid eligible days issue either in the position paper filing (or even as of March 8, 2023 when its response was filed). QRS ignores its obligation under 42 C.F.R. 405.1853(b)(2)-(3) and Board Rules 25 to fully brief the merits of the issue and provide all supporting documentation and this clearly include identifying the specific days at issue. QRS failed to identify those days even in its jurisdictional response or explain why those days have not been identified. Generically referring to the COVID-19 pandemic affecting the Provider's operations is not a sufficient explanation of why the Medicaid eligible days were not identified in the Provider position paper filing made on October 1, 2022 (or even when the March 8, 2023 jurisdictional response was filed). 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.[31] Accordingly, in light of these previous dismissals, it is unclear why QRS failed

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[30] (Emphasis added).
[31] 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

provide the Medicaid eligible days listing as part of the October 1, 2022 position paper filing or provide an explanation therein of why the information was not available.

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.[32]

****

In summary, the Board hereby dismisses the SSI Provider Specific issue from this appeal as it is duplicative of the issue in Case No. 22-1450GC and there is no final determination from which the Provider can appeal the SSI realignment portion of the issue. The Board also dismisses the Medicaid eligible days issue as the Provider failed to meet the Board requirements for position papers for this issue. As no issues remain pending, the Board hereby closes Case No. 22-0719 and removes it from the Board's docket.

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

Board Members Participating:

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

For the Board:

3/8/2023

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services

(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.

[32] 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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RE: ***Board Dismissal***
The Presbyterian Hospital (Prov. No. 34-0053)
FYE 12/31/2007
Case No. 13-0397

Dear Mr. Ravindran and Ms. Johnson,

The Provider Reimbursement Review Board (the Board) has reviewed the documentation submitted in the above-referenced appeal. The Board's jurisdictional decision is set forth below.

Background

The Provider submitted a request for hearing on January 11, 2013, based on a Notice of Program Reimbursement ("NPR") dated November 14, 2012. The Provider appealed the following nine issues:

1. Disproportionate Share Hospital Payment ("DSH") – Supplemental Security Income ("SSI") Percentage – Provider Specific
2. DSH Payment – SSI Percentage – Systemic Errors
3. DSH Payment – Medicaid Eligible Days
4. DSH Payment – Medicare Managed Care Part C Days
5. DSH Payment – Medicaid Eligible Labor Room Days
6. DSH Payment – Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days and No-Pay Part A Days) – SSI Fraction and Medicaid Fraction
7. Rural Floor Budget Neutrality Adjustments
8. Outlier Payment – Fixed Loss Threshold ("FLT")
9. Outlier Payment – FLT – Operating Cost to Charge Ratio and Outlier Reconciliation Adj.

On August 26, 2013, the Provider filed the following transfer requests to common issue related party ("CIRP") groups:

- Issue 2 to PRRB Case No. 13-2906GC – QRS Novant 2007 SSI Percentage Baystate Errors CIRP Group,
- Issue 4 to PRRB Case No. 13-3009GC – QRS Novant 2007 DSH Medicare Managed Care Pt. C Days CIRP Group,

- Issue 5 to PRRB Case No. 13-2841GC – QRS Novant 2007 DSH Medicaid Eligible Labor Room Days CIRP Group,
- Issue 8 to PRRB Case No. 13-2955GC – QRS Novant 2007 Outlier Payments – Fixed Loss Threshold, and
- The SSI Fraction portion of the Issue 6 to Case No. 13-2903GC – QRS Novant 2007 SSI Fraction Dual Eligible Days CIRP Group and the Medicaid Fraction portion of the Issue 6 to PRRB Case No. 13-2904GC – QRS Novant 2007 Medicaid Fraction Dual Eligible Days CIRP Group.

Finally, by letters dated June 23, 2016, January 13, 2014, and April 27, 2016, the Provider withdrew Issues 1, 7, and Issue 9 respectively.

Accordingly, after all transfers and withdrawals, the sole remaining issue in this appeal is Issue 3 – DSH Payment – Medicaid Eligible Days. The Provider identified Issue 3 in its initial appeal request as follows:

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

Pursuant to a Partial Administrative Resolution executed March 6, 2017, the parties agreed to partially resolve Issue 3. The Medicare Contractor agreed to include an additional 3,212 Medicaid eligible days in the cost report. However, the Medicare Contractor did ***not*** include any additional Medicaid eligible days occurring in the Provider's Adolescent Psychiatric Unit based on its finding that these days occurred in an excluded unit and, therefore, were not allowable in the DSH calculation. Thus, the Issue 3 sub-issue Medicaid Eligible Days for the Adolescent Psychiatric Unit was identified by the Parties as remaining in dispute.

On September 9, 2022, the Medicare Contractor submitted a jurisdictional challenge on this Issue 3 sub-issue. 44.4.2 specifies that responses to a jurisdictional challenge be filed within 30 days. However, QRS did not file its response to the Jurisdictional Challenge within the 30-day response period but waited until November 8, 2022 to make that filing (*i.e*., 30 days late).

In the interim, QRS filed a request for record hearing on October 20, 2022 without acknowledging the pending jurisdictional challenge or even complying Board Rule 32.4 instructions on the content for a record hearing request (*e.g*., the request fails to explain why the case is suitable for a record hearing, explain whether material facts are in dispute, confirm the record is substantially complete, and include stipulations of fact). Indeed, on that same day, FSS filed its object to the record hearing request noting that there is a pending jurisdictional challenge that is dispositive of the appeal.

Medicare Contractor's Position

The Medicare Contractor explains that it became aware of the Adolescent Psychiatric Days issue as the Provider filed substantially similar appeals for FYEs December 31, 2001 and December 31, 2002 in Case Nos. 06-1851 and 06-1852 respectively. In those two individual PRRB cases, Presbyterian appealed the issue of Medicaid eligible days and raised the sub-issue regarding adolescent psychiatric days. The appeals were consolidated and a hearing took place on September 15, 2015.[1]

The Medicare Contractor goes on to explain that on February 10, 2017, the Provider and the Appeals Support Contractor ("ASC") agreed to stipulations in the instant case that, among other things, stipulated that the issue of whether the days for inpatient stays in the adolescent psychiatric unit should be counted and included in the DSH calculation be held in abeyance pending the Board ruling in Case Nos. 06-1851 and 06-1852.[2]

On March 6, 2017, the Parties executed a Partial Administrative Resolution to include DSH Medicaid Eligible Days and adjust DSH Percentage accordingly. The Medicare Contractor did not include any additional Medicaid eligible days that occurred in the Provider's Adolescent Psychiatric Unit.[3]

The Medicare Contractor states that the provider submitted its Final Position Paper on August 17, 2022. The Medicare Contractor notes that the Provider ***failed*** to brief the sub-issue of the Medicaid eligible days for the adolescent psychiatric unit. In fact, the Final Position Paper submitted by the Provider on August 17, 2022 is almost identical to the Provider's previous Final Position Paper submitted on March 30, 2016. Neither Final Position Paper specifically addresses the sub-issue related to the adolescent psychiatric days. In addition, the August 17, 2022 Final Position Paper does ***not*** address the Partial Administrative Resolution or the terms of that agreement.[4]
The Medicare Contractor points to the regulation at 42 C.F.R. § 405.1853(b)(2) which states:

[1] The Board ultimately dismissed the cases in a jurisdictional decision issued November 17, 2017.
[2] Medicare Contractor's jurisdictional challenge at 3.
[3] Medicare Contractor's jurisdictional challenge at 3.
[4] Medicare Contractor's jurisdictional challenge at 4.

> 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.

The Medicare Contractor then points to Board Rule 27.2 that addresses the content of a Final Position Paper:

> The final position paper should address each remaining issue in the appeal. The *minimum* requirements for the position paper narrative and exhibits are the same as those outlined for preliminary position papers at Rule 25.

Finally, Board Rule 25 sets forth the requirements for the Provider's Final Position Paper and provides in relevant part:

> **25.1 Content of Position Paper Narrative**
>
> The text of the position papers must contain the elements addressed in the applicable sub-section.
>
> **25.1.1 Provider's Position Paper**
>
> A. Identify any issues that were raised in the appeal but are already resolved (whether by administrative resolution, agreement to reopen, transfer, withdrawal, dismissal, etc.) and require no further documentation to be submitted.
>
> B. For each issue that has not been fully resolved, provide a ***fully*** developed narrative that:
>
> - States the material facts that support the provider's claim.
> - Identifies the controlling authority (*e.g.*, statutes, regulations, policy, or case law) supporting the provider's position.
> - Provides a conclusion applying the material facts to the controlling authorities.
>
> C. Comply with Rule 25.2 addressing Exhibits.
>
> **25.2 Position Paper Exhibits**
>
> **25.2.1 General**
>
> With the position papers, the parties must exchange ***all*** available documentation as exhibits to fully support your position. The

> Medicare contractor must also give the provider all evidence the Medicare contractor considered in making the determination (see 42 C.F.R. § 405.18539(a)(3)) and identify any documentary evidence that the Medicare contractor believes is necessary for resolution but has not been submitted by the provider. When filing those exhibits in the preliminary position paper, ensure that the documents are redacted in accordance with Rule 1.4. Unredacted versions should be exchanged by the parties separately from the position paper, if necessary.
>
> **25.2.2. Unavailable and Omitted Documents**
>
> If documents necessary to support your position are still unavailable, then provide the following information in the position papers:
>
> 1. Identify the missing documents;
> 2. Explain why the documents remain unavailable;
> 3. State the efforts made to obtain the documents; and
> 4. Explain when the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.
>
> **25.2.3 List of Exhibits**
>
> Parties must attach a list of the exhibits exchanged with the position paper.

The Medicare Contractor observes that in the Board's filing requirements at Board Rule 25.3, parties should file a **complete** 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. If the Provider fails to brief an appealed issue in its position paper, the Board will consider the unbriefed issue abandoned and effectively withdrawn.

Lastly, the Medicare Contractor cites the regulations at 42 C.F.R. § 405.1868 which state:

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

(1) Dismiss the appeal with prejudice;

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

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

The Medicare Contractor contends that the Provider abandoned the sole remaining issue in the appeal, DSH Medicaid Eligible Days for the Adolescent Psychiatric Unit, when it failed to brief the issue in its final position paper submitted on August 17, 2022. Specifically, the Provider failed to state the material facts that support its claims that the Medicare Contractor failed to include the disputed adolescent psychiatric days in the DSH calculation and failed to identify or produce any documents explaining or demonstrating that those Medicaid eligible days should have been included. The Provider also failed to reference the Partial Administrative Resolution and the fact that the appeal related to DSH Medicaid Eligible Days was partially resolved.[5]

Provider's Position

The Provider did not submit a timely response to the jurisdictional challenge within the 30 days provided under Board Rule 44.4.3 (*i.e.*, by Monday, October 11, 20226). Rather, the QRS filed 28 days late on November 8, 2022. In filing its response QRS failed to acknowledge that it was late and, as such, failed to include any good cause for the late filing. Indeed, the filing of the request for record hearing on October 20, 2022 suggests that QRS was fully capable of timely filing a response.

QRS' November 8, 2022 filing makes the following arguments:

1. The Issue 3 sub-issue is properly part of this appeal because "[t]he Provider was not required to either make a specific claim on its cost report for the additional Medicaid eligible days or show a practical impediment, in order for the Board to have jurisdiction over its appeals" and because "[e]ven if the Provider were required to make a specific claim on its cost report for the additional Medicaid-eligible days or show a practical impediment, it did demonstrate a practical impediment that prevented it from identifying additional Medicaid-eligible days prior to filing its costs reports."

2. The Provider has not abandoned the Issue 3 sub-issue because: (a) it presented the adolescent psych days in dispute to the Medicare Contractor as demonstrated by "MAC work papers (Exhibit 3, page 6 March 01, 2017 [as attached to the November 8, 2022 filing]) in which it is noted that: the Adolescent Psychiatric days received by the MAC were filtered out prior to the sampling process and the issue will proceed to hearing"; and (b) the MAC acknowledges that it contends that the MAC acknowledged in its final position paper that it was aware the Provider was still pursuing the Issue 3 sub-issue.

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[5] Medicare Contractor's jurisdictional challenge at 6.
6 As the deadline fell on Sunday, October 9th and Monday, October 10th was a federal holiday (Columbus Day), the filing date fell on Tuesday, October 11th.

<u>Board's Decision</u>

Pursuant to 42 C.F.R. § 405.1853(b)(2), "[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." Similarly, § 405.1853(b)(3) states that "[e]xhibit 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."

The Board issued Board Rules governing position papers consistent with § 405.1853(b)(2)-(3). In this regard, the Critical Due Dates Notice setting the Providers' final position paper deadline referenced the Providers to Board Rule 27 governing final position papers. In particular, this Rule (Nov. 1, 2021 version) the following in pertinent part:

> **Rule 27 – Final Position Papers**
>
> **27.1 – General**
>
> The final position paper should reflect *the refinement of the issues* from the preliminary position paper . . . .
>
> **27.2 – Content**
>
> The final position paper should address each remaining issue including, at a minimum:
>
> a. Identification of each issue and its reimbursement impact.
>
> b. Procedural history of the dispute.
>
> c. A statement of facts that:
>
> i. Indicates which facts are undisputed.
> ii. Indicates, for each material disputed fact, the evidence that the party asserts supports those facts with supporting exhibits and page references.
>
> d. Argument and Authorities – *A <u>thorough</u> explanation of the party's position* of how the authorities apply to the facts.
>
> **27.3 – Revised or Supplemental Final Position Papers**
>
> Except on written agreement of the parties, *revised or supplemental position papers should **not** present new positions, arguments or evidence*. However, the Board encourages revised or supplemental final position papers which, for administrative efficiency, further *<u>narrow</u>* the parties' positions or provide legal development (such as new case law) that has occurred since the final position paper was filed. Prior to filing such papers, the parties should contact each

> other to discuss the anticipated substance of such papers and anticipated objections. If a revised or supplemental position paper is filed to further refine or narrow the issues, the opposing party may file a rebuttal or reserve such rebuttal for hearing.
>
> **27.4 – Arguments Expanding the Scope of Final Position Papers**
>
> If at hearing or through a revised position paper, a party presents an argument or evidence expanding the scope of the position papers, the Board may, upon objection, exclude such arguments or evidence from consideration.7

For further context for Board Rule 27, it is important to look at Board Rule 25 governing preliminary position papers since the final position paper is filed after preliminary position papers have been filed. Board Rule 25 (July 1, 2015 version) states in pertinent part:

> **Rule 25 – Preliminary Position Papers**
>
> **COMMENTARY**:
>
> Under the PRRB Regulations effective August 21, 2008, all issues will have been identified within 60 days of the end of the appeal filing period. The Board will issue a notice setting deadlines for the first position paper generally at eight months after filing the appeal request for the provider, and twelve months for the Medicare contractor. Even though it will not be address in the Board's notice, the provider may file an optional response no later than ninety days following the due date for the Medicare contractor's preliminary position paper. Therefore, the Board requires preliminary position papers to present the ***fully-*** developed positions of the parties and expects that the parties will be diligent in planning and conducting any required investigation, discovery, and analysis well in advance of the filing deadline.
>
> To address complaints under the previous Rules that the parties have not had sufficient time to develop meaningful position papers, . . . , the Board will set deadlines for the first position paper generally at eight months after filing the appeal request for the Provider, twelve months for the Intermediary and fifteen months for the Provider's response. . . .
>
> **25.1 – Content of Position Paper Narrative**
>
> The text of the position papers must include the elements addressed in the applicable sub-section.

7 (Italicized and underline emphasis added.)

25.1.1 Provider's Position Paper

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

B. For each issue that has not been fully resolved, provide a fully developed narrative that:

- States the material facts that support the provider's claim.
- Identifies the controlling authority (e.g., statutes, regulations, policy, or case law) supporting the provider's position.
- Provides a conclusion applying the material facts to the controlling authorities.

C. Comply with Rule 25.2 addressing Exhibits.

****

25.2 Position Paper Exhibits

25.2.1 General

With the position papers, the parties must exchange ***all*** available documentation as exhibits to fully support your position. The Medicare contractor must also give the provider all evidence the Medicare contractor considered in making the determination (*see* 42 C.F.R. § 405.1853(a)(3)) and identify any documentary evidence that the Medicare contractor believes is necessary for resolution but has not been submitted by the provider. When filing those exhibits in the preliminary position paper, ensure that the documents are redacted in accordance with Rule 1.4. Unredacted versions should be exchanged by the parties separately from the position paper, if necessary.

25.2.2 Unavailable and Omitted Documents

If documents necessary to support your position are still unavailable, then provide the following information in the position papers:

1. Identify the missing documents;
2. Explain why the documents remain unavailable;
3. State the efforts made to obtain the documents; and
4. Explain when the documents will be available.

> Once the documents become available, promptly forward them to the Board and the opposing party. Common examples of unavailable documentation include pending discovery requests, pending requests filed under the federal Freedom of Information Act (also known as FOIA requests), or similar requests for information pending with a state Medicaid agency.
>
> ****
>
> **25.3 – Filing Requirements to Board**
>
> The Board requires the parties file a ***complete*** preliminary position paper that includes a fully developed narrative (Rule 25.1), all exhibits (Rule 25.2), a listing of exhibits, and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. If the provider fails to brief an appealed issue in its position paper, the Board will consider the unbriefed issue abandoned and effectively withdrawn.[8]

Similarly, the following Commentary at Board Rule 23.3 (Nov. 1, 2021 version) discussing preliminary position papers and proposed joint scheduling orders ("JSOs") is also relevant[9]:

> **COMMENTARY**: The regulations and Board Rules impose preliminary position paper requirements that ensure full development of the parties' positions in order to foster efficient use of the administrative review process. The due date timeframe is set to give the parties the optimal opportunity to ***fully*** develop their case. Because the date for adding issues will have expired and transfers are to be made ***prior to*** filing preliminary position papers, the Board requires preliminary position papers to be ***fully*** developed and include ***all*** available documentation necessary to provide a thorough understanding of the parties' position.
>
> CAUTION: New arguments and documents not included in the preliminary position paper may be excluded at the hearing unless the parties demonstrate good cause (*e.g.*, subsequent case law or documents were unavailable through no fault of the party offering the evidence). *See also* Rule 25.2.3 addressing documents omitted or unavailable when the preliminary position paper is filed.

8 (Italics and underline emphasis added.)
9 (Underline emphasis added to Commentary quote.)

Board Rule 25.3 (Nov. 2021) states that position papers[10] must be complete, and that "[i]f the provider fails to brief an appealed issue in its position paper, the Board will consider the unbriefed issue *abandoned and effectively withdrawn*."

The regulations governing position papers can be found at 42 C.F.R. § 405.1853:

> (b) Position papers. (1) After any preliminary narrowing of the issues, the parties must file position papers in order to narrow the issues further. In each case, and as appropriate, the Board establishes the deadlines as to when the provider(s) and the contractor must submit position papers to the Board.
> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper must set forth the relevant facts and arguments regarding the Board's jurisdiction ***over each remaining matter at issue in the appeal*** (as described in §405.1840 of this subpart), and the merits of the provider's Medicare payment claims for each remaining issue.

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

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

The Board finds that the sole remaining issue, the Issue 3 sub-issue Medicaid Eligible Days for the Adolescent Psychiatric Unit was not briefed in the Provider's Final Position Paper filed on August 17, 2022. Pursuant to Board Rule 25.3, the Board deems this unbriefed issue abandoned.

[10] Board Rule 27.2 establishes that the minimum requirements for Final Position Papers are the same as those outlined for Preliminary Position Papers in Rule 25.

Indeed, *even though the fiscal year at issue had ended* ***more than 14 ½ years earlier***, the Provider's August 17, 2022 final position paper filing does not identify a single Medicaid eligible day in dispute, much less any adolescent psychiatric unit days in dispute, and includes no exhibits to establish that any days are in dispute.[11] The Provider failed to cure this defect in its filing of the jurisdictional response which was filed on November 8, 2022.

Moreover, whether adolescent psychiatric days may be included in the numerator of the Medicaid fraction is not the typical Medicaid eligible day where the provider is simply establishing that it was a Medicaid eligible day that, through no fault of its own, was not included in the Medicaid eligible listing used calculate the DSH adjustment for the year at issue. In this regard, the Board notes that the Provider had appealed adolescent psychiatric days as an issue in its appeals for FYs 2001 and 2002 under Case Nos. 06-1851 and 06-1852 but that, on November 17, 2017, the Board dismissed the adolescent psychiatric days because these were unclaimed costs and the provider failed to meet the issue-specific dissatisfaction requirement.[12] In that case, the Provider appealed all adolescent psychiatric days from that unit, meaning that this was not a case where a small subset of days were not paid due to retroactive determinations; rather, the Provider had inadvertently been treating the unit for 20 years as an excluded Medicare unit:

> . . . Novant admits it billed services furnished in the adolescent psychiatric unit using its Medicare excluded unit billing number; and . . . Novant's consultant readily recognized that [the Provider] would cull out those Medicaid days did not qualify to be counted for Medicare DSH purposes such as days attributable to Medicare excluded units but could not explain how the Medicaid adolescent psychiatric days at issue were treated under process. . . .
>
> In particular, Novant acknowledges that it made the following misrepresentations or inconsistencies about the adolescent psychiatric unit:
>
> (1) Novant alleges that, over the course of 20 plus years, it had a history of submitting ***in error*** attestation letters to the State

---

[11] Exhibit 1 to the Provider's final position paper was supposed to be the eligibility listing and stated that it was "not included – being sent under separate cover." However, that listing has never been filed as an exhibit with the Board. Exhibit 2 to the Provider's final position paper is simply the original amount in controversy calculation included with the original appeal request using an estimated 2.5% as the amount in controversy. This estimate had never been updated with an actual listing and an actual amount in controversy. The Board also notes that the August 17, 2022 final position paper filing appears to be the ***same*** as the final position paper that it filed 6 years earlier on March 30, 2016 which similarly did ***not*** identify any specific days in dispute or provide a listing of days in dispute (much identify adolescent psychiatric days as being in dispute).

[12] *See* 73 Fed. Reg. 30190, 30194-98 (May 23, 2008); *St. Vincent Hosp. & Health Ctr. v. Blue Cross Blue Shield Ass'n*, PRRB Dec. No. 2013-D39 at 13-16 (Sept. 13, 2013) (explaining that the Board generally has interpreted 42 U.S.C. § 1395oo(a) as requiring that dissatisfaction be expressed with respect to the total reimbursement for "each claim" as opposed to a general dissatisfaction to the total reimbursement on the NPR because the Board has viewed the NPR as being comprised of many individual determination on various items for which the provider has sought payment in the as-filed cost report).

> survey office that its 20-bed adolescent psychiatric unit was an excluded Medicare unit. . . .
>
> (2) Novant admits that it used its Medicare exempt unit/NPI billing number whenever it billed the Medicaid program for services furnished in the adolescent psychiatric unit . . . .
>
> Once the extent of Novant's self-professed internal confusion and inconsistencies are appreciated, it is not surprising that Novant failed to report 95 and 100 percent of the universe of Medicaid adolescent psychiatric days during the cost reporting process for FYs 2001 and 2002 respectively. In this same vein, it stretches credulity to believe that, prior to the filing the as-filed cost reports for FYs 2001 and 2002, Novant had not receive payment and remittance advices from North Carolina Medicaid on virtually *any* of the universe of Medicaid adolescent psychiatric days for FYs 2001 and 2002, and that Novant essentially had no internal records on the Medicaid eligibility for the universe of Medicaid adolescent psychiatric days for FYs 2001 and 2002.[13]

Accordingly, the Board determined that all of the days at issue for FYs 2001 and 2002 were ***unclaimed*** costs because they had been paid by North Carolina Medicaid and that "due to choice, error, and/or inadvertence, Novant failed to identify and include the days at issue on the as-filed cost reports or the new listings submitted during the desk review process."[14]

Here, the Provider failed to timely respond to the Medicare Contractor's jurisdictional challenge and, as such, the Board declines to give it any weight because it was not timely filed and is wholly inadequate. The Provider admits in its response to the jurisdictional challenge that "[t]his appeal is, on its merits, identical to the appeal for the Provider's 2001 and 2002 cost years (Case Numbers 06-1851 and 06-1852), for which an extensive record was made prior to, and at the hearing for those years." However, the Provider did not include *any* of that record as part of this appeal or even discuss that record or underlying facts ***in its final position paper*** even though the very facts regarding the merits of the Provider's position in FYs 2001 and 2002 were the ones the Board used to dismiss the FYs 2001 and 2002 appeals by letter dated November 17, 2017

[13] (Footnote omitted.)

[14] Copy attached as Exhibit C-7. In other words, there was no practical impediment preventing Novant from claiming the adolescent psychiatric days on the cost report. In this regard, the Board is aware that State Medicaid programs often require prior authorization for adolescent psychiatric care and, in such situations, the provider can readily identify those days and include them in their Medicaid eligible days as appropriate since Medicaid coverage is establish prior to the day even occurring and presumably remittance advice would be issued for the prior authorized days. *See, e.g.*, *St. Anthony Hospital v. Novitas Solutions, Inc.*, PRRB Dec. No. 2022-D29 (Sept. 19, 2022) (addressing whether certain Oklahoma adolescent psychiatric care days were includable in the numerator of the Medicaid fraction, discussing fact that all acute and residential psychiatric care for children under 18 must go through prior authorization, and acknowledging that all the days at issue were Medicaid paid days which necessarily would have gone through that prior authorization); *Integris Health 2007 DSH Inpatient Behavior Health Days CIRP group v. Novitas Solutions, Inc.*, PRRB Dec. No. 2023-D05 (Feb. 17, 2023).

(notwithstanding the fact that this dismissal occurred *nearly 5 years* ***prior to*** the Providers' filing of its final position paper on August 17, 2022). Indeed, the Board notes that, per 42 C.F.R. § 405.1853(b)(2), the Provider is ***required*** to fully brief jurisdiction for each issue. However, the Provider failed to comply with this regulation because it failed to discuss the very facts surrounding the merits of the case that also establish that the days at issue are unclaimed costs (as described in the Board's dismissal of FYs 2001 and 2002) and failed to discuss or distinguish the facts of FY 2007 from the findings the Board used to dismiss the adolescent psychiatric days for FYs 2001 and 2002. Without an identification of the specific adolescent psychiatric days at issue and additional information from the Provider (*e.g.*, entering into the record relevant documents from the FYs 2001 and 2002 case and confirming how many, if any, adolescent psychiatric days were included on the as-filed cost report), the Board is unable to determine that it has jurisdiction over the alleged days at issue and, without information to the contrary, must assume that these are unclaimed costs that fail to meet the dissatisfaction requirement similar to FYs 2001 and 2002 and incorporates that decision as included at Exhibit C-7 into this determination.

