DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Board Determination on Pending CIRP Group Without Participants***

Houston Methodist CY 2018 SSI Percentage CIRP Group
Case Number: 25-1169GC

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("the Board") has reviewed the subject common issue related party ("CIRP") group appeal and notes that it was not properly filed. The pertinent facts and the Board's determination are set forth below.

Pertinent Facts:

On **December 23, 2024**, Quality Reimbursement Services, Inc. ("QRS") filed a CIRP group on behalf of Houston Methodist Hospital System ("Houston Methodist") for the calendar year ("CY") 2018 SSI Percentage issue under Case No. 25-1169GC. The group appeal was formed in the Office of Hearings Case & Document Management System ("OH CDMS") without any participants.

On **February 5, 2025**, the Medicare Contractor filed a Corrected Rule 15.2 Review letter in which it advised the Board that the subject group had been formed in OH CDMS without any participants and that the group had still not been brought into compliance with Board Rule 12.6 as no participants were transferred or added.

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.

42 C.F.R. § 405.1837(b)(1) discusses the use of Mandatory groups and states:

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

42 C.F.R. § 405.1837(b)(3) provides the details for initiating a group appeal and indicates:

> 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….

Regarding the establishment of groups in OH CDMS, the commentary under Board Rule 12.1 indicates:

> . . . if a group is to be formed solely through transfers, it **may initially** be established in OH CDMS **with no participating providers. In such cases, the providers must be transferred i*mmediately* following the establishment of the group case** in order to fulfill the regulatory requirement for the minimum number of providers per Rule 12.6. **The Board will close all group cases that do not meet the minimum participant requirements**.[1,2]

Board Rule 12.6.1 further states that "[a] CIRP group **may be initiated by a single provider under common ownership or control**, but at least two different providers must be in the group upon full formation. (See Rule 19.)"[3]

The Board finds that the subject group appeal, under Case No. 25-1169GC, is a CIRP group that was formed without any providers. Further, there have been no additions or transfers to the group in more than seventy-one days since its formation. Because the CIRP group was not filed in compliance with Board Rules or the regulations, the Board hereby dismisses the CIRP group, Case No. 25-1169GC.[4] Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

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[1] Board Rules v, 3.2 (Dec. 15, 2023)
[2] Bold emphasis added.
[3] Bold emphasis added.
[4] Should QRS identify a Houston Methodist participant appealing this issue for CY 2018, it may form a new CIRP group by either effectuating a transfer or by including a CIRP provider when the group is formed (i.e., Direct Add from receipt of the final determination).

Finally, the Board notes that QRS has filed many group appeals, both CIRP and optional, over the years. It is also noted that QRS is not new to using OH CDMS, which became mandatory for all filings in November 2021. The improper formation of this "provider-less" CIRP group appears to be an attempt by QRS to create a "holding spot" for the future addition or transfer of related providers pursuing the SSI Percentage issue. Although the Commentary at Board Rule 12.1 does permit a "shell" to be formed in OH CDMS, it is only on a limited basis - for the sole purpose of allowing the ***transfer*** of issues from pending individual appeals. QRS' formation of this CIRP group, where there have been no transfers effectuated in over seventy-one days, violates the intent of the Board's rules and creates an unnecessary administrative burden on the Board and its staff (***i.e.***, having to formally dismiss the CIRP group.) The Board admonishes QRS for again failing to follow Board Rules governing the formation of a group.[5] The Representative is on notice that if this type of filing violation continues, the Board may prohibit the Representative from re-filing a perfected CIRP group for the same issue/CY in future cases.

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

For the Board:

3/4/2025

X Kevin D. Smith, CPA

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

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services
Michael Redmond, Novitas Solutions, Inc. c/o GuideWell Source (J-H)

[5] The Board has recently dismissed QRS optional groups formed with only a single provider. See January 15, 2025 determination issued in Case No. 25-0972G, and January 17, 2025 determination issued in Case Nos. 20-1971GC and 20-1973GC. In addition, on January 22, 2025, the Board dismissed a CIRP group under Case No. 25-1011GC as it was filed without participants and none were transferred or added in over a month.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Ms. Ashlyn Hillburn
Administrator
Louisiana Veterans Home
4739 Highway 10
Jackson, LA 70748

Mr. Michael Redmond, Manager
JH & JL Provider Audit & Reimbursement
Novitas Solutions, Inc.
2020 Technology Parkway, Suite 100
Mechanicsburg, PA 17050

RE: **Board Determination re: Controversy Amount Threshold**
Louisiana Veterans Home
Appealed Period: FFY 2025
PRRB Case No.: 25-1811

Dear Ms. Hillburn and Mr. Redmond:

The above-captioned appeal was filed with the Provider Reimbursement Review Board ("Board") via the Office of Hearings Case and Document Management System ("OH CDMS"). After review of the facts outlined below, the Board has determined that the subject appeal has not met the jurisdictional requirements as set forth in the Board Rules and 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840. The Board's review and determination is set forth below.

BACKGROUND:

On January 31, 2025, the Provider filed an appeal for the Federal Fiscal Year ("FFY") 2025 based on the *Notice of Quality Reporting Program Noncompliance Decision Upheld* dated October 4, 2024. The Provider advised that it was representing itself in the appeal. The Provider entered the amount in controversy in OH CDMS as $1,900. However, the calculation support states that the amount in controversy is $3,800.

RULES AND REGULATIONS:

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

More specifically, 42 C.F.R. § 405.1839 **Amount in Controversy** provides:

(a) ***Single provider appeals.***

(1) In order to satisfy the amount in controversy requirement under § 405.1811(a)(2) or § 405.1811(c)(3) for a contractor hearing or the amount in controversy requirement under § 405.1835(a)(2) or § 405.1835(c)(3) for a Board hearing for a single provider, the provider must demonstrate that if its appeal were successful, the provider's total program reimbursement for each cost reporting period under appeal would increase by at least $1,000 but by less than $10,000 for a contractor hearing, or by at least $10,000 for a Board hearing, as applicable.

Board Rule 1.1 – Authority states, in part:

> The Provider Reimbursement Review Board Rules will be referred to as "Rules." These Rules govern proceedings before the Provider Reimbursement Review Board ("PRRB" or "Board") and they are consistent with § 1878 of the Social Security Act (codified at 42 U.S.C. § 1395oo) and 42 C.F.R. §§ 405.1801 – 405.1889. The Board has discretion to take action as outlined in 42 C.F.R. § 405.1868 if a party fails to comply with these Rules or fails to comply with a Board Order or Instruction. While these Rules cite regulatory cross-references as a guide, the omission of a cross-reference does not excuse the parties from meeting all controlling statutory and regulatory requirements.

Board Rule 4.1 – General Requirements state:

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

Similarly, Board Rule 6.4 (Dec. 2023), Amount in Controversy, states:

> *An individual appeal request must have a total amount in controversy of at least $10,000 at the time of filing*. See 42 C.F.R. §§ 405.1835 and 405.1839. A calculation of the amount in controversy with supporting documentation must be provided for ***each*** issue.[1]

BOARD DECISION:

The Board notes that the Quality Reporting issue in dispute is the sole issue in the subject appeal and that the Provider has stated that the amount in controversy for that one issue as either $1,900, as entered into OH CDMS, or $3,800 as supported by calculation support documentation filed. As a result, the Board finds that neither amount meets the controversy amount threshold of $10,000 at the time of the initial filing of the subject individual appeal. Therefore, the Board hereby dismisses case number 25-1811 and removes it from its docket.

However, please note that pursuant to 42 C.F.R. § 405.1839(a)(1), the Provider may have rights to a Medicare contractor hearing provided it meets the applicable filing requirements for that hearing.

[1] Italics and underlined emphasis added; bold emphasis in original.

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

Board Members:

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

FOR THE BOARD:

3/4/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

cc: Wilson C. Leong, Federal Specialized Services

[1] Italics and underlined emphasis added; bold emphasis in original.

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Via Electronic Delivery

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

RE: ***Board Determination – Dismissal of Appeals***
Hollywood Presbyterian Medical Center (Provider Number 05-0063)
PRRB Case Nos. 25-1616 *et. al* (see **Attachment A** listing 26 appeals)

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") is in receipt of your letter dated February 6, 2025, requesting a 30-day extension to submit an updated Representation Letter for the appeals in **Attachment A**. The Board's decision is set forth below.

Background

On January 22 and 23, 2025, QRS filed 26 individual appeals for Hollywood Presbyterian Medical Center (Provider Number 05-0063). The Representation Letter uploaded with all appeals was signed by Robert Allen, President and Chief Executive Officer of Hollywood Presbyterian Medical Center and is dated June 4, 2020. In lieu of submitting the final determination in each appeal, QRS submitted a CMS Change Request detailing the "Instructions for Processing Requests for SSI Realignment for Cost Reporting Periods Starting Before October 1, 2013."

On January 23, 2025, the Board issued Acknowledgement & Critical Due Dates Notices ("ACCD") in all 26 cases, all of which included a request to submit an updated Representation Letter ***(due by February 7, 2025)***. The ACCD explained that the submitted Letter of Representation was more than four (4) years old and set a deadline of February 7, 2025 to submit updated Letters of Representation.

On February 6, 2025, the day before the deadline, the Provider Representative, Quality Reimbursement Services, Inc. ("QRS") requested a 30-day extension for submitting an updated Representation Letter in all 26 cases. QRS indicated that "due to turn over at the Medical Center," it is taking "longer than expected" for them to receive a current, up-to-date Representation Letter.[1]

[1] Request for Extension at 1 (Feb. 6, 2025).

The current Representation Letter for this Provider has multiple problems:

1. The letter is over **four and a half years old**, as it is dated June 4, 2020.
2. The letter was signed by Robert Allen, who left the Provider organization in 2020, less than 4 months after signing the letter in question. A new president and CEO was hired and replaced him on October 5, 2020.[2] Robert Allen is no longer with the Provider and currently is employed by a different company, where he has been since November, 2020.[3]
3. The letter filed with the appeals was not addressed to the Board nor did it reference the filing of PRRB appeals. The letter was addressed to the Medicare Contractor, Noridian Healthcare Solutions, LLC, not the Board, and made no mention of PRRB appeals. The letter appointed QRS as its designated representative "with respect to the SSI Recalculation" for FYE 12/31/2013 and all years prior.[4]

The outdated authorization letter, in conjunction with the fact that QRS did not have immediate access to the final determinations in these cases, suggests that the Provider may have been unaware of QRS' filings on its behalf. The Board ACDD notices included a warning that failure to meet the deadline to submit the updated Representation letter would result in dismissal by the Board. As of the date of this letter, QRS has not submitted updated Representation Letters in any of these appeals.

Board Determination:

With respect to Letters of Representation, Board Rule 5.4 reads:[5]

> **5.4 Representation letter**
> A representation letter is required ***whether designating an external or internal case representative***. If the provider is not commonly owned or controlled when the representation letter is being executed, then the letter designating the case representative must be on the provider's letterhead and be ***signed by an authorizing official of the provider organization***. If the provider is commonly owned or controlled when the representation letter is being executed, ***then the letter designating the case representative*** must be on letterhead that identifies the parent corporation (whether it's the provider's letterhead or the parent corporation's letterhead) and must be signed by an authorizing official of the provider or parent organization.
>
> In addition, the representation letter must reflect the provider's name, number, and fiscal year under appeal. The letter must not be issue specific unless it is for participation in a group appeal in which there is only one issue permitted to be raised. Finally, the

[2] https://labusinessjournal.com/healthcare/cha-hollywood-presbyterian-medical-center-names-ve/ (last accessed Mar. 4, 2025).
[3] https://www.pipelinehealth.us/leadership/ (last accessed Mar. 4, 2025).
[4] Representation Letter at 1.
[5] Board Rule 5.4 (effective Dec. 15, 2023) (emphasis added).

> representation letter must contain the following contact information regarding the case representative:
>
> - name,
> - organization,
> - address,
> - telephone number, and
> - email address.

QRS has not provided a Representation Letter ***signed by an authorizing official of the provider organization***. The Representative from the Provider that signed the form over 4 and a half years ago has not been with the organization since 2020. The Board finds, therefore, that QRS has not provided a representation letter from anyone at the Provider who is authorized to designate a case representative on behalf of the hospital. Additionally, even if the person who signed the letter was still employed at the Provider, the Provider did not authorize QRS as its representative for an appeal before the PRRB, the letter is only for a reopening request for SSI realignment with the Medicare Contractor.

Last, the Board specifically requested that QRS submit the updated letters of representation. Although QRS did request a postponement of that deadline, the Board did not grant that request, therefore the deadline of February 7, 2025 remained in effect for the submission of updated letters of representation. As of the date of this letter, which is almost a month beyond the deadline set by the Board, QRS has not submitted updated letters.

42 C.F.R. § 405.1868 states that:

> (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.[6]

[6] Emphasis added.

Therefore, the Board has an alternative reason to dismiss the appeals as QRS did not timely respond to a Board set filing deadline in accordance with 42 C.F.R. § 405.1868(b).

The 26 appeals listed in Attachment A are hereby closed and removed from the Board's docket.

The Board notes that QRS filed requests for Expedited Judicial Review ("EJR") in these 26 appeals on February 27, 2025. The Board finds that these requests are now moot and will not rule on them as the appeals have been dismissed based on the unauthorized letter of representation and QRS' failure to timely respond to the Board's deadline.

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

For the Board:

3/4/2025

X Kevin D. Smith, CPA

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

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services
Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E)
Cynthia Cronin-Yoder, Hollywood Presbyterian Medical Center

ATTACHMENT A

LISTING OF 26 CASES

Case No.	Case Name
25-1616	Hollywood Presbyterian Medical Center (05-0063), FYE 06/30/1989
25-1619	Hollywood Presbyterian Medical Center (05-0063), FYE 06/30/1990
25-1622	Hollywood Presbyterian Medical Center (05-0063), FYE 06/30/1991
25-1625	Hollywood Presbyterian Medical Center (05-0063), FYE 06/30/1992
25-1628	Hollywood Presbyterian Medical Center (05-0063), FYE 06/30/1993
25-1630	Hollywood Presbyterian Medical Center (05-0063), FYE 06/30/1994
25-1632	Hollywood Presbyterian Medical Center (05-0063), FYE 06/30/1995
25-1633	Hollywood Presbyterian Medical Center (05-0063), FYE 06/30/1996
25-1634	Hollywood Presbyterian Medical Center (05-0063), FYE 06/30/1997
25-1636	Hollywood Presbyterian Medical Center (05-0063), FYE 06/12/1998
25-1637	Hollywood Presbyterian Medical Center (05-0063), FYE 05/31/1999
25-1639	Hollywood Presbyterian Medical Center (05-0063), FYE 05/31/2000
25-1640	Hollywood Presbyterian Medical Center (05-0063), FYE 05/31/2001
25-1642	Hollywood Presbyterian Medical Center (05-0063), FYE 05/31/2002
25-1643	Hollywood Presbyterian Medical Center (05-0063), FYE 05/31/2003
25-1644	Hollywood Presbyterian Medical Center (05-0063), FYE 05/31/2004
25-1646	Hollywood Presbyterian Medical Center (05-0063), FYE 12/31/2004
25-1647	Hollywood Presbyterian Medical Center (05-0063), FYE 12/31/2005
25-1649	Hollywood Presbyterian Medical Center (05-0063), FYE 12/31/2006
25-1650	Hollywood Presbyterian Medical Center (05-0063), FYE 12/31/2007
25-1652	Hollywood Presbyterian Medical Center (05-0063), FYE 12/31/2008
25-1653	Hollywood Presbyterian Medical Center (05-0063), FYE 12/31/2009
25-1654	Hollywood Presbyterian Medical Center (05-0063), FYE 12/31/2010
25-1656	Hollywood Presbyterian Medical Center (05-0063), FYE 12/31/2011
25-1657	Hollywood Presbyterian Medical Center (05-0063), FYE 12/31/2012
25-1658	Hollywood Presbyterian Medical Center (05-0063), FYE 12/31/2013

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Via Electronic Delivery

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

RE: ***Board Determination – Notice of Dismissal***
St. Francis Health System CIRP Groups
Case Numbers: 25-1692GC *et. al* (see **Attachment A** listing 25 appeals)

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the subject common issue related party ("CIRP") group appeals. The pertinent facts of these cases and the Board's determination are set forth below.

Pertinent Facts:

From **January 24 to January 27, 2025,** Quality Reimbursement Services, Inc. ("QRS") filed 25 CIRP group appeals for St. Francis Health System. The Representation Letter uploaded with all appeals was addressed to the Medicare Contractor, Novitas Solutions, Inc. It appointed QRS as its designated representative "with respect to the SSI Recalculation" for FYEs 1988-2024.[1] The letter does not reference appeals with the Board or state that QRS may be its representative before the Board.

Further, in lieu of submitting the final determination in each appeal, QRS submitted a CMS Change Request detailing the "information and implementation instructions for CMS-1739-F issued August 13, 2024, which concerned the treatment of Medicare Part C days for the purposes of calculating Medicare DSH."

From **January 28 to January 30, 2025** the Board issued Acknowledgement & Critical Due Dates Notices ("ACCD") in all 25 cases, notifying the parties that they are responsible for pursuing the appeal in accordance with the Board's Rules.

The Representation Letter submitted by QRS in each of the 25 cases has two main issues:

1. The letter is close to one year old, as it is dated February 29, 2024.

[1] Representation Letter at 1 (Feb. 29, 2024).

2. The Letter of Representation filed with the appeals was not addressed to the Board nor did it reference the filing of PRRB appeals. The letter was addressed to the Medicare Contractor, Novitas Solutions, ATTN Cost Report Reopening. It appointed QRS as its designated representative "with respect to the SSI Recalculation."

Board Determination:

With respect to Letters of Representation, Board Rule 5.4 reads:[2]

> **5.4 Representation letter**
> A representation letter is required ***whether designating an external or internal case representative***. If the provider is not commonly owned or controlled when the representation letter is being executed, then the letter designating the case representative must be on the provider's letterhead and be ***signed by an authorizing official of the provider organization***. If the provider is commonly owned or controlled when the representation letter is being executed, ***then the letter designating the case representative*** must be on letterhead that identifies the parent corporation (whether it's the provider's letterhead or the parent corporation's letterhead) and must be signed by an authorizing official of the provider or parent organization.
>
> In addition, the representation letter must reflect the provider's name, number, and fiscal year under appeal. The letter must not be issue specific unless it is for participation in a group appeal in which there is only one issue permitted to be raised. Finally, the representation letter must contain the following contact information regarding the case representative:
> - name,
> - organization,
> - address,
> - telephone number, and
> - email address.

The Board finds that the Providers in the referenced group appeals have not authorized QRS to ***file an appeal before the PRRB*** on their behalf, as the letters of representation submitted related only to requests for SSI realignment. Without this proper authorization to file the appeals, the Board finds that QRS was not authorized to file these appeals, and therefore dismisses the appeals and removes them 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.

[2] Board Rule 5.4 (effective Dec. 15, 2023) (emphasis added).

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

For the Board:

3/4/2025

X Kevin D. Smith, CPA

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

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

ATTACHMENT A

LISTING OF 25 CASES

Case No.	Case Name
25-1692GC	St. Francis Health System CY 1989 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-1693GC	St. Francis Health System CY 1990 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-1694GC	St. Francis Health System CY 1991 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-1696GC	St. Francis Health System CY 1992 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-1697GC	St. Francis Health System CY 1993 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-1698GC	St. Francis Health System CY 1994 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-1699GC	St. Francis Health System CY 1995 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-1700GC	St. Francis Health System CY 1996 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-1701GC	St. Francis Health System CY 1997 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-1702GC	St. Francis Health System CY 1998 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-1703GC	St. Francis Health System CY 1999 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-1704GC	St. Francis Health System CY 2000 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-1705GC	St. Francis Health System CY 2001 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-1706GC	St. Francis Health System CY 2002 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-1707GC	St. Francis Health System CY 2003 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-1742GC	St. Francis Health System CY 2004 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-1743GC	St. Francis Health System CY 2005 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-1744GC	St. Francis Health System CY 2006 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-1745GC	St. Francis Health System CY 2007 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-1746GC	St. Francis Health System CY 2008 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group

25-1747GC	St. Francis Health System CY 2009 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-1748GC	St. Francis Health System CY 2010 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-1749GC	St. Francis Health System CY 2011 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-1750GC	St. Francis Health System CY 2012 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-1751GC	St. Francis Health System CY 2013 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group

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

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

RE: ***Dismissal of Untimely Filed Appeals***

25-1655 - Poplar Bluff Reg. Med. Center (Provider Number: 26-0119), FFY 2009
25-1659 - Poplar Bluff Reg. Med. Center (Provider Number: 26-0119), FFY 2011
25-1660 - Poplar Bluff Reg. Med. Center (Provider Number: 26-0119), FFY 2012
25-1661 - Sandhills Regional Med Ctr. (Provider Number: 34-0106), FFY 2009
25-1662 - St. Luke's Hosp.-Easton Camp. (Provider Number: 39-0162), FFY 2013
25-1663 - ShorePoint Hlth. Port Charlotte (Provider Number 10-0077), FFY 2011

Dear Mr. Ravindran and Mr. Lamprecht:

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

BACKGROUND:

On January 23, 2025, Quality Reimbursement Services, Inc. ("QRS") filed the subject individual appeals.[1] The appeals were all filed from the July 26, 2024, CMS Transmittal 12747- which provided Medicare Contractors ("MACs") with Instructions on Processing SSI Realignment Requests for Cost Report periods prior to 10/1/2013. The Confirmations of Correspondence generated by the Office of Hearings Case and Document Management System ("OH CDMS") verify that the appeals were each filed on January 23, 2025.

RULES/REGULATIONS:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is

[1] On the same date, QRS also filed appeals for Hollywood Presbyterian Medical Center (Prov. No. 05-0063) for FYEs 12/31/2011, 2012 and 2013 under respective Case Nos. 25-1656, 25-1657 and 25-1658. The Board has addressed those cases under separate cover.

dissatisfied with the contractor's final determination, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of receipt of the final determination. Specifically, 42 C.F.R. § 405.1835(a)(3) indicates that, "unless the Provider qualifies for a good cause extension", the Board must receive a Provider's hearing request "***no later than 180 days after the date of receipt by the Provider of the final contractor or Secretary determination.***"[2]

Board Rule 4.3, Commencement of Appeal Period, specifies types of final determinations and includes, and states:

> 4.3.1 **Contractor/CMS/Secretary Final Determination**
>
> Final Determinations include:
> - Notices of Program Reimbursement;
> - Revised Notices of Program Reimbursement;
> - Exception Determinations;
> - Quality Reporting Program Payment Reduction Determinations; and
> - Other determinations issued by CMS or its ***contractors with regard to the amount of total reimbursement due the provider***.
>
> The date of receipt of a contractor/CMS/Secretary final determination is presumed to be five (5) days after the date of issuance. This presumption, which is otherwise conclusive, may be overcome if it is established by a preponderance of the evidence that such materials were actually received on a later date. *See* 42 C.F.R. § 405.1801(a)(1)(iii).[3]

This rule also explains that there is no five (5) day mailing presumption for appeals from Federal Register Notices:

> 4.3.2 **Federal Register Notice**
>
> The date of receipt of a Federal Register Notice is the date the Federal Register is ***published***. The appeal period begins on the ***date of publication*** and ends 180 days from that date.[4]

Board Rule 4.5, Date of Receipt by the Board, states that the timeliness of a filing is determined based on the date of receipt by the Board, and the date of receipt is presumed to be the date of filing in OH CDMS as evidenced by the Confirmation of Correspondence generated by the system.[5]

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[2] Emphasis added.
[3] Emphasis added.
[4] Emphasis added.
[5] *See also* 42 C.F.R. § 405.1801(a)(2)(iii).

BOARD DETERMINATION:

After its review, the Board has determined that QRS' appeal requests under Case Nos. 25-1655, 25-1659, 25-1660, 25-1661, 25-1662 and 25-1663 were not timely filed in accordance with the regulations at 42 C.F.R. §§ 405.1835(a)(3) and Board Rule 4.3.

The final determination support QRS uploaded for each Provider is a copy of the July 26, 2024, CMS Transmittal 12747- which provided MACs with Instruction on Processing SSI Realignment Requests for Cost Report periods prior to 10/1/2013.[6] In each case, QRS characterized the final determination type as "Other" in OH CDMS.

Although one of the types of determinations detailed in Board Rule 4.3.1 includes "Other determinations issued by CMS," the Rule is explicit that the determination must be ". . . with regard to the amount of total reimbursement due the provider." However, here the Board finds that the CMS Transmittal under appeal is not specific to each respective provider, rather it is a Transmittal publication that applies to the MAC's treatment of Part C days for calculating the Disproportionate Share ("DSH").

The Board finds that this document is more analogous to a Federal Register Notice, in that the Transmittal is not specific to any provider and also has a published publication date. Pursuant to Board Rule 4.3.2, the Board finds the date of receipt for this publication is the date the CMS Transmittal was ***published***, and the Providers' appeal period began on that date, without a five (5) day mailing presumption that is allowed for other determination types.

Under that scenario, allowing for the 180-day appeal period, the 180th day fell on Wednesday, January 22, 2025. The subject appeals were received on Thursday, January 23, 2025, one day beyond the deadline. Since the appeals were untimely filed, the Board hereby dismisses Case Nos. 25-1655, 25-1659, 25-1660, 25-1661, 25-1662 and 25-1663 in their entirety and removes each case from the Board's docket.

Review of this determination may be available under the provisions of 42 U.S.C. §1395oo(f) and 42 C.F.R. §§ 405.1875 and 105.1877.

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

FOR THE BOARD:

3/6/2025

X Kevin D. Smith, CPA

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

cc: Wilson C. Leong, Federal Specialized Services

[6] CMS Pub 100-20 One -Time Notification; Transmittal 12747, published on July 26, 2024.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Board Determination – Dismissal of Appeals***

25-1607GC	Asante Health System FFY 2008 Medicare Fraction (SSI)-Statutory & Systemic Errors CIRP
25-1758GC	Asante Health System CY 2009 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP
25-1763GC	Asante Health System CY 2011 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP
25-1773GC	Asante Health System CY 2012 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP
25-1774GC	Asante Health System CY 2013 Medicare Fraction (SSI)- Statutory & Systemic Errors CIRP

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the above-captioned common issue related party ("CIRP") groups and finds issue with the Representation Letter submitted for the participants in each group. The pertinent facts and the Board's decision are set forth below.

Background:

On January 22 and 28, 2025, QRS filed five (5) CIRP group appeals on the behalf of the Asante Health System parent organization. Each CIRP group appeal contains two providers: Asante Three Rivers Medical Center (Provider Number 38-0002) and Asante Rogue Regional Medical Center (Provider Number 38-0018). The Representation Letters filed with these appeals were signed by Rick Fernandez, Reimbursement Manager of Asante Health System and were dated on September 3 or 5, 2013 (Case Nos. 25-1607GC, 25-1758GC, and 25-1763GC), August 16, 2014 (Case No. 25-1773GC), or February 16, 2016 (Case No. 25-1774GC). In lieu of submitting the final determination in each appeal, QRS submitted a CMS Change Request detailing the "Instructions for Processing Requests for SSI Realignment for Cost Reporting Periods Starting Before October 1, 2013."

On January 23 and 30, 2025 the Board issued Acknowledgement & Critical Due Dates (ACDD) notices for all cases. In addition, also on January 30, 2025, QRS filed a supplemental document in Case No. 25-1774GC titled "Appointment of Designated Representative" in Case No. 25-1774GC for Asante Three Rivers Medical Center. This Representation Letter had the letterhead of AHMC Healthcare, Inc., not Asante Health System, and, further, Asante Three Rivers Medical Center was not included on the Representation Letter's listing of providers.

Consequently, on January 31, 2025, the Board removed the supplemental document from the record and directed QRS to submit an updated Representation Letter for Case No. 25-1774GC.

The current Representation Letters for these Providers have two problems:

1. The letters are 9-11 years old, as they are dated between September 3, 2013 and February 16, 2016.
2. The letters were signed by Rick Fernandez who may no longer have the authority to designate a representative for appeals before the Board so many years later.

The outdated authorization letters, in conjunction with the fact that QRS did not have immediate access to the final determinations in these cases, suggest that the Provider may have been unaware of QRS' filings on its behalf. As of the date of this letter, QRS has not submitted current Representation Letters in any of these appeals.

Board Determination:

With respect to Letters of Representation, Board Rule 5.4[1] reads:

> **5.4 Representation Letter**
> A representation letter is required ***whether designating an external or internal case representative***. If the provider is not commonly owned or controlled when the representation letter is being executed, then the letter designating the case representative must be on the provider's letterhead and be ***signed by an authorizing official of the provider organization***. If the provider is commonly owned or controlled when the representation letter is being executed, ***then the letter designating the case representative*** must be on letterhead that identifies the parent corporation (whether it's the provider's letterhead or the parent corporation's letterhead) and must be signed by an authorizing official of the provider or parent organization.
>
> In addition, the representation letter must reflect the provider's name, number, and fiscal year under appeal. The letter must not be issue specific unless it is for participation in a group appeal in which there is only one issue permitted to be raised. Finally, the representation letter must contain the following contact information regarding the case representative:
>
> • name,
> • organization,
> • address,
> • telephone number, and
> • email address.

QRS has not provided a current Representation Letter ***signed by an authorizing official of the provider organization***. The Representative signed the form over nine years ago. The Board finds,

[1] Board Rule 5.4 (effective December 15, 2023) (emphasis added).

therefore, that it cannot be assured that this representation letter is signed by anyone currently at the Provider who is authorized to designate a case representative on behalf of the hospital at this time.

42 C.F.R. § 405.1868 states that:

> (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.[2]

Therefore, the five (5) aforementioned appeals are hereby closed and removed from the Board's docket.

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

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

For the Board:

3/10/2025

X Kevin D. Smith, CPA

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

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services
Dean Wolfe, Noridian Healthcare Solutions (J-E)

[2] Emphasis added.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Notice of Dismissal***
San Angelo Community Medical Center, Prov. No. 45-0340, FYE 08/31/2016
Case No. 19-1699

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 19-1699. Set forth below is the decision of the Board to dismiss the 2 remaining issues in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") for SSI Percentage (Provider Specific) and Medicaid Eligible Days.

Background

A. *Procedural History for Case No. 19-1699*

On **September 11, 2018**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end August 31, 2016.

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

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

On **April 15, 2019**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

[1] On October 22, 2019, this issue was transferred to PRRB Case No. 19-1409GC.
[2] On November 5, 2024, the Provider withdrew this issue.
[3] On October 22, 2019, this issue was transferred to PRRB Case No. 19-1410GC.

> Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the Provider will use to support its position* and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. *See* Board Rule 25.[4]

The Provider is commonly owned/controlled by Community Health Systems (hereinafter "CHS") and, thereby, is subject to the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1). For that reason, on **October 22, 2019**, the Provider transferred Issues 1 and 5 to CHS groups.

On **October 29, 2019**, the Provider filed its preliminary position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> The Provider contends that its SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation based on the Provider's Fiscal Year End (August 31).
>
> Similar to *Loma Linda Community Hospital v. Dept of Health and Human Services*, No. CV—94-0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records.
> However, at this time, the Provider has been unable to analyze the Medicare Part A data because it has not yet received the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR"), HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000 from CMS. *See* 65 Fed. Reg. 50,548 (2000). Upon release of the complete MEDPAR data, the Provider will seek to reconcile its records with that of CMS, and identify patients believed to 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 following is the Provider's ***complete*** position on Issue 3 set forth therein:

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[4] (Emphasis added).
[5] Provider's Preliminary Position Paper at 8-9 (Oct. 29, 2019).

> The Provider disagrees with the MAC's calculation 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…
>
> CMS 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 hospital days of service for patients who were eligible on that day for medical assistance under a state Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for these inpatient hospital services.
>
> Based on the Listing of Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its 2016 cost report does not reflect an accurate number of Medicaid eligible days, as required by HCFA Ruling 97-2 and the pertinent Federal court decisions.[6]

On **February 24, 2020**, the Medicare Contractor filed its preliminary position paper.

On **June 17, 2024**, the Board issued a Notice of Hearing and Critical Due Dates, providing among other things, the filing deadlines for the parties' final position papers. This Notice also gave the following instructions to the Provider regarding the content of its final position paper:

> Provider's Final Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the Provider will use to support its position* and a statement indicating

[6] Provider's Preliminary Position Paper at 7-8 (Oct. 29, 2019).

> how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. *See* Board Rule 27.[7]

On **December 17, 2024**, the Provider timely filed its final position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> The Provider contends that its SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation.
>
> The Provider is seeking a *full and complete* set of the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. *See* 65 Fed. Reg. 50,548 (2000). Although some MEDPAR data is now routinely made available to the provider community, what is provided lacks all data records necessary to fully identify all patients properly includable in the SSI fraction. The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction. The [Provider] hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra (Appellants' reply brief included as Exhibit P-3).[8]

The following is the Provider's ***complete*** position on Issue 3 set forth therein:

> The Provider disagrees with the MAC's calculation 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

[7] (Emphasis added).
[8] Provider's Final Position Paper at 8-9 (Dec. 17, 2024).

decisions were rendered by the Fourth, Eighth and Ninth Circuits…

CMS 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 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.

Under section 1886(d)(5)(F)(vi)(II) of the Social Security Act (42 U.S.C. § 1395ww(d)(5)(F)(vi)(ii) and 42 C.F.R. § 412.106(b)(4)(1), Medicaid eligible days (including section 1115 waiver days, which are paid under the authority of section 1115 of the Social Security Act and regarded and treated as Medicaid eligible days) are to be included in the numerator of the Provider's Medicaid Fraction of the disproportionate patient percentage. The issue is whether the Medicare Administrative Contractor (MAC) included in the Provider's Medicaid Fraction of the disproportionate patient percentage all Medicaid eligible days (including section 1115 waiver days).

Based on the Listing of Medicaid Eligible days being sent under separate cover directly to the MAC, including Section 1115 waiver days, the Provider contends that the total number of days reflected in its 2016 cost report does not reflect an accurate number of Medicaid eligible days, as required by HCFA Ruling 97-2 and the pertinent Federal court decisions.

With respect to section 1115 waiver days, the courts have firmly rejected CMS's interpretation of its regulations, holding instead that the plain language of the statute and the regulations require inclusion in the Medicaid Fraction of the days belonging to individuals who are included in a section 1115 demonstration project. *See Forrest General Hospital*, 926 F.3d 221 (5th Cir. 2019); *HealthAlliance Hospitals, Inc. v. Azar*, 346 F. Supp. 3d 43 (D.D.C. 2018); *Bethesda Health Inc., v. Azar*, 389 F. Supp. 3d 32, (D.D.C. 2019), *aff'd,* 980 F.3d 121 (D.C. Cir. 2020). CMS has acquiesced in *Bethesda* and is now following the statute and the plain meaning of its own regulations (which regulations represent the official policy of CMS all along) and properly accounting for

> 1115 Waiver days as Medicaid Eligible days. *See* CMS Manual Instructions System, Change Request 12669, Transmittal No. 11912 (March 16, 2023) ("Transmittal 11912").[9]

On **January 17, 2025**, the Medicare Contractor timely filed its final position paper.

On **February 4, 2025**, the Medicare Contractor filed a jurisdictional challenge, requesting the dismissal of Issues 1 and 3. The Provider filed a timely response to the jurisdictional challenge on **February 24, 2025**.

On **February 11, 2025**, the Provider requested a Change of Representative to Quality Reimbursement Services, Inc

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

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

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

[9] Provider's Final Position Paper at 9-10 (De. 17, 2024).

> days associated with individuals that were "eligible" for SSI but did not receive an SSI payment.[10]

The group issue statement in Case No. 19-1409GC, CHS CY 2016 DSH SSI Percenatge CIRP Group, to which the Provider transferred Issue 2 reads, in part:

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

[10] Issue Statement at 1 (Mar. 6, 2019).

> Medicaid fraction consists of days of patients who were both eligible for medical assistance under Title XIX, or Medicaid, and not entitled to benefits under Part A of Title XVIII, or Medicare. The denominator for the Medicaid fraction is the hospital's total patient days for the period.
>
> CMS considers an individual to be "entitled to benefits under Part A" regardless of whether the days were "covered" or paid by Medicare. This means that now Part C days, Exhausted Benefit days, and Medicare Secondary Payor ("MSP") days are included in the denominator of the Medicare/SSI fraction even when there is no payment by Medicare, which is a departure from the treatment of these days as excluded from the Medicare/SSI fraction prior to the 2004 rule.
>
> The Provider(s) contend(s) that if CMS includes unpaid Medicare Part A days in the denominator of the Medicare/SSI fraction, then unpaid SSI eligible patient days must be included in the numerator of the Medicare/SSI fraction, utilizing SSI payment codes that reflect the individuals' eligibility for SSI – even if the individuals did not receive SSI payments, as a matter of statutory consistency.[11]

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $28,000.

C. Description of Issue 3 in the Appeal Request

In its Individual Appeal Request, the Provider summarizes its DSH Payment – Medicaid Eligible Days issue as follows:

> 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)(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

[11] Group Issue Statement at 1-2 (Mar. 15, 2019).

> the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.[12]

The Provider estimated the reimbursement impact of the issue at $28,625 based on an increase of 50 additional Medicaid days but failed to include a list of the additional days.[13]

MAC's Jurisdictional Challenge

Issue 1 – DSH Payment/SSI Percentage (Provider Specific)
The Medicare Contractor notes that according to the Provider's appeal request, Issue 1 has three components: 1) SSI data accuracy; 2) realignment; and 3) individuals who are eligible for SSI but did not receive SSI payment. [14]

The Medicare Contractor contends that the first and third sub-issues should be dismissed because they are duplicative of Issue 2 which was transferred to Group Case No. 19-1409GC, CHS CY 2016 DSH SSI Percentage CIRP Group. This means that the Provider is appealing an issue from a single final determination in more than one appeal, which is prohibited by Board Rule 4.6.1.[15]

The Medicare Contractor goes on to contend that the second sub-issue, SSI realignment, has been abandoned. The Provider did not brief the issue of SSI realignment within its preliminary or final position papers. As a result, it should be considered withdrawn in accordance with Board Rule 25.3. Alternatively, the Medicare Contractor asserts that the Board does not have jurisdiction over realignment. There was no final determination over SSI realignment and the appeal is premature as the Provider has not exhausted all available remedies. [16]

Lastly, the Medicare Contractor asserts that Issue 1 should be dismissed because the Provider failed to file a complete preliminary and final position paper in accordance with 42 C.F.R. § 405.1853(b)(2) and Board Rules 25 and 27. The Medicare Contractor contends that the Provider was in violation of Board Rules 25.3 and 27 when it failed to sufficiently develop and set forth the relevant facts and arguments regarding the merits of its claim in its Preliminary and Final Position Papers. 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.[17]

The Medicare Contractor contends that the Provider offers no evidence or analysis to demonstrate that CMS calculated its SSI percentage inaccurately. The Provider failed to include any evidence to establish the material facts in this case relating to inaccuracies in the SSI percentage calculation at issue or any evidence pertaining to the alleged systemic SSI ratio data match errors like those referenced in the *Baystate* case. The Provider has not set forth any

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[12] Issue Statement at 3 (Mar. 6, 2019).
[13] *Id*.
[14] Medicare Contractor's Jurisdictional Challenge at 2.
[15] *Id.* at 2 and 6.
[16] *Id.* at 2, 11-12.
[17] *Id.* at 2 and 10.

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 and 25.2.2 or 27.[18]

Issue 3 – DSH Payment – Medicaid Eligible Days

The Medicare Contractor contends that this issue should be dismissed because the Provider failed to complete preliminary or final position papers 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.

The Medicare Contractor notes that a Medicaid eligible days listing was never received with the Provider's preliminary position paper. The Medicare Contractor goes on to note that with its final position paper, the Provider submitted Exhibit P-1, identified as "1115 Waiver and Additional ME Days Consolidated." The Exhibit states "Listing pending finalizing upon receipt of state eligibility data", indicating that the listing is not the final listing suitable for audit. Additionally, the Medicare Contractor notes that to date, the Provider has not submitted an unredacted listing, suitable for audit.[19]

The Medicare Contractor contends that the Provider was in violation of Board Rules 25.3 and 27.2 when it failed to sufficiently develop and set forth the relevant facts and arguments regarding the merits of its claim in its preliminary and final 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. The Provider has not submitted accurate and sufficient data to demonstrate that patients were eligible for Medicaid on the claimed patient hospital days or identified as to why the data is not yet available or when it will become available. [20]

Additionally, the Medicare Contractor argues this issue should be dismissed because the Provider is attempting to untimely and improperly add the issue of Section 1115 waiver days as a sub-issue via its final position paper filed on December 17, 2024. The Medicare Contractor issued the Provider's NPR on September 11, 2018. In accordance with 42 C.F.R. § 415.1835(e), the deadline for adding issues to the appeal was May 9, 2019. The issue was informally added through the Provider's final position paper, over five years after the filing deadline to add an issue. [21]

The Medicare Contactor contends that the Section 1115 Waiver Days issue is one component of the DSH issue that must be appealed as a separate issue. The Medicare Contractor notes that Board Rule 8 explains that one issue can have multiple components. Within Board Rule 8, some

[18] Medicare Contractor's Jurisdictional Challenge at 10.
[19] *Id.* at 10.
[20] *Id.* at 13 and 15.
[21] *Id.* at 13 and 15.

of the disproportionate share hospital (DSH) components are identified. Specifically, the Board identifies Section 1115 waiver days as a distinct DSH component that the Provider must appeal separately.[22]

Provider's Jurisdictional Response

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

The Provider contends that the Medicare Contractor is incorrect when it states that the SSI Percentage (Provider Specific) issue is duplicative of the SSI Percentage (Systemic Errors) issue that was transferred to a group appeal. 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. 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 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 previously been identified in the *Baystate* litigation. Once these patients are identified, the Provider contends it will be entitled to a correction of these errors of omission to its SSI percentage. The DSH/SSI percentage was adjusted on the Provider's cost report. Therefore, the Board should find jurisdiction over the SSI provider specific issue in the instant appeal. [23]

Issue 3 – DSH Payment – Medicaid Eligible Days

The Provider notes the Medicare Contractor's assertion that the Provider has a "abandoned" the Medicaid Eligible Days issue by not including supporting documentation, i.e., a listing of Medicaid eligible days, with its Preliminary Position Paper. The Provider contends that the Medicare Contractor relies on Board rule 25.3. It is unclear, however, whether the Medicare Contractor relies on the current Board rules version 3.1 or the Board Rules Version 2.0 (8/29/2018), which was in effect in 2024 when the Final 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. It was the reasonable understanding and expectation of the Provider, therefore, that the outside date for submission of the listing of additional Medicaid eligible days was the Final Position Paper deadline.[24]

The Provider argues that the phrasing of its issue statement with respect to the Medicaid Eligible Days issue makes clear that the Provider appealed all Medicaid eligible days, including section 1115 waiver days. By definition, section 1115 waiver days are Medicaid eligible days. Whereas the Medicare Contractor states that the Section 1115 Waiver Days issue is one component of the DSH issue, the regulations at 42 C.F.R. § 405.1835 contain requirements for appealing an

[22] *Id.* at 17.
[23] Provider's Jurisdictional Response at 2.
[24] *Id.* at 2.

"issue" and a time limit on adding an "issue" – not on clarifying "sub-issues" or "components" of an issue. Both a June 25, 2004 proposed rule (69 *Fed. Reg.* 35716) and a May 23, 2008 final rule (73 *Fed. Reg.* 30190) indicate that an "issue" is encapsulated by a specific cost report adjustment. They do not slice and dice an "issue" into component parts, including the specific reason why Medicaid eligible days were not counted in the numerator of the Medicaid Fraction of the Disproportionate Payment Percentage. There is no dispute that the same cost report adjustment that affects other types of Medicaid eligible days also affects section 1115 waiver days.[25]

The Provider goes on to contend that the version of Board Rule 8 (July 1, 2015) that it alleges was effective when the Provider filed its appeal, makes no mention of "section 115 waiver days" nor even "Medicaid eligible days." Thus, even if Rule 8's extension to "components of issues" were valid (and the Provider contends it is not), the Provider had no notice that it was required to specify section 1115 waiver days in its appeal request, and it would be a denial of due process for the PRRB to dismiss the section 1115 waiver days component of its appeal of Medicaid eligible days.[26]

Finally, the Provider contends that subsequent to the Provider's Preliminary Position Paper, the Fifth Circuit ruled that the statute and CMS's own regulations require that CMS regard inpatient days attributable to an uncompensated care pool population as Medicaid eligible days, *Forrest General Hospital v. Azar*, 926 F.3d 221 (5th Cir. 2019). The Medicare Contractor is required by specific command of CMS to accept and audit the Provider's section 1115 waiver days in providers' Medicaid Fractions. Following a string of litigation defeats, including those in *Forrest General Hospital* and *Bethesda Health, Inc. v. Azar*, 980 F.3d 121 (D.C. Cir.2020), CMS issued Change Request 12669, Transmittal No. 11912 (March 16, 2023). The Provider asserts that under this Transmittal, the Medicare Contractor has the duty to accept the Provider's listing of section 1115 days and audit them. The Provider states that it submitted an unredacted listing to the Medicare Contractor on February 24, 2025.[27]

Decision of the Board

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

As set forth below, the Board hereby ***dismisses*** the Provider's two (2) remaining issues.

A. DSH Payment/SSI Percentage (Provider Specific)

[25] *Id.* at 3-4.
[26] *Id.* at 5.
[27] *Id.* at 5-6.

The jurisdictional analysis for Issue 1 has several relevant aspects to consider: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period; and 3) the Provider incorporating the arguments from *Advocate Christ*[28] into its appeal. As set forth below, the Board dismisses all aspects of Issue 1.

1. *First and Third Aspects of Issue 1*

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH SSI Percentage (Systemic Errors) issue that was appealed in PRRB Case No. 19-1409GC.

The DSH Payment/SSI Percentage (Provider Specific) issue in the present appeal concerns "whether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation."[29] The Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[30] 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."[31]

The Provider's DSH SSI Percentage (Systemic Errors) issue in group Case No. 19-1409GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds the DSH Payment/SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH SSI Percentage (Systemic Errors) in Case No. 19-1409GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6.1,[32] the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

The Board has previously noted that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and the Provider has failed to explain how this argument is ***specific to this provider***. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may

[28] The Provider has included the Appellants' Reply Brief in *Advocate Christ Med. Ctr. v. Becerra*, No. 22-5214 (D.C. Cir.), which is on appeal from the decision in *Advocate Christ Med. Ctr. V. Azar*, 17-cv-1519 (TSC), 2022 WL 2064830, (D.D.C. June 8, 2022).
[29] Issue Statement at 1.
[30] Issue Statement at 1.
[31] Issue Statement at 1.
[32] PRRB Rules v. 3.2 (Dec. 2023).

impact the SSI percentage for each provider differently.[33] Accordingly, Provider's reference to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, Provider has failed to sufficiently distinguish (by sufficient explanation or evidence) how the alleged "provider specific" errors averred in Issue 1 are distinguished from the alleged "systemic" issues argued in Issue 2, and why those alleged "provider specific" errors should not be subsumed into the "systemic errors" issue appealed in Case No. 19-1409GC.