In summary, based on the record before it (on which the Provider has otherwise requested a record hearing on October 19, 2022),[15] the Provider failed to brief the adolescent psychiatric day issue in compliance with 42 C.F.R. § 405.1853(a)-(b) and Board Rule 25 (via Board Rule 27.2). In particular, no actual specific adolescent psychiatric days have been identified for the record and, accordingly, the Board must presume that no adolescent days are in dispute and that the actual amount in controversy for this issue is $0.[16] Regardless, *as a separate and independent basis for dismissal*, based on the Provider's admission that this case has the same facts as FYs 2001 and 2002, the Board would dismiss the issue as unclaimed costs consistent with its dismissal of the issue for FYs 2001 and 2002. Accordingly, the Board hereby dismisses the Issue 3 sub-issue Medicaid Eligible Days for the Adolescent Psychiatric Unit from the appeal. Since no issues remain in the appeal, Case No. 13-0397 will be closed and removed from the Board's docket.

[15] The presentment or sharing of documents with an opposing party does not make it part of the record before the Board and such an exchange does not comply with each parties responsibility under 42 C.F.R. § 405.1853(b)(3) and Board Rule 25.2.2 (as applied to final position papers through Board Rule 27.2) to include with its position paper all available documentation as exhibits to fully support your position and, if it is not available, to explain why and when it will become available. Similarly, the fact that the Medicare Contractor administratively resolved part of the Medicaid eligible days issue does not change the fact that it was not properly briefed before the Board in the Provider's final position paper and would have been subject to dismissal had the Provider pursued that issue in its entirety.

[16] 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. 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. These dismissals occurred ***prior to*** the QRS' filing the Provider's October 17, 2022 final position paper and its ***untimely*** response to the jurisdictional challenged filed on November 8, 2022.

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

Board Members Participating:

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

For the Board:

3/9/2023

X Clayton J. Nix

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

cc: Wilson C. Leong, Federal Specialized Services

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RE: ***Board Decision* – SSI Percentage (Provider Specific) and Medicaid Eligible Days**
Baylor Medical Center at Irving (Prov. No. 45-0079)
FYE 06/30/2006
Case No. 16-2205

Dear Mr. Galinsky and Mr. Tisdale:

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the documentation in Case No. 16-2205 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. 16-2205

On January 28, 2016, the Provider was issued a ***Revised*** Notice of Program Reimbursement ("RNPR") for fiscal year end June 30, 2006. Audit Adjustment 4 was proposed to W/S E, Part A "To update the SSI percentage in accord with the remand of PRRB Case 08-2975GC." Audit Adj 6 adjusted W/S L and also stated "to update the SSI percentage in accord with the remand of PRRB Case 08-2975GC." No notice of reopening was included with the appeal request, to document the rational for the reopening, and no adjustments revised Medicaid Days on Worksheet S-3.

On August 1, 2016, the Board received the Provider's individual appeal request, from the RNPR. The RNPR appeal contained nine (9) issues:

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

[1] On April 28, 2017, this issue was transferred to PRRB Case No. 17-1179GC.
[2] On April 28, 2017, this issue was transferred to PRRB Case No. 17-1180GC.
[3] On April 28, 2017, this issue was transferred to PRRB Case No. 17-1182GC.
[4] On April 28, 2017, this issue was transferred to PRRB Case No. 17-1181GC.

6. DSH Payment – Medicaid Fraction/Dual Eligible Days[5]
7. DSH Payment – Medicaid Eligible Days
8. DSH Payment – Medicare Managed Care Part C Days[6]
9. DSH Payment – Dual Eligible Days[7]

As the Provider is commonly owned and, thereby, subject to the mandatory common issue related party ("CIRP") group regulation at 42 C.F.R. § 405.1837(b)(1), the Provider transferred Issues 2, 3, 4, 5, 6, and 8 to CIRP groups. As a result, there are only 2 days remaining issues – Issue 1 (the DSH Payment/SSI Percentage (Provider Specific) issue) and Issue 7 (the DSH Payment – Medicaid Eligible Days issue).

On May 4, 2018, the Medicare Administrative Contractor ("MAC") filed a Jurisdictional Challenge. The Provider's response was due on Monday June 4, 2018 per Board Rule 44.4 (2015). However, the Provider filed its response to the Jurisdictional Challenge 7 days late, on June 11, 2018.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 21-1466GC

In their Individual Appeal Request, Provider summarizes its DSH/SSI – Provider Specific issue as follows:

> The Provider contends 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.
>
> 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

[5] On April 28, 2017, this issue was transferred to PRRB Case No. 17-1183GC.
[6] On April 28, 2017, this issue was transferred to PRRB Case No. 17-1181GC.
[7] On April 28, 2017, this issue was transferred to PRRB Case No. 17-1183GC.

> 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.[8]

The amount in controversy listed for the DSH SSI Provider Specific issue by the provider in Case No. 16-2205 is $58,000.

As the Provider is commonly owned by Baylor Scott & White Health, the Provider was also directly added to the common issue related party ("CIRP") group under Case No. 17-1179GC entitled "QRS BSWH 2006 DSH SSI Percentage CIRP Group." This CIRP group has the following issue statement:

> **Statement of the Issue:**
>
> Whether the Medicare/SSI fraction used in the Medicare Disproportionate Share Hospital and LIP payment calculations accurately and correctly counted the correct number of patient days to be included in the numerator and denominator of the Medicare/SSI fraction calculation per the Medicare Statute at 42 U.S.C. §1395ww(d)(5)(F)(vi)?
>
> **Statement of the Legal Basis**
>
> The Provider(s) contend(s) that the Lead MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww (d)(5)(F)(vi). The Provider contends that the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") and used by the Lead MAC to settle their Cost Report were incorrectly computed.
>
> The Providers also contend(s) that CMS inconsistently interprets the term "entitled" as it is used in the statute. CMS requires SSI payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the denominator. CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days of care) as Medicare Part A days, yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment.

[8] Issue Statement at 1. (Aug. 1, 2016).

> The Provider(s) further contend(s) that the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") fail to address all the deficiencies as described in *Baystate Medical Center v. Michael O. Leavitt*, 545 F. Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37, 44 (D.D.C. 2008) and incorporate a new methodology inconsistent with the Medicare Statute.
>
> Providers in this case are also seeking resolution of the following additional aspects of the Medicare fraction that were 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. Covered days vs. Total days and
> 6. Failure to adhere to required notice and comment rulemaking procedures[9]

The amount in controversy listed for the Provider as a participant in 17-1179GC is $58,000. This is the same amount that is listed as the amount in controversy for the Provider Specific issue in 16-2205.

MAC's Contentions:

Issue 1 – DSH SSI Percentage (Provider Specific)

The MAC argued that the Board lacks jurisdiction over the DSH/SSI Percentage - Provider Specific issue because it is duplicative of the issue which was transferred to case 17-1179GC.[10] The MAC cites prior Board decisions that these issues are considered the same issues.[11]

The MAC also argues that the Board should dismiss the portion of the Provider Specific issue pertaining to realignment because: (1) the decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election; and (2) the Provider has not exhausted all available remedies prior to requesting a PRRB appeal to resolve the issue.[12]

Issue 2 – DSH Medicaid Eligible Days

The MAC points out that for the DSH – Medicaid Eligible Days issue, the Provider cited adjustments 4 and 6 in the Audit Adjustment Report as the sources of dissatisfaction.[13]

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[9] Group Issue Statement, Case No. 17-1179GC.
[10] Jurisdictional Challenge at 2. (May 4, 2018).
[11] *Id*. at 8.
[12] *Id*.
[13] *Id*. at 5.

> The MAC contends that the revision adjustments the Provider cited deal solely with updating the SSI% in various parts of the cost report. None of the adjustments render a final determination with respect to the Medicaid ratio issues.
>
> The MAC made no adjustment to the revised cost report applicable to these issues.
>
> . . .
>
> Adjustment 4 and 6 were proposed to update the Medicare ratio (i.e., the DSH SSI ratio) for operating and capital DSH and the Allowable Disproportionate Share Percentage.[14]

<u>Provider's Response</u>:

The Provider ***untimely*** filed its Jurisdictional Response on June 14, 2018,[15] which argued that the Board has jurisdiction over the DSH/SSI issues which includes both the "provider specific" and realignment sub-issues.[16] The Provider asserted that it is "not only addressing a realignment of the SSI percentage, but also addressing the various errors of omission and commission that do not fit into the 'systemic errors' category"[17] and that the two appeal issues "represent different aspects/components of the SSI issue."[18] However, the Provider did not explain the basis for those assertions or provide any exhibits in support of those assertions.

On the Medicaid Eligible Days issue, the Provider argues that the MAC did adjust the Provider's DSH in Audit Adjustment Number 4, and said adjustment is enough to warrant Board Jurisdiction over this issue.[19] The Provider contends that the Board has jurisdiction pursuant to Board Rule 7.2(B) and under the provisions of 42 U.S.C. § 1395oo(a)(1)(B).[20] Further, the Provider argues that: (1) DSH Does Not Have to Be Adjusted, or Claimed in a Cost Report[21]; (2) The Board's Jurisdiction is Not Contingent upon Claiming Each Disputed Item in the Cost Report, i.e.: Presentment Requirement is not Valid[22]; and (3) Presentment Requirement Pursuant to Board Rule 7.2(C), Even if Valid, does not Apply in This Situation.[23]

<u>Board Analysis and Decision</u>:

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

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[14] *Id*.
[15] As previously noted, per Board Rule 44.4 (2015), the Providers response was due Monday, June 4, 2018.
[16] Provider's Jurisdictional Response at 1-2 (June 14, 2018).
[17] *Id*. at 2.
[18] *Id*.
[19] *Id*. at 3.
[20] *Id*.
[21] *Id*.
[22] *Id*. at 5.
[23] *Id*. at 6.

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 and Third 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. 17-1179GC, *QRS BSWH 2006 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. 17-1179GC. 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."[24] 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)."[25] 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."[26] The DSH systemic issues filed into Case No. 17-1179GC, 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 $58,000.

Thus, the Board finds that the first aspect of Issue 1 in this appeal is duplicative of the group issue in Case No. 17-1179GC, 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 17-1179GC. Further, any

[24] Individual Appeal Request, Issue 1.
[25] *Id.*
[26] *Id.*

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.[27] Provider is misplaced in referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) in its appeal request of how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 17-1179GC.

The Board also finds that the third aspect of Issue 1, the Provider arguing over the interpretation of "entitled to" and "eligible for" benefits for purposes of calculating the numerator of the SSI fraction is duplicative of the issue that the Provider transferred to Case No. 17-1179GC. In fact, the Provider included the same paragraph discussing this issue in both Issues 1 and 2:

> 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.

Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6 (Aug. 29, 2018), the Board dismisses this third aspect of the DSH/SSI (Provider Specific) issue.

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

> 25.2.2 Unavailable and Omitted Documents 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.

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

> Once the documents become available, promptly forward them to the Board and the opposing party. 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.[28]
> 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."[29]

Similarly, the Board notes that the Provider's discussion in the appeal request that CMS has inconsistently interpreted the term "entitled". However, this same assertion was made in the group appeal and is subject to the mandatory CIRP group regulations. Further, the Provider's response to the jurisdictional challenged makes bald assertions and provides no example or proof to establish that Issue 1 is separate and distinct from Issue 2 transferred to the CIRP group. In this regard, as discussed above, referencing Baystate does not support the Provider's position as the issues raised in *Baystate* were systemic issues (*i.e.*, *Baystate* dealt with the *process* that CMS used for data matching and addressed systemic issues with the process that generated errors or caused SSI paid days not to be identified).

[28] (Last accessed Nov. 21, 2022.)
[29] (Emphasis added.)

Accordingly, based on the record before it, the Board must find that Issues 1 and the group issue in Group Case 17-1179GC, are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH/SSI (Provider Specific) issue.

2. *Second Aspect of Issue 1*

The second aspect of the DSH SSI 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

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.[30]

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[.]" The Provider's appeal request has stated its RNPR appeal of Medicaid Days is Audit Adjustment No. 4 and 6. As explained above, Audit Adjustment No. 4 and 6 simply reflects the revision to the SSI percentage based on the remand of 08-2975GC and the DSH payment change, based on the SSI update. As such, it is clear that Audit Adjustments 4 and 6 did *not* adjust the Medicaid fraction (much less Medicaid eligible days) and the Provider had no right under 42 C.F.R. § 405.1889(b) (as referenced in § 405.1835(a)(1)) to appeal issue 7 from the RNPR since there was no specific adjustment on the RNPR for that issue. Based on the foregoing, the Board finds that it lacks jurisdiction over the Medicaid Eligible Days issue because it was not specifically revised in the RNPR which is the basis for the appeal.

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In summary, the Board hereby dismisses the SSI Provider Specific issue from this appeal as it is duplicative of the issue in Case No. 17-1179GC, there is no final determination from which the Provider can appeal the SSI realignment portion of the issue. The Board also dismisses the Medicaid eligible days issue as the issue was not specifically revised in the RNPR, which is the basis for the appeal. As no issues remain pending, the Board hereby closes Case No. 16-2205 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:

3/9/2023

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

cc: Wilson Leong, Federal Specialized Services

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[30] 42 C.F.R. § 405.1889(b).

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

James Taylor
Baptist St. Anthony's Health Sys.
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Bill Tisdale
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RE: ***Board Decision* – SSI Percentage (Provider Specific) and Medicaid Eligible Days**
Baptist St. Anthony's Hospital (Prov. No. 45-0231)
FYE 12/31/2006
Case No. 16-2245

Dear Mr. Taylor and Mr. Tisdale:

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the documentation in Case No. 16-2245 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. 16-2245

On February 12, 2016, the Provider was issued a ***Revised*** Notice of Program Reimbursement ("RNPR") for fiscal year end December 31, 2006. Audit adjustment 4 was proposed to W/S E, Part A to update the SSI percentage and the total DSH payment and stated "After adjustments, the SSI and DSH percentages will be properly stated". Audit Adj 6 adjusted W/S L and stated "After adjustments, the SSI and DSH percentages will be properly stated." No notice of reopening was included with the appeal request, to document the rational for the reopening, and no adjustments revised Medicaid Days on Worksheet S-3.

On August 15, 2016, the Board received the Provider's individual appeal request, from the RNPR. The RNPR appeal contained nine (9) issues:

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

[1] On May 1, 2017, this issue was transferred to PRRB Case No. 17-1423G.
[2] On May 1, 2017, this issue was transferred to PRRB Case No. 17-1424G which was closed on April 8, 2019.
[3] On May 1, 2017, this issue was transferred to PRRB Case No. 17-1426G which was closed on June 10, 2022.
[4] On May 1, 2017, this issue was transferred to PRRB Case No. 17-1425G which was closed on April 8, 2019.

6. DSH Payment – Medicaid Fraction/Dual Eligible Days[5]
7. DSH Payment – Medicaid Eligible Days
8. DSH Payment – Medicare Managed Care Part C Days[6]
9. DSH Payment – Dual Eligible Days[7]

As the Provider is commonly owned and subject to the mandatory common issue related part ("CIRP") group regulation at 42 C.F.R. § 405.1837(b)(1), the Provider transferred Issues 2, 3, 4, 5, 6, 8 and 9 to CIRP groups. As a result of these transfers, the issues remaining in this appeal are Issue 1 (the DSH Payment/SSI Percentage (Provider Specific) issue) and Issue 7 (the DSH Payment – Medicaid Eligible Days issue).

On May 4, 2018, the Medicare Administrative Contractor ("MAC") filed a Jurisdictional Challenge. The Provider did ***not*** file a response and, in this regard, the Board notes that Board Rule 44.4 (2015) states, in pertinent part: "The responding party must file a response within 30 days of the Intermediary's jurisdictional challenge. *Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record*."[8]

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 17-1423G

In their Individual Appeal Request, Provider summarizes its DSH/SSI – Provider Specific issue as follows:

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

[5] On May 1, 2017, this issue was transferred to PRRB Case No. 17-1427G which was closed on June 10, 2022.
[6] On May 1, 2017, this issue was transferred to PRRB Case No. 17-1425G which was closed on April 8, 2019 .
[7] On May 1, 2017, this issue was transferred to PRRB Case No. 17-1427G which was closed on June 10, 2022.
[8] (Emphasis added.)

> require Medicare Part A payment for days to be counted in the denominator. CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days of care) as Medicare Part A days, yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment.[9]

The amount in controversy listed for the DSH SSI Provider Specific issue by the provider in Case No. 16-2245 is $132,000.

The Provider was also directly added to the optional group under Case No. 17-1423G entitled "QRS 2006 DSH SSI Percentage Group #3". This optional group has the following issue statement:

> **<u>Statement of the Issue:</u>**
>
> Whether the Medicare/SSI fraction used in the Medicare Disproportionate Share Hospital and LIP payment calculations accurately and correctly counted the correct number of patient days to be included in the numerator and denominator of the Medicare/SSI fraction calculation per the Medicare Statute at 42 U.S.C. §1395ww(d)(5)(F)(vi)?
>
> **<u>Statement of the Legal Basis</u>**
>
> The Provider contends that the Lead MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww (d)(5)(F)(vi). The Provider contends that the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") and used by the Lead MAC to settle their Cost Report were incorrectly computed.
>
> The Providers also contend that CMS inconsistently interprets the term "entitled" as it is used in the statute. CMS requires SSI payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the denominator. CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days

[9] Issue Statement at 1. (Aug. 15, 2016).

> of care) as Medicare Part A days, yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment.
>
> The Provider further contends that the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") fail to address all the deficiencies as described in *Baystate Medical Center v. Michael O. Leavitt*, 545 F. Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37, 44 (D.D.C. 2008) and incorporate a new methodology inconsistent with the Medicare Statute.
>
> Providers in this case are also seeking resolution of the following additional aspects of the Medicare fraction that were 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. Covered days vs. Total days and
> 6. Failure to adhere to required notice and comment rulemaking procedures[10]

The amount in controversy listed for the Provider as a participant in 17-1423G is $132,000. This is the same amount that is listed as the amount in controversy for the Provider Specific issue in 16-2245.

MAC's Contentions:

Issue 1 – DSH SSI Percentage (Provider Specific)

The MAC argued that the Board lacks jurisdiction over the DSH/SSI Percentage - Provider Specific issue because it is duplicative of the issue which was transferred to case 17-1423G.[11] The MAC cites prior Board decisions that these issues are considered the same issues.[12]

The MAC also argues that the Board should dismiss the portion of the Provider Specific issue pertaining to realignment because: (1) the decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election; and (2) the Provider has not exhausted all available remedies prior to requesting a PRRB appeal to resolve the issue.[13]

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[10] Group Issue Statement, Case No. 17-1423G.
[11] Jurisdictional Challenge at 2. (May 4, 2018).
[12] *Id*. at 8.
[13] *Id*.

Issue 2 – DSH Medicaid Eligible Days

The MAC points out that for the DSH – Medicaid Eligible Days issue, the Provider cited adjustments 4 and 6 in the Audit Adjustment Report as the sources of dissatisfaction.[14]

> The MAC contends that the revision adjustments the Provider cited deal solely with updating the SSI% in various parts of the cost report. None of the adjustments render a final determination with respect to the Medicaid ratio issues.
>
> The MAC made no adjustment to the revised cost report applicable to these issues.
>
> . . .
>
> Adjustment 4 and 6 were proposed to update the Medicare ratio (i.e., the DSH SSI ratio) for operating and capital DSH and the Allowable Disproportionate Share Percentage.[15]

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.[16] The Provider has not filed a response in this case and the time for doing so is long overdue. Accordingly, per Board Rule 44.4 (2015), the Board must base its determination on the record before it.

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.

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[14] *Id*. at 5.
[15] *Id*.
[16] Board Rule 44.4.3, v. 1.3. (July 2015).

1. First and third 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. 17-1423G, *QRS 2006 DSH SSI Percentage Group #3*.

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. 17-1423G. 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."[17] 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)."[18] 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."[19] The DSH systemic issues filed into Case No. 17-1423G, 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 $132,000.

Thus, the Board finds that the first aspect of Issue 1 in this appeal is duplicative of the group issue in Case No. 17-1423G, 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 17-1423G. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[20] 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

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

from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 17-1423G.

The Board also finds that the third aspect of Issue 1, the Provider arguing over the interpretation of "entitled to" and "eligible for" benefits for purposes of calculating the numerator of the SSI fraction is duplicative of the issue that the Provider transferred to Case No. 17-1423G. In fact, the Provider included the same paragraph discussing this issue in both Issues 1 and 2:

> 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.

Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6 (Aug. 29, 2018), the Board dismisses this third aspect of the DSH/SSI (Provider Specific) issue.

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

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

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

> https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH.[21]
> 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."[22]

Accordingly, based on the record before it,[23] the Board must find that Issues 1 and the group issue in Group Case 17-1423GC, are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH/SSI (Provider Specific) issue.

2. *Second Aspect of Issue 1*

The second aspect of the DSH SSI 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

[21] (Last accessed Nov. 21, 2022.)
[22] (Emphasis added.)
[23] Again the Board notes that the Provider failed to respond to the jurisdictional challenge and, as a result, per Board Rule 44.4 (2015), the Board must make a jurisdictional determination based on the record before it.

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

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.[24]

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[.]" The Provider's appeal request has stated its RNPR appeal of Medicaid Days is Audit Adjustment No. 4 and 6. As explained above, Audit Adjustment No. 4 and 6 simply reflects the revision to the SSI percentage and the DSH payment change, based on the SSI update. As such, it is clear that Audit Adjustments 4 and 6 did not adjust the Medicaid fraction, much less Medicaid eligible days, and therefore the Provider had no right under 42 C.F.R. § 405.1889(b) (as referenced in § 405.1835(a)(1)) to appeal issue 7 from the RNPR since there was no specific adjustment on the RNPR for that issue. Based on the foregoing, the Board finds that it lacks jurisdiction over the

[24] 42 C.F.R. § 405.1889(b).

Medicaid Eligible Days issue because it was not specifically revised in the RNPR which is the basis for the appeal.

****

In summary, the Board hereby dismisses the SSI Provider Specific issue from this appeal as it is duplicative of the issue in Case No. 17-1423GC, there is no final determination from which the Provider can appeal the SSI realignment portion of the issue. The Board also dismisses the Medicaid eligible days issue as the issue was not specifically revised in the RNPR, which is the basis for the appeal. As no issues remain pending, the Board hereby closes Case No. 16-2245 and removes it from the Board's docket.

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

Board Members Participating:

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

For the Board:

3/9/2023

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

cc: Wilson Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

James Ravindran
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RE: ***Board Decision* – SSI Percentage (Provider Specific)**
Weatherford Regional Medical Center (Provider Number 45-0203)
FYE: 10/31/2015
Case Number: 19-0652

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. 19-0652*

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

On November 29, 2018, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained five (5) issues:

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

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

[1] On June 14, 2019, this issue was transferred to PRRB Case No. 18-0552GC.
[2] The Provider withdrew this issue on January 13, 2023.
[3] On June 14, 2019, this issue was transferred to PRRB Case No. 18-0555GC.
[4] On June 14, 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 – Provider Specific issue as follows:

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

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
> 2. Failure to adhere to required notice and comment rulemaking procedures

---

[5] Issue Statement at 1 (Nov. 29, 2018).

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 to the CIRP group under Case Number 18-0552GC, *QRS CHS 2015 DSH SSI Percentage CIRP Group*, on June 14, 2019. The Group Issue Statement for that case is identical to the DSH/SSI issue in case 19-0652.

MAC's Contentions:

The Medicare Contractor filed a Jurisdictional Challenge on May 30, 2018 arguing the DSH Provider Specific and DSH/SSI issues are identical. It also noted that Issue 2 – DSH/SSI was transferred to group case 18-0552GC. Since the issues are identical the Medicare Contractor requests that the Board dismiss the DSH Provider Specific Issue.

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 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 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 concerns "whether the Medicare Administrative Contractor used the correct [SSI] percentage in the [DSH]

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[6] *Id.* at Issue 2.
[7] Board Rule 44.4, v. 1.3. (July 2015).

Calculation."[8] 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)."[9] 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."[10] 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).

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. 18-0552GC. 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.[11] 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.

Accordingly, the Board must find that the first aspect of issue 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 4.5 (2015), the Board dismisses this component of the DSH/SSI (Provider Specific) issue.

2. *Second Aspect of Issue 1*

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

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

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 will close and be 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.

f

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For the Board:

3/9/2023

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 (Provider Specific) and Medicaid Eligible Days**
St. Luke's Hospital of Kansas City (Prov. No. 26-0138)
FYE 12/31/2017
Case No. 21-1728

Dear Mr. Ravindran and Mr. Lamprecht:

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the documentation in Case No. 21-1728 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. 21-1728

On September 14, 2021, St. Luke's Hospital of Kansas City, appealed a Notice of Program Reimbursement ("NPR") dated July 12, 2021, for its fiscal year ending December 31, 2017 ("FY 2017"). The Provider appealed the following 2 issues:[1]

- **Issue 1** – Disproportionate Share Hospital (DSH) – Supplemental Security Income (SSI) Percentage (Provider Specific)
- **Issue 2** – DSH – Medicaid Eligible Days

On August 24, 2022, the Medicare Contractor filed a Jurisdictional Challenge regarding ***both*** Issues 1 and 2, addressing the DSH Supplemental Security Income ("SSI") Percentage related issue and the DSH Medicaid Eligible Days issue.[2] 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."

[1] Provider's Request for Hearing, Issue Statement (Sep. 14, 2021).
[2] MAC Jurisdictional Challenge, at 1 (Aug. 24, 2022).

Significantly, the Provider is commonly owned by the St. Luke's Health System ("SLHS"). As a result, the Provider is subject to the mandatory common issue relate party ("CIRP") group regulations at 42 C.F.R. § 405.1837(b)(1). To this end, the Provider also directly added certain 2017 issues common to SLHS providers to SLHS CY 2017 CIRP groups.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 21-1466GC

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

> The Provider contends that the MAC did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the MAC's calculation of how the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations.
>
> The provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both 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.[3]

As the Provider is commonly owned by St. Luke's Health System, the Provider was also directly added to the common issue related party ("CIRP") group under Case No. 21-1466GC entitled "St. Luke's Health CY 2017 DSH SSI Percentage CIRP Group." This CIRP group has the following issue statement:

> **<u>Statement of the Issue:</u>**
>
> 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

[3] Provider's Request for Hearing, Issue Statement.

> 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?
>
> **<u>Statement of the Legal Basis</u>**
>
> 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.[4]

The amount in controversy listed for the Provider as a participant in Case No. 21-1466GC is $169,381.

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:

> **<u>Calculation of the SSI Percentage</u>**
>
> **Provider Specific**
>
> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation based on the Provider's Fiscal Year End (December 31).
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.

[4] Group Issue Statement, Case No. 21-1466GC.

> 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).[5]

The only exhibit included with the preliminary position paper that relates to Issue 1 was Exhibit 1, which shows that the amount in controversy for the issue is $169,381. This is the ***same*** amount that is listed as the amount in controversy for this Provider as a participant in Case No. 21-1466GC.

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. 21-1466GC, *St. Luke's Health CY 2017 DSH SSI Percentage CIRP Group*.[6] 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.[7]

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.