To this end, the Board also reviewed the Provider's Preliminary and Final Position Papers to see if they 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 and Final Position Papers failed to comply with the Board Rules 25 and 27 governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 and explain the nature of the any alleged "errors" in its Preliminary or Final Position Papers and include *all* exhibits.

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

> **25.2.2 Unavailable and Omitted Documents**
>
> *If documents necessary to support your position are still unavailable,* identify the missing documents; explain why the documents remain unavailable; state the efforts made to obtain the documents; and explain when the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.[34]

The Provider only cites to the 2000 Federal Register but additional issuances and developments on the availability of data underlying the SSI fraction, such as MEDPAR data, have occurred. For example, as noted in the FY 2006 IPPS Final Rule, "[b]eginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108–173), we will arrange to furnish, consistent with the Privacy Act, MedPAR 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***

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

reporting period. Under this provision, *the hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year*. The data set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year." Further highlighting the perfunctory nature of the briefing is the fact that providers *can* obtain certain data used to calculate their DSH SSI ratios directly from CMS and in some cases on a self-service basis as explained on the following webpage:

> https://www.cms.gov/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh.[35]

This CMS webpage describes access to DSH data ***from 1998 to 2022*** and instructs providers to send a request via email to access their DSH data."[36]

Indeed, the D.C. Circuit affirmed in *Advocate Christ Med. Ctr. v. Becerra*, 80 F.4th 346 (D.C. Cir. 2023) that "What [MMA] section 951 cannot mean is that HHS must give hospitals data that it never received from SSA in the first place. And SSA does not provide HHS with the specific codes assigned to individual patients. See 75 Fed. Reg. at 50,276." Here, the Provider does not explain what information it needs or is waiting on or claims that it should have access to or why this is not a common issue already covered by the CIRP group under Case No. 19-1409GC.

Accordingly, the Board finds that the issue in the instant appeal and the group issue from Group Case 19-1409GC are the same issue.[37] Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6.1, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

Additionally, in its Final Position Paper, the Provider states, "The [Provider] hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra [sic] (Appellants' reply brief included as Exhibit P-3)." The Board finds that this incorporation by reference does not comply with the regulatory and Board rule requirements to *fully* develop the Provider's position in the position papers. Particularly, 42 C.F.R. § 405.1853 provides 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 §

[35] Last accessed March 7, 2025.
[36] Emphasis added.
[37] Moreover, even if it were not a prohibited duplicate, it was not properly in the individual appeal because it is a common issue that would be required to be in a CHS CIRP group per 42 C.F.R. § 405.1837(b)(1).

> 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.[38]

An incorporation of arguments by reference from a different case simply fails to do so. Accordingly, the Board dismisses that portion of the issue as well.

2. *Second Aspect of Issue 1*

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

Under 42 C.F.R. § 412.106(b)(3), the applicable regulation for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." Moreover, without this written request, the Medicare Contractor cannot issue a final determination with which the Provider can be dissatisfied for Board appeal purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding DSH SSI Percentage *realignment*. Therefore, in accordance with 42 C.F.R. § 405.1835(a)(1), the Board dismisses this aspect of the appeal.

B. DSH Payment – Medicaid Eligible Days

1. *Section 1115 Waiver Days*

The Board finds that the section 1115 Waiver days issue is not a part of this appeal as it was not properly or timely added. The Provider failed to include section 1115 Waiver days as a cost issue in its appeal request and failed to timely and properly add this additional issue to the appeal. While the Provider appealed Medicaid eligible days, this issue is separate and distinct from the section 1115 Waiver days.

The appeal was filed with the Board in March of 2019 and the regulations required the following:

> (b) *Contents of request for a Board hearing on final contractor determination.* The provider's request for a Board hearing…must be submitted in writing to the Board, and the request must include…
>
> (2) For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final…determination under appeal, including an account of…

[38] (Emphasis added).

> (i) why the provider believes Medicare payment is incorrect for each disputed item...[and]
>
> (ii) how and why the provider believes Medicare payment must be determined differently for each disputed item…[39]

Board Rule 7.2.1 (2018) elaborated on this regulatory requirement instructing providers:

> The following information and supporting document must be submitted for each issue raised in the appeal request.
>
> - An issue title and a concise issue statement describing:
>   - the adjustment, including the adjustment number,
>   - the controlling authority,
>   - why the adjustment is incorrect,
>   - how the payment should be determined differently,
>   - the reimbursement effect, and
>   - the basis for jurisdiction before the Board.[40]

Board Rule 8 (2018) explains that when framing issues for adjustments involving multiple components, that providers must specifically identify each item in dispute, and "…each contested component must be appealed as a separate issue and described as narrowly as possible…". The Rule goes on:

> Several examples are identified below, but these examples are not exhaustive lists of categories or issues.
>
> **A. Disproportionate Share Hospital Payments**
>
> Common examples include :. . . ***Section 1115 waiver days (program/waiver specific)***[41]

Effective August 21, 2008, following the appropriate notice and comment period, new Board regulations went into effect that limited the addition of issues to appeals.[42] 42 C.F.R. § 405.1835(e) provides in relevant part:

> (c) *Adding issues to the hearing request*. After filing a hearing request… a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the Board, only if –

[39] 42 C.F.R. § 405.1835(b).
[40] v. 2.0 (Aug. 2018).
[41] (Bold and italic emphasis added).
[42] *See* 73 Fed. Reg. 30190 (May 23, 2008).

> . . .
>
> (2) The Board receives the provider's request to add issues no later than 60 days after the expiration of the applicable 180–day period prescribed in paragraph (a)(3) or paragraph (c)(2) of this section.

In practice this means that new issues had to be added to this case no later than 240 days after receipt of the contractor's determination. However, there is no evidence in the record to indicate the Provider added the section 1115 Waiver days to the case properly or timely.

In this regard, the Board notes that section 1115 Waiver days are not traditional Medicaid eligible days and indeed were only incorporated into the DSH calculation effective January 20, 2000.[43] Rather, they relate to Medicaid expansion program(s) and are only includable in the DSH adjustment calculation if they meet the requirements in 42 C.F.R. § 412.106(b)(4) relating to section 1115 Waiver days. Indeed, not every state Medicaid program has a qualifying 1115 expansion program ***and*** not every inpatient day associated with beneficiary enrolled in an 1115 waiver program qualifies to be included in the Medicaid fraction.[20] In contrast, every state has a Medicaid state plan, and every state Medicaid plan includes inpatient hospital benefits.

Specifically, § 412.106(b)(4) states in pertinent part:

> (4) *Second computation*. The fiscal intermediary determines, for the same cost reporting period used for the first computation, the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period. For purposes of this second computation, the following requirements apply:
>
> (i) For purposes of this computation, a patient is deemed eligible for Medicaid on a given day only if the patient is eligible for inpatient hospital services under an approved State Medicaid plan **or under a waiver authorized under section 1115(a)(2) of the Act** on that day, regardless of whether particular items or services were covered or paid under the State plan or the authorized waiver.
>
> **(ii) Effective with discharges occurring on or after January 20, 2000, for purposes of counting days under paragraph (b)(4)(i) of this section, hospitals may include all days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of**

[43] 65 FR 47054, 47087 (Aug. 1, 2000).

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

Because the Provider did not raise the section 1115 Waiver days prior to the deadline to add issues, and it is a distinct issue, the Board finds that the issue was not properly or timely appealed. The DSH Medicaid Eligible Days issue as stated in the original appeal request cannot be construed to include section 1115 Waiver days. Additionally, there is no indication that any 1115 waiver days were included with the as-filed cost report which, if true, would make them an unclaimed cost and provide an independent basis for dismissal.

2. *Medicaid Eligible Days*

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

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

> **7.3.2 No Access to Data**
>
> If the provider elects to not claim an item on the cost report because, through no fault of its own, it did not have access to the underlying information to determine whether it was entitled to payment, describe the circumstances why the underlying information was unavailable upon the filing of the cost report.

42 C.F.R. § 405.1853(b)(2)-(3) addresses the content of position papers:

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

> **timeframe to be decided by the Board** through a schedule applicable to a specific case or through general instructions.[44]

The regulations require the parties to fully brief the merits of each issue in their position paper (including the relevant facts and legal arguments) and specify that the Board has discretion about setting the time frame for the submission of exhibits supporting the merits of the appeal.

Board Rule 25 (Aug. 2018) requires the Provider to file its complete, *fully* developed preliminary position paper with all available documentation and gives the following instruction on the content of position papers:

> **Rule 25 Preliminary Position Papers**[45]
>
> **COMMENTARY**:
>
> Under the PRRB regulations effective August 21, 2008, all issues will have been identified within 60 days of the end of the appeal filing period. The Board will set deadlines for the first position paper generally at eight months after filing the appeal request for the provider, twelve months for the Medicare contractor, and fifteen months for the provider's response. Therefore, preliminary position papers are expected to present fully developed positions of the parties and, therefore, require analysis well in advance of the filing deadline.
>
> **25.1 Content of Position Paper Narrative**
>
> The text of the position papers must include the elements addressed in the following sub-sections.
>
> **25.1.1 Provider's Position Paper**
>
> A. Identify any issues that were raised in the appeal but are already resolved (whether by administrative resolution, agreement to reopen, transfer, withdrawal, dismissal, etc.) and require no further documentation to be submitted.
> B. For *each* issue that has not been fully resolved, state the material facts that support the provider's claim.
> C. Identify the controlling authority (e.g. statutes, regulations, policy, or case law) supporting the provider's position.
> D. Provide a conclusion applying the material facts to the controlling authorities

[44] (Bold emphasis added.)
[45] (Emphasis added.)

25.2 Position Paper Exhibits

25.2.1 General

With the position papers, the parties must exchange ***all*** available documentation as exhibits to fully support your position. . . . When filing those exhibits in the preliminary position paper, ensure that the documents are redacted in accordance with Rule 1.4. Unredacted versions should be exchanged by the parties separately from the position paper, if necessary.

25.2.2 Unavailable and Omitted Documents

If documents necessary to support your position are still unavailable, identify the missing documents, explain why the documents remain unavailable, state the efforts made to obtain the documents, and explain when the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.

25.2.3 List of Exhibits

Parties must attach a list of the exhibits exchanged with the position paper.

25.3 Filing Requirements to the Board

Parties should file with the Board a **complete** preliminary position paper with a fully developed narrative (Rule 23.1), all exhibits (Rule 23.2), a listing of exhibits, and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. Any issue appealed, but not briefed by the Provider in its position paper will be considered withdrawn.

> **COMMENTARY**: Note that this is a change in previous Board practice. Failure to file a complete preliminary position paper with the Board will result in dismissal of your appeal or other actions in accordance with 42 C.F.R. § 405.1868. (*See* Rule 23.4.)

The Notice of Case Acknowledgement and Critical Due Dates issued to the Provider on April 15, 2019 included instructions on the content of the Provider's preliminary position paper consistent with the above Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

Moreover, in connection with Issue 3, Medicare regulations specifically place the burden on hospitals to provide documentation from the State to establish ***each*** *Medicaid eligible day* being claimed. Specifically, when determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(4)(iv) 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.[46]

Along the same line, 42 C.F.R. § 405.1871(a)(3) makes clear that, in connection with appeals to the Board, "the provider carrie[s the] burden of production of evidence and burden of proof by establishing, by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue."

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

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

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

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

On October 29, 2019, the Provider filed its preliminary position paper in which it indicated that the eligibility listing was imminent by promising that the listing was being sent under separate cover.[47] Significantly, the position paper did ***not*** include *the material fact* of how many Medicaid eligible days remained in dispute in this case, but rather continued to reference the "estimated impact" included with its appeal request (i.e., the estimated impact of $28,625 based on an estimated 50 days).

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[46] (Emphasis added.)
[47] Provider's Preliminary Position Paper at 10.

On December 17, 2024, the Provider filed its final position paper. Attached as Exhibit P-1 was a listing entitled "1115 Waiver and Additional ME Days Consolidated." The listing contained the caveat "Listing [is] pending finalization upon receipt of State eligibility data." The Listing was 6 pages with 931 Medicaid eligible days. The position paper did not explain why the listing of days was being submitted at this late date or why it was not final (*i.e*., why it was "pending finalization") at this late date, ***more than 6 years after the fiscal year at issue had closed***. NOTE—the 931 days included in this belated listing is *exponentially* larger than the original estimate of 50 days included with the appeal request. Regardless, this filing, *importantly,* ***was roughly 5 years past the deadline for including it with its preliminary position paper*** since the position paper deadline was November 1, 2019.

The Board concurs with the Medicare Contractor that the Provider is required to identify *the material facts* (*i.e*., the number of days at issue) and provide relevant supporting documentation to identify and prove the specific additional Medicaid Eligible days at issue and for which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3), Board Rule 25, and 42 C.F.R. § 412.106(b)(iii). Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. § 412.106(b)(iii) and 405.1853(b)(2)-(3) and Board Rules 25.2.1 and 25.2.2 related to the submission of documentary evidence required to support its claims or describe why said evidence is unavailable. The Board finds that the Provider also failed to fully develop the merits of the Medicaid eligible days issue because the provider has failed to identify any specific Medicaid eligible days at issue (much less any supporting documentation for those days).

Finally, pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[48] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. As the Provider failed to submit a finalized listing of Medicaid eligible days, notwithstanding its obligations under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25, the Board must find that there are no such days in dispute and that the actual amount in controversy is $0.

Based on the above, the Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(iii) and Board Rules 25.2.1 and 25.2.2 related to identifying the days in dispute (a material fact) and the timely submission of documentary evidence required to support its claims or describe why said evidence is unavailable, which the Provider has failed to do.[49]

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[48] (Emphasis added.)

[49] *See also Evangelical Commty Hosp. v. Becerra*, No. 21-cv-01368, 2022 WL 4598546 at *5 (D.D.C. 2022):

> The Board acts reasonably, and not arbitrarily and capriciously, when it applies its "claims-processing rules faithfully to [a provider's] appeal." *Akron*, 414 F. Supp. 3d at 81. The regulations require that a RFH provide "[a]n explanation [ ]for each specific item under appeal." 42 C.F.R. § 405.1835(b)(2).

Based on the foregoing, the Board dismisses the two (2) remaining issues in this case – (Issues 1 and 3). As no issues remain, the Board hereby closes Case No. 19-1699 and removes it from the Board's docket.

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

Board Members Participating:

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

For the Board:

3/10/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

cc: Michael Redmond, Novitas Solutions, Inc. c/o GuideWell Source (J-H)
Wilson Leong, Federal Specialized Services

The Board rules further explain that "[s]ome issues may have multiple components," and that "[t]o comply with the regulatory requirement to specifically identify the items in dispute, each contested component must be appealed as a separate issue and described as narrowly as possible." Board Rules § 8.1. The Board rules also specifically delineate how a provider should address, as here, a challenge to a Disproportionate Share Hospital reimbursement. Board Rule 8.2 explains that an appeal challenging a Disproportionate Share Hospital payment adjustment is a "common example" of an appeal involving issues with "multiple components" that must be appealed as "separate issue[s] and described as narrowly as possible." Board Rules §§ 8.1, 8.2.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Nicole Stoychev, Reimbursement Manager
West Virginia University Hospital System
One Medical Center Drive, P.O. Box 8261
Morgantown, WV 26506

Re: ***Dismissal for Failure to Meet Minimum Filing Requirements & Failure to Timely Cure Defect After Board Request***

Case Number 25-1226 - Barnesville Hospital Assoc., Inc. (Provider Number 36-1321)
FYE: 12/31/2022
Case Number 25-1227 - Braxton County Mem. Hospital (Provider Number 51-1308)
FYE: 12/31/2022

Dear Ms. Stoychev:

The Provider Reimbursement Review Board ("Board") has reviewed the above-referenced appeal requests. After review of the facts outlined below, the Board has determined that the appeal requests are fatally flawed as they were not filed in accordance with the regulations and Board Rules. The Pertinent Facts of both cases, the Board's review, and determination are set forth below.

Pertinent Facts:

On December 31, 2024, West Virginia University Health System ("WVU Health") filed an individual appeal with the Board on behalf of Barnesville Hospital Assoc., Inc. for FYE 12/31/2022 under Case No. 25-1226. The appeal was filed from a Notice of Program Reimbursement ("NPR") dated September 18, 2024.

On the same date, WVU Health also filed an individual appeal on behalf of Braxton County Memorial Hospital for FYE 12/31/2022 under Case No. 25-1227. The appeal was filed from a Notice of Program Reimbursement ("NPR") dated October 17, 2024.

In both cases WVU Health uploaded a short letter as support for both the Representative Letter and the Issue Statement.[1]

- In **Case No. 25-1226**, although the letter is titled "Request to Appeal Medicare Hospital Cost Report," it is addressed to the Medicare Contractor, CGS, and the Appeals Support

[1] The Board notes that the document uploaded as the "Representative Letter" in both cases advises the Board to contact Alex Solomon, Director of Enterprise Reimbursement. The designated representative that actually filed the appeals is Nicole Stoychev, Reimbursement Manager at WVU Health.

> Contractor, Federal Specialized Services ("FSS"). In it the Provider ". . . requests to amend the hospital's submitted Medicare Cost Report for the six- month period ending December 31, ***2023***."[2] (*The subject line indicates the appeal period is 12/31/2022*).

- In **Case No. 25-1227**, the letter is titled "Cost Report Re-Opening/Appeal and, again, is addressed to the Medicare Contractor, Palmetto GBA, and FSS. In it the Provider "requests the re-opening, appeal, and amendment of its Medicare Cost Report for fiscal year ***2023***."[3] (When Case No. 25-1227 was established in the Office of Hearings Case & Document Management System ("OH CDMS"), the FYE was entered as 12/31/2022 and the NPR support reflects the FYE as 12/31/2022.

On January 6, 2025, the Board issued Acknowledgement and Critical Due Date ("ACDD") notices in which it set the deadlines for the Parties to file preliminary position papers AND in both cases, requested that the Providers submit updated Representative Letters (per Board Rule 5.4), as well as updated Issue Statements (per Board Rule 7.2.1.)[4] In both cases, the deadlines for the Representative Letters and updated Issue Statements were set for January 22, 2025.

On January 23, 2025, when due date for the updated Representative Letters and Issue Statements had passed, the Board issued a "Final" Request for Information in both cases. Again, there has been no response.

Rules/Regulations:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the 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.

42 C.F.R. § 405.1835(b) establishes the required contents for an appeal request.

> The provider's request for a Board hearing under paragraph (a) of this section must be submitted in writing in the manner prescribed by the Board, and the request ***must include the elements described in paragraphs (b)(1) through (4)*** of this section. If the provider submits a hearing request that does not meet the requirements of paragraph (b)(1), (2), or (3) of this section, the ***Board may dismiss*** with prejudice the appeal or take any other remedial action it considers appropriate.
>
> (1) A demonstration that the provider satisfies the requirements for a Board hearing as specified in paragraph (a) of this section, including a specific

[2] Request to Appeal Medicare Hospital Cost Report (Case No. 25-1226) at 1 (Dec. 12, 2024).
[3] Cost Report Re-Opening/Appeal (Case No. 25-1227) at 1 (undated).
[4] The ACDD for Case No. 25-1227, also advised that WVU Health had uploaded "Other Issue Support" titled "Braxton Amendment CL FYE2022.pdf" but the support actually referred to FYE 2023, rather than the FYE under appeal.

> identification of the final contractor or Secretary determination under appeal.
>
> (2) For each specific item under appeal, ***a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final contractor or Secretary determination under appeal***, including an account of all of the following:
>
> (i) Why the provider believes Medicare payment is incorrect for each disputed item (or, where applicable, why the provider is unable to determine whether Medicare payment is correct because it does not have access to underlying information concerning the calculation of its payment).
>
> (ii) How and why the provider believes Medicare payment must be determined differently for each disputed item.
>
> (iii) If the provider self-disallows a specific item (as specified in § 413.24(j) of this chapter), an explanation of the nature and amount of each self-disallowed item, the reimbursement sought for the item, and why the provider self-disallowed the item instead of claiming reimbursement for the item.

Board Rules 6, 7, and 8 further address individual appeal requirements and support for the appealed final determination, availability of issue-related information, and basis for dissatisfaction. Board Rule 6.1.1 advises that "[t]he Board will dismiss appeal requests that do not meet the *minimum* filing requirements as identified in 42 C.F.R. § 405.1835(b)."

Further, Board Rule 5.2 makes it clear that the Provider's representative is responsible for being familiar with Board Rules and Regulations, meeting the Board's deadlines and responding to correspondence or requests from the Board.

Finally, Board Rule 41.2 permits the Board to dismiss a case (or an issue) on its own motion, "upon failure of the provider . . . to comply with Board procedures or filing deadlines (*see* 42 C.F.R. § 405.1868)."

Board Determination:

The Board has determined that the Provider's appeal requests are fatally flawed as they were not filed in accordance with the regulations at 42 C.FR. § 405.1835(b) nor with the Board Rules.

First, the Board finds that the document WVU Health uploaded and described as an "Issue Statement" appears to be a copy of the Provider's requests for reopening of their respective cost reports from the Medicare Contractor. These documents do not constitute an issue statement consistent with the appeal content requirements in Board Rule 7.2 and 42 C.F.R. § 405.1835(b). Board Rule 7.2 requires, among other things, that an issue statement include an issue title and a concise statement describing any relevant adjustment numbers, the controlling authority, why the

adjustment is incorrect, how the payment should be determined differently and the basis for the Board's jurisdiction.

Secondly, the Board finds that WVU Health was afforded two separate opportunities to cure the noted deficiencies. WVU Health failed to respond to the Board's requests as detailed in the January 6, 2025 ACDD notifications and the January 23, 2025 Final Request for Information. Accordingly, the Board hereby dismisses Case No. 25-2485 since the appeal request is fatally flawed and does not meet the *minimum* filing requirements as outlined above and based on WVU Health's failure to respond by the deadline.

Based on the above, the Board closes Case Nos. 25-1226 and 25-1227 and removes both from its docket. Review of this determination may be available under the provisions of 42 U.S.C. §1395oo(f) and 42 C.F.R. §§ 405.1875 and 105.1877.

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

For the Board:

3/11/2025

X Kevin D. Smith, CPA

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

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services
Dana Johnson, Palmetto GBA c/o National Govt. Services, Inc. (J-M)
Judith Cummings, CGS Administrator (J-15)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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410-786-2671

Via Electronic Delivery

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

RE: ***Dismissal of Part C Issue and Case Closure***
Moses Taylor Hospital (Provider Number 39-0119)
FYE: 06/30/14
Case Number: 17-1178

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board or PRRB") is in receipt of the Provider's February 21, 2025 Request for Postponement of the March 19, 2025 hearing in Case No. 17-1178. The provider claims that the remaining issue(s) in the appeal specifically relate to the "treatment of Medicare Managed Care Part C days in the DSH calculation" which is "pending the final outcome of Allina Health Services, et al v. Thomas Price in the United States Court of Appeals for the District of Columbia Circuit."[1] The provider suggests that the Board stay the case ". . . to await the decision of the Supreme Court."[2] The Board's decision dismissing the issue(s) is laid out below.

Discussion

The Provider filed its appeal request for the fiscal year ended ("FYE") 6/30/2014 on March 9, 2017. The Provider's representative identified 11 issues in the appeal. Three of the issues, issues 3, 5 and 8, were related to the treatment of Medicare Managed Care Part C days. Issue 3 was specific to the SSI fraction, Issue 5 related to the Medicaid fraction, and issue 8 was a combination SSI (Exclusion)/Medicaid (Inclusion) fraction for the Part C issue. In the appeal request, the Provider also identified that it was part of the Community Health Systems ("CHS") chain for the fiscal year under appeal, ending 6/30/2014.

The Board reviewed its inventory and identified that 2014 CHS Part C appeals had been filed by the CHS chain in 2016. These included Case No. 16-1295GC, CHS 2014 DSH SSI/Medicaid Part C Days CIRP Group, and Case No. 16-1279GC, CHS 2014 DSH Medicaid Fraction Part C Days CIRP Group.[3]

[1] Request for Postponement at 1 (Feb. 21, 2025).
[2] *Id.*
[3] The Board notes on August 3, 2021, the Provider Representative in Case Nos. 16-1295GC, 16-1279GC, 17-0574GC (QRS HMA 2014 DSH Medicaid Fraction Medicare Managed Care Part C Days CIRP Group), and 17-0576GC (QRS HMA 2014 DSH SSI Fraction Medicare Managed Care Part C Days CIRP Group), filed a request to merge the group appeals asserting that CHS has inadvertently created multiple group appeals for the same issue for hospital cost reports ending in calendar year 2014. Therefore, they requested the Board merge the groups into a single group appeal.

The Board notes that the above-referenced Provider, Moses Taylor Hospital (Prov. No. 39-0119), FYE 6/30/14, was directly added to these CIRP group appeals on February 7, 2017.[4] Then on March 9, 2017, the Provider Representative filed an Individual Appeal Request (assigned Case No. 17-1178) for the same Provider, Moses Taylor Hospital (Prov. No. 39-0119), FYE 6/30/14, appealing the same Part C days issue, from the same final determination as in the group appeals (Issues 3, 5, & 8).

Decision of the Board

Board Rule 4.5 provides: "[a] provider may not appeal an issue from a final determination in more than one appeal."[5] Further, the Certification page of group appeal requests 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 providers, nor has it been adjudicated, withdrawn or dismissed from any other PRRB appeal."[6]

The Part C days issue for the above-referenced Provider, Moses Taylor Hospital, FYE 6/30/14, is currently pending in 2 appeals, 17-1178 and 16-1295GC. The Provider is appealing the same Part C days issue from its September 23, 2016 Notice of Program Reimbursement, in both the group appeal and its individual appeal.

As Board Rule 4.5 bars a provider from being a participant in more than one appeal for the same issue from the same determination, the Board dismisses the Part C days issues (Issues 3, 5, & 8) from the individual appeal, Case No. 17-1178; the Board denies the Provider's Request for postponement. As no issues remain in the individual appeal after dismissal of the Part C days issues, the Board closes Case No. 17-1178.

The Board admonishes QRS/CHS for filing multiple appeals for the same Provider/FYE/Issue and failing to recognize the duplicative nature. If QRS/CHS continues to make improper duplicate filings, the Board may consider taking additional remedial actions as authorized by 42 C.F.R. § 405.1868(b) (e.g., dismissal of improper duplicate appeal).

In addition, the Supreme Court case decision, for which the provider requested that the Board reschedule the case, was issued on June 2, 2019, over five years ago. Therefore, it is unclear as to why the Provider Representative is requesting a stay, subject to its issuance.

Then, on April 28, 2022, the Board issued a Duplication of Common Issue Related Party Groups letter to the parties stating "[f]or purposes of the CHS chain and its CY 2014 Managed Care Part C Days issue, there can be only one CIRP group appeal." The Board asserted [it] has determined that it would close Case Nos. 17-0574GC (Medicaid Fraction Part C Days) and 17-0576GC (SSI Fraction Part C Days) as duplicates of Case Nos. 16-1279GC and 16-1295GC. Further, since the Board at that time considered the Medicare and Medicaid Fraction Part C Days issue to be a single issue, the Board consolidated the CHS 2014 DSH Medicaid Fraction Part C Days CIRP Group under Case No. 16-1279GC into the CHS 2014 DSH SSI Fraction Part C Days CIRP Group under Case No. 16-1295GC.

[4] *See* June 24, 2022 Schedule of Providers Case No. 16-1295GC (No. 71, Tab 71B), *See also* 16-1279GC Complete Case File 1 of 5 at 374.

[5] Board Rules v. 1.3 (July 1, 2015).

[6] Appendix B: Model Form B – Group Appeal Request (Aug. 29, 2018).

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

Board Members Participating:

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

For the Board:

3/12/2025

X Kevin D. Smith, CPA

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

cc: Wilson C. Leong, Federal Specialized Services
Joseph Bauers, Esq. Federal Specialized Services
Michael Redmond, Novitas Solutions, Inc. c/o Guidewell Source
Byron Lamprecht, WPS Government Health Administrators

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Baltimore, MD 21244 1850
410-786-2671

Via Electronic Delivery

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

Re: ***Dismissal for Failure to Meet Minimum Filing Requirements & Failure to Timely Cure Defect After Board Request***

Case Number 25-2485 - Baptist Medical Center (Provider Number 45-0058)
FYE: 08/31/2000

Dear Mr. Ravindran:

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

Pertinent Facts:

On February 10, 2025, Quality Reimbursement Services, Inc. ("QRS") filed an individual appeal with the Board on behalf of Baptist Medical Center under Case No. 25-2485. The appeal was filed from an "Other" determination, the CMS Manual SSI Publication dated August 13, 2024.

Although QRS filed a copy of the final determination, a Representative Letter, and Calculation Support, QRS inadvertently uploaded an extra copy of the Calculation Support rather than the required Issue Support. The Calculation Support does not meet the criteria in Board Rule 7.2 and does not meet the requirements of an Issue Statement, per the same Rule.[1]

On February 13, 2025, the Board issued an Acknowledgement and Critical Due Dates Notice ("ACDD") in which it set a briefing schedule for the Parties to file preliminary position papers and requested an Issue Statement. The ACDD stated that "the Calculation Support document was filed in lieu of an Issue Statement. An Issue Statement must include: An issue title and a concise issue statement describing: the relevant adjustment(s), including the adjustment number(s); the controlling authority (e.g., specific regulation, Federal Register issuance, manual provision, or Ruling); why the adjustment(s) is incorrect; how the payment should be determined differently; the reimbursement effect, and the basis for jurisdiction." The deadline for the required Issue support was set for February 28, 2025.

[1] Board Rules Version 3.2 (Dec 15, 2023)

Rules/Regulations:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the 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.

42 C.F.R. § 405.1835(b) establishes the required contents for an appeal request.

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

Board Rules 6 and 7 and 8 further address individual appeal requirements and support for the appealed final determination, availability of issue-related information, and basis for dissatisfaction. Board Rule 6.1.1 advises that "[t]he Board will dismiss appeal requests that do not meet the *minimum* filing requirements as identified in 42 C.F.R. § 405.1835(b)."

Further, Board Rule 5.2 makes it clear that the Provider's representative is responsible for being familiar with Board Rules and Regulations, meeting the Board's deadlines and responding to correspondence or requests from the Board.

Finally, Board Rule 41.2 permits the Board to dismiss a case (or an issue) on its own motion "upon failure of the provider . . . to comply with Board procedures or filing deadlines (*see* 42 C.F.R. § 405.1868)."

Board Determination:

The Board has determined that the Provider's appeal request is fatally flawed as it was not filed in accordance with the regulations at 42 C.FR. § 405.1835(b) and with the Board Rules.

First, the Board finds that the document QRS uploaded and described as an "Issue Statement" is merely another copy of the Provider's Calculation Support showing the estimated reimbursement impact. This document does not constitute an issue statement consistent with the appeal content requirements in Board Rule 7.2 and 42 C.F.R. § 405.1835(b). Board Rule 7.2 requires, among other things, that an issue statement include an issue title and a concise statement describing any relevant adjustment numbers, the controlling authority, why the adjustment is incorrect, how the payment should be determined differently and the basis for the Board's jurisdiction.

Secondly, the Board finds that QRS was afforded an opportunity to cure the noted deficiency. QRS failed to respond to the Board's request as detailed in the February 13, 2025 ACDD notification. Accordingly, the Board hereby dismisses Case No. 25-2485 since the appeal request is fatally flawed and does not meet the *minimum* filing requirements as outlined above and based on QRS' failure to respond by the deadline.

Based on the above, the Board closes this case and removes it from its docket. Review of this determination may be available under the provisions of 42 U.S.C. §1395oo(f) and 42 C.F.R. §§ 405.1875 and 105.1877.

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

For the Board:

3/12/2025

X Kevin D. Smith, CPA

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

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services
Michael Redmond, Novitas Solutions, Inc. c/o GuideWell Source (J-H)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Theresa Chau, Reimbursement Manager
Dignity Health
10901 Gold Center Drive
Rancho Cordova, CA 95670

RE: ***Board Determination – Dismissal Due to Failure to Timely File Required Information***

Case Number 24-0859 - St. Joseph's Medical Center (Provider Number 05-0084)
FYE: 06/30/2019

Dear Ms. Chau:

The Provider Reimbursement Review Board (the "Board") has reviewed the subject individual appeal in response to the Representative's February 27, 2025 "Request for Consideration to Submit Supplemental Preliminary Position Paper" on the Nursing Allied Health Education ("NAHE") issue. The pertinent facts and the Board's determination are set forth below.

Pertinent Facts:

On **December 10, 2024**, the Board issued a determination advising the Parties that it was disbanding Dignity Health's common issue related party ("CIRP") group on the NAHE Elimination issue for CY 2019 under Case No. 24-1375GC. The Board's determination was issued in response to November 19, 2024 correspondence from the Group Representative, Toyon Associates, Inc., in which it conceded to the Board's earlier proposal to disband various NAHE group(s).[1]

As a result of the Board's determination, the Board transferred the NAHE Elimination issue from the CIRP group, Case No. 24-1375GC, back to two pending related party individual appeals for Mercy Medical Center Redding (Case No. 24-0448) and Mercy General Hospital (Case No. 23-1774). In addition, the Board transferred the NAHE Elimination issue from the group to two reinstated appeals for Mercy San Juan Medical Center (Case No. 24-0482) and St. Joseph's Medical Center (Case No. 24-0859).[2] The Board noted that, in the reinstated cases, preliminary position papers had not been filed prior to the case closures, so the Parties should expect to

[1] Toyon's November 19, 2024 correspondence referenced eleven groups, including the group discussed herein. Due to the varying fact patterns for group participants in each case, the Board issued separate determinations for the groups.

[2] Toyon had proposed the creation of new individual appeals for Providers that did not have pending cases, but because the cases had been closed within three years the Board, instead, elected to reinstate the two individual appeals.

receive a request for supplemental preliminary position papers for the NAHE Elimination issue under separate cover in each case. The group, Case No. 24-1375GC, was then closed.

The following day, on **December 11, 2024**, the Board issued a Request for Information ("RFI") in Case No. 24-0859, setting the Provider's supplemental preliminary position paper deadline for the NAHE issue for **February 11, 2025**. The Medicare Contractor's deadline to submit a supplemental preliminary position paper was set for April 11, 2025.

Specifically, the RFI listed the "Due Dates and Required Documents" to be submitted by February 11, 2025 as:

> **Provider's Suppl. Preliminary PP**– In a determination issued on December 10, 2024, the Board disbanded the NAHE Elimination CIRP group under Case No. 24-1375GC & returned the "Nursing and Allied Health Removal of Program Cost" issue back to this reinstated individual appeal. Because the issue was not previously briefed prior to the case closure & is now active in this case, you must file a preliminary position paper briefing the issue by the due date.

On **February 25, 2025**, the Medicare Contractor emailed Board staff (with a copy to Ms. Chau at Dignity Health) regarding the status of the subject individual appeal. The Medicare Contractor's email indicated that it appeared the case should be dismissed for not having timely filed a supplemental preliminary position paper by the deadline.

On **February 27, 2025**, (although the case had not yet been dismissed for the Provider's failure to comply with the deadline), Dignity Health filed an electronic "Request for Consideration to Submit Supplemental Preliminary Position Paper" through the Office of Hearings Case & Document Management System ("OH CDMS"). Apparently, the "Consideration Request" was filed in response to the Medicare Contractor's February 25, 2025 email communication. ***It should be noted that the Board had not considered the Medicare Contractor's email communication with regard to whether to dismiss as it had not been properly filed pursuant to Board Rule 2.2.1 which requires that all submissions be filed electronically through OH CDMS.***[3] Dignity Health explained that it missed its deadline because of a misunderstanding as to who was responsible for filing the supplemental preliminary position paper. Dignity Health was under the impression that the group consultant, Toyon Associates, Inc., that had had handled the NAHE issue in prior year appeals, would take care of the filing. Therefore, Dignity Health requested the Board's consideration to allow it to file the Supplemental Preliminary Position Paper, despite having missed the deadline, as well as the Board's guidance, as far as additional steps.[4]

Pertinent Regulations:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is

[3] Board Rules v. 3.2. (effective Dec.15, 2023).
[4] The "Request for Consideration" did not include the Supplemental Preliminary Position Paper.

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

Further 42 C.F.R. § 405.1868 states that:

> (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.[5]

Although Case No. 24-0859 was not dismissed at the time of Dignity Health's "Consideration Request," the Board directs Dignity Health to the following Board Rules which govern the requirements for motions for reinstatement and dismissals:

> **47.1 Motion for Reinstatement**
>
> A provider may request reinstatement of an issue(s) or case within three years from the date of the Board's decision to dismiss the issue(s)/case or, if no dismissal was issued, within three years of the Board's receipt of the provider's withdrawal of the issue(s) (*see* 42 C.F.R. § 405.1885 addressing reopening of Board decisions). The request for reinstatement is a motion and must be in writing setting out the reasons for reinstatement (see Rule 44 governing motions). The Board will ***not*** reinstate an issue(s)/case if the provider was at fault. If an issue(s)/case was remanded pursuant to a CMS ruling (*e.g.*, CMS Ruling 1498-R), the provider must address whether the CMS ruling permits reinstatement of such issue(s)/case. If the Board

[5] (Emphasis added.)

> reinstates an issue(s) or case, the provider will have the same rights (no greater and no less) that it had in its initial appeal. . . .
>
> ****
>
> **47.3 Dismissals for Failure to Comply with Board Procedures**
>
> *Upon written motion demonstrating good cause*, the Board *may reinstate* a case dismissed for failure to comply with Board procedures. *Generally, administrative oversight*, settlement negotiations or a change in representative *will not be considered good cause to reinstate*. If the dismissal was for failure to file with the Board a required position paper, Schedule of Providers, or other filing, the motion for reinstatement must, as a prerequisite, include the required filing before the Board will consider the motion.[6]

Board Rule 47.1 makes it clear that the Board will not reinstate if the provider was at fault and Board Rule 47.3 further clarifies that, when the dismissal is based on the failure to comply with Board Procedures (such as filing a required position paper), the Board may reinstate for good cause which does ***not*** include administrative oversight. Here, the Board finds that the Representative was at fault since it failed to meet the supplemental preliminary position paper deadline due to a self-admitted misunderstanding (*i.e.,* administrative error). Additionally, when requesting the Board's consideration to allow it to file the missing brief, despite having missed the deadline, it did not provide the missing document (as directed in Rule 47.3).

Therefore, because the deadline for submission of the supplemental preliminary position paper was missed due to an administrative oversight and the Representative did not provide the missing document, the Board declines Dignity Health's "Request for Consideration." Accordingly, the Board finds it appropriate to dismiss Case No. 24-0859 pursuant to its authority under 42 C.F.R. § 405.1868.

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

For the Board:

3/13/2025

X Kevin D. Smith, CPA

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

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

[6] (Emphasis added.)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Keith Bradley & Sven Collins
Squire Patton Boggs (US) LLP
717 17th Street, Suite 1825
Denver, CO 80202

RE: ***Board Decision***

19-0365GC	Banner Health CY 2016 Outlier Thresholds CIRP Group
18-1338G	Squire Patton Boggs 2016 Medicare Outliers Group
19-0375GC	Hackensack Meridian CY 2016 Outlier Thresholds CIRP Group
21-1761	Weirton Medical Center (51-0023), FYE 06/30/2017
19-0361GC	Allina Health CY 2016 Outlier Thresholds CIRP Group
19-0378G	Squire Patton Boggs CY 2016 Outlier Threshold Group

Dear Messrs. Bradley and Collins:

The Provider Reimbursement Review Board ("Board") has reviewed the pending "Request(s) for Partial Withdrawal" in the above-referenced appeals. The Board is dismissing the appeals, as set forth below.

Background:

The above-captioned appeals all include Squire Patton Boggs LLP as the Provider/Group Representative. All of the appeals are ***solely*** over the "Outlier Case Payments" issue and include substantively identical issue statements.

Issue:

The issue statements are substantively identical and included, in part, below:

> **The Issue:** Whether [CMS] reimbursed the providers in this Group Appeal (the "Providers") for the full amount of the supplemental Medicare outlier payments ("Outlier Case Payments") to which the Providers are entitled under the Social Security Act, §§ 1886(d)(5)(A)(i)-(iv) and (d)(3)(B); *see also* 42 U.S.C. §§ 1395ww(d)(5)(A)(i)-(iv) and (d)(3)(B) (the "Outlier Payment Statute").

Nature of the Group's Outliers Claim:

. . .

The Providers contend that the Medicare outlier regulations – specifically, the regulations found at 42 CFR §§ 412.80 through 412.86 and the series of annual inpatient prospective payment system ("IPPS") regulations resulting in establishing the Outlier fixed loss thresholds ("FLTs") for their FYE 2016 – are contrary to the Social Security Act and the intent of the Congress, are arbitrary and capricious, and are otherwise contrary to law. As a result, the FLTs established and used to calculate the Outlier Case Payments to which the Providers are entitled for FYE 2016 were invalid and must be recalibrated and reset, for the benefit of the Providers, so that the Providers may file amended and additional claims for Outlier Case Payments.

. . .

The Provider assert that the FLTs used to calculate their Outlier Case Payments for FYE 2016 were excessively high because they were established by the Secretary using hyper-inflated data and flawed assumptions, and were established without assessing and/or meaningfully accounting for the full impact of acknowledged trends in the data.

. . .

The Provider assert that the Secretary's errors resulted in FLTs that the Secretary knew or should have known would cause her to substantially and systemically underpay her projected Medicare Outlier Case Payments and, in fact, did cause her to underpay the Providers' number and amount of Outlier Case Payments.[1]

Request for Partial Withdrawal:

On February 18 and 19, 2025, the Providers' Representative filed a "Request for Partial Withdrawal of Appeal." The request reads, in relevant part:

> I hereby request that the following issue be withdrawn from the Providers' Group Appeal, filed on November 20, 2018:
>
> - Challenges to outlier payments for inpatient services provided to patients with discharge dates during federal fiscal year 2016

[1] *E.g.,* PRRB Case No. 19-0365GC, Statement of the Group's Issue (Bold emphasis included in original).

> This notice does not impact the remaining issues in this Group Appeal.[2]

Analysis and Decision:

First, five of the six cases listed are group appeals. 42 C.F.R. § 405.1837 reads:

> **(a)** Right to Board hearing as part of a group appeal: Criteria. A provider . . . has a right to a Board hearing, as part of a group appeal with other providers, with respect to a final contractor or Secretary determination for the provider's cost reporting period, only if—
>
> . . .
>
> **(2)** The matter at issue in the group appeal involves a ***single question of fact or interpretation of law, regulations, or CMS Rulings*** that is common to each provider in the group[3]

This requirement is also consistent with Board Rule 12.2.

Additionally, review of the individual appeal shows only one issue pending. The withdrawal of the only issue before the Board would result in the closure of the case. Board Rule 46 is relevant to both the individual appeal and the group appeals, here:

> **Rule 46 Withdrawal of An Appeal or Issue within an Appeal**
>
> If a provider desires to withdraw a case or issue(s), the provider must file a request to withdraw the issue(s) or case (*see* Rule 2). Further, it is the provider's responsibility to promptly file requests to withdraw in the following situations:
>
> . . .
>
> - A case in which all issues have been handled, whether by administrative resolution, transfer, dismissal, or withdrawal.
>
> When a provider notifies the Board that it is withdrawing an issue(s), the provider's notification must:
>
> 1. Describe the specific issue(s) being withdrawn;

[2] *E.g.,* PRRB Case No. 19-0365GC, Request for Partial Withdrawal of Appeal (Feb. 18, 2025).
[3] (Bold and italic emphasis added.)

2. Address the withdrawal is conditioned/dependent on the Medicare contractor's action through an administrative resolution or reopening; and

3. Confirm whether there are another issues remaining in the case and, if so, provider the status on each remaining issue.

NOTE: ***A provider's request for withdrawal is self-effectuating*** and does *not* require any action by the Board once it is filed. Notwithstanding, the Board or Board Staff generally will issue a notice acknowledging the withdrawal when it results in the closure of a case. The Board does ***not*** issue a similar notice when the withdrawal does not result in the closure of a case.[4]

Here, the Board finds that there is only one issue in the individual appeal, and, per Board Rules and regulations, only one issue in the group appeals. Indeed, for the group appeals, if there was another issue, the appeal would be in violation of regulations and Board Rules for group appeals, which require a ***single*** common issue. Therefore, it is not possible for there to be a "partial withdrawal."

For each of these appeals, the Board finds that the issue in the cases is limited to the issue from the appeal requests: a challenge to the reimbursement amount for the Outlier Case Payments. This issue has been voluntarily withdrawn.

The Board reviewed the appeals to determine if the issue or calculations included ***both*** the inpatient and outpatient outliers issues to determine if the outpatient outliers issue may still be under consideration. However, the Board finds that neither the issue statements, nor the calculation support provide any support that the outpatient outliers issue was part of any of the appeals.

The Board notes again that it has reviewed the records in these cases and has not identified exhibits or documentary evidence to establish any other issue under appeal other than the issue withdrawn on February 18 and 19. Therefore, the Board has processed the "partial withdrawals" as complete withdrawals of the outlier threshold issue in each appeal.

As no further issues remain, the cases are hereby closed and removed from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

[4] (Emphasis added).

Board Members Participating:

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

FOR THE BOARD:

3/13/2025

X Kevin D. Smith, CPA

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

cc: Byron Lamprecht, WPS Government Health Administrators (J-5)
Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E)
Michael Redmond, Novitas Solutions, Inc. c/o GuideWell Source (J-L)
Dana Johnson, Palmetto GBA c/o National Government Services, Inc. (J-M)
Pamela VanArsdale, National Government Services, Inc. (J-6)
Cecile Huggins, Palmetto GBA (J-J)
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

LaTonya Kemp, Sr. Financial Reimbursement Analyst
Emory Healthcare
2201 Henderson Mill Road
Attn: Finance
Atlanta, GA 30345

RE: ***Board Determination: Request for Reinstatement***
Emory University Hospital Midtown (Provider Number 11-0078)
FYE: 8/31/2020
Case Number: 24-1958

Dear Ms. Kemp:

The Provider Reimbursement Review Board (the "Board") has reviewed the January 29, 2025 correspondence from Emory Healthcare, in which it advised that it requested a correction with regard to the subject appeal. The pertinent facts and the Board's determination are set forth below.