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, which the Provider did not do with respect to the Medicaid eligible days issue.[8]

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[5] Provider's Preliminary Position Paper at 8 (May 14, 2022).
[6] Group Issue Statement, Case No. 21-1466GC.
[7] *Id*.
[8] *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. 21-1466GC, *St. Luke's 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 directly filed into Case No. 21-1466GC. 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] The DSH systemic issues filed into Case No. 21-1466GC, similarly alleges that the Medicare Contractor and CMS improperly

[9] Individual Appeal Request, Issue 1.
[10] *Id.*
[11] *Id.*

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 $169,381.

Thus, the Board finds that the first aspect of Issue 1 in this appeal is duplicative of the group issue in Case No. 21-1466GC, 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 21-1466GC. 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] Provider is misplaced in referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) in its appeal request of how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 21-1466GC.

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. 21-1466GC, 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;

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

> 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.[13] 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."[14]

Similarly, QRS has generically asserted that "the SSI entitlement of individuals can be ascertained from State records" but has failed to explain what those State records are for the specific year at issue (i.e., FY 2017), how they actually ***do*** establish SSI entitlement, or how those records are relevant to the *provider specific* issue. In this regard, the Board notes that the Provider is not located in California where *Loma Linda* was and, as such, involves a different State record system. Finally, the Provider fails to establish how the state information is other wise provider-specific and not a issue common to other SLHS providers, particularly those in the

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[13] (Last accessed Nov. 21, 2022.)
[14] (Emphasis added.)

same State. All of this information should have been part of the position paper filing consistent with 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rule 25.

Accordingly, based on the record before it,[15] the Board must find that Issues 1 and the group issue in Group Case 21-1466GC, 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 2 as:

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

[15] The Board again notes that the Provider failed to respond to the Jurisdictional Challenge. As noted in Board Rule 44.4.3: "Failure to respond will result in the Board making a jurisdictional determination *with the information contained in the record*." (Emphasis added.)

> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.[16]

The amount in controversy calculation and protested item documentation for this issue suggests that there are 1,272 Medicaid eligible days at issue. However, 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 May 14, 2022, the Provider filed their preliminary position paper in which it indicated that it would be sending the eligibility listing under separate cover.[17] Indeed, the position paper did not even identify how many Medicaid eligible days remained in dispute in this case (*e.g.*, whether there remained 1,272 as suggested in the appeal request or more or less). Specifically, the Provider's complete briefing of this issue in its position paper is as follows:

> **<u>Calculation of Medicaid Eligible Days</u>**
>
> 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:

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[16] *Id*.
[17] Provider's Preliminary Position Paper at 8.

> > [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*] 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.[18]

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 $87,737, 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]

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[18] *Id*. at 7-8.

[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.

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

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. *Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board through a schedule applicable to a specific case or through general instructions*.[20]

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

> If the provider, through no fault of its own, does not have access to the underlying information to determine whether the adjustment is correct, describe why the underlying information is unavailable.

Similarly, with regard to position papers,[21] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[22] This requirement is consistent with 42 C.F.R. § 405.1853(b)(3).

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.

[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.)

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

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

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

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

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

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

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

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, since no specific days were

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

identified as being in dispute with the position paper filing, the Board must assume that there are no days at issue and that the actual amount in controversy is $0.

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]

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In summary, the Board hereby dismisses the SSI Provider Specific issue from this appeal as it is duplicative of the issue in Case No. 21-1466GC, 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. 21-1728 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:

3/9/2023

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

cc: Wilson Leong, Federal Specialized Services

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[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

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RE: ***Board Decision* – SSI Percentage (Provider Specific) and Medicaid Eligible Days**
Saint Luke's Cushing Hospital (Prov. No. 17-0133)
FYE 12/31/2017
Case No. 22-0001

Dear Messrs. Ravindran and Lamprecht:

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the documentation in Case No. 22-0001 pursuant to a jurisdictional challenge filed by the Medicare Contractor ("MAC"). The Board's decision is set forth below.

Background

A. Procedural History for Case No. 22-0001

On October 1, 2021, Saint Luke's Cushing Hospital appealed a Notice of Program Reimbursement (NPR) dated April 7, 2021, for its fiscal year dating December 31, 2017 ("FY 2017"). The Provider appealed the following issues:[1]

- **Issue 1:** Disproportionate Share Hospital (DSH) Payment/Supplemental Security Income (SSI) Percentage (Provider Specific)
- **Issue 2:** DSH Medicaid Eligible Days
- **Issue 3:** DSH SSI Fraction Dual Eligible Days[2]
- **Issue 4:** DSH Medicaid Fraction Dual Eligible Days[3]

As the Provider is commonly owned and, thereby, subject to the mandatory common issue related party ("CIRP") group regulation at 42 C.F.R. § 405.1837(b)(1), the Provider transferred Issues 3 and 4 to the CIRP group under Case No. 21-1468GC on May 10, 2022. After those

[1] Provider's Request for Hearing, Tab 3, at Issue Statement (Oct. 1, 2021).
[2] The Provider transferred this issue to Group Case No. 21-1468GC on 05/10/2022.
[3] The Provider transferred this issue to Group Case No. 21-1468GC on 05/10/2022.

transfers, only two issues remain: Issue 1 (the DSH SSI Percentage (Provider Specific) issue) and Issue 2 (DSH Medicaid Eligible Days issue).[4]

ON May 31, 2022, the Provider filed its preliminary position paper.

On June 29, 2022, the Medicare Contractor filed a discover request that the Provider furnish a listing of the Medicaid eligible days at issue in this case and asked that the Provider respond within 45 days. Significantly, the Provider did ***not*** file a response.

On August 23, 2022, the Medicare Contractor filed a Jurisdictional Challenge regarding Issues 1 and 2, addressing the DSH Supplemental Security Income ("SSI") Percentage related issue and the DSH Medicaid Eligible Days issue.[5]

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. 21-1466GC

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

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

[4] MAC's Jurisdictional Challenge, at 1 (Aug. 23, 2022).
[5] *Id*.

> also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[6]

As the Provider is commonly owned by St. Luke's Health System, the Provider was also directly added to the CIRP group under Case No. 21-1466GC entitled "St. Luke's 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. 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.[7]

The amount in controversy listed for the Provider as a participant in Case No. 21-1466GC is $4,777.

On May 31, 2022, the Provider filed its preliminary position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

[6] Provider's Request for Hearing, Issue Statement (Oct. 1, 2021).
[7] Group Issue Statement, Case No. 21-1466GC.

> **<u>Calculation of the SSI Percentage</u>**
>
> **Provider Specific**
>
> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation based on the Provider's Fiscal Year End (December 31).
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.
>
> Similar to *Loma Linda Community Hospital v. Dept of Health* and Human Services, No. 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).

The only exhibit included with the preliminary position paper that relates to Issue 1 was Exhibit 1, which was listed as an Eligibility Listing, but noted that it would be sent under separate cover. Exhibit 2 shows the amount in controversy as $4,777. This is the ***same*** amount that is listed as the amount in controversy for this Provider as a participant in Case No. 21-1466GC.

<u>MAC's Contentions</u>

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. 21-1466GC, *St. Luke's Health CY 2017 DSH SSI Percentage CIRP Group*. The Portion of Issue 1 concerning realignment should be dismissed because there was no final determination over SSI realignment and the Provider's appeal is premature as the Provider has not exhausted all available remedies.[8]

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[8] *Id*.

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.

Issue 2 – DSH Medicaid Eligible Days

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.

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 (2014), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

A. 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 Group Case No. 21-1466GC, *St. Luke's 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 directly filed into Case No. 21-1466GC. 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] The DSH systemic issues filed into Case No. 21-1466GC, 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 $4,777.

Thus, the Board finds that the first aspect of Issue 1 in this appeal is duplicative of the group issue in Case No. 21-1466GC, for this same provider and fiscal year. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (Mar. 1, 2013), the Board dismisses this aspect of the DSH/SSI (Provider Specific) issue.

In making this finding, the Board further notes that CMS regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, is pursuing that issue as part of the group under Case 21-1466GC. 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] Provider is misplaced in referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 21-1466GC.

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. 21-1466GC, 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

[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 may the errors any less systemic. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). *See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).

and explain the nature of the any alleged "errors" in its Preliminary Position Paper and include *all* exhibits.

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

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

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

> https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH.[13]
> This CMS webpage describes access to DSH data ***from 1998 to***

[13] (Last accessed Mar. 7, 2023).

> ***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."[14]

Finally, the Board notes that the Provider failed to respond to the jurisdictional challenge to explain how the alleged provider specific issue is different than the systemic issue it directly added to the CIRP group.

Accordingly, based on the record before it,[15] the Board must find that Issues 1 and the group issue in Group Case 21-1466GC, are the same issue and that the Provider has failed to develop its case to distinguish the issues in its position paper as required by 42 C.F.R. § 405.1853(a)-(b) and Board Rule 25. 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 2 as:

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

[14] (Emphasis added.)
[15] Again, the Board notes that, per Board Rule 44.4 (2015), when a provider fails to respond to a jurisdictional challenge, the Board must base its findings on the record before it.

> 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.[16]

The amount in controversy calculation and protested item documentation for this issue suggests that there are 123 Medicaid eligible days at issue. However, 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 May 31, 2022, the Provider filed their preliminary position paper in which it indicated that it would be sending the eligibility listing under separate cover.[17] Indeed, the position paper did not even identify how many Medicaid eligible days remained in dispute in this case (*e.g.*, whether there remained 123 as suggested in the appeal request or more or less). Specifically, the Provider's complete briefing of this issue in its position paper is as follows:

> **<u>Calculation of Medicaid Eligible Days</u>**
>
> 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).

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[16] *Id.*
[17] Provider's Preliminary Position Paper at 8 (May 31, 2022).

> The Centers for Medicare and Medicaid Services ("CMS", formerly HCFA) acquiesced in the above decisions and issued HCFA Ruling 97-2, which in pertinent part reads as follows:
>
> > [T]he Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to include all inpatient hospital days of service for patients who were eligible on that day for medical assistance under a state Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for these inpatient hospital services.
>
> Based on the Listing of Medicaid Eligible Days being sent under separate cover, the Provider contends that the total number of days reflected in its' [*sic*] 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.

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 $18,972, 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.[18]

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*.[19]

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,[20] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[21] 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:

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[18] *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.

[19] (Emphasis added.)

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

[21] (Emphasis added.)

> 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.[22]

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

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

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, since no specific days are identified in the position paper filing, the Board must find that no days are in dispute and that the actual amount in controversy for this issue is $0.

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.[24] 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.[25]

****

In summary, the Board hereby dismisses the SSI Provider Specific issue from this appeal as it is duplicative of the issue in Case No. 21-1466GC, 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. 22-0001 and removes it from the Board's docket.

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

Board Members Participating:

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

For the Board:

3/9/2023

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

cc: Wilson Leong, Federal Specialized Services

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[24] 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.
[25] Examples of cases in which QRS was the designated representative and which the Board dismissed for failure of the Provider to provide a listing of Medicaid eligible days at issue include, but are not limited to: Case No. 14-2674 (by 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

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RE: ***Board Decision* – SSI Percentage (Provider Specific)**
Merit Health River Oaks (Provider Number 25-0138)
FYE: 09/30/2017
Case Number: 20-0530

Dear Messrs. Ravindran and Lamprecht,

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

Background:

A. *Procedural History for Case No. 20-0530*

On July 3, 2019, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end September 30, 2017. On December 9, 2019, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained nine (9) issues:

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

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[1] On July 20, 2020, this issue was transferred to PRRB Case No. 20-1332GC.
[2] On July 20, 2020, this issue was transferred to PRRB Case No. 20-1333GC.
[3] On July 20, 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 February 20, 2023.
[5] On July 20, 2020, this issue was transferred to PRRB Case No. 20-1335GC.
[6] On July 20, 2020, this issue was transferred to PRRB Case No. 20-1336GC.
[7] The Provider withdrew this issue on April 30, 2021.

9. 2 Midnight Census IPPS Payment Reduction[8]

The remaining issue is the SSI Percentage (Provider Specific) issue.

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

In their Individual Appeal Request, Provider summarizes its DSH/SSI – Provider Specific issue as follows:

> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> . . .
>
> The Provider 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 was transferred to PRRB Group Case No. 20-1332GC, "*CHS CY 2017 HMA DSH SSI Percentage CIRP Group.*" The Provider is appealing from the same final determination as in the instant appeal. In the Group Appeal, the SSI Percentage issue is described as "[w]hether the Secretary properly calculated the Provider's [DSH/SSI] percentage."[10] More specifically, Provider lists the following reasons for challenging its SSI percentage:

1. Availability of MEDPAR and SSA records,
2. Paid days vs Eligible days,
3. Not in agreement with provider's records,
4. Fundamentals problems in the SSI percentage calculation,
5. Covered days vs Total days, and
6. Failure to adhere to required notice and comment rulemaking procedures.[11]

On July 29, 2020, the Provider filed its preliminary position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

Provider Specific

[8] On July 20, 2020, this issue was transferred to PRRB Case No. 20-1337GC.
[9] Issue Statement at 1 (July 21, 2021).
[10] PRRB Case No. 20-1332GC, Issue Statement at 1 (March 4, 2020).
[11] *Id*.

> The Provider contends that its' [sic] SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation. This is based on certain data from the State of Mississippi and the Provider does not support the SSI percentage issued by CMS.
>
> The Provider has worked with the State of Mississippi and has learned that similar to *Loma Linda Community Hospital v. Dept of Health and Human Services*, No. CV-94-0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records.
>
> The Provider is seeking the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR"), HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000, from CMS in order to reconcile its record with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. *See* 65 Fed. Reg. 50,548 (2000). The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction.

The 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 $19,110. This is the same amount that is listed as the amount in controversy for this Provider as a participant in 20-1332GC.

<u>MAC's Contentions:</u>

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

> The decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election. It is not a fiscal intermediary determination. A hospital must make a formal request to CMS in order to receive a realigned SSI percentage. Once the hospital elects to use its own fiscal year end, it is bound by that decision, regardless of reimbursement impact.
>
> . . .

> The Provider's appeal of this item is premature. The Provider has not formally requested to have its SSI percentage realigned in accordance with 42 C.F.R. § 412.106(b)(3). The Provider has not exhausted all available remedies for this issue.[12]

In addition, the MAC argues that the DSH SSI Percentage - Provider Specific issue and the DSH SSI Percentage - Systemic Errors issue are considered the same issue by the Board, and cites several past Board decisions to that end.[13]

Lastly, the MAC contends 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.[14]

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.[15] 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.[16] Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

Board Analysis and Decision:

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

The Board finds that it does not have jurisdiction over the DSH/SSI Percentage - Provider Specific issue. The jurisdictional analysis for Issue No. 1 has two relevant aspects to consider: 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*

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[12] Jurisdictional Challenge at 7 (Oct. 15, 2020).
[13] *Id*. at 4-6.
[14] *Id*. at 6-7.
[15] Board Rule 44.4.3, v. 2. (Aug. 2018).
[16] 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/SSI Percentage - Provider Specific issue in the present appeal concerns "[w]hether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation."[17] The Provider's legal basis for its DSH/SSI - Provider Specific issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[18] The Provider argues that "its SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[19]

The Provider's DSH SSI Percentage - Systemic Errors issue in group Case No. 20-1332GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F).

In making this finding, the Board further notes that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, the Provider is pursuing that issue as part of the group under Case 20-1332GC. 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.[20] 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. 20-1332GC.

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 20-1332GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with the Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" in its Preliminary Position Paper and include *all* exhibits.

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[17] Issue Statement at 1.
[18] *Id.*
[19] *Id.*
[20] 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.

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.[21]
> This CMS webpage describes access to DSH data ***from 1998 to***

[21] Last accessed February 24, 2023.

> ***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."[22]

Accordingly, the Board must find that the remaining issue in the instant appeal and the group issue from 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, the Board dismisses this component of the DSH/SSI - Provider Specific issue.

2. *Second Aspect of Issue 1*

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

The Board finds that, under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." Without this written request, the Medicare Contractor cannot issue a final determination from which the Provider can be dissatisfied with for appealing purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding DSH SSI Percentage realignment. Therefore, the Board dismisses this aspect of the Issue. Further, the Board notes that the Provider's cost reporting year ends on 9/30, which is consistent with the federal fiscal year, and rendering any realignment of the SSI Percentage moot.

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In summary, the Board hereby dismisses the SSI Percentage (Provider Specific) issue from this appeal as it is duplicative of the issue in Case No. 20-1332GC and there is no final determination from which the Provider can appeal the SSI realignment portion of the issue. As no issues remain pending, the Board hereby closes Case No. 20-0530 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.

[22] Emphasis added.

Board Members Participating:

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

For the Board:

3/13/2023

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Board Decision – SSI Percentage (Provider Specific) and Medicaid Eligible Days***
Springs Memorial Hospital (Prov. No. 42-0036)
FYE 11/30/2015
Case No. 19-0671

Dear Messrs. Ravindran and Lamprecht,

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

Background:

A. *Procedural History for Case No. 19-0671*

Springs Memorial Hospital appealed a Notice of Program Reimbursement ("NPR") dated June 13, 2018, for fiscal year end November 30, 2015. On December 6, 2018, the Provider filed an individual appeal request which contained the following five (5) issues:

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

As the Provider is part of Community Health Systems, Inc. ("CHS") and is subject to the mandatory common issue related party ("CIRP") group regulation at 42 C.F.R. § 405.1837(b)(1), the Provider transferred Issues 2 through 5 to CIRP groups for CHS. The DSH – SSI Percentage (Provider Specific) and DSH – Medicaid Eligible Days issue remain in the appeal.

Pursuant to the Acknowledgement and Critical Due Dates Notice issued on January 15, 2019, the Provider's preliminary position paper was due August 3, 2019 and the Medicare Contactor's preliminary position paper was due December 1, 2019. Effective August 29, 2018, the Board

[1] On July 19, 2019, this issue was transferred to PRRB Case No. 18-0552GC.
[2] On July 19, 2019, this issue was transferred to PRRB Case No. 18-0555GC.
[3] On July 19, 2019, this issue was transferred to PRRB Case No. 18-0554GC.

revised Board Rule 25 to require that providers are now required to file the *complete* preliminary position paper for those appeals filed on or after August 29, 2018. In this regard, the Commentary to Board Rule 23 (Aug. 29, 2018) states:

> [P]arties are now required to file the ***complete*** preliminary position paper with the narrative, listing of exhibits, and all exhibits. As the Board will now obtain a full copy of the preliminary position paper, which is required to have the fully developed position and identification of the controlling authority needed to support each issue in the appeal, final position papers will be optional for new appeals filed on or after the effective date of the rules. Final position papers are still mandatory for all appeals that were filed prior to that date.[4]

On January 17, 2019, the Board issued a Board Alert to all external users and stakeholders regarding the change in the Board rules, both by email blast as well as an alert posted on the "Current Alerts" section of the Board's website. This Alert highlighted specific important changes including the requirement that a ***complete*** preliminary position paper be filed: *"*[r]equire the filing of the ***full*** preliminary position paper to both the opposing party and the Board (currently the preliminary position paper is only filed on the opposing party with only a cover letter to the Board)."[5]

Consistent with these revisions, on July 31, 2019, the Provider filed its ***complete*** preliminary position paper (*i.e.*, not just the cover page as previously required but rather filed a full copy of the position paper with any exhibits). With respect to the Medicaid eligible days issue, the position paper did not state how many days are in dispute nor include a listing of the days in dispute. Rather, it promised that the Medicaid eligible days listing was "being sent under separate cover."

On November 25, 2019, the Medicare Contractor filed its complete preliminary position paper with exhibits. With regard to Issue 3 (Medicaid eligible days), the Medicare Contractor noted that the FY 2015 NPR at issue was based on the Provider's second amended cost report filed on December 11, 2017 which was more than 25 months *after* the end of FY 2015) and, as a result, the Medicare Contactor was "unaware of any impediments preventing the provider from gathering Medicaid data prior to the filing of its cost report or at any time prior to the audit of its cost report." Moreover, the Medicare Contractor noted that the Provider failed to include a Medicaid eligibility listing with the copy of the preliminary position paper furnished to it (apparently the Provider furnished a compete copy of its position paper to the Medicare Contractor) but rather stated that "ELIGIBILITY LISTING NOT INCLUDED – BEING SENT UNDER SEPARTE COVER." Accordingly, the Medicare Contractor attached as Exhibit 2 to its position paper a request that the Provider submit a listing of the Medicaid eligible days at issue within 45 days.

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[4] Provider Reimbursement Review Board Rules, Commentary to Rule 23 (Aug. 29, 2018) (emphasis added).
[5] ALERT 15: Revised PRRB Rules (August 29, 2018) (emphasis added), Current Alerts, PRRB Review (last visited Jan. 17, 2019), https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/PRRB-Alerts.html.

On April 11, 2019 and November 14, 2022, the Medicare Contractor filed Jurisdictional Challenges in this appeal. The Provider filed timely responses to these challenges on May 8, 2019 and December 14, 2022 respectively.

Last, on December 28, 2022 the Medicare Contractor filed a Dismissal Request and Response to the Provider's December 2022 jurisdictional response. The Provider did *not* file a response to the Motion to Dismiss. Per Board Rule 44.3, the Provider's response was due on Friday, January 27, 2023 (*i.e.*, within 30 days).

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

In their Individual Appeal Request, Provider summarizes its DSH/SSI – Provider Specific issue as follows:

> [T]he MAC did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. §1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations.[6]

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.[7] The amount in controversy was listed as $28,000.[8]

In the SSI percentage issue in CIRP group Case No. 18-0552GC, to which this Provider transferred, the Providers assert that:
In the SSI percentage issue in CIRP group case 20-0997GC, 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) contend(s) that the SSI percentages calculated by the [CMS] and used by the Lead MAC to settle their Cost Reports were incorrectly computed.

***

[6] Provider's Request for Hearing, Issue 1 Issue Statement (Dec. 6, 2018).
[7] *Id.*
[8] *Id.*

> The Provider(s) further contends(s) that the SSI percentages calculated by [CMS] fail to address all the deficiencies as described in *Baystate Medical Center v. Michael O. Leavitt*, 545 F. Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37, 44 (D.D.C. 2008) and incorporate a new methodology inconsistent with the Medicare Statute.
>
> Providers in this case are also seeking resolution of the following additional aspects of the Medicare fraction that were not addressed in the Baystate case:
>
> 1. Availability of MEDPAR and SSA records
> 2. Failure to adhere to required notice and comment rulemaking procedures
> 3. Fundamental problems in the SSI percentage calculation
> 4. Not in agreement with provider's records
> 5. Paid days vs. Eligible days, and
> 6. Covered days vs. Total days.[9]

The amount in controversy for the Provider in Case No18-0552GC is $28,000 the same amount as Issue #1 in the Provider's individual appeal.

On July 31, 2019, the Provider filed its preliminary position paper ("PPP"). The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **<u>Calculation of the SSI Percentage</u>**
>
> **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 SI benefits in their calculation based on the Provider's Fiscal Year End (November 30).
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.
>
> Similar to *Loma Linda Community Hospital v. Dept. of Health and Human Services*, No. CV -94-0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from 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

[9] Group Issue Statement, Case No. 18-0552GC (Jan. 18, 2018).

> ("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).

The only exhibit included with the Provider's PPP that relates to Issue 1 was Exhibit 2, which shows that the amount in controversy for the issue is $28,005. This is the ***same*** amount that is listed as the amount in controversy for this Provider as a participant in the CIRP group under Case No. 18-0552GC.

MAC's November 14, 2022 Jurisdictional Challenge:

Issue 1 – DSH SSI Percentage (Provider Specific)

The MAC argues that the Board lacks jurisdiction over the DHS SSI% - Provider Specific issue for three reasons. First, the MAC argues that the appeal is premature:

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

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.[11]

Issue 3 – Medicaid Eligible Days

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

[10] Jurisdictional Challenge #1 at 7 (Apr. 11, 2019).
[11] *Id*. at 5-7.

> The MAC contends that the Provider was in violation of Board Rule 25.3 when they failed to sufficiently develop and set forth the relevant facts and arguments regarding the merits of its claim in its preliminary position paper. Moreover, the Provider neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2. Accordingly, the DSH – Medicaid Eligible Days issue should be dismissed. . .
>
> Within their preliminary position paper, the Provider makes the broad allegation, "[t]he Provider contends that the total number of days reflected in its' . . . cost report does not reflect an accurate number of Medicaid eligible days. . ." The Provider has failed to include any evidence to establish the material facts in this case relating to inaccuracies in the Medicaid Percentage calculation at issue. The Provider merely repeats its appeal request.[12]

Provider's December 14, 2022 Jurisdictional Response

Issue 1 – DSH SSI Percentage (Provider Specific)

The Provider argues that the issues are not duplicative because "issues #1 and 2 represent different components of the SSI issue, which was specifically adjusted during the audit."[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 Providers SSI percentage and the Provider is dissatisfied with the amount of DSH payments that it received for fiscal year 2015, as a result of its understated SSI percentage due to errors of omission and commission."[15]

Issue 5 – Medicaid Eligible Days

The Provider argues that it did not abandon the Medicaid eligible days issue by not including supporting documentation, *i.e.*, a listing of the additional Medicaid eligible days in dispute. The Provider asserts that the Medicare Contractor was incorrect in relying on Board Rules Version 2.0 dated August 29, 2019 because its appeal was filed prior to the effective date of those rule (i.e., prior to August 29, 2018) and "[f]or appeals filed prior to the effective date of the rules, the final position paper remains a required filing, and failure to timely file the final position papers

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[12] Jurisdictional Challenge #2 at 4 (Nov. 14, 2022).
[13] Jurisdictional Response #1 at 1 (May 7, 2019).
[14] *Id*. at 2.
[15] *Id*.

ay result in dismissal of the case, or any of the actions under 42 C.F.R. § 405.1868." Accordingly, the Provider's position is that the due date for the listing of additional Medicaid eligible days was the Final Position Paper deadline.[16] The Provider goes on to argue that

> The MAC entirely overlooks that the [CMS] has recognized that "practical impediments" frequently impede a provider's ability to obtain the necessary support claiming additional Medicaid eligible days.
>
> . . .
>
> These impediments are related to the State eligibility matching being unavailable at this time due to a change in the State's matching vendor changes. Concurrent with this letter to the Board the Providers are sending to the MAC the listing of additional Medicaid eligible days for providers not impacted by practical impediment.[17]

The Provider goes on to contend that they have provided the MAC with a listing of the additional Medicaid eligible days being sought and, thereby, "have cured the sole defect on which the MAC relies, and the Board should deny the MAC's motion to dismiss."[18] In addition, the Provider asserts that it filed a redacted version of this listing with the Board. However, *contrary to the Provider's assertion*, ***no such listing*** was, in fact, filed either as an exhibit to its response or as a separate filing.

MAC's December 28, 2022 Request for Dismissal:

On December 28, 2022, FSS, on behalf of the MAC, filed a Request for Dismissal in response to the Provider's response to the Jurisdictional Challenge. The Provider first argued that it had the reasonable expectation that it had until the submission of its Final Position Paper to submit the listing of additional Medicaid eligible days. The MAC explains that this appeal was filed *after* the August 29, 2018 effective date of Version 2.0 of the Board Rules, which requires that the Provider file its *complete* preliminary position paper, including any exhibits, etc.[19] Accordingly, the MAC maintains that the Provider in incorrect in arguing that Board Rule 27.1 somehow permits the filing of an *incomplete* preliminary position paper. In support of its position, the MAC cites to the Commentary to Board Rule 23 which makes clear that providers are to file the complete preliminary position paper, including exhibits.