Pertinent Facts:

On **June 19, 2024**, Southeast Reimbursement Group, LLC ("Southeast Reimbursement") timely filed an individual appeal on behalf of Emory University Hospital Midtown ("Emory Midtown"/Prov. No. 11-0078). The appeal, which was for FYE 08/31/2020, was based on a December 22, 2023 Notice of Program Reimbursement ("NPR") and included two issues:

1. Medicare Bad Debts
2. GME Base Year Cap

On **August 23, 2024**, Southeast Reimbursement added a third issue to the case:

3. GME- Implement Existing Regulations

On **January 29, 2025**, Emory Healthcare became the authorized representative for Case No. 24-1958. On the same date, Emory Healthcare ("Representative") withdrew the entire case in the Office of Hearings Case & Document Management System ("OH CDMS"). Accordingly, the Board acknowledged the withdrawal and closed the case.

On **January 29, 2025**, a few hours later, Emory Healthcare advised the Board that it withdrew the entire appeal in error. In its correspondence, Emory Healthcare indicated that it intended to only

withdraw the GME issues (#s 2 & 3) - not the Bad Debts issue (#1). Therefore, Emory Healthcare requested the Board correct the case to reflect the Bad Debts issue was still pending.

References:

- ***Board Rule 47***: "The Board will not reinstate an issue(s)/case if the provider was at fault."

- ***OH CDMS PRRB User Manual – Section 3.3.2.2*** discusses how to withdraw an issue in OH CDMS. It directs the Provider/Rep to "Select the Withdraw button for the issue you wish to withdraw. The Withdraw Issue confirmation window is displayed." Then the Provider/Rep must confirm by "Enter Yes in the field to confirm the withdrawal and select the Proceed button."

- ***OH CDMS PRRB User Manual - Section 3.3.4.3.2*** discusses case withdrawal - the box specifically states the provider is authorizing the withdrawal of a CASE and includes a confirmation button as noted above.

Board Determination:

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

> **47.1 Motion for Reinstatement**
>
> A provider may request reinstatement of an issue(s) or case within three years from the date of the Board's decision to dismiss the issue(s)/case or, if no dismissal was issued, within three years of the Board's receipt of the provider's withdrawal of the issue(s) (see 42 C.F.R. § 405.1885 addressing reopening of Board decisions). The request for reinstatement is a motion and must be in writing setting out the reasons for reinstatement (see Rule 44 governing motions). **The Board will not reinstate an issue(s)/case if the provider was at fault. . . .**
>
> . . . .
>
> **47.3 Dismissals for Failure to Comply with Board Procedures**
>
> **Upon written motion demonstrating good cause**, the Board may reinstate a case dismissed for failure to comply with Board procedures. Generally, **administrative oversight**, settlement negotiations or a change in representative **will not be considered good cause to reinstate**. . . .[1]

Board Rule 47.1 makes clear that the Board will not reinstate a case or issue **if the provider was at fault.** Additionally, the Board refers the Representative to Board Rule 47.3, which is specific to dismissals due to failure to comply with Board procedures. Although Emory Healthcare's

[1] Board Rules v. 3.2 (Dec. 15, 2023) (Bold emphasis added except the titles had bold emphasis in original.)

withdrawal of Case No. 24-1958 was not a matter of "a failure to comply with a Board procedure," this Rule is still pertinent because it details what the Board **does not consider to be good cause for reinstatement**, specifically, *administrative oversight*.

After review of the facts in this case, the Board finds that there is no basis for good cause to justify reinstatement of Case No. 24-1958, specifically, the Medicare Bad Debts issue. The Board finds that the guidance is clear when it comes to withdrawing a case versus withdrawing an issue. Specifically, the "**Withdraw Case**" button is a separate action in OH CDMS that must be selected from a drop-down menu. Whereas to withdraw an issue(s), the Provider is directed to use the "**Withdraw**" action button(s) on the case issues tab next to each respective issue.[2] In addition, as a fail-safe, OH CDMS requires the Provider/Representative to confirm before proceeding with either a withdrawal of an issue or an entire case. Here, when Emory Healthcare selected "Withdraw Case" from the drop-down menu, it was prompted with a second screen to confirm its action in OH CDMS before proceeding, which it did.

In summary, Emory Healthcare admitted its withdrawal of Case No. 24-1958 was an accident (***i.e.,*** an administrative error on their part.) The Rules in this situation, specifically Board Rule 47, are clear that "administrative error" is not considered good cause for reinstatement. Therefore, the Board rejects Emory Healthcare's explanation as a justification for good cause to reinstate Case No. 24-1958 for the purpose of pursuing the Medicare Bad Debts issue. The Board, therefore, denies the reinstatement of Case No. 24-1958 which remains closed.[3]

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

For the Board:

3/17/2025

X Kevin D. Smith, CPA

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

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services
Cecile Huggins, Palmetto GBA (J-J)

[2] The Provider/Representative is directed to "***Select the Withdraw button for the issue you wish to withdraw***. The Withdraw Issue confirmation window is displayed." Then, the Provider/Representative is directed to "Enter Yes in the field to ***confirm the withdrawal*** and select the Proceed button." (There are separate Transfer and Withdraw "buttons" for each issue and the user is prompted to confirm each action before proceeding.)

[3] 42 CFR §405.1885 allows for an audited cost report to be reopened within three years of the original NPR date. The Board notes that the provider is still within the 3-year window to request a reopening from its MAC, as the NPR was issued December 22, 2023.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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

Michael Redmond
Manager, Provider Audit & Reimbursement
Novitas Solutions, c/o GuideWell Source
2020 Technology Parkway, Suite 100
Mechanicsburg, PA 17050

RE: ***Board Determination - Dismissal of Appeals***

Parkview Medical Center Inc. (Provider Number 06-0020)
Fiscal Years Ended: 6/30/1990, 6/30/1991, 6/30/1992, 6/30/1993, 6/30/1994, 6/30/1995, 6/30/1996 and 6/30/1997
Case Numbers: 25-2690, 25-2692, 25-2736, 25-2737, 25-2739, 25-2741, 25-2742, and 25-2743

Dear Mr. Ravindran and Mr. Redmond:

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

BACKGROUND:

On February 13, 2025, Quality Reimbursement Services, Inc. ("QRS") filed the subject individual appeals on behalf of Parkview Medical Center (Prov. No. 06-0020) for the fiscal years (FYs) 1990 through 1997. The appeals were all filed from the August 13, 2024, CMS Transmittal 12785 - which provided Medicare Contractors ("MACs") with Instructions on Processing SSI Realignment Requests for Cost Report periods prior to 10/1/2013. The Confirmations of Correspondence generated by the Office of Hearings Case and Document Management System ("OH CDMS") verify that the appeals were each filed on February 13, 2025.

The Representation Letter uploaded with all appeals is dated February 6, 2025 and authorizes QRS to be the designated representative for Parkview Medical Center for FYs 1998 through 2014. These appeals do not fall within those fiscal year parameters.

On February 18 (Case Nos. 25-2690, 25-2692) and 19 (Case Nos. 25-2736, 25-2737, 25-2739, 25-2741, 25-2742, 25-2743), 2025, the Board issued Acknowledgement & Critical Due Dates

(ACDD) notices for all cases. In each ACDD notice, the Board noted that the Representation Letter did not cover the fiscal period in dispute. The Board set a deadline of March 5 (25-2690, 25-2692) or 6 (25-2736, 25-2737, 25-2739, 25-2741, 25-2742, 25-2743), 2025 for submitting a correct Representation Letter covering the fiscal years at issue.

As of the date of this letter, QRS has not submitted proper Representation Letters in any of the aforementioned appeals.

RULES/REGULATIONS:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the contractor's final determination, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of receipt of the final determination. Specifically, 42 C.F.R. § 405.1835(a)(3) indicates that, "[u]nless the provider qualifies for a good cause extension . . . ," the Board must receive a Provider's hearing request "***no later than 180 days after the date of receipt by the provider of the final contractor or Secretary determination."***[1]

Board Rule 4.3, Commencement of Appeal Period, specifies various types of final determinations, stating:

> 4.3.1 **Contractor/CMS/Secretary Final Determination**
>
> Final Determinations include:
> - Notices of Program Reimbursement;
> - Revised Notices of Program Reimbursement;
> - Exception Determinations;
> - Quality Reporting Program Payment Reduction Determinations; and
> - Other determinations issued by CMS or its ***contractors with regard to the amount of total reimbursement due the provider***.
>
> The date of receipt of a contractor/CMS/Secretary final determination is presumed to be five (5) days after the date of issuance. This presumption, which is otherwise conclusive, may be overcome if it is established by a preponderance of the evidence that such materials were actually received on a later date. *See* 42 C.F.R. § 405.1801(a)(1)(iii).[2]

This rule further explains that there is no five (5) day mailing presumption for appeals from Federal Register Notices:

---

[1] 42 C.F.R. § 405.1835(a)(3) (2020) (Emphasis added).
[2] Board Rules v. 3.2 (Dec. 15, 2023) (Emphasis added).

> 4.3.2 **Federal Register Notice**
>
> The date of receipt of a Federal Register Notice is the date the Federal Register is ***published***. The appeal period begins on the ***date of publication*** and ends 180 days from that date.[3]

Additionally, Board Rule 4.5, Date of Receipt by the Board, states that "[t]he timeliness of a filing is determined based on the date of receipt by the Board. The date of receipt is presumed to be . . . the date of filing in OH CDMS as evidenced by the Confirmation of Correspondence generated by the system."[4]

In addition, regarding the Representation Letters, Board Rule 5.4 reads:

> **5.4 Representation letter**
> A representation letter is required ***whether designating an external or internal case representative***. If the provider is not commonly owned or controlled when the representation letter is being executed, then the letter designating the case representative must be on the provider's letterhead and be signed by an authorizing official of the provider organization. If the provider is commonly owned or controlled when the representation letter is being executed, then the letter designating the case representative must be on letterhead that identifies the parent corporation (whether it's the provider's letterhead or the parent corporation's letterhead) and must be signed by an authorizing official of the provider or parent organization.
>
> In addition, the representation letter must reflect the provider's name, number, and ***fiscal year under appeal***. The letter must not be issue specific unless it is for participation in a group appeal in which there is only one issue permitted to be raised. Finally, the representation letter must contain the following contact information regarding the case representative:
>
> • name,
> • organization,
> • address,
> • telephone number, and
> • email address.[5]

BOARD DETERMINATION:

After its review, the Board has determined that QRS' appeal requests under Case Nos. 25-2690, 25-2692, 25-2736, 25-2737, 25-2739, 25-2741, 25-2742, and 25-2743 were not timely filed in accordance with the regulations at 42 C.F.R. §§ 405.1835(a)(3) and Board Rule 4.3, in addition

[3] *Id. (*Emphasis added).
[4] *Id. See also* 42 C.F.R. § 405.1801(a)(2)(iii).
[5] *Id.* (Bold & underline emphasis added).

to lacking the required documentation in accordance with Board Rule 5.4.

The final determination support which QRS uploaded for each Provider is a copy of the August 13, 2024, CMS Transmittal 12785 - which provided MACs with Instruction on Processing SSI Realignment Requests for Cost Report periods prior to 10/1/2013.[6] In each case, QRS characterized the final determination type as "Other" in OH CDMS.

Although one of the types of determinations detailed in Board Rule 4.3.1 includes "Other determinations issued by CMS," the Rule is explicit that the determination must be ". . . with regard to the amount of total reimbursement due the provider."[7] However, here the Board finds that the CMS Transmittal under appeal is not specific to each respective provider, rather it is a Transmittal publication that applies to the MAC's treatment of Part C days for calculating the Disproportionate Share ("DSH").[8]

The Board finds that this document is more analogous to a Federal Register Notice, in that the Transmittal is not specific to any provider and also has a specific, verifiable date of publication. Pursuant to Board Rule 4.3.2, the Board finds the date of receipt for this publication is the date the CMS Transmittal was ***published***, and the Providers' appeal period began on that date, without a five (5) day mailing presumption that is allowed for other determination types.

Therefore, under that scenario, allowing for the 180-day appeal period, the 180th day fell on Sunday, February 9, 2025. Pursuant to Board Rule 4.4.3, the final day of the appeal period would then be Monday, February 10, 2025. The subject appeals were received on Thursday, February 13, 2025, three days beyond the deadline.

Furthermore, QRS has not provided the Representation Letters with the appropriate authorization to represent the Provider for the fiscal years at issue in the subject appeals. The filed Representation Letter designates QRS as the Provider's representative for FYs 1998 through 2014, and these appeals cover FYs 1990 to 1997.

The Board, at its discretion, provided QRS an opportunity submit the correct letters of representation to cover the fiscal period in dispute. As of the date of this letter, which is over a week beyond the deadline set by the Board, QRS has not submitted corrected letters. Board Rule 41.2 allows the Board to "dismiss a case or an issue on its own motion. . . upon failure of the provider or group to comply with Board procedures or filing deadlines."[9] In this case, the Provider's rep has failed to reply to the Board's request for corrected letters.

Since the appeals were untimely filed and do not have correct Representation Letters authorizing QRS to act as the designated representative, the Board hereby dismisses Case Nos. 25-2690, 25-2692, 25-2736, 25-2737, 25-2739, 25-2741, 25-2742, and 25-2743 in their entirety and removes each case from the Board's docket.

---

[6] CMS Pub 100-20 One -Time Notification; Transmittal 12785, published on August 13, 2024.
[7] Board Rules v. 3.2.
[8] The Board does not reach the decision that this Transmittal is actually a final determination, noting only that the appeal was filed more than 180 days after the Transmittal was published.
[9] Board Rules v. 3.2.

Review of this determination may be available under the provisions of 42 U.S.C. §1395oo(f) and 42 C.F.R. §§ 405.1875 and 105.1877.

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

FOR THE BOARD:

3/17/2025

X Kevin D. Smith, CPA

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

cc: Wilson C. Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

VIA ELECTRONIC DELIVERY

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

RE: ***Board Determination on Pending CIRP Groups Without Participants***

Nuvance Health CY 1996 Medicare Fraction (SSI) – Statutory & Systemic Errors CIRP Group, Case Number: 25-2315GC

Nuvance Health CY 1997 Medicare Fraction (SSI) – Statutory & Systemic Errors CIRP Group, Case Number: 25-2316GC

Nuvance Health CY 1998 Medicare Fraction (SSI) – Statutory & Systemic Errors CIRP Group, Case Number: 25-2318GC

Nuvance Health CY 1999 Medicare Fraction (SSI) – Statutory & Systemic Errors CIRP Group, Case Number: 25-2319GC

Nuvance Health CY 2006 Medicare Fraction (SSI) – Statutory & Systemic Errors CIRP Group, Case Number: 25-2320GC

Nuvance Health CY 2007 Medicare Fraction (SSI) – Statutory & Systemic Errors CIRP Group, Case Number: 25-2321GC

Nuvance Health CY 2008 Medicare Fraction (SSI) – Statutory & Systemic Errors CIRP Group, Case Number: 25-2322GC

Nuvance Health CY 2013 Medicare Fraction (SSI) – Statutory & Systemic Errors CIRP Group, Case Number: 25-2323GC

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("the Board") has reviewed the subject common issue related party ("CIRP") group appeals and notes that they were not properly filed. The pertinent facts and the Board's determination are set forth below.

Pertinent Facts:

On **February 9, 2025**, Quality Reimbursement Services, Inc. ("QRS") filed the above referenced CIRP groups on behalf of Nuvance Health for calendar years ("CYs") 1996 through 1999, 2006 through 2008 and 2013, all appealing the Medicare Fraction (SSI) – Statutory & Systemic Errors issue. Each of the group appeals was formed in the Office of Hearings Case & Document Management System ("OH CDMS") without any participants.

On **March 12, 2025**, the Medicare Contractor filed Motions to Dismiss some of the group appeals. The Medicare Contractor advised the Board that the CYs 1999, 2007 and 2008 CIRP groups had been formed in OH CDMS without any participants and that the groups had still not been brought into compliance with Board Rule 12.6 since no participants have been transferred or added.[1]

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.

42 C.F.R. § 405.1837(b)(1) discusses the use of Mandatory groups and states:

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

42 C.F.R. § 405.1837(b)(3) provides the details for initiating a group appeal and indicates:

> 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….

[1] Although the Medicare Contractor has not yet filed a formal Motion to Dismiss in all of the referenced groups, the Board searched its database and found that the related appeals for CYs 1996 through 1998 and 2006 appealing the Medicare Fraction (SSI) – Statutory & Systemic Errors issue are improper filings for the same reason.

Regarding the establishment of groups in OH CDMS, the commentary under Board Rule 12.1 indicates:

> . . . if a group is to be formed solely through transfers, it **may initially** be established in OH CDMS **with no participating providers. In such cases, the providers must be transferred i*mmediately* following the establishment of the group case** in order to fulfill the regulatory requirement for the minimum number of providers per Rule 12.6. **The Board will close all group cases that do not meet the minimum participant requirements**.[2,3]

Board Rule 12.6.1, goes on to state that "[a] CIRP group **may be initiated by a single provider under common ownership or control**, but at least two different providers must be in the group upon full formation. (See Rule 19.)"[4]

The Board finds that the subject group appeals, under Case Nos. 25-2315GC, 25-2316GC and 25-2318GC through 25-2323GC are CIRP groups that were formed without any providers. Further, there have been no additions or transfers to the groups in more than thirty-seven ("37") days since its formation. Because the CIRP groups were not filed in compliance with Board Rules or the regulations, the Board hereby dismisses Case Nos. 25-2315GC, 25-2316GC and 25-2318GC through 25-2323GC.[5] Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Finally, the Board notes that QRS has filed many group appeals, both CIRP and optional, over the years. It is also noted that QRS is not new to using OH CDMS, which became mandatory for all filings on or after November 2021. The improper formation of these "provider-less" CIRP groups appears to be an attempt by QRS to create a "holding spot" for the future addition or transfer of related providers pursuing the Medicare Fraction (SSI) - Statutory & Systemic Errors issue. Although the Commentary at Board Rule 12.1 does permit a "shell" to be formed in OH CDMS, it is only on a limited basis - for the sole purpose of allowing the ***transfer*** of issues from pending individual appeals. QRS' formation of these CIRP groups, where there have been no transfers effectuated in over 37 days, violates the intent of the Board's rules and creates an unnecessary administrative burden on the Board and its staff (***i.e.***, having to formally dismiss the CIRP group.) The Board admonishes QRS for again failing to follow Board Rules governing the formation of a group.[6] The Representative is on notice that if this type of filing violation continues, the Board may prohibit the Representative from re-filing perfected CIRP groups for the same issue/CYs in future cases.

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[2] Board Rules v, 3.2 (Dec. 15, 2023)
[3] Bold emphasis added.
[4] Bold emphasis added.
[5] Should QRS identify a Nuvance Health participant appealing this issue for any of the referenced CYs, it may form a new CIRP group by either effectuating a transfer or by including a CIRP provider when the group is formed if it is still within the filing deadline (i.e., Direct Add from receipt of the final determination).
[6] In January and March of this year, the Board dismissed two other QRS CIRP groups under Case No. 25-1169GC and Case No. 25-1011GC for the same reason.

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

For the Board:

3/18/2025

X Kevin D. Smith, CPA

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

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services
Pamela VanArsdale, National Government Services (J-6) (MAC for 25-2315GC)
Danelle Decker, National Government Services (J-K)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Mail

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RE: **EJR Determination Hall Render DSH Dual Eligible SSI Patient Days Groups**

PRRB Cases: 17-1638GC *et al.* Hall Render DSH Medicare Fraction Dual Eligible Days Groups
(23 Cases – See **Appendix A**)

Dear Ms. Griffin:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' two Consolidated Requests for Expedited Judicial Review ("EJR") filed February 21, 2025 in the above-referenced appeals. The Board's decision with respect to EJR is set forth below.

I. Issue in Dispute

The issue for which the Board is considering EJR is:

> Whether the Medicare Disproportionate Share Hospital (DSH) calculation was understated due to the failure of the Centers for Medicare & Medicaid Services (CMS) and the Fiscal Intermediary (FI) to properly include all Dual Eligible Days, including all Dual Eligible Days that are Medicare Non-Covered Days ("DE MNC Days"), which include but are not limited to Medicare Exhaust Days and MSP (Medicare Secondary Payor) Days where Medicare is secondary to another payor, in the numerator of the Medicare or Medicaid Fraction of the DSH percentage as applicable pursuant to 42 U.S.C. § 1395ww(d)(5)(F).
>
> . . . .
>
> The Providers dispute CMS's position that only Dual Eligible Days, and DE MNC Days, that are also SSI Days go in the Medicare numerator of the DSH calculation. Since Medicare interprets "entitled" to Medicare as "eligible" for Medicare, and

> thus their basis for including these days in the Medicare ratio, then they also must interpret "entitled" to SSI as "eligible" for SSI and allow all Dual Eligible Days, including all such DE MNC 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 DSH Medicare numerator. [1]

II. Medicare Disproportionate Share Hospital (DSH) Payment Background

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").[2] One of these adjustments, the Medicare DSH adjustment, provides additional payments to certain qualifying hospitals that treat a disproportionate share of low income patients.[3] 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. 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…"; and (b) in the denominator, the number of days of care that are furnished to patients who were entitled to Medicare Part A.[4] 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,[5] administered by the Social Security Administration ("SSA"). The SSI statute, generally, does not use the term "entitled" to SSI benefits. Rather, the SSI statute typically refers to whether an individual is "eligible for benefits."[6] 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.[7]

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.[8] In addition, the Medicare program provides that certain qualifying individuals with end stage renal

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[1] *See, e.g.*, PRRB Case 17-1638GC, Issue Description for DSH SSI Ratio Dual Eligible Days.
[2] 42 C.F.R. Part 412.
[3] 42 U.S.C. § 1395ww(d)(5)(F)(i)(I).
[4] 42 U.S.C. § 1395w2(d)(5)(F)(vi)(I). *See also* 42 C.F.R. § 412.106(b)(2)(i)(B).
[5] 42 U.S.C. § 1382.
[6] 42 U.S.C. §§ 1381a, 1382(a) (emphasis added).
[7] 20 C.F.R. § 416.202.
[8] 42 U.S.C. § 426.

disease are entitled to Medicare Part A.[9]

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[10] and may terminate,[11] suspend[12] or stop payments to individuals who are either temporarily or permanently ineligible for payment of SSI benefits.[13] 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 Sections §§ 416.207-416.216:

1. The individual fails to give the SSA permission to contact financial institutions;[14]
2. The individual fails to apply for other benefits to which the individual may be entitled;[15]
3. The individual fails to participate in drug or alcohol addiction treatment;[16]
4. The individual is absent from the United States for more than 30 days;[17] or
5. The individual becomes a resident of a public institutions or prison.[18]

Under certain circumstances, the Social Security Administration may not pay benefits for administrative reasons, including removal of a representative payee, an unknown address for the beneficiary, or because of income from a previous month.[19]

After the Medicare DSH statutory provisions were enacted in 1984, the Health Care Financing Administration ("HCFA"), the predecessor to CMS, 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, the Social Security Administration ("SSA").[20] HCFA 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.[21] To compute the Medicare fraction, HCFA had to match individual Medicare billing records to individual SSI records.[22] Considering the administrative burdens and complexity of the data

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[9] 42 U.S.C. § 426-1.
[10] 20 C.F.R. § 416.204.
[11] 20 C.F.R. §§ 416.1331-1335.
[12] 20 C.F.R. §§ 416.1320-1330.
[13] 20 C.F.R. § 1320.
[14] 20 C.F.R. § 416.207.
[15] 20 C.F.R. § 416.210.
[16] 20 C.F.R. § 416.214.
[17] 20 C.F.R. § 416.215.
[18] 20 C.F.R. § 416.211.
[19] *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).
[20] 51 Fed. Reg. 31,454, 31,459 (Sept. 3, 1986).
[21] *Id.*
[22] *Id.*

matching process, HCFA 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.[23] HCFA/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.[24]

The Medicare DSH payment adjustment has been the subject of much litigation and 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. On April 28, 2010, CMS published Ruling 1498-R to respond to a court order in *Baystate*. Specifically, the Ruling stated that CMS had implemented the court 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."[25] 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 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."[26] 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."[27]

Consistent with Ruling 1498-R, CMS published the new data matching process in the FY 2011 proposed rule published on May 4, 2010[28] and finalized that data matching process in the final rule published on August 16, 2010 ("FY 2011 Final Rule").[29] Significantly, in the preamble to the FY 2011 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 is 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 matching process."[30] CMS responded in detail to this comment and explained that CMS interprets SSI entitlement to correspond with any month for which an individual *receives*

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[23] *Id.* at 31,459–31,460; 42 C.F.R. § 412.106(b).
[24] 42 C.F.R. § 412.106(b)(5); 42 C.F.R. § 405.1803.
[25] CMS-1498-R at 5.
[26] *Id.*
[27] *Id.* at 5-6.
[28] 75 Fed. Reg. 23,852, 24,002-24,007 (May 4, 2010).
[29] 75 Fed. Reg. 50,042, 50,280-50,281. (Aug. 16, 2010).
[30] *Id.* at 50,280.

payment of SSI benefits. In this regard, CMS stated that the inclusion of 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."[31] 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 those status codes was used."[32] 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]."[33]

While the new data matching process established in the FY 2011 Final Rule was effective October 1, 2010, 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.[34] 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.[35]

Finally, on April 22, 2015, CMS published Ruling 1498-R2 modifying and amending 1498-R by allowing providers 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.[36]

As a result of the Rulings, new regulation and data match process, CMS calculated new and/or recalculated existing SSI percentages for the Hospitals for all of fiscal years at issue in these appeals.[37] The Hospitals have appealed original NPRs which were based on the methodology articulated in the preamble, *i.e.*, use only the three SSI codes to denote SSI eligibility.