The Provider next argued that its operations were also disrupted by the COVID pandemic and stated, "Indeed, the Providers faced, and continue to face, the challenge of providing life-saving health services to patients suffering from COVID (and, more recently, children suffering from life-threatening respiratory disease)."[20] The MAC argues that this is "disingenuous" and there is *nothing* in the record to even suggest that the Provider has previously relied on Alert 19 in this

[16] Jurisdictional Response #2 at 1 (Dec. 14, 2022).
[17] *Id*. at 2.
[18] *Id*.
[19] MAC Request for Dismissal at 1-2 (Dec. 28, 2022).
[20] Provider's Jurisdictional Response at 1.

appeal.[21] As the MAC states: "To raise the recent raise in children respiratory illness cases as an extenuating circumstance for submitting preliminary position papers which fail to follow PRRB Rules is brazen, especially given that preliminary papers for the appeals were submitted between ten (10) to 42 months ago."

Last, the Provider argued that it "cured the sole defect on which the MAC relies" by submitting its listing of days. The MAC argues that it is not requesting that the Board deny jurisdiction for failure to claim the additional Medicaid eligible days, but rather based on a finding that the Provider effectively abandoned the issue when it did not submit the additional days listing with its Preliminary Position paper.[22]

Provider's Response to the MAC's Request for Dismissal:

The Provider did *not* file a response to the MAC's Request for Dismissal. Per Board Rule 44.3, the Provider's response was due on Friday, January 27, 2023 (*i.e.*, within 30 days).

Board Analysis and Decision:

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

A. DSH SSI Percentage (Provider Specific)

The Board finds that it does not have jurisdiction over the DSH/SSI Percentage - Provider Specific issue. The jurisdictional analysis for Issue No. 1 has two relevant aspects to consider: 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 Error issue that was appealed in PRRB Case No. 18-0552GC.

The DSH/SSI Percentage - Provider Specific issue in the present appeal concerns "whether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation."[23] The Provider's legal basis for its DSH/SSI -

[21] MAC Request for Dismissal at 3 (Dec. 28, 2022).
[22] *Id.*
[23] Issue Statement at 1.

Provider Specific issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[24] The Provider argues that "its SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[25]

The Provider's DSH SSI Percentage - Systemic Errors issue in group Case No. 18-0552GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds the DSH SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH SSI Percentage - Systemic Errors issue in Case No. 18-0552GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[26], the Board dismisses this aspect of the DSH/SSI Percentage - Provider Specific issue.

In making this finding, the Board further notes that CMS regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, is pursuing that issue as part of the group under Case No 18-0552GC. 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.[27] Provider is misplaced in referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 18-0552GC.

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 20-0997GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with the Board Rule 25 (as applied via Board Rule 27.2) and 42 C.F.R. § 4051853(b)(2)-(3) 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 consistent with those Rules and the regulation.

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

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

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

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

> https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH.[28]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."[29]

[28] Last accessed February 24, 2023.
[29] Emphasis added.

Similarly, the Provider's preliminary positon paper alludes to certain "State records" being relevant but fails to explain what those alleged "State records" are or how they are relevant to Issue 1. Indeed, the generic statement made in the position paper would apply to any CHS hospital located in the same state and would suggest that this is a common issue that should be in a CIRP group. Again the Provider has failed to fully develop the merits of this issue and to otherwise distinguish it from the common systemic issue in Case No 18-0552GC.

Accordingly, *based on the record before it*, the Board finds that Issue 1 in the instant appeal and the group issue from Group Case 18-0552GC are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH/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 and 42 C.F.R. § 405.1853(b)(2)-(3).

2. *Second Aspect of Issue 1*

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

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

B. Medicaid Eligible Days

According to its Appeal Request, the Provider asserts that all Medicaid eligible days were not included in the calculations of the DSH calculation. The Provider states Issue 2 as:

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

> of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.
>
> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.[30]

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.

According to the MAC, the Provider's preliminary position paper indicated that it would be sending the eligibility listing under separate cover.[31] The Provider has acknowledged this, but responds that there are practical impediments in that providers are impacted by the State eligibility matching being currently unavailable due to a change in the State's matching vendor changes.[32]

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, at the time it filed its Preliminary Position Paper in accordance with Board Rule 25.2.2.

The MAC thus asserts that the Provider essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it could not produce those documents, as required by the regulations and the Board Rules.[33] The MAC also asserts that the Provider is not able to cure that deficiency by now filing the listing of days.

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

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[30] Individual Appeal Request, Issue 2.
[31] Jurisdictional Challenge #1 at 2.
[32] Jurisdictional Response #2 at 1.
[33] *See also* Board's jurisdictional decision in *Lakeland Regional Health* (Case No. 13-2953, 11/20/2019), in which the Board found a Provider essentially abandoned its appeal by filing a position paper that failed to set forth the merits of its claim, explain why the agency's calculation was wrong, and identifying missing documents to support its claim and to explain why those documents remained unavailable.

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. *Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board through a schedule applicable to a specific case or through general instructions*.[34]

With regard to the filing of an individual appeal, Board Rule 7 (Support for Appealed Final Determination, Issue-Related Information and Claim of Dissatisfaction) (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,[35] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[36] This requirement is consistent with 42 C.F.R. § 405.1853(b)(3).

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

> *If documents necessary to support your position are still unavailable,* 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.[37]

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

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 was 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 at the time it filed its Preliminary Position Paper. 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"[38] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. 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.

The Board recognizes that the Provider alleges in its December 14, 2022 response to the jurisdictional challenge that it has now *belatedly* shared a Medicaid eligible days listing with the Medicare Contractor and that it filed a redacted copy of that listing with the Board. However,

[38] (Emphasis added).

contrary to the Provider's assertion, it did ***not*** file with the Board a redacted copy of that listing with the Board whether as an exhibit to its response to the jurisdictional challenge or as a separate filing ***nor*** did its filing indicate precisely how many days are, in fact, in dispute.[39] Further, *contrary to the Provider's assertion*, this case was filed after the effective date of the August 29, 2018 Board Rule changes (*i.e*., the appeal was filed on December 6, 2018, more than 3 months after those Rule changes were issued) and, as such, it was required to file its complete preliminary position paper. Moreover, the fact the Provider was required to file its *complete* preliminary position paper (as opposed to just the cover page) did not change the content requirements because, both prior to and following that Rule change, "the Board expects preliminary position papers to be ***fully*** *developed* ***and*** include ***all*** *available documentation* ***necessary to give the parties a thorough understanding*** *of their opponent's position*."[40] However, Alert 19 only relates to certain suspension of Board-set deadlines and ***not*** to the content of those filings if made. Here, the Provider did, in fact, file its preliminary position paper (rather than rely on Alert 19 and not make that filing). Without giving any specific information or explanation as it relates to the position paper filing made on July 31, 2019, the Provider *generically* suggests that it did not include the listing with the preliminary position paper due to the COVID-19 pandemic. However, when it filed its preliminary position paper on July 31, 2019, the Provider did not reference the pandemic nor otherwise indicate *why* ***its preliminary position paper*** was incomplete or *why* the Medicaid eligible days listing was not included with that position paper or *why* not even a single day was identified in the position papers as being in dispute. Rather, in its position paper, the Provider suggested the listing was imminent by obliquely promising that the Medicaid eligibility listing was "being sent under separate cover."[41] Similarly, the Provider did not respond to Medicare Contractor's November 25, 2019 request (attached as Exhibit 2 to its preliminary position paper) that the Provider furnish the promised listing within 45 days.

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[39] Providing a copy of a document to an opposing party (*e.g*., discovery) does not make that document exchange part of the record and does not satisfy Board Rule 25.2 or 42 C.F.R. § 405.1853(b)(3) regarding submission of documents into the record as exhibits. Further, per Board Rule 2.1.1, all filings must be submitted electronically using OH CDMS unless an exemption granted under Rule 2.1.2 applies.

[40] The July 2015 version of the Board Rules includes the following Commentary to Board Rule 23.3:

> **COMMENTARY**: The Regulations and these Rules impose preliminary position paper requirements that are more stringent than in the past. Full development of the parties' positions fosters efficient use of the administrative review process and due process. The due dates have been extended to give the parties a better opportunity to develop their case. Because the date for adding issues will have expired and transfers are severely limited, *the Board expects preliminary position papers to be fully developed and include all available documentation necessary to give the parties a thorough understanding of their opponent's position*. **CAUTION: Unless the parties demonstrate good cause (e.g., subsequent case law or documents were unavailable through no fault of the party offering the documents), new arguments and documents *not* included in the preliminary position paper may be excluded at the hearing**.

(Underline and italics emphasis added and bold emphasis in original). This same "commentary" is included in the August 2018 version of the Board Rules at Board Rule 23.3. As such, the Board's expectation that parties fully brief the merits of each issue in the preliminary position paper with all relevant exhibits was in effect both prior to and after August 29, 2018.

[41] The Board recognizes that as Exhibit 2 to the preliminary position paper the Provider included an "estimated impact" for the Medicaid eligible days based on a flat 100 Medicaid eligible days. However, this was the ***same estimated*** *impact* that the Provider filed with the appeal request and the Provider failed to update this estimate with the actual specific days in dispute.

The Provider's December 14, 2022 response to the jurisdictional challenges suggests that "practical impediments are preventing the provider from obtaining the necessary support" and that "[t]hese are related to the State eligibility matching being unavailable ***at this time*** due to a change in the State's matching vendor changes." However, this explanation is wholly deficient in that it does not explain why the Medicaid listing was not included *with the preliminary position paper* that was filed more than 3 years earlier. Moreover, as the Medicare Contractor noted in its November 25, 2019 preliminary position paper, the FY 2015 NPR at issue was based on the Provider's second amended cost report filed on December 11, 2017 which was more than 25 months *after* the end of FY 2015) and, as a result, the Medicare Contactor is "unaware of any impediments preventing the provider from gathering Medicaid data prior to the filing of its cost report or at any time prior to the audit of its cost report." Thus, Provider has given no explanation of what practical impediments there are at this late date other than referring to a change in the Medicaid vendor. However, through the use of the phrase "at this time", the December 2022 filing suggests that the change in Medicaid vendor only happened recently and not when the preliminary position paper had been filed more than 3 years earlier.

Even at this late date, the Provider still has ***not*** cured the record before the Board to include the promised information it was otherwise required to include with its preliminary position paper. Indeed, without any days identified in the position paper filing (or since that time), the Board must assume that, consistent with Board Rule 25 and 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(iii), there are no Medicaid eligible days at issue for FY 2015 and that the actual amount in controversy for the FY 2015 Medicaid eligible issue is $0.[42]

The Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its preliminary position papers and supporting documentation as set forth in Board Rule 25 (as applicable via Board Rule 27.2) and 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(iii). In particular, the Board finds that the Provider's preliminary position paper 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.[43]

****

In summary, the Board hereby dismisses the SSI Provider Specific issue from this appeal as it is duplicative of the issue in Case No. 18-0552GC and there is no final determination from which the Provider can appeal the SSI realignment portion of the issue. The Board also dismisses the Medicaid eligible days issue as the Provider failed to meet the Board requirements for position papers for this issue. As no issues remain pending, the Board hereby closes Case No. 19-0671 and removes it from the Board's docket.

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

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[42] *See supra* notes 40, 41 and 42 and accompanying text.
[43] 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.

Board Members Participating:

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

For the Board:

3/14/2023

X Clayton J. Nix

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

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

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RE: ***Board Decision* – SSI Percentage (Provider Specific) and Medicaid Eligible Days**
The Nebraska Medical Center (Provider Number 28-0013)
FYE: 06/30/2017
Case Number: 21-1470

Dear Mr. Ravindran and Mr. Lamprecht,

The Provider Reimbursement Review Board ("Board") has reviewed the documentation in Case No. 21-1470 in response to a jurisdictional challenge filed by the Medicare Contractor ("MAC") The decision of the Board is set forth below.

Background:

A. *Procedural History for Case No. 21-1470*

The Nebraska Medical Center appealed a Notice of Program Reimbursement ("NPR") dated January 28, 2021 for its fiscal year end June 30, 2017. On July 21, 2021, the Provider filed individual appeal request which contained two (2) issues:

1. DSH SSI Percentage (Provider Specific)
2. DSH Medicaid Eligible Days

On June 17, 2022, the Medicare Contractor filed a Jurisdictional Challenge regarding the DSH/SSI Percentage (Provider Specific) issue and then filed a Motion to Dismiss the DSH Medicaid eligible days issue on January 26, 2023.

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. 21-0130G

In its Individual Appeal Request, the Provider summarizes its DSH/SSI – Provider Specific issue as follows:

> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> . . .
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[1]

On July 21, 2021, the Provider was also directly added to PRRB Group Case No. 21-0130G, "*QRS CY 2017 DSH SSI Percentage Group*". The Provider is appealing from the same final determination as in the instant appeal. In the Group Appeal, the SSI Percentage issue is described as "[w]hether the Secretary properly calculated the Provider's DSH SSI percentage."[2] More specifically, the Provider lists the following reasons for challenging its SSI percentage:

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

On March 15, 2022, the Provider filed its preliminary position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Provider Specific**
>
> The Provider contends that its' [sic] SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation based on the Provider's Fiscal Year End (June 30).

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[1] Issue Statement at 1 (July 21, 2021).
[2] PRRB Case No. 21-0130G, Issue Statement at 1 (Oct. 27, 2020).
[3] *Id*.

> 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).[4]

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 $205,415. This is the same amount that is listed as the amount in controversy for this Provider as a participant in 21-0130G.

<u>MAC's Contentions:</u>

Issue 1 – DSH SSI Percentage (Provider Specific)

The MAC argues that the Board lacks jurisdiction over the DSH SSI Percentage - Provider Specific issue for three reasons. First, the MAC argues that the appeal is premature:

> The decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election. It is not a final contractor determination. A hospital must make a formal request to CMS in order to receive a realigned SSI percentage. Once the hospital elects to use its own fiscal year end, it is bound by that decision, regardless of reimbursement impact.
>
> . . .

[4] Provider's Preliminary Position Paper at 8-9 (Mar. 15, 2022).

> The Provider's appeal is premature. To date the Provider has not requested to have its SSI percentage realigned in accordance with 42 C.F.R. § 412.106(b)(3). Thus, the Provider has not exhausted all available remedies for this issue.[5]

In addition, the MAC argues the DSH SSI Percentage - Provider Specific issue and the DSH SSI Percentage - Systemic Errors issue, which the Provider is pursuing in Group Case No. 21-0130G, are considered the same issue by the Board, and cites several past Board decisions to that end.[6]

Finally, the MAC contends that the Provider did not file a complete position paper, in violation of Board rules:

> The MAC contends that the Provider was in violation of Board Rule 25.3 when it failed to sufficiently develop and set forth the relevant facts and arguments regarding the merits of its claim in its Preliminary Position Paper.
>
> . . .
>
> Notably, the Provider has not added any specific allegations, analysis or information related to the Baystate errors/DSH SSI Percentage Calculation Accuracy issue that would satisfy the requirements set forth in Board Rules 25.1.1 or 25.2.2.[7]

Issue 2 – Medicaid Eligible Days

The MAC requested that the Board make the following findings:

> a. That the Provider has filed to furnish documentation in supports of its claim for additional Medicaid Eligible Days or describe why such documentation was and continues to be unavailable.
> b. That the Provider has made affirmative statements in its Preliminary Position Paper that it was submitting such supporting documentation to the MAC.
> c. That the Provider's failure to furnish such documentation (or describe why such documentation is unavailable) is in violation of PRRB Rules 7, 27.2, 25.2.1 and 25.2.2.
> d. That the Provider has effectively abandoned its claim for additional Medicaid Eligible Days.

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[5] Jurisdictional Challenge at 5-6 (June 17, 2022).
[6] *Id*. at 4-5.
[7] *Id*. at 7-8.

e. That the Provider's claim for additional Medicaid Eligible Days is therefore dismissed. . .[8]

Provider's Response

The Provider did not file a response to the jurisdictional challenge. As previously noted, 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. DSH SSI Percentage (Provider Specific)

The Board finds that it does not have jurisdiction over the DSH/SSI Percentage - Provider Specific issue. The jurisdictional analysis for Issue No. 1 has two relevant aspects to consider: 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 the DSH/SSI Percentage - Provider Specific issue in the present appeal concerns "whether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation."[9] The Provider's legal basis for its DSH/SSI - Provider Specific issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[10] The Provider argues that "its SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[11]

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[8] MAC Motion to Dismiss issue (Jan. 26, 2023).
[9] Issue Statement at 1.
[10] *Id.*
[11] *Id.*

The Provider's DSH SSI Percentage - Systemic Errors issue in Group Case No. 21-0130G also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F).

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 21-0130G. 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. 21-0130G.

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. 21-0130G, 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,

[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).

> 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.[13]

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."[14]

Accordingly, the Board finds that the first aspect of Issue 1 in the instant appeal and the group issue from Group Case 21-0130G are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH/SSI (Provider Specific) issue.

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[13] Last accessed February 24, 2023.
[14] Emphasis added.

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), when 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.

B. Medicaid Eligible Days

According to its Appeal Request, the Provider asserts that all Medicaid eligible days were not included in the calculations of the DSH calculation. The Provider states Issue 2 as:

> **Statement of the Issue**
>
> Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.
>
> **Statement of the Legal Basis**
>
> The Provider contends that the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.
>
> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.[15]

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

On March 15, 2022, the Provider filed its preliminary position paper in which it indicated that it was sending the eligibility listing under separate cover.[16] As of the filing of the MAC Motion to

[15] Individual Appeal Request, Issue 2.
[16] Provider's Preliminary Position Paper at Exhibit 1.

Dismiss in January 2023, 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 $821,628, with an increase in days. The Medicare Contractor also previously sent a "MAC Request for DSH package" to the Provider on July 22, 2021, and a "2nd and Final Request for DHS Package" on May 2, 2022, prior to filing its Motion to Dismiss. To date, the Provider has not responded to the requests for the DSH package or the Motion to Dismiss, 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, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage when the DSH adjustment is calculated. Similar decisions were rendered by the Fourth, Eighth and Ninth Circuits: *Cabell Huntington Hospital, Inc. v. Shalala*, 101 F.3d 984 (4th Cir. 1996); *Deaconess Health Services Corp. v. Shalala*, 83 F.3d 1041 (8th Cir. 1996), *aff'g* 912 F. Supp. 478 (E.D. Mo. 1995); and *Legacy Emanuel Hospital and Health Center v. Shalala*, 97 F.3d 1261 (9th Cir. 1996).
>
> The Centers for Medicare and Medicaid Services ("CMS", formerly HCFA) acquiesced in the above decisions and issued HCFA Ruling 97-2, which in pertinent part reads as follows:
>
>> [T]he Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to include all inpatient hospital days of service for patients who were eligible on that day for medical assistance under a state Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for these inpatient hospital services.
>
> Based on the Listing of Medicaid Eligible Days being sent under separate cover, the Provider contends that the total number of days reflected in its' [*sic*] 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.[17]

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.[18]

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*.[19]

[17] *Id.* at 7-8.
[18] *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.
[19] (Emphasis added).

With regard to the filing of an individual appeal, Board Rule 7 (Support for Appealed Final Determination, Issue-Related Information and Claim of Dissatisfaction) (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,[20] Board Rule 25.2.1 requires that "the parties must exchange ***all** available* documentation as exhibits to fully support your position."[21] 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.[22]

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

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

> 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"[23] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. 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. This the Provider has failed to do.[24]

****

In summary, the Board hereby dismisses the SSI Provider Specific issue from this appeal as it is duplicative of the issue in Group Case No. 21-0130G and there is no final determination from which the Provider can appeal the SSI realignment portion of the issue. The Board also dismisses the Medicaid eligible days issue as the Provider failed to meet the Board requirements for position papers for this issue. As no issues remain pending, the Board hereby closes Case No. 21-1470 and removes it from the Board's docket.

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

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

Board Members Participating:

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

For the Board:

3/14/2023

X Kevin D. Smith, CPA

Clayton J. Nix, Esq.
Board Chair
Signed by: Kevin D. Smith -A

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Notice of Dismissal***
Case Nos. 23-0834GC, *et al.* (*see* Attachment A listing of 25 cases)

Dear Mr. Connelly:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal requests and final determinations in the 25 appeals identified on Attachment A. They are made up of 21 group appeals and 4 individual appeals. The Board's decision to dismiss these cases is set forth below.

Issue in Dispute

The Providers are appealing from the issuance of the Fiscal Year ("FY") 2023 Final Rule published in the Federal Register on August 10, 2022. The sole issue in these cases is "Failure to Correct the Unlawful DGME Fellows Penalty in Closed Cost Reports." The Providers' issue statements[1] describe the issue as follows:

> The Provider challenges one of the final determinations made by CMS in the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2023 Rates Final Rule, 87 Fed. Reg. 48,780, 49,066-49,072, 49,406, 49,456, 49,480 (Aug. 10, 2022) ("FY 2023 IPPS Final Rule"). In the FY 2023 IPPS Final Rule, CMS retroactively amended its regulation (42 C.F.R. §413.79(c)(2)(iii), (d)(3)) that dictates calculation of a hospital's weighted number of full-time equivalent ("FTE") residents for purposes of computing DGME payments. CMS conceded that its prior regulation was "inconsistent with the statutory requirements" of the Medicare Act and had caused what is known as the "fellows penalty" that understated DGME payments since federal fiscal year ("FY") 1997. *See id*. However, despite purporting to apply its amended regulation retroactively to cost reporting periods starting in FY 2001, CMS refused to correct DGME underpayments for any

[1] The Board's decision encompasses four (4) individual appeals, six (6) common issue related party ("CIRP") group appeals, and fifteen (15) optional group appeals. The issue statements are materially identical in all of the cases.

settled cost reports. See id. at 49,070. CMS must recalculate the Provider's DGME payments by applying the revised regulation, 42 C.F.R. § 413.79(c)(2)(iii) (2022) ("2022 regulation").

****

In Milton S. Hershey Medical Center v. Becerra, numerous hospitals challenged this regulation. The U.S. District Court for the District of Columbia held "that Defendant's application of the regulation to compute Plaintiffs' full-time equivalent residents was contrary to law because the regulation effectively changed the weighting factors statutorily assigned to residents and fellows."

****

On August 10, 2022, CMS published the FFY 2023 Final IPPS Rule, which changed the method for calculating DGME payments following the court's ruling in Hershey. See 87 Fed. Reg. 48,780, 49,066– 72 (Aug. 10, 2022). CMS conceded that its then "existing formula for computing the number of FTEs was inconsistent with the statutory requirements," and finalized a rule that applies a new formula for calculating FTEs, aligned with the decision in *Hershey*. 87 Fed. Reg. at 49,067, 49,066–072. CMS stated, "[a]fter reviewing the statutory language regarding the direct [graduate medical education] [fulltime equivalent] cap and the court's opinion [in Hershey]," the agency decided to "implement a modified policy to be applied prospectively for all teaching hospitals, as well as retroactively to the providers and cost years in Hershey and certain other providers." Id. at 48,784.

****

CMS stated the Final Rule's new FTE calculation is effective retroactively to cost reporting periods beginning on or after October 1, 2001. Id. at 49,067. Despite conceding that the prior regulation is unlawful, and promulgating a corrected rule retroactive to 2001, CMS refuses to reopen closed cost reports.

****

CMS's determination not to reopen and revise closed cost reports is contrary to law. The Medicare statute unambiguously requires CMS to weight fellows at no more than 0.5 in all cost reporting periods beginning on or after October 1, 1997. 42 U.S.C. § 1395ww(h)(4)(C), (h)(4)(F); *Hershey*, 2021 WL 1966572 at *2. CMS's regulations also require CMS to reopen and revise all cost reports beginning on or after October 1, 2001. 42 C.F.R. § 405.1885(c)(1). CMS's notice in the FFY 2023 Final IPPS Rule that the prior DGME payments are contrary to law constitutes notice

> obligating MACs to reopen[.] 42 C.F.R. § 405.1885(c)(1)(i); *see also In re Medicare Reimbursement Litigation*, 414 F.3d 7 (2005); *Monmouth Med. Ctr. v. Thompson*, 257 F.3d 807 (2001).
>
> CMS's concession that the pre-2022 regulation is contrary to the statute, and CMS's 2022 regulation, 42 C.F.R. § 413.79(c)(2)(iii) (2022), which is retroactive to 2001, renders the MAC's payments contrary to law "at the time the determination or decision was rendered by the contractor." Correcting closed cost reports is not a "prohibited reopening," 42 C.F.R. § 405.1885(c)(2), because CMS has no interpretive authority to violate the plain text of the Medicare statute. *Chevron U.S.A. Inc. v. Nat. Res. Def. Council, Inc.*, 467 U.S. 837, 842–43 (1984).
>
> ****
>
> Cost reports that have been closed for longer than three years must be reopened because CMS procured those determinations "by fraud or similar fault." 42 C.F.R. § 405.1885(b)(3). CMS, as the agency charged by Congress to implement the Medicare statute, committed "similar fault" because it retained Medicare funds to which it knew or should reasonably have been expected to know that it was not entitled. *Id.* § 405.980.
>
> CMS's determination not to apply the amended retroactive FTE count regulation to settled cost reports that were impacted by, and thus to correct for, the "fellows penalty" and DGME underpayments is contrary to the Medicare Act and the intent of the Congress, is contrary to CMS regulations, and is arbitrary and capricious, otherwise contrary to law, and/or procedurally invalid. *See* 5 U.S.C. § 706(2)(A) (providing that agency action shall be held unlawful and set aside where it is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law"); *id.* § 706(2)(C) (same where agency action is "in excess of statutory jurisdiction, authority, or limitations, or short of statutory right"); and *id.* § 706(2)(D) (same where agency action is "without observance of procedure required by law."). The Provider seeks its proper IPPS payments plus interest calculated under 42 U.S.C. § 1395oo(f)(2) and/or 42 U.S.C. § 1395g(d).

Background

A. History of the DGME Methodology

The Medicare statute requires the Secretary[2] to reimburse hospitals for the "direct" costs of hosting graduate medical training programs for physician residents (direct graduate medical

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

education or "DGME").[3] These costs include the salaries of teaching physicians and stipends paid to resident physicians.[4]

The Medicare statute prescribes a formula for computing annual DGME payments to hospitals. The statutory formula consists of three components:

1. The hospital's number of FTE residents, or "FTE count;"
2. The hospital's average cost per resident (*i.e.* the per resident amount or "PRA"); and
3. The hospital's patient load, which is the percentage of a hospital's inpatient treatment days attributable to Medicare Part A and Part C beneficiaries.[5]

This appeal concerns the first component of the DGME payment calculation—the resident FTE count.

A hospital's FTE count for DGME reimbursement is the number of residents trained at the hospital as adjusted by three statutory provisions. First, the statute, 42 U.S.C. § 1395ww(h)(4)(C), assigned different weights to residents depending on their status. The statute states that:

> (C) . . . [I]n calculating the number of full-time equivalent residents in an approved residency period---
>
> (ii) . . .for a resident who is in the resident's initial residency period . . . the weighting factor is 1.0 . . .
>
> (iv) . . .for a resident who is not in the resident's initial residency period . . . the weighting factor is .50.

Pursuant to this statutory provision, FTEs attributable to residents who are training in their initial residency period[6] ("IRP residents") are weighted at 100 percent or 1.0, while FTEs attributable to residents who are not in their initial residency period (commonly referred to as "fellows") are weighted at 50 percent or 0.5. The sum of the weighted FTEs for IRP residents and fellows in a given year is known as a hospital's "weighted FTE count." For example, under this weighting assignment, a hospital that trained 10 IRP residents and 10 fellows in a given year would have a weighted FTE count of 15.

On August 5, 1997, Congress enacted § 4623 of the Balanced Budget Act of 1997 ("BBA")[7] which added 42 U.S.C. § 1395ww(h)(4)(F) to establish a limit on the number of osteopathic and allopathic residents that a hospital can include in its FTE count for DGME payments. For cost reporting periods beginning on or after October 1, 1997, a hospital's unweighted DGME FTE

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[3] 42 U.S.C. § 1395ww(h).
[4] *See* S. Rep. No. 404, 89th Cong. 1st Sess. 36 (1965); H.R. No 213, 89th Cong., 1st Sess. 32 (1965).
[5] 42 U.S.C. § 1395(h).
[6] "Initial residency period" is defined in the statute as the minimum number of years required for Board eligibility. 42 U.S.C. § 1395ww(h)(5)(F).
[7] Pub. L. 105–33, § 4623, 111 Stat. 251, 477 (1997).

count could not exceed the hospital's unweighted FTE count for its most recent cost reporting period ending on or before December 31, 1996. In this regard, § 1395(h)(4)(F)(i) states:

> [F]or purposes of a cost reporting period beginning on or after October 1, 1997 . . . the total number of full-time equivalent residents before the application of the weighting factors (as determined under this paragraph) with respect to a hospital's approved medical residency training program in the fields of allopathic and osteopathic medicine *may not exceed* the number (or 130 percent of such number in the case of a hospital located in a rural area) of such full-time equivalent residents for the hospital's most recent cost reporting period ending on or before December 31, 1996.[8]

Further, 42 U.S.C. § 1395ww(h)(4)(G)(i) provides that residents are counted on a three-year average. Finally, 42 U.S.C. § 1395ww(h)(4)(A) directs the Secretary to "establish rules consistent with [§ 1395ww(h)(4)] for the computation of the number of full-time equivalent residents in an approved medical residency training program."

CMS implemented BBA § 4623, in part, by promulgating regulations at 42 C.F.R. § 413.86(g)(4) to implement the unweighted FTE cap.[9] Specifically, in the FY 1998 inpatient prospective payment system ("IPPS") final rule published on August 20, 1997 ("FY 1998 IPPS Final Rule"), CMS promulgated revisions to 42 C.F.R. § 413.86(g)(4) and included the following explanation in the preamble to that rule:

> *To address situations in which a hospital increases the number of FTE residents **over** the cap*, notwithstanding the limit established under section 1886(h)(4)(F), we are establishing the following policy for determining the hospital's weighted direct GME FTE count for cost reporting periods beginning on or after October 1, 1997.
>
> - *Determine the ratio of* the hospital's unweighted FTE count for residents in those specialties for the most recent cost reporting period ending on or before December 31, 1996, *to* the hospital's number of FTE residents without application of the cap for the cost reporting period at issue.
>
> - *Multiply the ratio determined above by* the weighted FTE count for those residents for the cost reporting period. Add the weighted count of residents in dentistry and podiatry to determine the weighted FTEs for the cost reporting period. This methodology should be used for purposes of determining payment for cost reporting periods beginning on or after October 1, 1997. . . .

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[8] 42 U.S.C. § 1395ww(h)(4)(F)(i) (emphasis added). Further, 42 U.S.C. § 1395ww(h)(4)(H) directs the Secretary to establish rules for determining the caps of hospitals that establish new programs after December 31, 1996.
[9] 62 Fed. Reg. 45966, 45967, 46004 (Aug. 29, 1997).

> For example, if the hospital's FTE count of residents in its cost reporting period ending December 31, 1996 is 100 residents before application of the initial residency weighting factors and the hospital's number of residents for its December 31, 1990 [*sic*] cost reporting period is 110 FTE residents, the ratio of residents in the two cost reporting periods equals 100/110. If the hospital's weighted FTE count is 100 FTE residents in the December 31, 1998 cost reporting period (that is, of the 110 unweighted residents, 20 are beyond the initial residency period and are weighted as 0.5 FTE), the hospital's weighted FTE count for determining direct GME payment is equal to (100/110) [x] 100, or 90.9 FTE residents. . . .
>
> ****
>
> We believe this ***proportional*** *reduction* in the hospital's unweighted FTE count is an equitable mechanism for implementing the statutory provision.[10]

Section 413.86(g)(4) remained unchanged until the FY 2002 IPPS final rule published on August 1, 2001 ("FY 2002 IPPS Final Rule").[11] Therein, the Secretary modified the allowable FTEs formula so that the proportionate reduction to the weighted FTE count would be calculated separately for FTEs attributable to residents trained in primary care, obstetrics and gynecology programs and residents training in nonprimary care programs. In that final rule, the modified methodology, effective for cost report periods beginning on or after October 1, 2001 was:

> *Step 1.* Determine that the hospital's total unweighted FTE counts in the payment year cost reporting period and the prior two immediately preceding cost reporting periods for all residents in allopathic and osteopathic medicine do not exceed the hospital's FTE cap for these residents in accordance with § 413.86(g)(4). *If the hospital's total unweighted FTE count in a cost reporting period exceeds its cap*, the hospital's weighted FTE count, for primary care and obstetrics and gynecology residents and nonprimary care residents, respectively, will be reduced *in the same* ***proportion*** that the number of these FTE residents for that cost reporting period exceeds the unweighted FTE count in the cap. The ***proportional reduction*** is calculated *for primary care* ***and*** *obstetrics and gynecology residents and nonprimary care residents separately* in the following manner:
>
>> (FTE cap/unweighted total FTEs in the cost reporting period) × (weighted primary care and

[10] 62 Fed. Reg. at 46005 (emphasis added).
[11] 66 Fed. Reg. 39826 (Aug. 1, 2001).

> obstetrics and gynecology FTEs in the cost reporting period)
>
> plus
>
> (FTE cap/unweighted total FTEs in the cost reporting period) × (weighted nonprimary care FTEs in the cost reporting period).
>
> Add the two products to determine the hospital's reduced cap.[12]

To codify this change, the Secretary added clause (iii) to 42 § 413.86(g)(4). In the final rule published on the August 11, 2004, CMS relocated 42 C.F.R. § 413.86(g)(4)(iii) to 42 C.F.R. § 413.79(c)(2)(iii) (2004).[13] This regulation is the focus this appeal, and it stated the following:

> If the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 2001 exceeds the limit described in this section [*i.e.*, the FTE cap or limit], the hospital's weighted FTE count (before application of the limit) for primary care and obstetrics and gynecology residents and nonresidents, respectively, will be reduced in the same proportion that the number of FTE residents for that cost reporting period exceeds the number of FTE residents for the most recent cost reporting period ending on or before December 31, 1996.[14]

As previously noted, this regulation addressed how to reduce a hospital's weighted FTE count for a fiscal year when the unweighted FTE count for that fiscal year exceeds the hospital's unweighted FTE cap.

On their cost reports, hospitals report the number of allopathic and osteopathic FTE residents (before applying the weighting factors mentioned above) that were actually trained at the facility in that year.[15]

In addition, the statute sets the number of FTEs a hospital can claim for reimbursement as the hospital's average FTE count between the present, prior and penultimate years. The statute states:

> [T]he total number of full-time equivalent residents for determining a hospital's graduate medical education payment shall equal the

[12] *Id.* at 39894 (emphasis added).
[13] *See* 69 Fed. Reg. 48916, 49258-64. As part of the relocation, CMS modified the language slightly by removing the references to "paragraph (g)" that was in the prior version of the regulation and replacing it them with reference to "the limit described in this section."
[14] 42 C.F.R. §§ 413.79(c)(2)(iii) (2011). The Secretary has not made any changes to § 413.79(c)(2)(iii) since the FY 2005 IPPS final rule.
[15] 77 Fed. Reg. 53258, 53423 (Aug. 31, 2012) (stating that when a hospital trains residents in excess of its cap, "it should report those FTE residents on its cost report regardless of whether or not it is training over its caps.")

> average of the actual full-time equivalent resident counts for the cost reporting period and the preceding two cost reporting periods.[16]

Therefore, a hospital's present year FTE count, after applying the weighting factors and FTE caps, was averaged with the FTE counts from the prior and penultimate years.

B. The Board's Analysis of 42 C.F.R. § 413.79(c)(2)(iii) (2004)

The Board has received a number of appeals concerning the DGME methodology for which it granted Expedited Judicial Review ("EJR").[17] Providers would typically assert that the regulation at 42 C.F.R. § 413.79(c)(2)(iii) (2004) penalized hospitals which exceeded their FTE caps. They would assert that § 413.79(c)(2)(iii) (2004) stated the following equation for calculating the weighted cap (*i.e.* "Allowable FTE Count") for a particular FY and that this formula resulted in the perceived disparate treatment between IRP residents and fellows. Specifically, in their EJR request, providers often presented the following equation used to calculate the allowable count for primary care and obstetrics and gynecology residents and separately for nonprimary care residents:

$$\text{WFTE}\left(\frac{\text{UCap}}{\text{UFTE}}\right) = \text{WCap}$$ [18]

Accordingly, the Board set out to confirm the Providers' assertion that § 413.79(c)(2)(iii) does in fact set forth the above equation.

The Board noted that, pursuant to the introductory phrase in § 413.79(c)(2)(iii) (*i.e.*, "[i]f the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 2001 exceeds the limit described in this section [*i.e.*, the FTE cap or limit]"), the above equation is used ***only*** when the "Unweighted FTE Count" for a FY exceeds the "Unweighted FTE Cap" in order to determine what the Providers describe as the "Allowable [weighted] FTE count" for the FY.[19] As such, the equation would logically appear to be a method used to translate the "Unweighted FTE Cap" into a *weighted* context where the "Allowable FTE count" for a FY is really a "weighted FTE cap" for the FY because it is ***only*** used when the unweighted FTE count exceeds the unweighted FTE cap. Indeed, the Board's description of the product of the equation as a "cap" was consistent with the Secretary's description of it as a "reduced cap" in the preamble to the FY 2002 IPPS Final Rule.[20] Accordingly, the Board referred to the variable "Allowable FTE count" for the FY as the "Weighted FTE Cap" to facilitate the Board's discussion below on how the equation is conceptually set forth in the text of § 413.79(c)(2)(iii) (2004).

Bearing this concept in mind, the Board reviewed the regulation closely and agreed that § 413.79(c)(2)(iii) (2004) essentially states the above equation, albeit in a slightly different form

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[16] 42 U.S.C. § 1395ww(h)(4)(G)(i).
[17] *See, e.g.,* PRRB Case 19-2489GC, EJR Determination (July 26, 2022).
[18] *Id.* at 4.
[19] *See also* 62 Fed. Reg. at 46005 (describing the purpose of the regulation being adopted in the final rule as follows: "To address situations in which a hospital increases the number of FTE residents over the cap, notwithstanding the limit established under section 1886(h)(4)(F), we are establishing the following policy for determining the hospital's *weighted* direct GME FTE count for cost reporting periods beginning on or after October 1, 1997." (Emphasis added.)).
[20] 66 Fed. Reg. at 39894 (emphasis added).

where the difference is inconsequential and it gives the same results. In its entirety, § 413.79(c)(2)(iii) (2004) stated:

> If the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 2001 exceeds the limit described in this section [*i.e.*, the FTE cap or limit], the hospital's weighted FTE count (before application of the limit) for primary care and obstetrics and gynecology residents and nonprimary care residents, respectively, *will be reduced* ***in the same proportion*** that the number of FTE residents for that cost reporting period exceeds the number of FTE residents for the most recent cost reporting period ending on or before December 31, 1996 [*i.e.*, the FTE cap or limit].[21]

At first blush, it would not appear that the equation is specifically stated in the regulation. However, once the regulation is unpacked around the words "in the same proportion," it is clear that the regulation is relying on ratios as the basis for the equation used to calculate the Weighted FTE Cap applicable for the fiscal year.[22] Indeed, CMS reiterates this in the preamble to the FY 1998 Final Rule by rationalizing § 413.79(c)(2)(iii) as follows: "We believe this ***proportional reduction*** in the hospital's unweighted FTE count is an equitable mechanism for implementing the statutory provision."[23] Essentially, the regulation is stating that the Weighted FTE Cap is to the FY's Weighted FTE Count as the Unweighted FTE Cap is to the FY's Unweighted FTE Count. The calculation of the Weighted FTE Cap is achieved through the operation of the following simple algebraic principle of equivalent fractions[24] (*i.e.*, ratios) using variables a, b, c, and d:

$$If\ \frac{a}{b} = \frac{c}{d}\ \ then\ \mathrm{c} = \frac{a}{b}\ x\ d$$

On the first side of the initial algebraic equation (*i.e.*, the ratio of "a / b") is the following phrase: "the number of FTE residents for that cost reporting period exceeds [the FTE cap or limit]." This phrase (the ***Unweighted FTE Cap*** is to the ***FY's Unweighted FTE Count***) expressed as a ratio ("a/b") is the Unweighted FTE Cap over the FY's Unweighted FTE Count.[25]

On the other side of the algebraic equation (*i.e.*, the ratio of "c /d") is the following phrase: "the hospital's weighted FTE count (before application of the limit) . . . will be reduced in the same

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[21] (Emphasis added.)
[22] *See* 62 Fed. Reg. at 46005 (emphasis added).
[23] *Id.* (emphasis added). *See also* 66 Fed. Reg. at 39894 ("[F]or primary care and obstetrics and gynecology residents and nonprimary care residents, respectively, will be reduced *in the same* ***proportion*** that the number of these FTE residents for that cost reporting period exceeds the unweighted FTE count in the cap. The ***proportional reduction*** is calculated *for primary care* ***and*** *obstetrics and gynecology residents and nonprimary care residents separately…."* (Emphasis added.)).
[24] Two alternative ways to express the algebraic principle of equivalent functions include:
If a/b = c/d, then c = (a x d) / b ; and
If a/b = c/d, then c = (a/b) x d.
[25] Note that, in using equivalent ratios, the key is the relationship of the ratios. As such, the relation between the ratios does not change if they are flipped. For example, if these ratios are flipped, then the initial equation becomes the FY's Weighted FTE Count (variable d) over the Weighted FTE Cap (variable c) equals the FY's Unweighted FTE Count (variable b) over the Unweighted FTE Cap (variable a). The unknown variable is still "c" and you would get the same results where rule would then be: If b/a = d/c, then c = (a/b) x d.

proportion." This phrase expressed as a ratio ("c/d") is an *unknown* Weighted FTE Cap over the FY's Weighted FTE Count. In other words, the unknown Weighted FTE Cap is the resulting value of the weighted FTEs being reduced in the same proportion as the FY Unweighted FTE Count exceeds the Unweighted FTE cap. The full proportional equation is expressed as follows:

$$\frac{Unweighted\ FTE\ Cap\ (a)}{FY's\ Unweighted\ FTE\ Count\ (b)} = \frac{Weighted\ \ FTE\ Cap\ (c)}{FY's\ Weighted\ FTE\ Count\ (d)}$$

The unknown Weighted FTE Cap (variable "c") is then determined by a/b x d. In other words, the unknown Weighted FTE Cap is determined by the following formula:

$$\boldsymbol{Weighted\ FTE\ cap} = \frac{Unweighted\ \ FTE\ Cap}{Unweighted\ FTE\ Count} \times \ Weighted\ FTE\ Count$$

This formula is clearly stated in the preambles to both the FYs 1998 and 2002 IPPS Final Rules as previously quoted.

Based on the above, the Board found that 42 C.F.R. § 413.79(c)(2)(iii) (2004) did set forth the equation being challenged and, accordingly, that the providers were challenging the validity of § 413.79(c)(2)(iii) (2004). The Board also found that EJR was appropriate for the issue under dispute in the cases challenging the DGME methodology.

C. Milton S. Hershey Med. Ctr. v. Becerra and 42 C.F.R. § 413.79(c)(2)(iii) (2022)[26]

One group of providers appealed to U.S. District Court for the District of Columbia in *Hershey* to challenge the regulation setting forth the DGME methodology.[27] The Court ultimately found that CMS' "application of the regulation to calculate [the providers'] reimbursement payments was unlawful because, in calculating the weighted number of FTE residents, the regulation effectively changed the weighting factors for residents and fellows that Congress established in the Medicare statute."[28]

The Court looked to the enabling statute for the DGME payment at 42 U.S.C. § 1395ww(h)(4)(C), noting it commanded that rules promulgated by the Secretary would weight residents at 1.0 and fellows at 0.5.[29] The regulation at 42 C.F.R. § 413.79(c)(2)(iii) (2004), however, effectively reduced the weighted FTE count when a hospital exceeds its FTE cap and employs fellows. The Court found that "the text of the statute does not give the Secretary the latitude to decide . . . to change the weights that Congress assigned to residents and fellows when he calculates the FTE residents for each hospital."[30] The Court also found the statute at 42 U.S.C. § 1395ww(h)(4)(C) was not ambiguous, but clear, and since the challenged regulation contradicted mandatory (*i.e.*, "shall")

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[26] 2021 WL 1966572 (D.D.C. 2021) ("*Hershey*").
[27] *Hershey* at *1.
[28] *Id.* at *3.
[29] *Id.* at *5.
[30] *Id.*

provisions of the statute, the regulation failed the first step in the analysis set forth in *Chevron*.[31] Thus, the Court held the DGME regulation was unlawful as applied to the providers in that case.[32]

Following the decision in *Hershey*, the Secretary issued the FY 2023 Final Rule to replace the policy at 42 C.F.R. § 413.79(c)(2)(iii) (2004) and implement a modified policy applicable to all teaching hospitals, effective as of October 1, 2021.[33] While the DGME methodology struck down in *Hershey* was first applicable to cost reports beginning October 1, 1997, the Secretary noted there did not appear to be any "open or reopenable" Notices of Program Reimbursement ("NPRs") for 1997-2001 and, as such, opted to amend the policy for cost reporting periods beginning on or after October 1, 2001.[34] The Secretary acknowledged that the policy set forth in 42 C.F.R. § 413.79(c)(2)(iii) (2004) was inconsistent with the statutory requirements of 42 U.S.C. § 1395ww(h)(4)(C). Since, however, 42 U.S.C. § 1395ww(h)(4)(A) directs the Secretary to "establish rules consistent with [§ 1395ww(h)(4)] for the computation of the number of full-time equivalent residents in an approved medical residency training program[,]" the Secretary determined retroactive rulemaking was necessary to modify the methodology for cost reporting periods beginning on or after October 1, 2001. As such, the regulation at 42 C.F.R. § 413.79(c)(2)(iii) and the related cost reporting instructions were revised to incorporate a new methodology that "would address situations for applying the FTE cap when a hospital's weighted FTE count was greater than its FTE cap, but would not reduce the weighting factor of residents that are beyond their IRP by an amount less than 0.5."[35] However, the Secretary specifically noted that, consistent with 42 C.F.R. § 405.1885(c)(2), the retroactive rule would ***not*** cover cost reporting periods for which any NPRs had already been settled.[36]

The Secretary maintained, over commenters' objections, that retroactive rulemaking was the appropriate means to implement its new DGME methodology because: (1) 42 U.S.C. § 1395ww(h)(4)(A) states that "[t]he Secretary shall establish rules *consistent with this paragraph* for the computation of the number of full-time equivalent residents in an approved medical residency training program; and (2) The Court in *Hershey* held, and the Secretary agreed, that the method for computing FTEs was not consistent with statutory requirements.[37] The Secretary also maintained that declining to open closed cost reports through this retroactive rule was consistent with 42 C.F.R. § 405.1885(c)(2), which states that a "change of legal interpretation or policy by CMS in a regulation . . . made in response to judicial precedent," is "not a basis for reopening a CMS or contractor determination."[38]

<u>Decision of the Board</u>

The Providers are challenging the refusal of the CMS to apply the newly revised 42 C.F.R. § 413.79(c)(2)(iii) (2022) to the fiscal years at issue.[39] They argue that the CMS' determination to

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[31] *Chevron v. Nat. Res. Def. Council*, 467 U.S. 837 (1984).
[32] *Id.*
[33] 87 Fed. Reg. 28108, 28410-28412 (May 10, 2022).
[34] *See* 87 Fed. Reg. 48780, 49067 (Aug. 10, 2022). CMS had solicited comments alerting them of any open or openable NPRs for 1997-2001, but this discussion suggests that apparently CMS did not receive any such comments.
[35] *Id.* at 49067-49068.
[36] *Id.* at 49067, 49070.
[37] *Id.* at 49068-49069.
[38] *Id.* at 49070.
[39] Issue Statement at 1.

not reopen and revise the closed cost reports at issue is contrary to law.[40] The Providers state that CMS is *required* to reopen and revise *all* cost reports beginning on or after October 1, 2001 (the effective date of the retroactive regulation) pursuant to 42 C.F.R. § 405.1885(c)(1)(i), which provides an example of a CMS-directed reopening:

> A contractor determination . . . must be reopened and revised if CMS provides explicit notice to the contractor that the contractor determination . . . is inconsistent with the applicable law, regulations, CMS ruling, or other interpretive rules, general statements of policy, and rules of agency organization, procedure, or practice established by CMS in effect, and as CMS understood those legal provisions, at the time the determination or decision was rendered by the contractor. CMS may also direct the contractor to reopen a particular contractor determination or decision in order to implement a final agency decision (as described in §§405.1833, 405.1871(b) and 405.1875 of this subpart), a final, non-appealable court judgment §405.1877, or an agreement to settle an administrative appeal or a lawsuit, regarding the same determination or decision.

The Providers argue that CMS' concession that the pre-2022 regulation is contrary to 42 U.S.C. § 1395ww(h)(4)(C) renders the Medicare Contractor's payments in closed cost reports contrary to law "at the time the determination or decision was rendered by the contractor." [41] As such, the Providers assert that CMS is *required* to reopen and revise these cost reports.

As set forth below, the Board finds that it does not have jurisdiction over the Providers' appeals of this issue.

A. The Providers have failed to appeal a "final determination" as that term is issued in 42 U.S.C. § 1395oo(a)(1).

While a provider typically has appeal rights from the publication of a final rule in the Federal Register,[42] the policy being appealed here is not a "***final*** determination"[43] within the context of 42 U.S.C. § 1395oo(a)(1) because the policy has no reimbursement impact on cost reports at issue *that have already been settled and closed*. 42 U.S.C. § 1395oo(a) typically allows two types of appeals: directly from a Medicare Contractor's "final determination" issued in the form of a Notice of Program Reimbursement ("NPR"), or from the issuance of a notice of what will be paid under the IPPS system.[44] With regard to the latter, once a hospital's IPPS payment amounts are finally determined or set by CMS, there has been a "final determination" that is subject to an appeal before the Board.[45] In these cases, the Providers' IPPS payment amounts were finally

[40] *Id.* at 2.
[41] *Id.* at 3.
[42] *See Washington Hosp. Ctr. v. Bowen,* 795 F.2d 139 (D.C. Cir. 1986).
[43] (Emphasis added.)
[44] *Id.* at 144-145.
[45] *Id.* at n.7. *See also Abbott-Northwestern Hosp. v. Leavitt*, 377 F.Supp.2d 119, 127 (D.D.C. 2005) (noting that a letter from the Secretary declining a hospital's request to revise certain payments was a "final determination" because it "did not suggest that the decision would be revisited, and it established definitely the amount" of certain

determined when their NPRs were issued in accordance with the prior DGME policy. The revised DGME policy set forth in the FY 2023 IPPS Rule has not altered or set any payment amount the Providers received or will receive. Indeed, that is the crux of the Providers' challenge: that their payment amounts have not been, and will not be, set to a different amount.

The Supreme Court addressed this very issue in its 1999 decision for *Your Home Visiting Nurse Services, Inc. v. Shalala*.[46] Specifically, the Supreme Court confirmed that the decision of the Medicare Contractor, CMS or the Secretary to not reopen a final determination is precluded from administrative and judicial review:

> Petitioner relies upon 42 U.S.C. § 1395*oo* (a)(1)(A)(i), which says that a provider may obtain a hearing before the Board with respect to a cost report if the provider "is dissatisfied with a final determination of . . . its fiscal intermediary . . . as to the amount of total program reimbursement due the provider . . . for the period covered by such report . . . ." Petitioner maintains that the refusal to reopen a reimbursement determination constitutes a separate "final determination . . . as to the amount of total program reimbursement due the provider." The Secretary, on the other hand, maintains that this phrase does not include a refusal to reopen, which is not a "final determination . . . as to the amount," but rather the *refusal* to make a new determination. The Secretary's reading of § 1395*oo* (a)(1)(A)(i) frankly seems to us the more natural—but it is in any event well within the bounds of reasonable interpretation, and hence entitled to deference under *Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc.,* 467 U.S. 837, 842 . . . (1984).

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payments.). In their appeal requests, the Providers cite to a 1993 decision of the Administrator pertaining to an appeal of the 1992 wage index rates published in the Federal Register. However, that decision is not supportive as made plain by the following excerpt from that decision:

> After a review of the record, the law, applicable regulations and court's decision in Washington Hospital Center, the Administrator determines that the Providers can appeal the validity of the wage index that the Secretary has established for Federal fiscal year 1992 for the District of Columbia hospitals, within 180 days of the publication of the wage index in the Federal Register. Both the Board and BPD, although finding that publication of the rates did not constitute a final determination of the Secretary, failed to cite what constituted such a determination for purposes of appeal under PPS.
>
> The controlling case law clearly holds that Congress did not intend for a PPS hospital to wait until the issuance of an NPR before it can appeal the final determination of the Secretary as to the amount of payment under subsection (b) or (d) of Section 1886 [PPS]. The publication of the wage index is the only formal notice, other than the NPR, that these Providers received regarding their DRG prospective payment rate under Section 1886(d) of the Act. Therefore, the finding that this publication is not a final determination of the Secretary conflicts with the court's reasoning in Washington Hospital Center. Based on the controlling case law, the Administrator determines that the publication of the wage index in the Federal Register constitutes a "final determination of the Secretary" for purposes of Section 1878(a)(1)(A)(ii) of the Act.

District of Columbia Hospital Association Wage Index Group Appeal, Adm'r Dec. (Jan. 15, 1993), *vacating* PRRB Juris. Dec., Case No. 92-1200G (Nov. 18, 1992) (footnotes omitted).

[46] 525 U.S. 449 (1999).