III. Providers' Position

The Providers note that, currently, CMS "interpret[s] entitlement to SSI program benefits to include only those patients who received a cash stipend from the SSI program for the month of their hospitalization." They assert, however, that under the rules of statutory construction and

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[31] *Id.* at 50,280-50,281.
[32] *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.
[33] *Id.* at 50285.
[34] CMS-1498-R at 6-7, 31-32.
[35] *Id.* at 28, 31.
[36] CMS-1498-R2 at 2, 6.
[37] The SSI ratios for FY 2009 and 2010 were published on March 16, 2012 and October 17, 2012, respectively. *See* https://www.cms.gov/Medicare/ Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.

binding Supreme Court precedent, "CMS is compelled to interpret entitlement to SSI benefits to include all inpatients who were eligible for and enrolled in the SSI program at the time of their hospitalization."[38] The Providers' Designated Representative notes that this issue has already been appealed before the Board, resulting in Board Decisions 2017-D11 and 2017-D12, which have been appealed and are currently pending before the Supreme Court in *Advocate Christ Med. Ctr. v. Becerra*.[39]

The Request for EJR also claims that "these appeals also centers [sic] on Providers' demand for access to data necessary to verify and challenge CMS's calculation of their DSH payments. Specifically, Providers seek to compel CMS to furnish Providers with the payment status code (PSC) the SSI program assigns to all SSI Eligible patients."[40] They claim they "are entitled to this data under Section 951 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003,[41] . . . and pursuant to the decision in *Pomona Valley Hosp. Med. Ctr. v. Azar*."[42]

The Providers explain the history of CMS' interpretation of the term "entitlement," and how CMS broadened this term with respect to Medicare Part A benefits in 2004 when it adopted a policy to include Part A beneficiaries in the Medicare Fraction regardless of whether they received any Part A benefits during their hospital stay.[43] They claim the current approach for Part A entitlement is that "CMS holds that a Medicare beneficiary remains entitled to Medicare Part A benefits even when no coverage under Part A exists and no Part A payments are made,"[44] and that this interpretation was upheld in *Becerra v. Empire Health Found.*[45] The interpretation of "entitled to SSI," however, has remained more narrow than this, "requiring them to actually receive payment of a cash stipend for the month of hospitalization in order to be included in the numerator of the Medicare Fraction."[46] They argue this narrow interpretation, however, is "clearly erroneous and unlawful," and that "SSI beneficiaries should be considered 'entitled' to SSI benefits so long as they meet the statutory criteria to qualify under Title XVI, regardless of receipt of benefits."[47]

The Providers note that in administering the SSI program, SSA assigns each beneficiary a Patient Status Code (PSC). The codes are "made up of two elements: a single letter reflecting payment status and a two-digit number indicating the reason for the payment status." Of the 77 PSC codes used by SSA, the Secretary announced in the Federal Register that only three PSC codes,

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[38] Consolidated Request for Expedited Judicial Review, 1-2 (Feb. 21, 2025). The two consolidated requests for EJR are materially identical except that the request for 21-0289GC *et al.* also addresses the validity of the Substantive Claim Regulations at 42 C.F.R. § 413.24(j) and 42 C.F.R. § 405.1873(a).
[39] *Id.* at 2-3.
[40] *Id.* at 3.
[41] Pub. L. 108-173.
[42] 2020 WL 5816486 (D.D.C. 2020).
[43] Consolidated Request for Expedited Judicial Review at 5.
[44] *Id.* at 6.
[45] 597 U.S. 424 (2022).
[46] Consolidated Request for Expedited Judicial Review at 7.
[47] *Id.* at 7-8.

C01, M01 and M02, are counted as "entitlement" for purposes of the DSH statute.[48] Thus, the Providers allege the other 74 codes used by SSA to determine payment status result in a significant number of SSI enrollees being excluded from the numerator of the Medicare fraction even though they are SSI eligible.[49] The Providers believe that the SSI enrollees remain entitled to SSI regardless of whether cash payment is received in the month of hospitalization under the holding in *Empire*.[50]

Further, the Providers assert in their request for EJR that CMS should provide the Providers with a listing of those SSI enrollees for the relevant hospitalizations so that they can ensure that their DSH adjustments were calculated in accordance with the Medicare statute. The Providers state that will "seek to compel CMS to provide the requisite data through a mandamus action, or a similar-type claim under 5 U.S.C. § 706(1) . . . . in federal court."[51]

The Consolidated Request for EJR concerning Cases 21-0289GC *et al*. include providers with fiscal years ending on December 31, 2016 or later and are, therefore, subject to the Substantive Claim Regulations, discussed *infra*. The Providers in that Consolidated Request for EJR also present lengthy arguments as to why the Substantive Claim Regulations are invalid.[52]

IV. 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) "'[t]he Board has jurisdiction to conduct a hearing on the specific matter at issue. . . [and] (ii) [t]he 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 group of Providers generally have a right to a hearing before the Board with respect to specific items claimed on timely filed cost reports if:

- They are dissatisfied with final determinations of the Medicare Contractor;
- The request for a hearing of each Provider is filed within 180 days of the date of receipt of the final determinations. Providers must appeal from a "final determination" related to their cost report or payment, which includes an NPR, a Revised NPR, or failure to timely issue a final determination; [53]
- The matter at issue involves single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group; and

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[48] *Id.* at 8-9 (citing 75 Fed. Reg. 50,042, 50280-50281 (Aug. 16, 2010)).
[49] *Id.* at 9.
[50] *Id.*
[51] *Id.* at 14.
[52] PRRB Cases 21-0289GC *et al.*, Consolidated Request for Expedited Judicial Review, 14-25 (Feb. 21, 2025).
[53] 42 U.S.C. § 1395oo(a); *see also Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 144-145 (D.C. Cir. 1986).

- The amount in controversy is, in the aggregate, $50,000 or more.[54]

The participants that comprise the group appeals within these two Consolidated EJR Requests have filed appeals involving various calendar years spanning 2003-2019.

A. Jurisdiction - FYEs Prior to December 31, 2008 (*Bethesda*)

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]

The Board has determined that that the "entitled to SSI" question is governed by 42 C.F.R. § 412.106(b)(2)(i)(B), which is a regulation/policy that left the Medicare Contractors without the authority to make the payment in the manner sought by the Providers in these cases. As such, for Providers with FYEs prior to December 31, 2008, and since they filed their cost reports in compliance with this regulation/policy, the Dual Eligible Days issue is governed by the ruling in *Bethesda* and the Providers are not barred from claiming dissatisfaction with the amount of reimbursement allowed by the regulation/policy. In addition, these participants' documentation shows that the estimated amount in controversy exceeds $50,000 in each appeal, as required for a group appeal.[57] The appeals were timely filed. Based on the above, the Board finds that it has jurisdiction for these underlying providers. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

B. Jurisdiction - FYEs December 31, 2008 to December 31, 2016 (1727-R)

On August 21, 2008, new regulations governing the Board were effective.[58] Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, that 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*

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[54] 42 C.F.R. §§ 405.1837.
[55] 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.).
[56] *Bethesda* at 1258-59.
[57] *See* 42 C.F.R. § 405.1837.
[58] 73 Fed. Reg. 30,190, 30,240 (May 23, 2008).

(Banner).[59] 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.[60]

The Secretary did not appeal the decision in *Banner* and decided to 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 finds that the "entitled to benefits" question is governed by 42 C.F.R. § 412.106(b)(2)(i)(B), which is a regulation that left the Medicare Contractors without the authority to make the payment in the manner sought by the Providers in these cases. Consequently, the Board finds that it has jurisdiction over the Providers in these cases.

The Board has determined that the participants involving FYEs December 31, 2008 to December 31, 2016 involved with the instant EJR request are governed by CMS Ruling CMS-1727-R. In addition, the participants' documentation shows that the estimated amount in controversy exceeds $50,000 in each appeal, as required for a group appeal.[61] The appeals were timely filed. Based on the above, the Board finds that it has jurisdiction for the above-captioned appeals and the underlying providers. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

C. Jurisdiction - FYEs on or after December 31, 2016 (Substantive Claim):

With regard to the cost reporting periods ending on or after December 31, 2016, the substantive claim regulations apply. For group cases, the MAC must file a Substantive Claim Challenge within 60 days of the final SOP being submitted.[62] Substantive claim challenges were filed concerning the cases and providers listed in **Appendix B** ("the Challenged Providers").

In the November 13, 2015 Final Outpatient Prospective Payment Rule,[63] the Secretary finalized new cost reporting regulations related to the substantive reimbursement requirement of an

[59] 201 F. Supp. 3d 131 (D.D.C. 2016)
[60] *Banner* at 142.
[61] *See* 42 C.F.R. § 405.1837.
[62] PRRB Rule 44.5.2.
[63] 80 Fed. Reg. 70298, 70551-70580 (Nov. 13, 2015).

appropriate cost report claim.[64] 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 MAC 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, again, for cost reports beginning on or after January 1, 2016 (hereinafter the "claim-specific dissatisfaction requirement"). As some of the participants in these cases have fiscal years that began on or after January 1, 2016, the claim-specific dissatisfaction requirement is not applicable.

1. *Board review of 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) requires that:

> (1) In order for a provider to receive or potentially qualify for reimbursement for a specific item for its cost reporting period, the provider's cost report, whether determined on an as submitted, as amended, or as adjusted basis (as prescribed in paragraph (j)(3) of this section), must include an appropriate claim for the specific item, by either—
>
> (i) Claiming full reimbursement in the provider's cost report for the specific item in accordance with Medicare policy, if the provider seeks payment for the item that it believes comports with program policy; or
>
> (ii) Self-disallowing the specific item in the provider's cost report, if the provider seeks payment that it believes may not be allowable or may not comport with Medicare policy (for example, if the provider believes the contractor lacks the authority or discretion to award the reimbursement the provider seeks for the item), by following the procedures (set forth in paragraph (j)(2) of this section) for properly self-disallowing the specific item in the provider's cost report as a protested amount.

[64] *Id.* at 70555.

> (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) states:

> (a) *General*. In order to receive or potentially receive reimbursement for a specific item, the provider must include in its cost report an appropriate claim for the specific item (as prescribed in § 413.24(j) of this chapter). **If** the provider files an appeal to the Board seeking reimbursement for the specific item and **any party** to such appeal **questions whether the provider's cost report included an appropriate claim for the specific item**, the Board must address such question in accordance with the procedures set forth in this section. (Emphasis added)

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

a. The Challenged Providers

i. <u>Cases 22-0215GC and 23-0069GC</u>

Board Rule 44.5.2 requires a Substantive Claim Challenge be made in group cases no later than

sixty (60) days after the group files its final Schedule of Providers.

In Case 22-0215GC, the Providers submitted their Final Schedule of Providers and jurisdictional documentation on January 26, 2023. Any Substantive Claim Challenges were due no later than March 24, 2023. The Medicare Contractor's designated representative, Federal Specialized Services ("FSS") filed a Substantive Claim Challenge on June 23, 2023.

In Case 23-0069GC, the Providers submitted their Board Rule 20 certification that this case's jurisdictional documentation was fully populated in OH CDMS (in lieu of a Final Schedule of Providers) on June 14, 2024. Any Substantive Claim Challenges were due no later than August 13, 2024. FSS filed a Substantive Claim Challenge on September 4, 2024.

Both of these Substantive Claim Challenges were untimely and, as such, the Board declines to consider them.

ii. Case 23-1583GC

The Providers in this group submitted their Board Rule 20 certification that this case's jurisdictional documentation was fully populated in OH CDMS (in lieu of a Final Schedule of Providers) on October 8, 2024. A timely Substantive Claim Challenge was filed by FSS on December 5, 2024 concerning the following Providers:

- East Alabama Medical Center (Prov. No. 01-0029)
- University of WI Hospitals & Clinics Authority (Prov. No. 52-0098)
- University of Illinois Hospitals and Clinics (Prov. No. 14-0150)

The challenge essentially argues that the narrative provided with the protested amounts was not specific enough to identify the appealed issue as it relates to the claimed amount in controversy.

The Providers filed a response, first arguing that "42 C.F.R. §§ 413.24(j) and 405.1873 violate hospitals' statutory right to a meaningful appeal," citing "*Bethesda*,[65] *Banner*,[66] and *Bayshore"*[67] in support.[68] They argue the Board should disregard the 2016 Substantive Claim regulations for the same reasons set forth in *Bethesda* and *Banner*. They also argue that they *did* submit appropriate cost report claims for the specific items in dispute. They seek supplemental reimbursement for their operating and capital DSH payments. The Providers argue they made appropriate claims for reimbursement of operating and capital DSH payments, but that they were understated as a matter of law.[69] They also argue that they clearly identified and protested the SSI Dual Eligible Days issue, and that arguments that the listed damages may overlap with other

[65] *Bethesda Hosp. Ass'n v. Bowen*, 485 U.S. 399 (1988).
[66] *Banner Heart Hospital, et al. v. Burwell*, 201 F.Supp.3d 131 (D.D.C. 2016).
[67] *Bayshore Cmty. Hosp. v. Azar*, 325 F. Supp. 3d 18, 21 (D.D.C. 2018).
[68] Provider's Response to MAC's Substantive Claim Challenge (Case No. 25-1583G) at 4 (Jan. 6, 2025).
[69] *Id.* at 17-19.

appealed issues is irrelevant.[70]

The Board has reviewed the record and supporting documents submitted in this case and determined that East Alabama Medical Center (Prov. No. 01-0029) and University of Illinois Hospitals and Clinics (Prov. No. 14-0150) **did** make an appropriate cost report claim for the specific item under appeal. The issue was listed as a protested issue and adequately described, with the detailed calculation showing a change in the SSI ratio used for the DSH calculation. This served to put the Medicare Contractor on notice that these Providers were specifically self-disallowing an amount based on this issue, even if the ultimate amounts of damages cannot be precisely calculated or may overlap with other issues (*i.e.*, a challenge to the same regulation or its application based on a different legal theory).

With regard to University of WI Hospitals & Clinics Authority (Prov. No. 52-0098), however, the Board has reviewed the records and determined that the protest calculation submitted with its cost report ***only*** seeks a change to the number of Medicaid Days included in its DSH calculation. This adjustment was not related to the issue under appeal, namely the number of days where a patient was "entitled to SSI" (as well as Part A) in the ***SSI Fraction***. No change was made in the SSI ratio to result in the calculated protested amount for DSH. Thus, the Provider's argument that the protested amount was filed and included the instant issue is not supported by the record before the Board. Based on the foregoing, the Board finds that this Provider did ***not*** make a specific claim for the item that is the subject of its appeal request and EJR Request.

iii. Cases 23-0031G, 22-1361GC, 22-0406G, 24-1343G, 21-0289GC, & 22-0765GC

x. Medicare Contractor's Challenges

The Providers in Case 23-0031G submitted their Board Rule 20 certification that this case's jurisdictional documentation was fully populated in OH CDMS (in lieu of a Final Schedule of Providers) on December 4, 2023. A timely[71] Substantive Claim Challenge was filed by FSS on January 29, 2024 concerning the following Provider:

- Aultman Hospital (Provider No. 36-0084)

The Providers in Case 22-1361GC submitted their Board Rule 20 certification that this case's jurisdictional documentation was fully populated in OH CDMS (in lieu of a Final Schedule of Providers) on February 16, 2023. A timely[72] Substantive Claim Challenge was filed by FSS on April 10, 2023, concerning the following Providers:

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[70] *Id.* at 19-20.
[71] Board Rule 44.5.2 requires a Substantive Claim Challenge be made in group cases no later than sixty (60) days after the group files its final Schedule of Providers.
[72] Board Rule 44.5.2 requires a Substantive Claim Challenge be made in group cases no later than sixty (60) days after the group files its final Schedule of Providers.

- Aultman Hospital (Prov. No. 36-0084)
- Alliance Community Hospital (Prov. No. 36-0131)

The Providers in Case 22-0406G submitted their Board Rule 20 certification that this case's jurisdictional documentation was fully populated in OH CDMS (in lieu of a Final Schedule of Providers) on February 13, 2023. A timely[73] Substantive Claim Challenge was filed by FSS on April 6, 2023, concerning the following Provider:

- Aultman Hospital (Prov. No. 36-0084)

The Providers in Case 21-1343G submitted their Board Rule 20 certification that this case's jurisdictional documentation was fully populated in OH CDMS (in lieu of a Final Schedule of Providers), as well as a Schedule of Providers and jurisdictional documents, on July 15, 2022. FSS filed a Substantive Claim Challenge on November 14, 2022.[74] The challenge concerns the following Providers:

- Norton Hospital (Prov. No. 18-0088)
- Hillsdale Hospital (Prov. No. 23-0037)
- Evangelical Community Hospital (Prov. No. 39-0013)

The Providers in Case 21-0289GC submitted their Board Rule 20 certification that this case's jurisdictional documentation was fully populated in OH CDMS (in lieu of a Final Schedule of Providers) on January 22, 2024. A timely[75] Substantive Claim Challenge was filed by FSS on March 4, 2024, concerning the following Provider:

- Dearborn County Hospital (Prov. No. 15-0086)

The Providers in Case 22-0765GC submitted their Board Rule 20 certification that this case's jurisdictional documentation was fully populated in OH CDMS (in lieu of a Final Schedule of

[73] Board Rule 44.5.2 requires a Substantive Claim Challenge be made in group cases no later than sixty (60) days after the group files its final Schedule of Providers.
[74] Pursuant to Board Rule Board Rule 44.5.2, any Substantive Claim Challenges would have typically been due no later than September 13, 2022. The deadline to file the challenge, however, was indefinitely stayed via Board Alert 19 due to the public health emergency created by the COVID-19 pandemic. (*Available at* https://www.cms.gov/files/document/prrb-alerts.pdf). This indefinite stay was lifted effective December 7, 2022 via Board Alert 23, which stated "***Effective Wednesday, December 7, 2022***, Board Order No. 3 ceases suspension of deadlines and will hold parties to the deadline specified in: (1) *any* Board rule or instruction; and/or (2) *any* Board notice or correspondence issued ***on or after that date.***" (*Available at* https://www.cms.gov/medicare/regulations-guidance/provider-reimbursement-review-board/current-prrb-alerts) (emphasis in original). There was no correspondence in Case 21-1343G, or general notice applicable to this case, which re-established deadlines for Substantive Claim Challenges. As such, the stay for the deadline for a Substantive Claim Challenge was never lifted and FSS' filing was not untimely.
[75] Board Rule 44.5.2 requires a Substantive Claim Challenge be made in group cases no later than sixty (60) days after the group files its final Schedule of Providers.

Providers) on April 8, 2023. A timely[76] Substantive Claim Challenge was filed by FSS on May 17, 2023, concerning the following Provider:

- Southwestern Medical Center (Prov. No. 37-0097)

In all of these challenges, the Medicare Contractor argues that any cited audit adjustments do not relate to SSI Fraction Dual Eligible Days and are insufficient to "claim full reimbursement for the specific item." It also notes that the protested Part A amounts for these providers is either $0 or do not list amounts specifically referencing SSI Fraction Dual Eligible Days.

y. Providers' Responses

The Providers filed a response in each of the above referenced cases, first arguing that 42 C.F.R. §§ 413.24(j) and 405.1873 violate hospitals' "statutory right to a meaningful appeal," citing "*Bethesda*, *Banner*, and *Bayshore"* in support.[77] They argue the Board should disregard the 2016 Substantive Claim regulations for the same reasons set forth in *Bethesda* and *Banner*.[78] They also argue that they *did* submit appropriate cost report claims for the specific items in dispute. They seek supplemental reimbursement for their operating and capital DSH payments. The Providers argue they made appropriate claims for reimbursement of operating and capital DSH payments, but that they were understated as a matter of law.[79] They argue that they are not required to "*also* expressly self-disallow *supplemental* payment sought for the same items under a purely legal challenge beyond the MAC's authority to address."[80]

In Case 21-0289GC, the Providers' response also insists that "because DSH reimbursement is allowed by Medicare policy, was claimed by the Provider, and was paid by the MAC, there was no requirement that the Provider also self-disallow the same items."[81] They argue that the exception at 42 C.F.R. § 413.24(j)(3)(ii) applies to the Providers in this group. They note that the SSI Ratios were adjusted at Worksheet E, Part A, Line 30 of the cost reports. The regulation states that:

> If the contractor adjusts the provider's cost report, as submitted originally by the provider and accepted by the contractor or as amended by the provider and accepted by the contractor, whichever is applicable, with respect to the specific item, then whether there is an appropriate cost report claim for the specific item must be determined by reference to the provider's cost report, as such cost report claim is adjusted for the specific item in the final contractor determination (as defined in § 405.1801(a) of

[76] Board Rule 44.5.2 requires a Substantive Claim Challenge be made in group cases no later than sixty (60) days after the group files its final Schedule of Providers.
[77] *See, e.g.,* PRRB Case 22-0765GC, Response to ASC'S Substantive Claim Letter at 4 (Jun. 16, 2023).
[78] *Id.* at 12.
[79] *Id.* at 16-17.
[80] *Id.* at 17.
[81] Provider's Response to MAC's Substantive Claim Challenge (Case No. 21-0289GC) at 19 (Apr. 3, 2024).

> this chapter) for the provider's cost reporting period, provided that the exception set forth in paragraph (j)(3)(iii) of this section does not apply.

The Board has reviewed the records and documentary support for these cases, and notes that it is ***undisputed*** that the Providers did not self-disallow or protest the SSI Fraction Dual Eligible Days issue. The Board disagrees that the Providers have made an appropriate cost report claim by claiming full reimbursement for the *specific item* sought. Simply being reimbursed for capital or operating DSH does not satisfy the appropriate cost report claim requirement. The regulation describes what it means to make an appropriate claim: "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***."[82] If the Provider believes it is entitled to reimbursement for something that is not allowable or "may not comport with Medicare policy" they are required to self-disallow that ***specific item***.[83]

The Board finds that the Challenged Providers in these six cases[84] have failed to make an appropriate cost report claim for the SSI Fraction Dual Eligible Days issue as required by 42 C.F.R. §§ 413.24(j). The Providers' appeal is based on the interpretation of a statute, which necessarily acknowledges that current Medicare Policy does not allow reimbursement for the days sought. As such, the Providers were required to self-disallow the supplemental costs sought in order to comply with the requirement to submit an appropriate cost report claim. While the Providers have requested the Board disregard the Substantive Claim regulations, the Board is bound to apply them as written.[85]

b. The Non-Challenged Providers

The Board interprets the regulation at 42 C.F.R. § 405.1873 to only require the Board to review a provider's "compliance"[86] 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.[87] In these group cases, the Medicare Contractor has failed to file a Substantive Claim Challenge[88] within the time frame specified by Board Rule 44.5.1 (2023) for any of the Providers with FYEs beginning on or after December 31, 2016 which are ***not*** listed in **Appendix B** ("the Non-Challenged Providers").

For these Non-Challenged Providers, since no party to the appeal has questioned, pursuant to

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[82] 42 C.F.R. § 413.24(j)(1)(i).
[83] 42 C.F.R. § 413.24(j)(1)(ii).
[84] Cases 23-0031G, 22-1361GC, 22-0406G, 24-1343G, 21-0289GC, & 22-0765GC.
[85] 42 C.F.R. § 405.1867.
[86] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."
[87] *See* 42 C.F.R. § 405.1873(a).
[88] Board Rule 44.5 states: "The Board adoption of the term 'Substantive Claim Challenge' simply refers to any question raised by a party concerning whether the cost report at issue included an appropriate claim for one or more of the specific items being appealed in order to receive or potentially qualify for reimbursement for those specific items."

§ 405.1873(a), whether an appropriate claim was made,[89] the Board finds there was no regulatory obligation for the Board to affirmatively, on its own, review the appeal documents to determine whether an appropriate claim was made. As a result, Board review under 42 C.F.R. § 405.1873(b) has not been triggered. Accordingly, the Board need not include any findings regarding compliance with the substantive claim requirements for the Non-Challenged Providers and may proceed to rule on the EJR request pursuant to 42 C.F.R. § 405.1873(d).

D. Jurisdictional Challenges:

A Jurisdictional Challenge was filed by the Medicare Contractor in Case 23-1583GC arguing that the issue presented was a duplicate of Case 22-1269G. The Medicare Contractor argues that the issue statements in the two groups both present the same Dual Eligible Days policy issue.[90] The Providers disagree, noting that the instant case is related to "CMS's method of counting SSI Dual Eligible Days and what it means to be 'entitled' to SSI" and that the two cases present challenges to two issues: the technical SSI Data Match deficiencies issue, and the SSI Dual Eligible Days policy issue.[91]

The Board finds that the cases cited above are not duplicative, rather they deal with two different issues. The SSI data match issue in Case 22-1269G is a technical issue which alleges that there are still errors that exist with CMS' revised matching process developed in response to *Baystate* and therefore does not properly capture all SSI eligible individuals. The SSI Dual Eligible Days issue in Case 23-1583GC is rooted in the legal arguments related to CMS' interpretation of the DSH statute, particularly the Medicare fraction, and CMS' policy decisions in which CMS interprets the term "entitlement" to Medicare Part A broadly while very narrowly interpreting the term with respect to SSI benefits and the failure to use the 77 Payment status codes. These are distinct issues and the cases cited by the Medicare Contractor are not duplicative of the instant cases. Therefore, the Board ***denies*** the Medicare Contractor's Jurisdictional Challenge in Case No. 23-1583GC.

D. Analysis Regarding 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.[92] 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.[93] Contemporaneous with CMS

[89] 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."
[90] Case 23-1583G, Medicare Administrative Contractor's Jurisdictional Challenge, 7 (Jan. 27, 2025).
[91] Case 23-1583G, Providers' Response to MAC's Jurisdictional Challenge, 2-3 (Feb. 26, 2025).
[92] CMS Ruling 1498-R at 27.
[93] *Id.* at 31.

Ruling 1498-R[94] the Secretary published a proposed IPPS rule[95] which proposed to adopt the same data match for 2011 and forward. This proposed rule was adopted as the 2011 Final IPPS Rule in which the Secretary explained that:

> . . . we 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.[96]

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[97]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.[98]

The Secretary did not incorporate the above new policy involving the revised data match process into the Code of Federal Regulations. 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 to be a binding but

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[94] *Id.* at 5.
[95] 75 Fed. Reg. 23,852, 24,002-07.
[96] 75 Fed. Reg. at 50,277.
[97] (Medicare) Enrollment Database.
[98] 75 Fed. Reg. at 50,285.

uncodified regulation and will refer to the above policy as "Uncodified SSI Data Match 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 for services" as a regulation."[99]

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 Data Match Regulation the published in the FY 2011 Final Rule and the Board does not have the authority to grant the relief sought by the Providers, namely invalidating the Uncodified SSI Data Match Regulation which they allege fails to include all of the PSC codes used by SSA to determine SSI eligibility. As a result, the Board finds that EJR is appropriate for the issue for the calendar years under appeal in these cases.

VI. 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 participants in these group appeals are entitled to a hearing before the Board,

2) The review process in 42 C.F.R. § 405.1873(a)-(b) has been triggered for all of the Challenged Providers listed in **Appendix B**, and

    a. The Board specifically finds that the Challenged Providers listed in **Appendix C** failed to include "an appropriate claim for the specific item" that is the subject of their respective group appeals as required under 42 C.F.R. § 413.24(j)(1); and
    b. The Board specifically finds that any Challenged Providers which are not listed in **Appendix C** did include "an appropriate claim for the specific item" that is the subject of their respective group appeals as required under 42 C.F.R. § 413.24(j)(1)

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

4) based upon the participants' assertions regarding FY 2011 Final IPPS Rule there are no findings of fact for resolution by the Board;

[99] 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 for services . . . shall take effect unless it is promulgated by the Secretary by regulation . . . ."

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

6) it is without authority to decide the legal question of whether the FY 2011 Final IPPS Rule is valid.

Accordingly, the Board finds that the question of the validity of the 2011 Final IPPS Rule properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for EJR (except as noted above) for the issue and the subject years. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute, the Board hereby closes these cases.

Board Members Participating:

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

FOR THE BOARD:

3/18/2025

X Kevin D. Smith, CPA

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

Enclosures: Schedules of Providers

cc: Pamela VanArsdale, National Government Services, Inc. (J-6)
Byron Lamprecht, WPS Government Health Administrators (J-5) (J-8)
Judith Cummings, CGS Administrators (J-15)
Cecile Huggins, Palmetto GBA (J-J)
Michael Redmond, Novitas Solutions, Inc. c/o GuideWell Source (J-H)
Dana Johnson, Palmetto GBA c/o National Government Services, Inc. (J-M)
Wilson Leong, FSS

Appendix A
(23 Hall Render Dual Eligible Cases)

PRRB Case Number	PRRB Case: Case Name
17-1638GC	*Quorum Health 2015 SSI Fraction Dual Eligible Days CIRP Group*
23-1583G	*Hall Render CY 2018 DSH SSI Dual Eligible Days Group*
23-0031G	*Hall Render CY 2016 DSH SSI Dual Eligible Days Group*
22-0215GC	*Spectrum Health CY 2017 DSH Dual Eligible Days CIRP Group*
21-0083G	*Hall Render CYs 2011- 2013 & 2015 DSH SSI Dual Eligible Days Group*
21-0121G	*Hall Render CY 2004 DSH Post 1498R SSI Dual Eligible Days Group*
21-0103G	*Hall Render CY 2003 DSH Post 1498R SSI Dual Eligible Days Group*
17-2211GC	*Ascension Health 2015 DSH SSI Fraction Dual Eligible Days CIRP Group*
15-3143GC	*Community Health Network 2012 SSI Dual Eligible Days CIRP Group*
15-2784GC	*Ascension Health 2013 DSH SSI Fraction Dual Eligible Days CIRP Group*
15-0398GC	*Community Health Network 2010 DSH SSI Ratio Dual Eligible Days CIRP Group*
16-2223GC	*Community Health Network 2013 DSH SSI Fraction Dual Eligible Days CIRP Group*
23-0069GC	*Premier Health Partners CY 2019 DSH Dual Eligible Days CIRP Group*
22-1361GC	*Aultman Health CY 2018 DSH Dual Eligible Days CIRP Group*
22-0406GC	*Aultman Health CY 2017 DSH Dual Eligible Days CIRP Group*
21-1343G	*Hall Render CY 2018 DSH SSI Dual Eligible Days Group*
21-0289GC	*St. Elizabeth Healthcare CY 2018 DSH Dual Eligible Days CIRP Group*
22-0765GC	*ScionHealth CY 2017 DSH Dual Eligible Days CIRP Group*
16-1376GC	*LifePoint 2014 Medicare Fraction Dual Eligible Days CIRP Group*
15-3180GC	*LifePoint 2013 IPPS Hospital Medicare Fraction Dual Eligible CIRP Group*
14-3467GC	*LifePoint 2012 Medicare Fraction Dual Eligible CIRP Group*
14-1977GC	*LifePoint 2011 DSH Medicare Fraction Dual Eligible CIRP Group*
19-2562GC	*Valley Health CY 2015 DSH SSI Dual Eligible Days CIRP Group*

Appendix B
(Challenged Providers for which a Substantive Claim Challenge was filed)

1. Case 23-1583GC
    a. East Alabama Medical Center (Prov. No. 01-0029)
    b. University of WI Hospitals & Clinics Authority (Prov. No. 52-0098)
    c. University of Illinois Hospitals and Clinics (Prov. No. 14-0150
2. Case 23-0031G
    a. Aultman Hospital (Provider No. 36-0084)
3. Case 22-0215GC (Untimely Challenge – not considered)
    a. Spectrum Health (Prov. No. 23-0038)
    b. Lakeland Hospital (Prov. No. 23-0021)
4. Case 23-0069GC (Untimely Challenge – not considered)
    a. Autumn Medical Center (Prov. No. 39-0076)
    b. Upper Valley Medical Center (Prov. No. 36-0174)
    c. Miami Valley Hospital (Prov. No. 36-0051)
5. Case 22-1361GC
    a. Aultman Hospital (Prov. No. 36-0084)
    b. Alliance Community Hospital (Prov. No. 36-0131)
6. Case 22-0406G
    a. Aultman Hospital (Prov. No. 36-0084)
7. Case 21-1343G
    a. Norton Hospital (Prov. No. 18-0088)
    b. Hillsdale Hospital (Prov. No. 23-0037)
    c. Evangelical Community Hospital (Prov. No. 39-0013)
8. Case 21-0289GC
    a. Dearborn County Hospital (Prov. No. 15-0086)
9. Case 22-0765GC
    a. Southwestern Medical Center (Prov. No. 37-0097)

Appendix C
(Challenged Providers for which the Board Finds No Appropriate Cost Report Claim was Made (*i.e.*, Substantive Claim Challenge was granted)

1. Case 23-0031G
    a. Aultman Hospital (Provider No. 36-0084)
2. Case 22-1361GC
    a. Aultman Hospital (Prov. No. 36-0084)
    b. Alliance Community Hospital (Prov. No. 36-0131)
3. Case 22-0406G
    a. Aultman Hospital (Prov. No. 36-0084)
4. Case 21-1343G
    a. Norton Hospital (Prov. No. 18-0088)
    b. Hillsdale Hospital (Prov. No. 23-0037)
    c. Evangelical Community Hospital (Prov. No. 39-0013)
5. Case 21-0289GC
    a. Dearborn County Hospital (Prov. No. 15-0086)
6. Case 22-0765GC
    a. Southwestern Medical Center (Prov. No. 37-0097)
7. Case 23-1583GC
    a. University of WI Hospitals & Clinics Authority (Prov. No. 52-0098)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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RE: **EJR Determination Hall Render DSH Dual Eligible SSI Patient Days Groups**

Cases: 18-1627GC *et al.* Hall Render DSH SSI/Medicare Fraction Dual Eligible Days Groups
(21 Cases – See **Appendix A**)

Dear Ms. Griffin:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' February 19, 2025 request for expedited judicial review ("EJR") in the above-referenced appeals. The Board's decision with respect EJR is set forth below.

I. Issue in Dispute

The issue for which the Board is considering EJR is:

> Whether the Medicare Disproportionate Share Hospital (DSH) calculation was understated due to the failure of the Centers for Medicare & Medicaid Services (CMS) and the Fiscal Intermediary (FI) to properly include all Dual Eligible Days, including all Dual Eligible Days that are Medicare Non-Covered Days ("DE MNC Days"), which include but are not limited to Medicare Exhaust Days and MSP (Medicare Secondary Payor) Days where Medicare is secondary to another payor, in the numerator of the Medicare or Medicaid Fraction of the DSH percentage as applicable pursuant to 42 U.S.C. § 1395ww(d)(5)(F).
>
> . . . .
>
> The Providers dispute CMS's position that only Dual Eligible Days, and DE MNC Days, that are also SSI Days go in the Medicare numerator of the DSH calculation. Since Medicare interprets "entitled" to Medicare as "eligible" for Medicare, and

> thus their basis for including these days in the Medicare ratio, then they also must interpret "entitled" to SSI as "eligible" for SSI and allow all Dual Eligible Days, including all such DE MNC 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 DSH Medicare numerator.[1]

II. Medicare Disproportionate Share Hospital (DSH) Payment Background

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").[2] One of these adjustments, the Medicare DSH adjustment, provides additional payments to certain qualifying hospitals that treat a disproportionate share of low income patients.[3] 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. 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…"; and (b) in the denominator, the number of days of care that are furnished to patients who were entitled to Medicare Part A.[4] 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,[5] administered by the Social Security Administration ("SSA"). The SSI statute, generally, does not use the term "entitled" to SSI benefits. Rather, the SSI statute typically refers to whether an individual is "eligible for benefits."[6] 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.[7]

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.[8] In addition, the Medicare program provides that certain qualifying individuals with end stage renal

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[1] *See, e.g.*, PRRB Case 23-0998GC, Issue Description for DSH SSI Ratio Dual Eligible Days.
[2] 42 C.F.R. Part 412.
[3] 42 U.S.C. § 1395ww(d)(5)(F)(i)(I).
[4] 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). *See also* 42 C.F.R. § 412.106(b)(2)(i)(B).
[5] 42 U.S.C. § 1382.
[6] 42 U.S.C. §§ 1381a, 1382(a) (emphasis added).
[7] 20 C.F.R. § 416.202.
[8] 42 U.S.C. § 426.

disease are entitled to Medicare Part A.[9]

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[10] and may terminate,[11] suspend[12] or stop payments to individuals who are either temporarily or permanently ineligible for payment of SSI benefits.[13] 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 Sections §§ 416.207-416.216:

1. The individual fails to give the SSA permission to contact financial institutions;[14]
2. The individual fails to apply for other benefits to which the individual may be entitled;[15]
3. The individual fails to participate in drug or alcohol addiction treatment;[16]
4. The individuals is absent from the United States for more than 30 days;[17] or
5. The individual becomes a resident of a public institutions or prison.[18]

Under certain circumstances, the Social Security Administration may not pay benefits for administrative reasons, including removal of a representative payee, an unknown address for the beneficiary, or because of income from a previous month.[19]

After the Medicare DSH statutory provisions were enacted in 1984, the Health Care Financing Administration ("HCFA"), the predecessor to CMS, 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, the Social Security Administration ("SSA").[20] HCFA 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.[21] To compute the Medicare fraction, HCFA had to match individual Medicare billing records to individual SSI records.[22] Considering the administrative burdens and complexity of the data

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[9] 42 U.S.C. § 426-1.
[10] 20 C.F.R. § 416.204.
[11] 20 C.F.R. §§ 416.1331-1335.
[12] 20 C.F.R. §§ 416.1320-1330.
[13] 20 C.F.R. § 1320.
[14] 20 C.F.R. § 416.207.
[15] 20 C.F.R. § 416.210.
[16] 20 C.F.R. § 416.214.
[17] 20 C.F.R. § 416.215.
[18] 20 C.F.R. § 416.211.
[19] *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).
[20] 51 Fed. Reg. 31,454, 31,459 (Sept. 3, 1986).
[21] *Id.*
[22] *Id.*

matching process, HCFA 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.[23] HCFA/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.[24]

The Medicare DSH payment adjustment has been the subject of much litigation and 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. On April 28, 2010, CMS published Ruling 1498-R to respond to a court order in *Baystate*. Specifically, the Ruling stated that CMS had implemented the court 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."[25] 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 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."[26] 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."[27]

Consistent with Ruling 1498-R, CMS published the new data matching process in the FY 2011 proposed rule published on May 4, 2010[28] and finalized that data matching process in the final rule published on August 16, 2010 ("FY 2011 Final Rule").[29] Significantly, in the preamble to the FY 2011 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 is 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 matching process."[30] CMS responded in detail to this comment and explained that CMS interprets SSI entitlement to correspond with any month for which an individual *receives*

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[23] *Id.* at 31,459–31,460; 42 C.F.R. § 412.106(b).
[24] 42 C.F.R. § 412.106(b)(5); 42 C.F.R. § 405.1803.
[25] CMS-1498-R at 5.
[26] *Id.*
[27] *Id.* at 5-6.
[28] 75 Fed. Reg. 23,852, 24,002-24,007 (May 4, 2010).
[29] 75 Fed. Reg. 50,042, 50,280-50,281. (Aug. 16, 2010).
[30] *Id.* at 50,280.

payment of SSI benefits. In this regard, CMS stated that the inclusion of 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."[31] 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 those status codes was used."[32] 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]."[33]

While the new data matching process established in the FY 2011 Final Rule was effective October 1, 2010, 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.[34] 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.[35]

Finally, on April 22, 2015, CMS published Ruling 1498-R2 modifying and amending 1498-R by allowing providers 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.[36]

As a result of the Rulings, new regulation and data match process, CMS calculated new and/or recalculated existing SSI percentages for the Hospitals for all of fiscal years at issue in these appeals.[37] The Hospitals have appealed original NPRs which were based on the methodology articulated in the preamble, *i.e.*, use only the three SSI codes to denote SSI eligibility.

III. Providers' Position

The Providers note that, currently, CMS "interpret[s] entitlement to SSI program benefits to include only those patients who received a cash stipend from the SSI program for the month of their hospitalization." They assert, however, that under the rules of statutory construction and

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[31] *Id.* at 50,280-50,281.
[32] *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.
[33] *Id.* at 50285.
[34] CMS-1498-R at 6-7, 31-32.
[35] *Id.* at 28, 31.
[36] CMS-1498-R2 at 2, 6.
[37] The SSI ratios for FY 2009 and 2010 were published on March 16, 2012 and October 17, 2012, respectively. *See* https://www.cms.gov/Medicare/ Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.

binding Supreme Court precedent, "CMS is compelled to interpret entitlement to SSI benefits to include all inpatients who were eligible for and enrolled in the SSI program at the time of their hospitalization."[38] The Providers' Designated Representative notes that this issue has already been appealed before the Board, resulting in Board Decisions 2017-D11 and 2017-D12, which have been appealed and are currently pending before the Supreme Court in *Advocate Christ Med. Ctr. v. Becerra*.[39]

The Request for EJR also claims that "these appeals also centers [sic] on Providers' demand for access to data necessary to verify and challenge CMS's calculation of their DSH payments. Specifically, Providers seek to compel CMS to furnish Providers with the payment status code (PSC) the SSI program assigns to all SSI Eligible patients."[40] They claim they "are entitled to this data under Section 951 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003,[41] . . . and pursuant to the decision in *Pomona Valley Hosp. Med. Ctr. v. Azar*."[42]

The Providers explain the history of CMS' interpretation of the term "entitlement," and how CMS broadened this term with respect to Medicare Part A benefits in 2004 when it adopted a policy to include Part A beneficiaries in the Medicare Fraction regardless of whether they received any Part A benefits during their hospital stay.[43] They claim the current approach for Part A entitlement is that "CMS holds that a Medicare beneficiary remains entitled to Medicare Part A benefits even when no coverage under Part A exists and no Part A payments are made,"[44] and that this interpretation was upheld in *Becerra v. Empire Health Found.*[45] The interpretation of "entitled to SSI," however, has remained more narrow than this, "requiring them to actually receive payment of a cash stipend for the month of hospitalization in order to be included in the numerator of the Medicare Fraction."[46] They argue this narrow interpretation, however, is "clearly erroneous and unlawful," and that "SSI beneficiaries should be considered 'entitled' to SSI benefits so long as they meet the statutory criteria to qualify under Title XVI, regardless of receipt of benefits."[47]

The Providers note that in administering the SSI program, SSA assigns each beneficiary a Patient Status Code (PSC). The codes are "made up of two elements: a single letter reflecting payment status and a two-digit number indicating the reason for the payment status." Of the 77 PSC codes used by SSA, the Secretary announced in the Federal Register that only three PSC codes, C01, M01 and M02, are counted as "entitlement" for purposes of the DSH statute.[48] Thus, the Providers allege the other 74 codes used by SSA to determine payment status result in a

[38] Consolidated Request for Expedited Judicial Review, 1-2 (Feb. 19, 2025).
[39] *Id.* at 2-3.
[40] *Id.* at 3.
[41] Pub. L. 108-173.
[42] 2020 WL 5816486 (D.D.C. 2020).
[43] Consolidated Request for Expedited Judicial Review at 5.
[44] *Id.* at 6.
[45] 597 U.S. 424 (2022).
[46] Consolidated Request for Expedited Judicial Review at 7.
[47] *Id.* at 7-8.
[48] *Id.* at 8-9 (citing 75 Fed. Reg. 50,042, 50280-50281 (Aug. 16, 2010)).

significant number of SSI enrollees being excluded from the numerator of the Medicare fraction even though they are SSI eligible.[49] The Providers believe that the SSI enrollees remain entitled to SSI regardless of whether cash payment is received in the month of hospitalization under the holding in *Empire*.[50]

Further, the Providers assert in their request for EJR that CMS should provide the Providers with a listing of those SSI enrollees for the relevant hospitalizations so that they can ensure that their DSH adjustments were calculated in accordance with the Medicare statute. The Providers state that will "seek to compel CMS to provide the requisite data through a mandamus action, or a similar-type claim under 5 U.S.C. § 706(1) . . . . in federal court."[51]

IV. 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) "'[t]he Board has jurisdiction to conduct a hearing on the specific matter at issue. . . [and] (ii) [t]he 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 group of Providers generally have a right to a hearing before the Board with respect to specific items claimed on timely filed cost reports if:

- They are dissatisfied with final determinations of the Medicare Contractor;
- The request for a hearing of each Provider is filed within 180 days of the date of receipt of the final determinations. Providers must appeal from a "final determination" related to their cost report or payment, which includes an NPR, a Revised NPR, or failure to timely issue a final determination; [52]
- The matter at issue involves single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group; and
- The amount in controversy is, in the aggregate, $50,000 or more.[53]

[49] *Id.* at 9.
[50] *Id.*
[51] *Id.* at 14.
[52] 42 U.S.C. § 1395oo(a); *see also Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 144-145 (D.C. Cir. 1986).
[53] 42 C.F.R. §§ 405.1837.