> The reasonableness of the Secretary's construction of the statute is further confirmed by *Califano v. Sanders,* 430 U.S. 99 . . . (1977), in which we held that § 205(g) of the Social Security Act does not authorize judicial review of the Secretary's decision not to reopen a previously adjudicated claim for benefits. In reaching this conclusion we relied, in part, upon two considerations: that the opportunity to reopen a benefit adjudication was afforded only by regulation and not by the Social Security Act itself; and that judicial review of a reopening denial would frustrate the statutory purpose of imposing a 60–day limit on judicial review of the Secretary's final decision on an initial claim for benefits. *Id.,* at 108. Similar considerations apply here. The right of a provider to seek reopening exists only by grace of the Secretary, and the statutory purpose of imposing a 180–day limit on the right to seek Board review of NPRs, see 42 U.S.C. § 1395*oo* (a)(3), would be frustrated by permitting requests to reopen to be reviewed indefinitely.
>
> Finally, we do not think that the Secretary's position is inconsistent with 42 U.S.C. § 1395x(v)(1)(A)(ii), which provides that the Secretary's cost-reimbursement regulations shall "provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive." Petitioner asserts that the reopening regulations, as construed by the Secretary, do not create a "suitable" procedure for making "retroactive corrective adjustments" because an intermediary's refusal to reopen a determination is not subject to administrative review. . . .
>
> This argument fails for two reasons. First, and most importantly, petitioner's construction of § 1395x(v)(1)(A)(ii) is inconsistent with our decision in *Good Samaritan Hospital v. Shalala,* 508 U.S. 402 . . . (1993), in which we held that the Secretary reasonably construed clause (ii) to refer to the year-end reconciliation of monthly payments to providers, see 42 U.S.C. § 1395g, with the total amount of program reimbursement determined by the intermediary. Although we did not specifically consider the procedure for reopening determinations *after* the year's books are closed, we think our conclusion there—that clause (ii) refers to the year-end book balancing—forecloses petitioner's contention that clause (ii) requires any particular procedure for reopening reimbursement determinations. And second, the procedures for obtaining reimbursement would not be "unsuitable" simply because an intermediary's refusal to reopen is not administratively reviewable. Medicare providers already have the right under § 1395*oo* (a)(3) to appeal an intermediary's reimbursement determination to the Board. Title 42 C.F.R. § 405.1885 (1997) generously gives them a second chance to get the decision

> changed—this time at the hands of the intermediary itself, but without the benefit of administrative review. That is a "suitable" procedure, especially in light of the traditional rule of administrative law that an agency's refusal to reopen a closed case is generally " 'committed to agency discretion by law' " and therefore exempt from judicial review. See *ICC v. Locomotive Engineers,* 482 U.S. 270, 282 . . . (1987).[47]

Accordingly, it is clear that the Providers have no basis to appeal CMS' refusal to reopen the cost reports at issue.

Indeed, the substantive rule actually promulgated (*i.e.*, amending a regulation to implement a new DGME policy at 42 C.F.R. § 413.79(c)(2)(iii) (2022)) is not being challenged. Rather, the Providers' arguments, as a whole, challenge CMS' decision not to reopen certain cost reports. Again, the Supreme Court has affirmed that the refusal to reopen a reimbursement determination is not a final determination for which the Board has jurisdiction to review.[48] Refusing to reopen is, more simply, a refusal to make a new determination.[49] 42 C.F.R. § 405.1885(a)(6) also specifically states that "a determination or decision to reopen or not to reopen a determination or decision is not a final determination or decision" which is subject to administrative or judicial review. Pursuant to 42 C.F.R. § 405.1867, the Board is bound by that regulation and must find that the Providers have failed to appeal a final determination over which it has jurisdiction under 42 U.S.C. § 1395oo(a)(1).

B. CMS' decision not to reopen is consistent with its regulations governing reopening of final determinations.[50]

The Providers make additional arguments as to why CMS should be required to reopen and revise the cost reports that were finalized prior to the FY 2023 Final Rule. However, none of the Providers' arguments are valid. Briefly, 42 C.F.R. § 405.1885(c) specifies that Medicare contractors have discretion whether to reopen final determinations that they have issued, but with one caveat. The Medicare contractor's exercise of discretion is "***subject to a directive from CMS*** to reopen ***or not reopen*** the determination . . . ."[51] With regard to the retroactive application of 42 C.F.R. § 413.79(c)(iii) (2022), CMS has specifically directed Medicare contractors *to* ***not*** *reopen and revise* closed or settled cost reports.[52]

Further, the Providers' argue that, pursuant to 42 C.F.R. § 405.1885(c)(1)(I), CMS' concession in the FY 2023 Final Rule that its then current regulation was unlawful qualifies as an "explicit notice to the contractor that the contractor determination . . . is inconsistent with the applicable law." Even if the Board were to accept their argument, it would still fail because the regulation

[47] *Id.* at 453-55. *See also Barlett Mem. Med. Ctr., Inc. v. Thompson*, 347 F.3d 828 (10th Cir. 2003); *Sebelius v. Auburn Reg. Med. Ctr.*, 568 U.S. 145 (2013); *Baptist Mem. Hosp. v. Sebelius*, 603 F.3d 57 (D.C. Cir. 2010).
[48] *Your Home Visiting Nurse Services, Inc. v. Shalala,* 525 U.S. 449, 449-450 (1999).
[49] *Id.*
[50] The Board has no authority to otherwise alter or amend the Secretary's policy finalized in the preamble to the FFY 2023 IPPS Final Rule. In this section, the Board is merely expounding on the Secretary's rationale on how the reopening regulation serves as a basis for its policy.
[51] (Emphasis added.) *See also* 42 C.F.R. § 405.1885(a)(3) ("A contractor's discretion to reopen or not reopen a matter is subject to a contrary directive from CMS to reopen or not reopen that matter.").
[52] 87 Fed. Reg. at 49067.

specifies that a contractor decision must be reopened only if "*CMS understood those legal provisions, **at the time the determination or decision was rendered by the contractor***"[53] to be inconsistent with the applicable law. It was not until 2021, following the *Hershey* Court's decision, that CMS concluded its existing formula for computing the number of FTEs was inconsistent with the statutory requirements.[54]

Regardless, contrary to the Providers' position, reopening the cost reports in question would be "prohibited reopening[s]" under 42 C.F.R. § 405.1885(c)(2). In support of their position, Providers assert that CMS has no interpretive authority to violate the plain text of the Medicare statute.[55] However, it is, in fact, CMS' obligation to interpret and apply the Medicare Statute.[56] Further, consistent with this obligation, 42 C.F.R. § 405.1885(c)(2) specifically states that a "change of legal interpretation or policy by CMS in a regulation . . . *whether made in response to judicial precedent or otherwise*, is ***not*** a basis for reopening a CMS or contractor determination . . . ."[57] This is precisely the situation in these cases; CMS changed its interpretation of 42 U.S.C. § 1395ww(h)(4)(C) as set forth in its regulations "in response to judicial precedent" (*i.e.*, the *Hershey* decision).[58]

The Providers also argue that any cost reports that have been closed longer than three years "must be reopened [pursuant to 42 C.F.R. § 405.1885(b)(3)] because CMS procured those determinations 'by fraud or similar fault.'"[59] They claim CMS committed "similar fault" "because it retained Medicare funds to which it knew or should reasonably have been expected to know that it was not entitled."[60] The Board finds no merit in this argument because there is no basis to find either "fraud" or "similar fault" in these cases. CMS simply changed the regulation in response to the *Hershey* decision. There is no indication, much less evidence, of fraud or similar fault in these cases. In any event, reopening in such situations is *permissive* where a decision to not reopen would not be reviewable per *Your Home* and there is no indication that the Providers have requested reopening based on "fraud or similar" fault.[61] Moreover, these appeals cannot be considered a request that the Board reopen the determinations at issue because the Board did not make the determination at issue and, as a result, has no authority to reopen the final determinations at issue.

Finally, the Providers make bald allegations that CMS' actions are arbitrary and capricious and/or procedurally invalid,[62] but there is no discussion or suggestion that the notice-and-comment rulemaking for the FY 2023 Final Rule was deficient. CMS has opted to not reopen and revise cost reports consistent with its policy favoring finality embedded in 42 C.F.R.

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[53] (Emphasis added.)
[54] 87 Fed. Reg. at 49067.
[55] Issue Statement at 3 (citing *Chevron*, 467 U.S. 837, 842-43 (1984)).
[56] *See, e.g., MacKenzie Med. Supply,, Inc., v. Leavitt*, 506 F.3d 341, 346 (4th Cir. 2007) (". . . the Secretary is charged with administering the Medicare Act . . . .")
[57] (Emphasis added.)
[58] 87 Fed. Reg. at 49067.
[59] Issue Statement at 3 (citing 42 C.F.R. § 405.1885(b)(3)).
[60] *Id.* (citing 42 C.F.R. § 405.980).
[61] *See* 42 C.F.R. § 405.1885(b)(3) (2023) ("A Secretary or contractor determination or decision by the reviewing entity may be reopened and revised at any time if it is established that the determination or decision was procured by fraud or similar fault of any party to the determination or decision.").
[62] Issue Statement at 3.

§ 405.1885(c)(2).[63] The Providers have not made any statements or arguments to suggest how this would be deemed arbitrary.

Conclusion:

The Board hereby dismisses the twenty-five (25) appeals from the FY 2023 IPPS Final Rule listed on Attachment A filed by Powers, Pyles, Sutter & Verville, PC. because the Providers failed to appeal a "final determination" as that term is issued in 42 U.S.C. § 1395oo(a)(1) and a decision not to reopen is not an appealable determination per the Supreme Court decision in *Your Home*. Moreover, CMS' decision not to reopen is consistent with its regulations governing reopening of final determinations. 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:

3/17/2023

X Clayton J. Nix

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

cc: Bill Tisdale Novitas Solutions, Inc. (J-H)
Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E)
John Bloom, Noridian Healthcare Solutions (J-F)
Dana Johnson, Palmetto GBA c/o National Government Services, Inc. (J-M)
Byron Lamprecht, WPS Government Health Administrators (J-5)
Bruce Snyder, Novitas Solutions, Inc. (J-L)
Wilson Leong, FSS

[63] 87 Fed. Reg. at 49070.

Attachment A - List of Cases

23-0834GC	Banner Health FFY 2023 Failure to Correct DGME Fellows Penalty in Closed CY 2005 CIRP Group
23-0835GC	Banner Health FFY 2023 Failure to Correct DGME Fellows Penalty in Closed CY 2010 CIRP Group
23-0836GC	Banner Health FFY 2023 Failure to Correct DGME Fellows Penalty in Closed CY 2011 CIRP Group
23-0837GC	Banner Health FFY 2023 Failure to Correct DGME Fellows Penalty in Closed CY 2012 CIRP Group
23-0838GC	Banner Health FFY 2023 Failure to Correct DGME Fellows Penalty in Closed CY 2013 CIRP Group
23-0839GC	Banner Health FFY 2023 Failure to Correct DGME Fellows Penalty in Closed CY 2014 CIRP Group
23-0856G	Powers Pyles FFY 2023 Failure to Correct DGME Fellows Penalty in Closed CY 2001 Cost Yrs Grp
23-0858G	Powers Pyles FFY 2023 Failure to Correct DGME Fellows Penalty in Closed CY 2002 Cost Yrs Grp
23-0865G	Powers Pyles FFY 2023 Failure to Correct DGME Fellows Penalty in Closed CY 2003 Cost Yrs Grp
23-0867G	Powers Pyles FFY 2023 Failure to Correct DGME Fellows Penalty in Closed CY 2004 Cost Yrs Grp
23-0871G	Powers Pyles FFY 2023 Failure to Correct DGME Fellows Penalty in Closed CY 2005 Cost Yrs Grp
23-0872G	Powers Pyles FFY 2023 Failure to Correct DGME Fellows Penalty in Closed CY 2006 Cost Yrs Grp
23-0873G	Powers Pyles FFY 2023 Failure to Correct DGME Fellows Penalty in Closed CY 2007 Cost Yrs Grp
23-0878G	Powers Pyles FFY 2023 Failure to Correct DGME Fellows Penalty in Closed CY 2008 Cost Yrs Grp
23-0883G	Powers Pyles FFY 2023 Failure to Correct DGME Fellows Penalty in Closed CY 2009 Cost Yrs Grp
23-0885G	Powers Pyles FFY 2023 Failure to Correct DGME Fellows Penalty in Closed CY 2010 Cost Yrs Grp
23-0893G	Powers Pyles FFY 2023 Failure to Correct DGME Fellows Penalty in Closed CY 2011 Cost Yrs Grp
23-0898G	Powers Pyles FFY 2023 Failure to Correct DGME Fellows Penalty in Closed CY 2012 Cost Yrs Grp
23-0899G	Powers Pyles FFY 2023 Failure to Correct DGME Fellows Penalty in Closed CY 2013 Cost Yrs Grp
23-0900G	Powers Pyles FFY 2023 Failure to Correct DGME Fellows Penalty in Closed CY 2014 Cost Yrs Grp
23-0901G	Powers Pyles FFY 2023 Failure to Correct DGME Fellows Penalty in Closed CY 2015 Cost Yrs Grp
23-0902	Main Line Hospital Lankenau (Prov. No. 39-0195), FFY 2023 Failure to Correct DGME Fellows Penalty in Closed FYE 6/30/2016
23-0903	Main Line Hospital Lankenau (Prov. No. 39-0195), FFY 2023 Failure to Correct DGME Fellows Penalty in Closed FYE 6/30/2017
23-0904	Main Line Hospital Lankenau (Prov. No. 39-0195), FFY 2023 Failure to Correct DGME Fellows Penalty in Closed FYE 6/30/2018
23-0905	Hospital for Special Surgery (Prov. No. 33-0270), FFY 2023 Failure to Correct DGME Fellows Penalty in Closed FYE 12/31/2002

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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RE: ***Notice of Dismissal***
Case Nos. 23-0808GC, *et al.* (*see* Attachment A listing of 50 cases)

Dear Ms. Goldsmith:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal requests and final determinations in the fifty (50) appeals identified on Attachment A. They are made up of forty-six (46) group appeals and four (4) individual appeals. The Board's decision to dismiss these cases is set forth below.

Issue in Dispute

The Providers are appealing from the issuance of the Fiscal Year ("FY") 2023 Final Rule published in the Federal Register on August 10, 2022. The sole issue in these cases is "Failure to Correct the Unlawful DGME Fellows Penalty in Closed Cost Reports." The Providers' issue statements[1] describe the issue as follows:

> The Provider challenges one of the final determinations made by CMS in the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2023 Rates Final Rule, 87 Fed. Reg. 48,780, 49,066-49,072, 49,406, 49,456, 49,480 (Aug. 10, 2022) ("FY 2023 IPPS Final Rule"). In the FY 2023 IPPS Final Rule, CMS retroactively amended its regulation (42 C.F.R. §413.79(c)(2)(iii), (d)(3)) that dictates calculation of a hospital's weighted number of full-time equivalent ("FTE") residents for purposes of computing DGME payments. CMS conceded that its prior regulation was "inconsistent with the statutory requirements" of the Medicare Act and had caused what is known as the "fellows penalty" that understated DGME payments since federal fiscal year ("FY") 1997. *See id*. However, despite purporting to apply its amended regulation retroactively to cost reporting periods starting in FY

[1] The Board's decision encompasses four (4) individual appeals, thirty-four (34) common issue related party ("CIRP") group appeals, and twelve (12) optional group appeals. The issue statements are materially identical in all of the cases.

2001, CMS refused to correct DGME underpayments for any settled cost reports. See id. at 49,070. CMS must recalculate the Provider's DGME payments by applying the revised regulation, 42 C.F.R. § 413.79(c)(2)(iii) (2022) ("2022 regulation").

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In Milton S. Hershey Medical Center v. Becerra, numerous hospitals challenged this regulation. The U.S. District Court for the District of Columbia held "that Defendant's application of the regulation to compute Plaintiffs' full-time equivalent residents was contrary to law because the regulation effectively changed the weighting factors statutorily assigned to residents and fellows."

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On August 10, 2022, CMS published the FFY 2023 Final IPPS Rule, which changed the method for calculating DGME payments following the court's ruling in Hershey. See 87 Fed. Reg. 48,780, 49,066– 72 (Aug. 10, 2022). CMS conceded that its then "existing formula for computing the number of FTEs was inconsistent with the statutory requirements," and finalized a rule that applies a new formula for calculating FTEs, aligned with the decision in *Hershey*. 87 Fed. Reg. at 49,067, 49,066–072. CMS stated, "[a]fter reviewing the statutory language regarding the direct [graduate medical education] [fulltime equivalent] cap and the court's opinion [in Hershey]," the agency decided to "implement a modified policy to be applied prospectively for all teaching hospitals, as well as retroactively to the providers and cost years in Hershey and certain other providers." Id. at 48,784.

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CMS stated the Final Rule's new FTE calculation is effective retroactively to cost reporting periods beginning on or after October 1, 2001. Id. at 49,067. Despite conceding that the prior regulation is unlawful, and promulgating a corrected rule retroactive to 2001, CMS refuses to reopen closed cost reports.

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CMS's determination not to reopen and revise closed cost reports is contrary to law. The Medicare statute unambiguously requires CMS to weight fellows at no more than 0.5 in all cost reporting periods beginning on or after October 1, 1997. 42 U.S.C. § 1395ww(h)(4)(C), (h)(4)(F); *Hershey*, 2021 WL 1966572 at *2. CMS's regulations also require CMS to reopen and revise all cost reports beginning on or after October 1, 2001. 42 C.F.R. § 405.1885(c)(1). CMS's notice in the FFY 2023 Final IPPS Rule that

the prior DGME payments are contrary to law constitutes notice obligating MACs to reopen[.] 42 C.F.R. § 405.1885(c)(1)(i); *see also In re Medicare Reimbursement Litigation*, 414 F.3d 7 (2005); *Monmouth Med. Ctr. v. Thompson*, 257 F.3d 807 (2001).

CMS's concession that the pre-2022 regulation is contrary to the statute, and CMS's 2022 regulation, 42 C.F.R. § 413.79(c)(2)(iii) (2022), which is retroactive to 2001, renders the MAC's payments contrary to law "at the time the determination or decision was rendered by the contractor." Correcting closed cost reports is not a "prohibited reopening," 42 C.F.R. § 405.1885(c)(2), because CMS has no interpretive authority to violate the plain text of the Medicare statute. *Chevron U.S.A. Inc. v. Nat. Res. Def. Council, Inc.*, 467 U.S. 837, 842–43 (1984).

****

Cost reports that have been closed for longer than three years must be reopened because CMS procured those determinations "by fraud or similar fault." 42 C.F.R. § 405.1885(b)(3). CMS, as the agency charged by Congress to implement the Medicare statute, committed "similar fault" because it retained Medicare funds to which it knew or should reasonably have been expected to know that it was not entitled. *Id.* § 405.980.

CMS's determination not to apply the amended retroactive FTE count regulation to settled cost reports that were impacted by, and thus to correct for, the "fellows penalty" and DGME underpayments is contrary to the Medicare Act and the intent of the Congress, is contrary to CMS regulations, and is arbitrary and capricious, otherwise contrary to law, and/or procedurally invalid. *See* 5 U.S.C. § 706(2)(A) (providing that agency action shall be held unlawful and set aside where it is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law"); *id.* § 706(2)(C) (same where agency action is "in excess of statutory jurisdiction, authority, or limitations, or short of statutory right"); and *id.* § 706(2)(D) (same where agency action is "without observance of procedure required by law."). The Provider seeks its proper IPPS payments plus interest calculated under 42 U.S.C. § 1395oo(f)(2) and/or 42 U.S.C. § 1395g(d).

Background

A. History of the DGME Methodology

The Medicare statute requires the Secretary[2] to reimburse hospitals for the "direct" costs of hosting graduate medical training programs for physician residents (direct graduate medical education or "DGME").[3] These costs include the salaries of teaching physicians and stipends paid to resident physicians.[4]

The Medicare statute prescribes a formula for computing annual DGME payments to hospitals. The statutory formula consists of three components:

1. The hospital's number of FTE residents, or "FTE count;"
2. The hospital's average cost per resident (*i.e.* the per resident amount or "PRA"); and
3. The hospital's patient load, which is the percentage of a hospital's inpatient treatment days attributable to Medicare Part A and Part C beneficiaries.[5]

This appeal concerns the first component of the DGME payment calculation—the resident FTE count.

A hospital's FTE count for DGME reimbursement is the number of residents trained at the hospital as adjusted by three statutory provisions. First, the statute, 42 U.S.C. § 1395ww(h)(4)(C), assigned different weights to residents depending on their status. The statute states that:

> (C) . . . [I]n calculating the number of full-time equivalent residents in an approved residency period---
>
> (ii) . . .for a resident who is in the resident's initial residency period . . . the weighting factor is 1.0 . . .
>
> (iv) . . .for a resident who is not in the resident's initial residency period . . . the weighting factor is .50.

Pursuant to this statutory provision, FTEs attributable to residents who are training in their initial residency period[6] ("IRP residents") are weighted at 100 percent or 1.0, while FTEs attributable to residents who are not in their initial residency period (commonly referred to as "fellows") are weighted at 50 percent or 0.5. The sum of the weighted FTEs for IRP residents and fellows in a given year is known as a hospital's "weighted FTE count." For example, under this weighting

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[2] of the Department of Health and Human Services.
[3] 42 U.S.C. § 1395ww(h).
[4] *See* S. Rep. No. 404, 89th Cong. 1st Sess. 36 (1965); H.R. No 213, 89th Cong., 1st Sess. 32 (1965).
[5] 42 U.S.C. § 1395(h).
[6] "Initial residency period" is defined in the statute as the minimum number of years required for Board eligibility. 42 U.S.C. § 1395ww(h)(5)(F).

assignment, a hospital that trained 10 IRP residents and 10 fellows in a given year would have a weighted FTE count of 15.

On August 5, 1997, Congress enacted § 4623 of the Balanced Budget Act of 1997 ("BBA")[7] which added 42 U.S.C. § 1395ww(h)(4)(F) to establish a limit on the number of osteopathic and allopathic residents that a hospital can include in its FTE count for DGME payments. For cost reporting periods beginning on or after October 1, 1997, a hospital's unweighted DGME FTE count could not exceed the hospital's unweighted FTE count for its most recent cost reporting period ending on or before December 31, 1996. In this regard, § 1395(h)(4)(F)(i) states:

> [F]or purposes of a cost reporting period beginning on or after October 1, 1997 . . . the total number of full-time equivalent residents before the application of the weighting factors (as determined under this paragraph) with respect to a hospital's approved medical residency training program in the fields of allopathic and osteopathic medicine *may not exceed* the number (or 130 percent of such number in the case of a hospital located in a rural area) of such full-time equivalent residents for the hospital's most recent cost reporting period ending on or before December 31, 1996.[8]

Further, 42 U.S.C. § 1395ww(h)(4)(G)(i) provides that residents are counted on a three-year average. Finally, 42 U.S.C. § 1395ww(h)(4)(A) directs the Secretary to "establish rules consistent with [§ 1395ww(h)(4)] for the computation of the number of full-time equivalent residents in an approved medical residency training program."

CMS implemented BBA § 4623, in part, by promulgating regulations at 42 C.F.R. § 413.86(g)(4) to implement the unweighted FTE cap.[9] Specifically, in the FY 1998 inpatient prospective payment system ("IPPS") final rule published on August 20, 1997 ("FY 1998 IPPS Final Rule"), CMS promulgated revisions to 42 C.F.R. § 413.86(g)(4) and included the following explanation in the preamble to that rule:

> *To address situations in which a hospital increases the number of FTE residents* ***over*** *the cap*, notwithstanding the limit established under section 1886(h)(4)(F), we are establishing the following policy for determining the hospital's weighted direct GME FTE count for cost reporting periods beginning on or after October 1, 1997.
>
> - *Determine the ratio of* the hospital's unweighted FTE count for residents in those specialties for the most recent cost reporting period ending on or before December 31, 1996, *to* the hospital's number of FTE residents without application of the cap for the cost reporting period at issue.

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[7] Pub. L. 105–33, § 4623, 111 Stat. 251, 477 (1997).
[8] 42 U.S.C. § 1395ww(h)(4)(F)(i) (emphasis added). Further, 42 U.S.C. § 1395ww(h)(4)(H) directs the Secretary to establish rules for determining the caps of hospitals that establish new programs after December 31, 1996.
[9] 62 Fed. Reg. 45966, 45967, 46004 (Aug. 29, 1997).

> - *Multiply the ratio determined above by* the weighted FTE count for those residents for the cost reporting period. Add the weighted count of residents in dentistry and podiatry to determine the weighted FTEs for the cost reporting period. This methodology should be used for purposes of determining payment for cost reporting periods beginning on or after October 1, 1997. . . .
>
> For example, if the hospital's FTE count of residents in its cost reporting period ending December 31, 1996 is 100 residents before application of the initial residency weighting factors and the hospital's number of residents for its December 31, 1990 [*sic*] cost reporting period is 110 FTE residents, the ratio of residents in the two cost reporting periods equals 100/110. If the hospital's weighted FTE count is 100 FTE residents in the December 31, 1998 cost reporting period (that is, of the 110 unweighted residents, 20 are beyond the initial residency period and are weighted as 0.5 FTE), the hospital's weighted FTE count for determining direct GME payment is equal to (100/110) [x] 100, or 90.9 FTE residents. . . .
>
> ****
>
> We believe this ***proportional*** *reduction* in the hospital's unweighted FTE count is an equitable mechanism for implementing the statutory provision.[10]

Section 413.86(g)(4) remained unchanged until the FY 2002 IPPS final rule published on August 1, 2001 ("FY 2002 IPPS Final Rule").[11] Therein, the Secretary modified the allowable FTEs formula so that the proportionate reduction to the weighted FTE count would be calculated separately for FTEs attributable to residents trained in primary care, obstetrics and gynecology programs and residents training in nonprimary care programs. In that final rule, the modified methodology, effective for cost report periods beginning on or after October 1, 2001 was:

> *Step 1.* Determine that the hospital's total unweighted FTE counts in the payment year cost reporting period and the prior two immediately preceding cost reporting periods for all residents in allopathic and osteopathic medicine do not exceed the hospital's FTE cap for these residents in accordance with § 413.86(g)(4). *If the hospital's total unweighted FTE count in a cost reporting period exceeds its cap*, the hospital's weighted FTE count, for primary care and obstetrics and gynecology residents and nonprimary care residents, respectively, will be reduced *in the same* ***proportion*** that the number of these FTE residents for that

[10] 62 Fed. Reg. at 46005 (emphasis added).
[11] 66 Fed. Reg. 39826 (Aug. 1, 2001).

> cost reporting period exceeds the unweighted FTE count in the cap. The ***proportional reduction*** is calculated *for primary care* ***and*** *obstetrics and gynecology residents and nonprimary care residents separately* in the following manner:
>
> > (FTE cap/unweighted total FTEs in the cost reporting period) × (weighted primary care and obstetrics and gynecology FTEs in the cost reporting period)
> >
> > plus
> >
> > (FTE cap/unweighted total FTEs in the cost reporting period) × (weighted nonprimary care FTEs in the cost reporting period).
>
> Add the two products to determine the hospital's reduced cap.[12]

To codify this change, the Secretary added clause (iii) to 42 § 413.86(g)(4). In the final rule published on the August 11, 2004, CMS relocated 42 C.F.R. § 413.86(g)(4)(iii) to 42 C.F.R. § 413.79(c)(2)(iii) (2004).[13] This regulation is the focus this appeal, and it stated the following:

> If the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 2001 exceeds the limit described in this section [*i.e.*, the FTE cap or limit], the hospital's weighted FTE count (before application of the limit) for primary care and obstetrics and gynecology residents and nonresidents, respectively, will be reduced in the same proportion that the number of FTE residents for that cost reporting period exceeds the number of FTE residents for the most recent cost reporting period ending on or before December 31, 1996.[14]

As previously noted, this regulation addressed how to reduce a hospital's weighted FTE count for a fiscal year when the unweighted FTE count for that fiscal year exceeds the hospital's unweighted FTE cap.

On their cost reports, hospitals report the number of allopathic and osteopathic FTE residents (before applying the weighting factors mentioned above) that were actually trained at the facility in that year.[15]

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[12] *Id.* at 39894 (emphasis added).
[13] *See* 69 Fed. Reg. 48916, 49258-64. As part of the relocation, CMS modified the language slightly by removing the references to "paragraph (g)" that was in the prior version of the regulation and replacing it them with reference to "the limit described in this section."
[14] 42 C.F.R. §§ 413.79(c)(2)(iii) (2011). The Secretary has not made any changes to § 413.79(c)(2)(iii) since the FY 2005 IPPS final rule.
[15] 77 Fed. Reg. 53258, 53423 (Aug. 31, 2012) (stating that when a hospital trains residents in excess of its cap, "it should report those FTE residents on its cost report regardless of whether or not it is training over its caps.")

In addition, the statute sets the number of FTEs a hospital can claim for reimbursement as the hospital's average FTE count between the present, prior and penultimate years. The statute states:

> [T]he total number of full-time equivalent residents for determining a hospital's graduate medical education payment shall equal the average of the actual full-time equivalent resident counts for the cost reporting period and the preceding two cost reporting periods.[16]

Therefore, a hospital's present year FTE count, after applying the weighting factors and FTE caps, was averaged with the FTE counts from the prior and penultimate years.

B. The Board's Analysis of 42 C.F.R. § 413.79(c)(2)(iii) (2004)

The Board has received a number of appeals concerning the DGME methodology for which it granted Expedited Judicial Review ("EJR").[17] Providers would typically assert that the regulation at 42 C.F.R. § 413.79(c)(2)(iii) (2004) penalized hospitals which exceeded their FTE caps. They would assert that § 413.79(c)(2)(iii) (2004) stated the following equation for calculating the weighted cap (*i.e.* "Allowable FTE Count") for a particular FY and that this formula resulted in the perceived disparate treatment between IRP residents and fellows. Specifically, in their EJR request, providers often presented the following equation used to calculate the allowable count for primary care and obstetrics and gynecology residents and separately for nonprimary care residents:

$$\text{WFTE}\left(\frac{\text{UCap}}{\text{UFTE}}\right) = \text{WCap}$$ [18]

Accordingly, the Board set out to confirm the Providers' assertion that § 413.79(c)(2)(iii) does in fact set forth the above equation.

The Board noted that, pursuant to the introductory phrase in § 413.79(c)(2)(iii) (*i.e.*, "[i]f the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 2001 exceeds the limit described in this section [*i.e.*, the FTE cap or limit]"), the above equation is used ***<u>only</u>*** when the "Unweighted FTE Count" for a FY exceeds the "Unweighted FTE Cap" in order to determine what the Providers describe as the "Allowable [weighted] FTE count" for the FY.[19] As such, the equation would logically appear to be a method used to translate the "Unweighted FTE Cap" into a *weighted* context where the "Allowable FTE count" for a FY is really a "weighted FTE cap" for the FY because it is ***only*** used when the unweighted FTE count exceeds the unweighted FTE cap. Indeed, the Board's description of the product of the equation as a "cap" was consistent with the Secretary's description of it as a "reduced cap" in the preamble

[16] 42 U.S.C. § 1395ww(h)(4)(G)(i).
[17] *See, e.g.,* PRRB Case 19-2489GC, EJR Determination (July 26, 2022).
[18] *Id.* at 4.
[19] *See also* 62 Fed. Reg. at 46005 (describing the purpose of the regulation being adopted in the final rule as follows: "To address situations in which a hospital increases the number of FTE residents over the cap, notwithstanding the limit established under section 1886(h)(4)(F), we are establishing the following policy for determining the hospital's *weighted* direct GME FTE count for cost reporting periods beginning on or after October 1, 1997." (Emphasis added.)).

to the FY 2002 IPPS Final Rule.[20] Accordingly, the Board referred to the variable "Allowable FTE count" for the FY as the "Weighted FTE Cap" to facilitate the Board's discussion below on how the equation is conceptually set forth in the text of § 413.79(c)(2)(iii) (2004).

Bearing this concept in mind, the Board reviewed the regulation closely and agreed that § 413.79(c)(2)(iii) (2004) essentially states the above equation, albeit in a slightly different form where the difference is inconsequential and it gives the same results. In its entirety, § 413.79(c)(2)(iii) (2004) stated:

> If the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 2001 exceeds the limit described in this section [*i.e.*, the FTE cap or limit], the hospital's weighted FTE count (before application of the limit) for primary care and obstetrics and gynecology residents and nonprimary care residents, respectively, *will be reduced* ***in the same proportion*** that the number of FTE residents for that cost reporting period exceeds the number of FTE residents for the most recent cost reporting period ending on or before December 31, 1996 [*i.e.*, the FTE cap or limit].[21]

At first blush, it would not appear that the equation is specifically stated in the regulation. However, once the regulation is unpacked around the words "in the same proportion," it is clear that the regulation is relying on ratios as the basis for the equation used to calculate the Weighted FTE Cap applicable for the fiscal year.[22] Indeed, CMS reiterates this in the preamble to the FY 1998 Final Rule by rationalizing § 413.79(c)(2)(iii) as follows: "We believe this ***proportional reduction*** in the hospital's unweighted FTE count is an equitable mechanism for implementing the statutory provision."[23] Essentially, the regulation is stating that the Weighted FTE Cap is to the FY's Weighted FTE Count as the Unweighted FTE Cap is to the FY's Unweighted FTE Count. The calculation of the Weighted FTE Cap is achieved through the operation of the following simple algebraic principle of equivalent fractions[24] (*i.e.*, ratios) using variables a, b, c, and d:

$$\textit{If } \frac{a}{b} = \frac{c}{d} \textit{ then } \mathrm{c} = \frac{a}{b}\ x\ d$$

On the first side of the initial algebraic equation (*i.e.*, the ratio of "a / b") is the following phrase: "the number of FTE residents for that cost reporting period exceeds [the FTE cap or

[20] 66 Fed. Reg. at 39894 (emphasis added).
[21] (Emphasis added.)
[22] *See* 62 Fed. Reg. at 46005 (emphasis added).
[23] *Id.* (emphasis added). *See also* 66 Fed. Reg. at 39894 ("[F]or primary care and obstetrics and gynecology residents and nonprimary care residents, respectively, will be reduced *in the same* ***proportion*** that the number of these FTE residents for that cost reporting period exceeds the unweighted FTE count in the cap. The ***proportional reduction*** is calculated *for primary care* ***and*** *obstetrics and gynecology residents and nonprimary care residents separately…."* (Emphasis added.)).
[24] Two alternative ways to express the algebraic principle of equivalent functions include:
If a/b = c/d, then c = (a x d) / b ; and
If a/b = c/d, then c = (a/b) x d.

limit].” This phrase (the ***Unweighted FTE Cap*** is to the ***FY’s Unweighted FTE Count***) expressed as a ratio (“a/b”) is the Unweighted FTE Cap over the FY’s Unweighted FTE Count.[25]

On the other side of the algebraic equation (*i.e.*, the ratio of “c /d”) is the following phrase: “the hospital’s weighted FTE count (before application of the limit) . . . will be reduced in the same proportion.” This phrase expressed as a ratio (“c/d”) is an *unknown* Weighted FTE Cap over the FY’s Weighted FTE Count. In other words, the unknown Weighted FTE Cap is the resulting value of the weighted FTEs being reduced in the same proportion as the FY Unweighted FTE Count exceeds the Unweighted FTE cap. The full proportional equation is expressed as follows:

$$\frac{Unweighted\ FTE\ Cap\ (a)}{FY's\ Unweighted\ FTE\ Count\ (b)} = \frac{Weighted\ \ FTE\ Cap\ (c)}{FY's\ Weighted\ FTE\ Count\ (d)}$$

The unknown Weighted FTE Cap (variable “c”) is then determined by a/b x d. In other words, the unknown Weighted FTE Cap is determined by the following formula:

$$\boldsymbol{Weighted\ FTE\ cap} = \frac{Unweighted\ \ FTE\ Cap}{Unweighted\ FTE\ Count} \times\ Weighted\ FTE\ Count$$

This formula is clearly stated in the preambles to both the FYs 1998 and 2002 IPPS Final Rules as previously quoted.

Based on the above, the Board found that 42 C.F.R. § 413.79(c)(2)(iii) (2004) did set forth the equation being challenged and, accordingly, that the providers were challenging the validity of § 413.79(c)(2)(iii) (2004). The Board also found that EJR was appropriate for the issue under dispute in the cases challenging the DGME methodology.

C. Milton S. Hershey Med. Ctr. v. Becerra and 42 C.F.R. § 413.79(c)(2)(iii) (2022)[26]

One group of providers appealed to U.S. District Court for the District of Columbia in *Hershey* to challenge the regulation setting forth the DGME methodology.[27] The Court ultimately found that CMS’ “application of the regulation to calculate [the providers’] reimbursement payments was unlawful because, in calculating the weighted number of FTE residents, the regulation effectively changed the weighting factors for residents and fellows that Congress established in the Medicare statute.”[28]

The Court looked to the enabling statute for the DGME payment at 42 U.S.C. § 1395ww(h)(4)(C), noting it commanded that rules promulgated by the Secretary would weight residents at 1.0 and

[25] Note that, in using equivalent ratios, the key is the relationship of the ratios. As such, the relation between the ratios does not change if they are flipped. For example, if these ratios are flipped, then the initial equation becomes the FY’s Weighted FTE Count (variable d) over the Weighted FTE Cap (variable c) equals the FY’s Unweighted FTE Count (variable b) over the Unweighted FTE Cap (variable a). The unknown variable is still “c” and you would get the same results where rule would then be: If b/a = d/c, then c = (a/b) x d.
[26] 2021 WL 1966572 (D.D.C. 2021) (“*Hershey*”).
[27] *Hershey* at *1.
[28] *Id.* at *3.

fellows at 0.5.[29] The regulation at 42 C.F.R. § 413.79(c)(2)(iii) (2004), however, effectively reduced the weighted FTE count when a hospital exceeds its FTE cap and employs fellows. The Court found that "the text of the statute does not give the Secretary the latitude to decide . . . to change the weights that Congress assigned to residents and fellows when he calculates the FTE residents for each hospital."[30] The Court also found the statute at 42 U.S.C. § 1395ww(h)(4)(C) was not ambiguous, but clear, and since the challenged regulation contradicted mandatory (*i.e.*, "shall") provisions of the statute, the regulation failed the first step in the analysis set forth in *Chevron.*[31] Thus, the Court held the DGME regulation was unlawful as applied to the providers in that case.[32]

Following the decision in *Hershey*, the Secretary issued the FY 2023 Final Rule to replace the policy at 42 C.F.R. § 413.79(c)(2)(iii) (2004) and implement a modified policy applicable to all teaching hospitals, effective as of October 1, 2021.[33] While the DGME methodology struck down in *Hershey* was first applicable to cost reports beginning October 1, 1997, the Secretary noted there did not appear to be any "open or reopenable" Notices of Program Reimbursement ("NPRs") for 1997-2001 and, as such, opted to amend the policy for cost reporting periods beginning on or after October 1, 2001.[34] The Secretary acknowledged that the policy set forth in 42 C.F.R. § 413.79(c)(2)(iii) (2004) was inconsistent with the statutory requirements of 42 U.S.C. § 1395ww(h)(4)(C). Since, however, 42 U.S.C. § 1395ww(h)(4)(A) directs the Secretary to "establish rules consistent with [§ 1395ww(h)(4)] for the computation of the number of full-time equivalent residents in an approved medical residency training program[,]" the Secretary determined retroactive rulemaking was necessary to modify the methodology for cost reporting periods beginning on or after October 1, 2001. As such, the regulation at 42 C.F.R. § 413.79(c)(2)(iii) and the related cost reporting instructions were revised to incorporate a new methodology that "would address situations for applying the FTE cap when a hospital's weighted FTE count was greater than its FTE cap, but would not reduce the weighting factor of residents that are beyond their IRP by an amount less than 0.5."[35] However, the Secretary specifically noted that, consistent with 42 C.F.R. § 405.1885(c)(2), the retroactive rule would ***not*** cover cost reporting periods for which any NPRs had already been settled.[36]

The Secretary maintained, over commenters' objections, that retroactive rulemaking was the appropriate means to implement its new DGME methodology because: (1) 42 U.S.C. § 1395ww(h)(4)(A) states that "[t]he Secretary shall establish rules *consistent with this paragraph* for the computation of the number of full-time equivalent residents in an approved medical residency training program; and (2) The court in *Hershey* held, and the Secretary agreed, that the method for computing FTEs was not consistent with statutory requirements.[37] The Secretary also maintained that declining to open closed cost reports through this retroactive rule was consistent with 42 C.F.R. § 405.1885(c)(2), which states that a "change of legal interpretation or policy by

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[29] *Id.* at *5.
[30] *Id.*
[31] *Chevron v. Nat. Res. Def. Council*, 467 U.S. 837 (1984).
[32] *Id.*
[33] 87 Fed. Reg. 28108, 28410-28412 (May 10, 2022).
[34] *See* 87 Fed. Reg. 48780, 49067 (Aug. 10, 2022). CMS had solicited comments alerting them of any open or openable NPRs for 1997-2001, but this discussion suggests that apparently CMS did not receive any such comments.
[35] *Id.* at 49067-49068.
[36] *Id.* at 49067, 49070.
[37] *Id.* at 49068-49069.

CMS in a regulation . . . made in response to judicial precedent," is "not a basis for reopening a CMS or contractor determination."[38]

Decision of the Board

The Providers are challenging the refusal of the CMS to apply the newly revised 42 C.F.R. § 413.79(c)(2)(iii) (2022) to the fiscal years at issue.[39] They argue that the CMS' determination to not reopen and revise the closed cost reports at issue is contrary to law.[40] The Providers state that CMS is *required* to reopen and revise *all* cost reports beginning on or after October 1, 2001 (the effective date of the retroactive regulation) pursuant to 42 C.F.R. § 405.1885(c)(1)(i), which provides an example of a CMS-directed reopening:

> A contractor determination . . . must be reopened and revised if CMS provides explicit notice to the contractor that the contractor determination . . . is inconsistent with the applicable law, regulations, CMS ruling, or other interpretive rules, general statements of policy, and rules of agency organization, procedure, or practice established by CMS in effect, and as CMS understood those legal provisions, at the time the determination or decision was rendered by the contractor. CMS may also direct the contractor to reopen a particular contractor determination or decision in order to implement a final agency decision (as described in §§405.1833, 405.1871(b) and 405.1875 of this subpart), a final, non-appealable court judgment §405.1877, or an agreement to settle an administrative appeal or a lawsuit, regarding the same determination or decision.

The Providers argue that CMS' concession that the pre-2022 regulation is contrary to 42 U.S.C. § 1395ww(h)(4)(C) renders the Medicare Contractor's payments in closed cost reports contrary to law "at the time the determination or decision was rendered by the contractor." [41] As such, the Providers assert that CMS is *required* to reopen and revise these cost reports.

As set forth below, the Board finds that it does not have jurisdiction over the Providers' appeals of this issue.

A. The Providers have failed to appeal a "final determination" as that term is issued in 42 U.S.C. § 1395oo(a)(1).

While a provider typically has appeal rights from the publication of a final rule in the Federal Register,[42] the policy being appealed here is not a "***final*** determination"[43] within the context of 42 U.S.C. § 1395oo(a)(1) because the policy has no reimbursement impact on cost reports at issue *that have already been settled and closed*. 42 U.S.C. § 1395oo(a) typically allows two types of

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[38] *Id.* at 49070.
[39] Issue Statement at 1.
[40] *Id.* at 2.
[41] *Id.* at 3.
[42] *See Washington Hosp. Ctr. v. Bowen,* 795 F.2d 139 (D.C. Cir. 1986).
[43] (Emphasis added.)

appeals: directly from a Medicare Contractor's "final determination" issued in the form of a Notice of Program Reimbursement ("NPR"), or from the issuance of a notice of what will be paid under the IPPS system.[44] With regard to the latter, once a hospital's IPPS payment amounts are finally determined or set by CMS, there has been a "final determination" that is subject to an appeal before the Board.[45] In these cases, the Providers' IPPS payment amounts were finally determined when their NPRs were issued in accordance with the prior DGME policy. The revised DGME policy set forth in the FY 2023 IPPS Rule has not altered or set any payment amount the Providers received or will receive. Indeed, that is the crux of the Providers' challenge: that their payment amounts have not been, and will not be, set to a different amount.

The Supreme Court addressed this very issue in its 1999 decision for *Your Home Visiting Nurse Services, Inc. v. Shalala*.[46] Specifically, the Supreme Court confirmed that the decision of the Medicare Contractor, CMS or the Secretary to not reopen a final determination is precluded from administrative and judicial review:

> Petitioner relies upon 42 U.S.C. § 1395*oo* (a)(1)(A)(i), which says that a provider may obtain a hearing before the Board with respect to a cost report if the provider "is dissatisfied with a final determination of . . . its fiscal intermediary . . . as to the amount of total program reimbursement due the provider . . . for the period covered by such report . . . ." Petitioner maintains that the refusal to reopen a reimbursement determination constitutes a separate "final determination . . . as to the amount of total program reimbursement due the provider." The Secretary, on the other hand, maintains that

[44] *Id.* at 144-145.
[45] *Id.* at n.7. *See also Abbott-Northwestern Hosp. v. Leavitt*, 377 F.Supp.2d 119, 127 (D.D.C. 2005) (noting that a letter from the Secretary declining a hospital's request to revise certain payments was a "final determination" because it "did not suggest that the decision would be revisited, and it established definitely the amount" of certain payments.). In their appeal requests, the Providers cite to a 1993 decision of the Administrator pertaining to an appeal of the 1992 wage index rates published in the Federal Register. However, that decision is not supportive as made plain by the following excerpt from that decision:

> After a review of the record, the law, applicable regulations and court's decision in Washington Hospital Center, the Administrator determines that the Providers can appeal the validity of the wage index that the Secretary has established for Federal fiscal year 1992 for the District of Columbia hospitals, within 180 days of the publication of the wage index in the Federal Register. Both the Board and BPD, although finding that publication of the rates did not constitute a final determination of the Secretary, failed to cite what constituted such a determination for purposes of appeal under PPS.
>
> The controlling case law clearly holds that Congress did not intend for a PPS hospital to wait until the issuance of an NPR before it can appeal the final determination of the Secretary as to the amount of payment under subsection (b) or (d) of Section 1886 [PPS]. The publication of the wage index is the only formal notice, other than the NPR, that these Providers received regarding their DRG prospective payment rate under Section 1886(d) of the Act. Therefore, the finding that this publication is not a final determination of the Secretary conflicts with the court's reasoning in Washington Hospital Center. Based on the controlling case law, the Administrator determines that the publication of the wage index in the Federal Register constitutes a "final determination of the Secretary" for purposes of Section 1878(a)(1)(A)(ii) of the Act.

District of Columbia Hospital Association Wage Index Group Appeal, Adm'r Dec. (Jan. 15, 1993), *vacating* PRRB Juris. Dec., Case No. 92-1200G (Nov. 18, 1992) (footnotes omitted).
[46] 525 U.S. 449 (1999).

this phrase does not include a refusal to reopen, which is not a "final determination . . . as to the amount," but rather the *refusal* to make a new determination. The Secretary's reading of § 1395*oo* (a)(1)(A)(i) frankly seems to us the more natural—but it is in any event well within the bounds of reasonable interpretation, and hence entitled to deference under *Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc.,* 467 U.S. 837, 842 . . . (1984).

The reasonableness of the Secretary's construction of the statute is further confirmed by *Califano v. Sanders,* 430 U.S. 99 . . . (1977), in which we held that § 205(g) of the Social Security Act does not authorize judicial review of the Secretary's decision not to reopen a previously adjudicated claim for benefits. In reaching this conclusion we relied, in part, upon two considerations: that the opportunity to reopen a benefit adjudication was afforded only by regulation and not by the Social Security Act itself; and that judicial review of a reopening denial would frustrate the statutory purpose of imposing a 60–day limit on judicial review of the Secretary's final decision on an initial claim for benefits. *Id.,* at 108. Similar considerations apply here. The right of a provider to seek reopening exists only by grace of the Secretary, and the statutory purpose of imposing a 180–day limit on the right to seek Board review of NPRs, see 42 U.S.C. § 1395*oo* (a)(3), would be frustrated by permitting requests to reopen to be reviewed indefinitely.

Finally, we do not think that the Secretary's position is inconsistent with 42 U.S.C. § 1395x(v)(1)(A)(ii), which provides that the Secretary's cost-reimbursement regulations shall "provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive." Petitioner asserts that the reopening regulations, as construed by the Secretary, do not create a "suitable" procedure for making "retroactive corrective adjustments" because an intermediary's refusal to reopen a determination is not subject to administrative review. . . .

This argument fails for two reasons. First, and most importantly, petitioner's construction of § 1395x(v)(1)(A)(ii) is inconsistent with our decision in *Good Samaritan Hospital v. Shalala,* 508 U.S. 402 . . . (1993), in which we held that the Secretary reasonably construed clause (ii) to refer to the year-end reconciliation of monthly payments to providers, see 42 U.S.C. § 1395g, with the total amount of program reimbursement determined by the intermediary. Although we did not specifically consider the procedure for reopening determinations *after* the year's books are closed, we think our conclusion there—that clause (ii) refers to the year-end book balancing—forecloses

> petitioner's contention that clause (ii) requires any particular procedure for reopening reimbursement determinations. And second, the procedures for obtaining reimbursement would not be "unsuitable" simply because an intermediary's refusal to reopen is not administratively reviewable. Medicare providers already have the right under § 1395*oo* (a)(3) to appeal an intermediary's reimbursement determination to the Board. Title 42 C.F.R. § 405.1885 (1997) generously gives them a second chance to get the decision changed—this time at the hands of the intermediary itself, but without the benefit of administrative review. That is a "suitable" procedure, especially in light of the traditional rule of administrative law that an agency's refusal to reopen a closed case is generally " 'committed to agency discretion by law' " and therefore exempt from judicial review. See *ICC v. Locomotive Engineers,* 482 U.S. 270, 282 . . . (1987).[47]

Accordingly, it is clear that the Providers have no basis to appeal CMS' refusal to reopen the cost reports at issue.

Indeed, the substantive rule actually promulgated (*i.e.*, amending a regulation to implement a new DGME policy at 42 C.F.R. § 413.79(c)(2)(iii) (2022)) is not being challenged. Rather, the Providers' arguments, as a whole, challenge CMS' decision not to reopen certain cost reports. Again, the Supreme Court has affirmed that the refusal to reopen a reimbursement determination is not a final determination for which the Board has jurisdiction to review.[48] Refusing to reopen is, more simply, a refusal to make a new determination.[49] 42 C.F.R. § 405.1885(a)(6) also specifically states that "a determination or decision to reopen or not to reopen a determination or decision is not a final determination or decision" which is subject to administrative or judicial review. Pursuant to 42 C.F.R. § 405.1867, the Board is bound by that regulation and must find that the Providers have failed to appeal a final determination over which it has jurisdiction under 42 U.S.C. § 1395oo(a)(1).

B. CMS' decision not to reopen is consistent with its regulations governing reopening of final determinations.[50]

The Providers make additional arguments as to why CMS should be required to reopen and revise the cost reports that were finalized prior to the FY 2023 Final Rule. However, none of the Providers' arguments are valid. Briefly, 42 C.F.R. § 405.1885(c) specifies that Medicare contractors have discretion whether to reopen final determinations that they have issued, but with one caveat. The Medicare contractor's exercise of discretion is "***subject to a directive from CMS*** to reopen ***or not reopen*** the determination . . . ."[51] With regard to the retroactive application of 42

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[47] *Id.* at 453-55. *See also Barlett Mem. Med. Ctr., Inc. v. Thompson*, 347 F.3d 828 (10th Cir. 2003); *Sebelius v. Auburn Reg. Med. Ctr.*, 568 U.S. 145 (2013); *Baptist Mem. Hosp. v. Sebelius*, 603 F.3d 57 (D.C. Cir. 2010).
[48] *Your Home Visiting Nurse Services, Inc. v. Shalala,* 525 U.S. 449, 449-450 (1999).
[49] *Id.*
[50] The Board has no authority to otherwise alter or amend the Secretary's policy finalized in the preamble to the FFY 2023 IPPS Final Rule. In this section, the Board is merely expounding on the Secretary's rationale on how the reopening regulation serves as a basis for its policy.
[51] (Emphasis added.) *See also* 42 C.F.R. § 405.1885(a)(3) ("A contractor's discretion to reopen or not reopen a matter is subject to a contrary directive from CMS to reopen or not reopen that matter.").

C.F.R. § 413.79(c)(iii) (2022), CMS has specifically directed Medicare contractors *to **not** reopen and revise* closed or settled cost reports.[52]

Further, the Providers' argue that, pursuant to 42 C.F.R. § 405.1885(c)(1)(I), CMS' concession in the FY 2023 Final Rule that its then current regulation was unlawful qualifies as an "explicit notice to the contractor that the contractor determination . . . is inconsistent with the applicable law." Even if the Board were to accept their argument, it would still fail because the regulation specifies that a contractor decision must be reopened only if "*CMS understood those legal provisions, **at the time the determination or decision was rendered by the contractor***"[53] to be inconsistent with the applicable law. It was not until 2021, following the *Hershey* Court's decision, that CMS concluded its existing formula for computing the number of FTEs was inconsistent with the statutory requirements.[54]

Regardless, contrary to the Providers' position, reopening the cost reports in question would be "prohibited reopening[s]" under 42 C.F.R. § 405.1885(c)(2). In support of their position, Providers assert that CMS has no interpretive authority to violate the plain text of the Medicare statute.[55] However, it is, in fact, CMS' obligation to interpret and apply the Medicare Statute.[56] Further, consistent with this obligation, 42 C.F.R. § 405.1885(c)(2) specifically states that a "change of legal interpretation or policy by CMS in a regulation . . . *whether made in response to judicial precedent or otherwise*, is ***not*** a basis for reopening a CMS or contractor determination . . . ."[57] This is precisely the situation in these cases; CMS changed its interpretation of 42 U.S.C. § 1395ww(h)(4)(C) as set forth in its regulations "in response to judicial precedent" (*i.e.*, the *Hershey* decision).[58]

The Providers also argue that any cost reports that have been closed longer than three years "must be reopened [pursuant to 42 C.F.R. § 405.1885(b)(3)] because CMS procured those determinations 'by fraud or similar fault.'"[59] They claim CMS committed "similar fault" "because it retained Medicare funds to which it knew or should reasonably have been expected to know that it was not entitled."[60] The Board finds no merit in this argument because there is no basis to find either "fraud" or "similar fault" in these cases. CMS simply changed the regulation in response to the *Hershey* decision. There is no indication, much less evidence, of fraud or similar fault in these cases. In any event, reopening in such situations is *permissive* where a decision to not reopen would not be reviewable per *Your Home* and there is no indication that the Providers have requested reopening based on "fraud or similar" fault.[61] Moreover, these appeals cannot be considered a

[52] 87 Fed. Reg. at 49067.
[53] (Emphasis added.)
[54] 87 Fed. Reg. at 49067.
[55] Issue Statement at 3 (citing *Chevron*, 467 U.S. 837, 842-43 (1984)).
[56] *See, e.g., MacKenzie Med. Supply,, Inc., v. Leavitt*, 506 F.3d 341, 346 (4th Cir. 2007) (". . . the Secretary is charged with administering the Medicare Act . . . .")
[57] (Emphasis added.)
[58] 87 Fed. Reg. at 49067.
[59] Issue Statement at 3 (citing 42 C.F.R. § 405.1885(b)(3)).
[60] *Id.* (citing 42 C.F.R. § 405.980).
[61] *See* 42 C.F.R. § 405.1885(b)(3) (2023) ("A Secretary or contractor determination or decision by the reviewing entity may be reopened and revised at any time if it is established that the determination or decision was procured by fraud or similar fault of any party to the determination or decision.").

request that the Board reopen the determinations at issue because the Board did not make the determination at issue and, as a result, has no authority to reopen the final determinations at issue.

Finally, the Providers make bald allegations that CMS' actions are arbitrary and capricious and/or procedurally invalid,[62] but there is no discussion or suggestion that the notice-and-comment rulemaking for the FY 2023 Final Rule was deficient. CMS has opted to not reopen and revise cost reports consistent with its policy favoring finality embedded in 42 C.F.R. § 405.1885(c)(2).[63] The Providers have not made any statements or arguments to suggest how this would be deemed arbitrary.

Conclusion:

The Board hereby dismisses the fifty (50) appeals from the FY 2023 IPPS Final Rule listed on Attachment A filed by Bass, Berry & Sims, PLC because the Providers failed to appeal a "final determination" as that term is issued in 42 U.S.C. § 1395oo(a)(1) and a decision not to reopen is not an appealable determination per the Supreme Court decision in *Your Home*. Moreover, CMS' decision not to reopen is consistent with its regulations governing reopening of final determinations. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

3/17/2023

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

cc: Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E)
Dana Johnson, Palmetto GBA c/o National Government Services, Inc. (J-M)
Bruce Snyder, Novitas Solutions, Inc. (J-L)
Judith Cummings, CGS Administrators (J-15)
Danelle Decker, National Government Services, Inc. (J-K)
Wilson Leong, FSS

[62] Issue Statement at 3.
[63] 87 Fed. Reg. at 49070.

Attachment A - List of Cases

23-0808GC	Premier Health Partners FFY 2023 DGME Fellows Penalty in Closed CY 2005 Cost Reports CIRP Group
23-0810GC	Premier Health Partners FFY 2023 DGME Fellows Penalty in Closed CY 2006 Cost Reports CIRP Group
23-0811GC	Premier Health Partners FFY 2023 DGME Fellows Penalty in Closed CY 2007 Cost Reports CIRP Group
23-0812GC	Premier Health Partners FFY 2023 DGME Fellows Penalty in Closed CY 2008 Cost Reports CIRP Group
23-0813GC	Premier Health Partners FFY 2023 DGME Fellows Penalty in Closed CY 2009 Cost Reports CIRP Group
23-0814GC	Premier Health Partners FFY 2023 DGME Fellows Penalty in Closed CY 2011 Cost Reports CIRP Group
23-0815GC	Premier Health Partners FFY 2023 DGME Fellows Penalty in Closed CY 2012 Cost Reports CIRP Group
23-0816GC	Premier Health Partners FFY 2023 DGME Fellows Penalty in Closed CY 2013 Cost Reports CIRP Group
23-0817GC	Hackensack Meridian FFY 2023 DGME Fellows Penalty in Closed CY 2006 Cost Reports CIRP Group
23-0818GC	Hackensack Meridian FFY 2023 DGME Fellows Penalty in Closed CY 2007 Cost Reports CIRP Group
23-0819GC	Hackensack Meridian FFY 2023 DGME Fellows Penalty in Closed CY 2008 Cost Reports CIRP Group
23-0820GC	Hackensack Meridian FFY 2023 DGME Fellows Penalty in Closed CY 2009 Cost Reports CIRP Group
23-0821GC	Hackensack Meridian FFY 2023 DGME Fellows Penalty in Closed CY 2013 Cost Reports CIRP Group
23-0822GC	UPMC FFY 2023 DGME Fellows Penalty in Closed CY 2007 Cost Reports CIRP Group
23-0823GC	UPMC FFY 2023 DGME Fellows Penalty in Closed CY 2008 Cost Reports CIRP Group
23-0824GC	UPMC FFY 2023 DGME Fellows Penalty in Closed CY 2009 Cost Reports CIRP Group
23-0825GC	UPMC FFY 2023 DGME Fellows Penalty in Closed CY 2010 Cost Reports CIRP Group
23-0826GC	UPMC FFY 2023 DGME Fellows Penalty in Closed CY 2011 Cost Reports CIRP Group
23-0827GC	UPMC FFY 2023 DGME Fellows Penalty in Closed CY 2012 Cost Reports CIRP Group
23-0828GC	UPMC FFY 2023 DGME Fellows Penalty in Closed CY 2013 Cost Reports CIRP Group
23-0829GC	UPMC FFY 2023 DGME Fellows Penalty in Closed CY 2014 Cost Reports CIRP Group
23-0830GC	Univ. of PA Health Sys. FFY 2023 DGME Fellows Penalty in Closed CY2008 Cost Reports CIRP Group
23-0831GC	Univ. of PA Health Sys. FFY 2023 DGME Fellows Penalty in Closed CY2009 Cost Reports CIRP Group
23-0832GC	Univ. of PA Health Sys. FFY 2023 DGME Fellows Penalty in Closed CY2010 Cost Reports CIRP Group
23-0833GC	Univ. of PA Health Sys. FFY 2023 DGME Fellows Penalty in Closed CY2011 Cost Reports CIRP Group
23-0840GC	Univ. of PA Health Sys. FFY 2023 DGME Fellows Penalty in Closed CY2012 Cost Reports CIRP Group
23-0841GC	Univ. of PA Health Sys. FFY 2023 DGME Fellows Penalty in Closed CY2014 Cost Reports CIRP Group
23-0842G	Bass, Berry & Sims, PLC FFY 2023 DGME Fellows Penalty in Closed CY2004 Cost Reports Group
23-0843G	Bass, Berry & Sims, PLC FFY 2023 DGME Fellows Penalty in Closed CY2005 Cost Reports Group
23-0844G	Bass, Berry & Sims, PLC FFY 2023 DGME Fellows Penalty in Closed CY2006 Cost Reports Group
23-0845G	Bass, Berry & Sims, PLC FFY 2023 DGME Fellows Penalty in Closed CY2007 Cost Reports Group
23-0846G	Bass, Berry & Sims, PLC FFY 2023 DGME Fellows Penalty in Closed CY2008 Cost Reports Group
23-0847	Miami Valley Hospital (36-0051), FFY 2023
23-0848	Good Samaritan Hospital (36-0052), FFY 2023
23-0849	Magee Women's Hospital of UPMC Health System (39-0114), FFY 2023
23-0851GC	Univ of Rochester FFY 2023 DGME Fellows Penalty in Closed CY2004 Cost Reports CIRP Group
23-0852GC	Univ of Rochester FFY 2023 DGME Fellows Penalty in Closed CY2005 Cost Reports CIRP Group

23-0854GC	Univ of Rochester FFY 2023 DGME Fellows Penalty in Closed CY2006 Cost Reports CIRP Group
23-0855GC	Univ of Rochester FFY 2023 DGME Fellows Penalty in Closed CY2007 Cost Reports CIRP Group
23-0857GC	Univ of Rochester FFY 2023 DGME Fellows Penalty in Closed CY2008 Cost Reports CIRP Group
23-0859G	Bass, Berry & Sims, PLC FFY 2023 DGME Fellows Penalty in Closed CY 2009 Cost Reports Group
23-0860G	Bass, Berry & Sims, PLC FFY 2023 DGME Fellows Penalty in Closed CY 2010 Cost Reports Group
23-0861G	Bass, Berry & Sims, PLC FFY 2023 DGME Fellows Penalty in Closed CY2011 Cost Reports Group
23-0862G	Bass, Berry & Sims, PLC FFY 2023 DGME Fellows Penalty in Closed CY2012 Cost Reports Group
23-0864G	Bass, Berry & Sims, PLC FFY 2023 DGME Fellows Penalty in Closed CY 2013 Cost Reports Group
23-0866G	Bass, Berry & Sims, PLC FFY 2023 DGME Fellows Penalty in Closed CY2014 Cost Reports Group
23-0870G	Bass, Berry & Sims, PLC FFY 2023 DGME Fellows Penalty in Closed CY2003 Cost Reports Group
23-0874	James Cancer Hospital & Solove Research Institute (36-0242), FFY 2023
23-0876GC	Ohio State Health Sys. FFY 2023 DGME Fellows Penalty in Closed CY 2009 Cost Reports CIRP Group
23-0877GC	Ohio State Health Sys. FFY 2023 DGME Fellows Penalty in Closed CY2008 Cost Reports CIRP Group

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Nathan Summar
Community Health Systems, Inc.
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Byron Lamprecht
WPS Gov. Health Admin'rs
2525 N 117th Ave., Ste. 200
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RE: ***Board Decision* – SSI Percentage (Provider Specific) & Medicaid Eligible Days**
Bayfront Health Port Charlotte (Prov. No. 10-0077)
FYE 12/31/2014
Case No. 18-0283

Dear Messrs. Summar and Lamprecht:

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the documentation in Case No. 18-0283 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. 18-0283

On November 29, 2017, Bayfront Health Port Charlotte, appealed a Notice of Program Reimbursement (NPR) dated June 2, 2017, for its fiscal year dating December 31, 2014 ("FY 2014"). The Provider appealed the following issues:[1]

- Issue 1: DSH SSI Percentage (Provider Specific)
- Issue 2: DSH SSI Percentage
- Issue 3: DSH SSI Percentage - Medicare Managed Care Part C Days
- Issue 4: DSH SSI Percentage - Dual Eligible Days (Exhausted Part A Benefit Days, MSP Days and No-Part A Days)
- Issue 5: DSH - Medicaid Eligible Days
- Issue 6: DSH - Dual Eligible Medicaid Fraction (Medicare Managed Care Part C Days)
- Issue 7: DSH - Dual Eligible Days Medicaid Fraction (Exhausted Part A Benefit Days, MSP Days and No-Part A Days)
- Issue 8: DSH - Uncompensated Care Distribution Pool[2]
- Issue 9: Two Midnight Rule

[1] Provider's Request for Hearing, Tab 3, at Issue Statement (Nov. 29, 2017).
[2] The UCC issue was transferred to group case no. 17-0573GC, which was subsequently closed after this provider transfer occurred.

As the Provider is part of Community Health Systems ("CHS") and is thereby subject to the common issue related party ("CIRP") group regulation at 42 C.F.R. § 405.1837(b)(1), the Provider transferred Issues 2, 3, 4, 6, 7, 8, and 9 to CHS CIRP group cases on July 23, 2018. As a result of these transfers, only two issues remain: Issue 1, DSH SSI Percentage (Provider Specific), and Issue 5, DSH – Medicaid Eligible Days.[3]

On July 26, 2018, the Provider filed the cover page to its preliminary position paper in compliance with Board Rule 25 (July 2015). Similarly, the Medicare Contractor filed its preliminary position paper on November 21, 2018.

On April 11, 2018, the Medicare Contractor filed a Jurisdictional Challenge, regarding Issue 1, addressing the DSH SSI Percentage (Provider Specific) issue, and Issue 8, the DSH – Uncompensated Care issue.[4] While the Uncompensated Care issue was transferred, DSH – Medicaid Eligible days remains. 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."

Separately, on August 24, 2022, the Medicare Contractor filed a Final Request for Information ("Final RFI"), requesting that the Medicaid eligible days listing be provided within 30 day. In support, the Medicare Contractor noted its previous attempts to acquire information regarding Medicaid Eligible days from the Provider, and the lack of any response.[5] The Provider did not respond to the Medicare Contractor's Final RFI.

Finally, on January 9, 2023, the Medicare Contractor filed a Motion to Dismiss the Medicaid Eligible Days issue. Significantly, the Provider did not file a response within the 30 days allotted under Board Rule 44.4.3:

> 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.

[3] MAC's Jurisdictional Challenge, at 1 (Apr. 11, 2018).
[4] Issue 8, DSH – Uncompensated Care, was transferred to group case 19-0863G, and will not be adjudicated within this challenge.
[5] MAC's Final Request for Information (Aug. 24, 2022).

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 17-0578GC

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

> The Provider contends that the MAC did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the MAC's calculation of how the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations.
>
> The provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both 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.[6]

As the Provider is commonly owned by Community Health Systems, Inc. ("CHS"), the Provider was also directly added to the common issue related party ("CIRP") group under Case No. 17-0578GC entitled "QRS HMA 2014 DSH SSI Percentage CIRP Group." This CIRP group has the following issue statement:

> **<u>Statement of the Issue:</u>**
>
> 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?

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[6] Provider's Request for Hearing, Issue Statement (Nov. 29, 2017).

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.[7]

On July 26, 2018, 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 (December 31).

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

Similar to *Loma Linda Community Hospital v. Dept of Health* and Human Services, No. 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,

[7] Group Issue Statement, Case No. 17-0578GC.

> the Provider will seek to reconcile its' records with that of CMS, and identify patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS based on the Federal Fiscal Year End (September 30) when it determined the Provider's SSI. *See Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).

The only exhibit included with the preliminary position paper that relates to Issue 1 was Exhibit 1, which shows that the amount in controversy for the issue is $80,000. This is the same amount that is listed as the amount in controversy for this Provider as a participant in 17-0578GC.

The MACs Jurisctional Challence and RFI and the Provider's Reponses:

A. 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 transferred into Group Case No. 17-0578GC, QRS HMA 2014 DSH SSI Percentage CIRP Group. The Portion of Issue 1 concerning realignment should be dismissed because there was no final determination over SSI realignment and the Provider's appeal is premature as the Provider has not exhausted all available remedies.[8]

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.

MAC's Final Request for Information

Within the MAC's August 24, 2022, Final Request for Information, the MAC noted that on that same day, August 24, 2022, the Board issued the notice of hearing for this appeal. The MAC documented that it initially reached out to the Provider requesting a DSH package on November 13, 2018. In addition, on February 22, 2019, the MAC, *on its own motion*, reopened the cost report to review for Medicaid eligible days if and when the Provider submitted a DSH package. A little over 3 years later, on April 25, 2022, the MAC closed that reopening *due to total lack of cooperation*. Specifically, the Provider submitted nothing. The MAC wrote to remind that it is now ***almost eight years*** from the end of the cost reporting period and, if the Provider wishes to pursue the issue, the MAC will need documentation related to the additional days.[9] Also, if information is not available, the MAC would require a response to the queries in the following list that is in accordance with PRRB Rules 7.3.1.2 and 25.2.2, on or before September 23, 2022. The MAC noted that it would expect a withdrawal of this appeal if, ***within 30 days***, the Provider does not submit a package which includes:

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[8] *Id*. at 2.
[9] MAC's Final Request for Information, at 1.

1. An electronic list (in Excel format) of Medicaid days included on the filed cost report or which was submitted for audit. For each patient record on the list, please include the patient's name, patient account number, date of admission and discharge, birth date, Social Security number, medical record number, Medicaid number, DRG, location of stay (PPS area, Rehab, SNF, Psych, Observation, Swing, etc.), days claimed per patient, and in total;
2. The electronic list (in Excel format) of the additional Medicaid days included in the appeal request. The list should include all necessary information as described in item 1 above;
3. Ensure all non-allowable days (including but not limited to: Dual eligible days, Medicare Part C days, general assistance days, unmet spend down days, duplicates days, etc.) are excluded from the list of additional days;
4. Documentation of Medicaid eligibility for each of the patients during their respective stays related to the additional days requested, in a searchable electronic format;
5. Documentation to support all additional days were related to a unit or ward of the hospital providing acute care services generally payable under the prospective payment system. This should also be submitted in a searchable electronic format;
6. If information is unavailable, please identify what information is unavailable, why the information has been unavailable up to this point, and document the efforts made to obtain the information.[10]

The MAC requested a response ***within 30 days*** *of their letter*, as well as including a request for the Provider to withdraw Issue 1, the Provider Specific SSI issue, due to its assertion that it is duplicative, as originally presented in its jurisdictional challenge from April 11, 2018.

B. Provider's Response to the MAC's RFI

The Provider did ***not*** file a response to the jurisdictional challenge or the MAC's RFI. 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."

C. MAC's Motion to Dismiss

As the Provider failed to respond to its RFI, the MAC filed a Motion to Dismiss the Medicaid Eligible Days issue on January 9, 2023. In support of dismissal, the MAC cites to the following facts:

> 3. The Provider submitted its complete Preliminary Position Paper to the MAC on July 28, 2018. More than five years have passed since the Provider submitted its preliminary paper, and at no time did it submit a listing for review. Its preliminary paper

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[10] *Id*. at 1-2.

failed to specify the number of additional days to which it contends it is entitled. Rather, the preliminary paper included Exhibit 1, which states in total:

ELIGIBILIY LISTING
NOT INCLUDED – TO BE EMAILED SEPARATELY

4. On November 13, 2018, the MAC inquired (via email to Nathan Summar – CHS, Provider Rep) about a DSH package for the Medicaid eligible day issue. The MAC asked Mr. Summar to submit a DSH package or inform when he believed one will be forthcoming.

5. On January 31, 2019, the MAC sent an email to Mr. Summar, requesting a listing of the additional Medicaid eligible days at issue. The MAC's email was forwarded by Mr. Summar to QRS, the Provider's DSH consultant. No response was received.

6. On February 22, 2019, the MAC initiated a reopening to review additional Medicaid eligible days. The MAC had hoped the issuance of the reopening would prompt the submission of a DSH package by the Provider.

7. On April 28, 2021, the MAC sent a follow up email to Mr. Summar, requesting a status update for a DSH package. The email pointed out that the MAC originally sought the DSH package in January 2019, and then initiated a reopening in February 2019 for the Medicaid eligible day issue. The MAC also pointed out that it had received nothing from the Provider in the more than two years since the issuance of the reopening. Lastly, the MAC asked that the Provider withdraw the issue from appeal if there is no DSH package.

8. On August 31, 2021, the MAC again followed up with Mr. Summar, asking him to inform whether there would be a forthcoming DSH package, and if not, whether the appeal would be withdrawn.

9. On April 25, 2022, the MAC closed the reopening due to the fact that none of the requested supported documentation was ever received.

10. On August 24, 2022, the MAC made a final request for information (via letter uploaded through OH-CDMS), asking that

> the Provider submit several items that would customarily be submitted with a DSH package or, if such documentation is unavailable, a response in accordance with Board Rules 7.3.1.2 and 25.2.2. The MAC asked for a response within 30 days. No response was received.
>
> 11. On December 5, 2022, the MAC followed up with Mr. Summar and QRS pointing out that the appeal had been pending for several years with no cooperation from the Provider, despite numerous attempts by the MAC to work with the Provider. The MAC asked that the appeal be withdrawn.
>
> 12. On December 6, 2022, QRS responded, apologizing for the delay and indicated the Provider still wished to pursue the issue. QRS indicated that it would try to get a listing in the next few weeks.
>
> 13. On December 8, 2022, the MAC responded to QRS, indicating it would hold off on filing a motion to dismiss for the next couple of weeks to allow the submission of a DSH package. The MAC asked that QRS ensure that its submission complies with PRRB rules 7.3.1.2 and 25.2.2 (Rules 7.1 and 25.2.B from 2015 Rules).
>
> 14. To date, despite the representation in its Preliminary Position Paper, the Provider has failed to respond to the MAC's request for documentation and has otherwise failed to tender to the MAC an eligibility listing or necessary documentary support for the additional Medicaid eligible days to which it asserts it is entitled.

The MAC noted that the Provider has an affirmative duty and burden to supply all required documentation and State validation of any additional Medicaid eligible days per 42 C.F.R. §§ 413.24(c) and 412.106(b)(4)(iii) and per Board Rules 7 and 25.2.1. However, the Provider failed to supply this documentation as it relates to the Medicaid eligible days issue either as part of its preliminary position paper as required under Board Rule 25.2.1 (or an explanation of why it was not available in compliance with Board Rule 25.2.2) or after the MAC has made multiple discovery requests from the Provider, both formal and informal, notwithstanding the fact that it has been more than 8 years since the fiscal year at issue closed..

D. Provider's Response to the MAC's Motion to Dismiss

The Provider did ***not*** file a response to the MAC's Motion to Dismiss. Board Rule 44.3 addresses the time for filing a response to a motion: "Unless the Board imposes a different

deadline, an opposing party may file a response, with relevant supporting documentation, ***within 30 days*** from the date that the motion was sent to the Board and opposing party."[11]

Board Analysis and Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2014), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

A. 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 Group Case No. 17-0578GC, QRS HMA 2014 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. 17-0578GC. 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. 17-0578GC, 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 $80,000.

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[11] (Emphasis added.)
[12] Individual Appeal Request, Issue 1.
[13] *Id.*
[14] *Id.*

Thus, the Board finds that the first aspect of Issue 1 in this appeal is duplicative of the group issue in Case No. 17-0578GC, for this same provider and fiscal year. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (Mar. 1, 2013), the Board dismisses this aspect of the DSH/SSI (Provider Specific) issue.

In making this finding, the Board further notes that CMS regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, is pursuing that issue as part of the group under Case 17-0578GC. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[15] Provider is misplaced in referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 17-0578GC. Indeed, the Provider is subject to the CIRP group regulations and any systemic issues would be a common issue subject to the CIRP group rules for which the Provider must pursue as part of a CIRP group.

To this end, the Board also reviewed the Provider's Preliminary Position Paper (a complete copy of which was included in the record as Exhibit C-1 to the MAC's Motion to Dismiss) to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 17-0578GC, 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;

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

> 3. State the efforts made to obtain the documents; and
> 4. Explain when the documents will be available.
>
> Once the documents become available, promptly forward them to the Board and the opposing party. Common examples of unavailable documentation include pending discovery requests, pending requests filed under the federal Freedom of Information Act (also known as FOIA requests), or similar requests for information pending with a state Medicaid agency.

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

> https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH.[16] This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows: "DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[17]

Accordingly, *based on the record before it (which the Provider had an obligation to develop per Board Rules 25 and 44.4.3 and 42 C.F.R. § 405.1853(b)(2)-(3))*, the Board must find that Issues 1 and the group issue in Group Case 17-0578GC, 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.

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[16] (Last accessed Nov. 21, 2022.)
[17] (Emphasis added.)

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 5 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 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 amount in controversy calculation and protested item documentation for this issue suggests the number of Medicaid eligible days at issue. However, 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.

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[18] *Id.*

While the Calculation Support filed with their appeal notes a net impact of $88,000, 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.[19] 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.[20]

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*

[19] A complete copy of the Provider's preliminary position paper was included in the record as Exhibit C-1 to the MAC's Motion to Dismiss.

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

> *timeframe to be decided by the Board through a schedule applicable to a specific case or through general instructions*.[21]

With regard to the filing of an individual appeal, Board Rule 7 (Support for Appealed Final Determination, Issue-Related Information and Claim of Dissatisfaction) (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, regarding position papers,[22] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[23] This requirement is consistent with 42 C.F.R. § 405.1853(b)(3).

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

> *If documents necessary to support your position are still unavailable,* then provide the following information in the position papers:
>
> 1. Identify the missing documents;
> 2. Explain why the documents remain unavailable;
> 3. State the efforts made to obtain the documents; and
> 4. Explain when the documents will be available.
>
> Once the documents become available, promptly forward them to the Board and the opposing party.[24]

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

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

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

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

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

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

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

The Board concurs with the Medicare Contractor that the Provider is required to identify and provide documentation to prove what additional Medicaid Eligible days are at issue and to which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rule 25. Further, pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed" [25] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. Based on the record before the Board, the Board finds that the Provider has failed to provide a listing or other supporting documentation for the Medicaid Eligible Days issue as required by the controlling regulations and Board Rules. Nor has the Provider provided any explanation as to why the documentation was absent or what is being done to obtain it consistent with Board Rule 25.2.2. Based on the Provider's failure to specify the actual specific Medicaid eligible days at issue in its preliminary position paper (coupled with a failure to explain why such information was not available), failure to respond to the MAC's subsequent formal and informal requests for information, and failure to respond to the MAC's Motion to Dismiss, the Board must conclude that the there is no actual Medicaid eligible days in dispute and that the amount in controversy for this issue is, in fact, $0. Indeed, based on the non-responsiveness of the Provider, the Board must assume that the Provider has abandoned this issue, *particularly since this appeal was filed over 5 years ago and the fiscal year itself ended more than 9 years*.[26]

The Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of Board Rules 25.2.1 and 25.2.2 and 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) related to identifying the days in dispute and the

[25] (Emphasis added.)
[26] In this regard, the Board notes that, in addition to not filing a response to the MAC's Motion to Dismiss, the Provider failed to file its final position paper by the February 3, 2023 filing deadline specified in the August 24, 2023 Notice of Hearing.

submission of documentary evidence required to support its claims or describe why said evidence is unavailable, which the Provider has failed to do.[27] Indeed, there were many subsequent attempts to obtain the information and the Provider has been silent without filing any response, including to the Motion to Dismiss. The Board takes administrative notice that it has made similar dismissal in other cases in which CHS was the designated representative and, notwithstanding, CHS failed to provide the Medicaid eligible days listing or otherwise file a response to) the MAC's August 24, 2022 RFI and the MAC's subsequent January 9, 2023 Motion to Dismiss.

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In summary, the Board hereby dismisses the SSI Provider Specific issue from this appeal as it is duplicative of the issue in Case No. 17-0578GC, 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 and has abandoned the issue as demonstrated by its failure to respond to any filings made the MAC in this case, including the MAC's Motion to Dismiss. As no issues remain pending, the Board hereby closes Case No. 18-0283 and removes it from the Board's docket.

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

Board Members Participating:

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

For the Board:

3/28/2023

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services

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