A. Jurisdiction - FYEs December 31, 2008 to December 31, 2016 (1727-R)

The participants that comprise the group appeals within this EJR request have filed appeals involving calendar years 2016-2019.

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 the Dual Eligible Days 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 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 that 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 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

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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. 30,190, 30,240 (May 23, 2008).
[57] 201 F. Supp. 3d 131 (D.D.C. 2016)
[58] *Banner* at 142.

the matter under protest. The Board finds that the "entitled to benefits" question is governed by 42 C.F.R. § 412.106(b)(2)(i)(B), which is a regulation that left the Medicare Contractors without the authority to make the payment in the manner sought by the Providers in these cases. Consequently, the Board finds that it has jurisdiction over the Providers in these cases.

The Board has determined that the participants involving FYEs December 31, 2008 to December 31, 2016 involved with the instant EJR request are governed by CMS Ruling CMS-1727-R. In addition, the participants' documentation shows that the estimated amount in controversy exceeds $50,000 in each appeal, as required for a group appeal.[59] The appeals were timely filed. Based on the above, the Board finds that it has jurisdiction for the above-captioned appeals and the underlying providers. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

B. Jurisdiction - FYEs on or after December 31, 2016 (Substantive Claim):

The participants that comprise these CIRP group appeals have filed appeals involving calendar years 2016-2019. With regard to the cost reporting periods ending on or after December 31, 2016, the substantive claim regulations apply. For group cases, the MAC must file a Substantive Claim Challenge within 60 days of the final SOP being submitted.[60] No substantive claim challenges were filed in the instant cases and, thus, the Board's review of whether an appropriate cost report claim was made has not been triggered.

In the November 13, 2015 Final Outpatient Prospective Payment Rule,[61] the Secretary finalized new cost reporting regulations related to the substantive reimbursement requirement of an appropriate cost report claim.[62] 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 MAC 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, again, for cost reports beginning on or after January 1, 2016 (hereinafter the "claim-specific dissatisfaction requirement"). As some of the participants in these cases have fiscal years that began on or after January 1, 2016, the claim-specific dissatisfaction requirement is not applicable.

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[59] *See* 42 C.F.R. § 405.1837.
[60] PRRB Rule 44.5.2.
[61] 80 Fed. Reg. 70298, 70551-70580 (Nov. 13, 2015).
[62] *Id.* at 70555.

1. *Board review of 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)*

The participants that comprise these CIRP group appeals have filed appeals involving calendar years 2016-2019. 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) requires that:

> (1) In order for a provider to receive or potentially qualify for reimbursement for a specific item for its cost reporting period, the provider's cost report, whether determined on an as submitted, as amended, or as adjusted basis (as prescribed in paragraph (j)(3) of this section), must include an appropriate claim for the specific item, by either—
>
> (i) Claiming full reimbursement in the provider's cost report for the specific item in accordance with Medicare policy, if the provider seeks payment for the item that it believes comports with program policy; or
>
> (ii) Self-disallowing the specific item in the provider's cost report, if the provider seeks payment that it believes may not be allowable or may not comport with Medicare policy (for example, if the provider believes the contractor lacks the authority or discretion to award the reimbursement the provider seeks for the item), by following the procedures (set forth in paragraph (j)(2) of this section) for properly self-disallowing the specific item in the provider's cost report as a protested amount.
>
> (2) Self-disallowance procedures. In order to properly self-disallow a specific item, the provider must—
>
> (i) Include an estimated reimbursement amount for each specific self-disallowed item in the protested amount line (or lines) of the provider's cost report; and
>
> (ii) Attach a separate work sheet to the provider's cost report for each specific self-disallowed item, explaining why the provider self-disallowed each specific item (instead of claiming full reimbursement in its cost report for the specific item) and describing how the provider calculated the estimated reimbursement amount for each specific self-disallowed item.

In conjunction with the regulation above, 42 C.F.R. § 405.1873(a) states:

> (a) *General*. In order to receive or potentially receive reimbursement for a specific item, the provider must include in its cost report an appropriate claim for the specific item (as prescribed in § 413.24(j) of this chapter). **If** the provider files an appeal to the Board seeking reimbursement for the specific item and **any party** to such appeal **questions whether the provider's cost report included an appropriate claim for the specific item**, the Board must address such question in accordance with the procedures set forth in this section. (Emphasis added)

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

The Board interprets the regulation at 42 C.F.R. § 405.1873 to only require the Board to review a provider's "compliance"[63] 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.[64] In these group cases, the Medicare Contractor has failed to file a Substantive Claim Challenge[65] within the time frame specified by Board Rule 44.5.1 (2023) for any of the Providers with FYEs beginning on or after December 31, 2016.

As such, since no party to the appeal has questioned, pursuant to § 405.1873(a), whether an appropriate claim was made,[66] the Board finds there was no regulatory obligation for the Board to affirmatively, on its own, review the appeal documents to determine whether an appropriate claim was made. As a result, Board review under 42 C.F.R. § 405.1873(b) has not been triggered. Accordingly, the Board need not include any findings regarding compliance with the

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[63] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."
[64] *See* 42 C.F.R. § 405.1873(a).
[65] Board Rule 44.5 states: "The Board adoption of the term 'Substantive Claim Challenge' simply refers to any question raised by a party concerning whether the cost report at issue included an appropriate claim for one or more of the specific items being appealed in order to receive or potentially qualify for reimbursement for those specific items."
[66] 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."

substantive claim requirements and may proceed to rule on the EJR request pursuant to 42 C.F.R. § 405.1873(d).

C. Jurisdictional Challenges:

Jurisdictional challenges were filed by the Medicare Contractor in cases 18-1627G and 21-0059G arguing that the issue presented was a duplicate of other group cases.[67] The Medicare Contractor argues that the issue statements in the two groups both argue that the numerator of the SSI Fraction does not contain all Dual Eligible days, including exhausted benefit days.[68] The Providers disagree, noting that the instant cases are strictly related to "CMS's improper statutory interpretation of 'entitled to' benefits" while the other cases are appealing "CMS's failure to fix technical data-matching errors."[69]

The Board finds that the cases cited above are not duplicative, rather they deal with two different issues. The SSI data match issue is a technical issue which alleges that there are still errors that exist with CMS' revised matching process developed in response to *Baystate* and therefore does not properly capture all SSI eligible individuals. The SSI Dual Eligible Days issue is rooted in the legal arguments related to CMS' interpretation of the DSH statute, particularly the Medicare fraction, and CMS' policy decisions in which CMS interprets the term "entitlement" to Medicare Part A broadly while very narrowly interpreting the term with respect to SSI benefits and the failure to use the 77 Payment status codes. These are distinct issues and the cases cited by the Medicare Contractor are not duplicative of the instant cases. Therefore, the Board ***denies*** the Medicare Contractor's Jurisdictional Challenges in Case Nos. 18-1627G and 21-0059G.

D. Analysis Regarding 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.[70] 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.[71] Contemporaneous with CMS Ruling 1498-R[72] the Secretary published a proposed IPPS rule[73] which proposed to adopt the same data match for 2011 and forward. This proposed rule was adopted as the 2011 Final IPPS Rule in which the Secretary explained that:

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[67] The challenges argued that case 18-1627G was a duplicate of 18-1629G, and that case 21-0059G was a duplicate of 21-0058G.
[68] *E.g.,* Case 21-0059G, Medicare Administrative Contractor's Jurisdictional Challenge, 4 (Aug. 18, 2021).
[69] *E.g.*, Case 21-0059G, Providers' Response to ASC's Jurisdictional Challenge, 1 (Sept. 17, 2021).
[70] CMS Ruling 1498-R at 27.
[71] *Id.* at 31.
[72] *Id.* at 5.
[73] 75 Fed. Reg. 23,852, 24,002-07.

> . . . we 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.[74]

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[75]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.[76]

The Secretary did not incorporate the above new policy involving the revised data match process into the Code of Federal Regulations. 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 to be a binding but uncodified regulation and will refer to the above policy as the "Uncodified SSI Data Match Regulation." Indeed, this finding is consistent with the Secretary's obligations under 42 U.S.C.

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[74] 75 Fed. Reg. at 50,277.
[75] (Medicare) Enrollment Database.
[76] 75 Fed. Reg. at 50,285.

§ 1395hh(a)(2) to promulgate any "substantive legal standard governing . . . the payment of services" as a regulation."[77]

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 Data Match Regulation the published in the FY 2011 Final Rule and the Board does not have the authority to grant the relief sought by the Providers, namely invalidating the Uncodified SSI Data Match Regulation which they allege fails to include all of the PSC codes used by SSA to determine SSI eligibility. As a result, the Board finds that EJR is appropriate for the issue for the calendar years under appeal in these cases.

VI. 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 participants in these group appeals are entitled to a hearing before the Board,

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

3) based upon the participants' assertions regarding FY 2011 Final IPPS Rule there are no findings of fact for resolution by the Board;

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

5) it is without authority to decide the legal question of whether the FY 2011 Final IPPS Rule is valid.

Accordingly, the Board finds that the question of the validity of the 2011 Final IPPS Rule properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for EJR (except as noted above) for the issue and the subject years. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute, the Board hereby closes these cases.

[77] 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 for services . . . shall take effect unless it is promulgated by the Secretary by regulation . . . ."

Board Members Participating:

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

FOR THE BOARD:

3/18/2025

X Kevin D. Smith, CPA

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

Enclosures: Schedules of Providers

cc: Pamela VanArsdale, National Government Services, Inc. (J-6)
Byron Lamprecht, WPS Government Health Administrators (J-5) (J-8)
Judith Cummings, CGS Administrators (J-15)
Dean Wolfe, Noridian Healthcare Solutions (J-F)
Cecile Huggins, Palmetto GBA (J-J)
Danelle Deker, National Government Services, Inc. (J-K)
Wilson Leong, FSS

Appendix A
(21 Hall Render Dual Eligible Cases)

PRRB Case Number	PRRB Case: Case Name
23-0998GC	*Truman Med Ctr CYs 2018- 2019 DSH Dual Eligible Days CIRP Group*
22-1356G	*Hall Render CY 2017 DSH Dual Eligible Days III Group*
18-1627GC	*Ascension Health CY 2016 DSH SSI Fraction Dual Eligible Days CIRP CIRP Group*
23-0984GC	*Franciscan Alliance CY 2018 DSH Dual Eligible Days CIRP Group*
23-0750GC	*Beacon Health CY 2016 and 2018 DSH Dual Eligible Days CIRP Group*
23-0286G	*Hall Render CY 2019 DSH SSI Dual Eligible Days Group*
22-1365GC	*Community Healthcare CY 2018 DSH Dual Eligible Days CIRP Group*
22-1268G	*Hall Render CY 2018 DSH Dual Eligible Days Group*
22-0615GC	*Community Health Network CY 2017 DSH Dual Eligible Days CIRP Group*
21-1412GC	*IU Health CY 2017 DSH SSI Dual Eligible Days CIRP Group*
21-1300GC	*IU Health CY 2016 DSH SSI Dual Eligible Days CIRP Group*
20-2008GC	*McLaren Health CY 2017 DSH SSI Fraction Dual Eligible Days CIRP Group*
23-0409GC	*St. Elizabeth Healthcare CY 2019 DSH Dual Eligible Days CIRP Group*
22-1440GC	*Premier Health Partners CY 2018 DSH Dual Eligible Days CIRP Group*
21-1500G	*Hall Render CY 2017 DSH SSI Fraction Dual Eligible Days Group*
20-1642GC	*St. Elizabeth Healthcare CY 2017 DSH SSI Dual Eligible Days CIRP Group*
23-1403GC	*PeaceHealth CY 2018 DSH SSI Fraction Dual Eligible Days CIRP Group*
21-0585GC	*SCL Health CY 2016 DSH SSI Dual Eligible Days CIRP Group*
21-0059G	*Hall Render CY 2016 DSH SSI Dual Eligible Days Group*
23-1054GC	*Medisys Health CY 2018 DSH Dual Eligible Days CIRP Group*
21-1796GC	*Medisys Health CY 2017 DSH SSI Dual Eligible Days CIRP Group*

DEPARTMENT OF HEALTH & HUMAN SERVICES

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410-786-2671

Via Electronic Delivery

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

RE: **Notice of Dismissal**
Trinity Hospital of Augusta (Provider Number 11-0039)
FYE: 06/30/2010
Case Number: 25-2027

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the above-captioned individual appeal and finds that the Representation Letter submitted on behalf of the provider organization is deficient. The pertinent facts and the Board's decision to dismiss the appeal is set forth below.

Background:

On February 6, 2025, QRS filed an individual appeal on behalf of Trinity Hospital of Augusta (Prov. No. 11-0039), which operates under the parent organization Quorum Health Corporation ("Quorum Health"). The Representation Letter uploaded with the appeal is dated February 5, 2025, appoints Quality Reimbursement Services, Inc. ("QRS") as the designated representative of Quorum Health Corporation and includes a listing of providers under the Quorum Health umbrella.

The Representation Letter submitted in Case No. 25-2027 does not authorize QRS to be the designated representative of Trinity Hospital of Augusta. The listing of Quorum Health providers does not include Trinity Hospital of Augusta or its associated provider number.

Board Determination:

With respect to Letters of Representation, Board Rules 5.1 and 5.4 read:[1]

> **5.1 Persons**
> A party may be represented by legal counsel or by any other person appointed to act as its case representative at any proceedings before the Board. All actions

[1] Board Rules 5.1 and 5.4 (effective December 15, 2023). Emphasis added

taken by the case representative are considered to be those of the provider and notice of any action or decision sent to the case representative has the same effect as if it had been sent to the provider itself.

The case representative is the individual with whom the Board maintains contact. The case representative may be an external party (e.g., attorney or consultant) or an internal party (e.g., employee or officer of the provider or its parent organization), but there may be only one case representative per appeal (see Rule 4.6 prohibiting duplicate appeals). ***The Board will not accept an appeal or other correspondence from any external organization that is not the case representative's organization.***

5.4 Representation letter

A representation letter is required whether designating an external or internal case representative. If the provider is not commonly owned or controlled when the representation letter is being executed, then the letter designating the case representative must be on the provider's letterhead and be ***signed by an authorizing official of the provider organization***. If the provider is commonly owned or controlled when the representation letter is being executed, then the letter designating the case representative must be on letterhead that identifies the parent corporation (whether it's the provider's letterhead or the parent corporation's letterhead) and must be signed by an authorizing official of the provider or parent organization.

In addition, ***the representation letter must reflect the provider's name, number, and fiscal year under appeal.*** The letter must not be issue specific unless it is for participation in a group appeal in which there is only one issue permitted to be raised. Finally, the representation letter must contain the following contact information regarding the case representative:

- name,
- organization,
- address,
- telephone number, and
- email address.

The Representation Letter submitted ***does not include or mention Trinity Health of Augusta***. The Board finds, as a result, that QRS has not provided a representation letter from anyone at the Provider who is authorized to designate a case representative on behalf of the hospital.

42 C.F.R. § 405.1868 states that:

> (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.[2]

Therefore, as QRS was not authorized to file Case No. 25-2027, the appeal is hereby dismissed and removed from the Board's docket.

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

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

For the Board:

3/19/2025

X Kevin D. Smith, CPA

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

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services
Cecille Huggins, Palmetto GBA (J-J)
Heather Mangeot, Quorum Health

[2] Emphasis added.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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410-786-2671

Via Electronic Delivery

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

Re: ***Dismissal for Failure to Meet Minimum Filing Requirements & Failure to Timely Cure Defect After Board Request***

QRS CY 1991 Medicare Fraction (SSI) - Statutory & Systemic Errors Group
Case Number: 25-1955G

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the above-referenced group appeal request. After review of the facts outlined below, the Board has determined that the appeal request is fatally flawed as it was not filed in accordance with the regulations and Board Rules. The Pertinent Facts, and the Board's Review and Determination are set forth below.

Pertinent Facts:

On **February 5, 2025**, Quality Reimbursement Services, Inc. ("QRS") filed an optional group appeal for the 1991 Medicare Fraction (SSI) - Statutory & Systemic Errors issue with the Board under Case No. 25-1955G. The appeal was filed with a single provider that filed from an "Other" determination - the CMS Manual SSI Publication dated August 13, 2024.[1]

When it filed the group, QRS uploaded an Appointment of Designated Representative letter ("Representative letter") rather than the required Issue Support. Board Rule 7.2 indicates that an Issue Statement must include: An issue title and a concise issue statement describing: the relevant adjustment(s), including the adjustment number(s); the controlling authority (e.g., specific regulation, Federal Register issuance, manual provision, or Ruling); why the adjustment(s) is incorrect; how the payment should be determined differently; the reimbursement effect, and the basis for jurisdiction. The Representative letter does not meet these criteria and therefore, does not qualify as an Issue Statement.[2]

[1] Between February 7, 2025 and February 14, 2025, seven additional providers were directly added to the group.
[2] Board Rules Version 3.2 (Dec 15, 2023)

Further direction regarding the filing of a group issue statement in the Office of Hearing Case & Document Management System ("OH CDMS") is specified in Section 3.2.2.1.2 of the OH CDMS User Manual, where it directs the user to (1.) Identify a brief Issue Title and (2.) Select the Upload button to attach the Issue Statement.[3]

On **February 12, 2025**, the Board issued an Acknowledgement and Critical Due Dates Notice ("ACDD") in which it set a briefing schedule for the Parties to file preliminary position papers and requested an Issue Statement. The ACDD stated that ". . . [t]he Issue Statement as submitted is insufficient pursuant to the Board's rules. It is noted the Representation Letter was uploaded for the Issue Statement document. Please submit an Issue Statement in accordance with Board Rule 7 and Board Rule 8." The deadline for the required Issue Support was set for **February 19, 2025**.

Rules/Regulations:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the 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.

42 C.F.R. § 405.1837(c)(2) establishes the required contents for a group appeal which must include:

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

Finally, Board Rule 41.2 permits the Board to dismiss a case (or an issue) on its own motion ". . . upon failure of the provider or group to comply with Board procedures or filing deadlines (*see* 42 C.F.R. § 405.1868)."

[3] PRRB External User Manual (Aug. 22, 2018)

Board Determination:

The Board has determined that the Providers' appeal request is fatally flawed as it was not filed in accordance with the regulations at 42 C.FR. § 405.1837(c)(2) and Board Rules.

First, the Board finds that the document QRS uploaded and described as an "Issue Statement" is merely another copy of the Representative Letter for the originating provider in the group – Community Memorial Hospital of San Buenaventura. This document does not constitute an issue statement consistent with the appeal content requirements in Board Rule 7.2 and 42 C.F.R. § 405.1837(c)(2). Board Rule 7.2 requires, among other things, that an issue statement include an issue title and a concise statement describing any relevant adjustment numbers, the controlling authority, why the adjustment is incorrect, how the payment should be determined differently and the basis for the Board's jurisdiction.

Second, the Board finds that QRS was afforded an opportunity to cure the noted deficiency but failed to respond to the Board's request as detailed in the February 12, 2025 ACDD notification. Accordingly, the Board hereby dismisses Case No. 25-1955G since the appeal request is fatally flawed and does not meet the *minimum* filing requirements as outlined above and based on QRS' failure to respond by the deadline.

Based on the above, the Board closes this case and removes it from its docket. Review of this determination may be available under the provisions of 42 U.S.C. §1395oo(f) and 42 C.F.R. §§ 405.1875 and 105.1877.

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

For the Board:

3/20/2025

X Kevin D. Smith, CPA

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

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

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Via Electronic Delivery

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

RE: **Notice of Dismissal**
Affinity Medical Center (Provider Number 36-0151)
Case Numbers: 25-2003, 25-2005, & 25-2006

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the above-captioned individual appeals and finds that the Representation Letter submitted on behalf of the provider organization in all three appeals is deficient. The pertinent facts and the Board's decision to dismiss the appeals is set forth below.

Background:

On February 6, 2025, Quality Reimbursement Services ("QRS") filed three individual appeals on behalf of Affinity Medical Center (Prov. No. 36-0151), which operates under the parent organization Quorum Health Corporation ("Quorum Health"). The Representation Letter uploaded with the appeal is dated February 5, 2025, and appoints QRS as the designated representative of Quorum Health and includes a listing of providers under the Quorum Health umbrella.

The Representation Letter submitted in each of the above-captioned appeals does not authorize QRS to be the designated representative of Affinity Medical Center. The listing of Quorum Health providers ***does not*** include Affinity Medical Center or its associated provider number.

Board Determination:

With respect to Letters of Representation, Board Rules 5.1 and 5.4 read:[1]

> **5.1 Persons**
> A party may be represented by legal counsel or by any other person appointed to act as its case representative at any proceedings before the Board. All actions taken by the case representative are considered to be those of the provider and

[1] Board Rules 5.1 and 5.4 (effective December 15, 2023). Emphasis added

notice of any action or decision sent to the case representative has the same effect as if it had been sent to the provider itself.

The case representative is the individual with whom the Board maintains contact. The case representative may be an external party (e.g., attorney or consultant) or an internal party (e.g., employee or officer of the provider or its parent organization), but there may be only one case representative per appeal (see Rule 4.6 prohibiting duplicate appeals). ***The Board will not accept an appeal or other correspondence from any external organization that is not the case representative's organization.***

5.4 Representation letter

A representation letter is required whether designating an external or internal case representative. If the provider is not commonly owned or controlled when the representation letter is being executed, then the letter designating the case representative must be on the provider's letterhead and be ***signed by an authorizing official of the provider organization***. If the provider is commonly owned or controlled when the representation letter is being executed, then the letter designating the case representative must be on letterhead that identifies the parent corporation (whether it's the provider's letterhead or the parent corporation's letterhead) and must be signed by an authorizing official of the provider or parent organization.

In addition, ***the representation letter must reflect the provider's name, number, and fiscal year under appeal.*** The letter must not be issue specific unless it is for participation in a group appeal in which there is only one issue permitted to be raised. Finally, the representation letter must contain the following contact information regarding the case representative:

- name,
- organization,
- address,
- telephone number, and
- email address.

The Representation Letter ***does not include or mention Affinity Medical Center***. The Board finds, as a result, that QRS has not provided a representation letter from anyone at the Provider who is authorized to designate a case representative on behalf of the hospital.

42 C.F.R. § 405.1868 states that:

> (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.[2]

Therefore, as QRS was not authorized to file Case Nos. 25-2003, 25-2005, and 25-2006, the three (3) appeals are hereby dismissed and removed from the Board's docket.

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

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

For the Board:

3/20/2025

X Kevin D. Smith, CPA

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

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services
Judith Cummings, CGS Administrators (J-15)
Heather Mangeot, Quorum Health

[2] Emphasis added.

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Via Electronic Delivery

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Arcadia, CA 91006

RE: ***Board Determination on Pending CIRP Groups Without Participants***

Houston Methodist CY 2008 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group, Case Number: 25-2168GC

Houston Methodist CY 2009 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group, Case Number: 25-2170GC

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("the Board") has reviewed the subject common issue related party ("CIRP") group appeals and notes that they were not properly filed. The pertinent facts and the Board's determination are set forth below.

Pertinent Facts:

On **February 7, 2025**, Quality Reimbursement Services, Inc. ("QRS") filed the above referenced CIRP groups on behalf of Houston Methodist Hospital System ("Houston Methodist") Health for calendar years ("CYs") 2008 and 2009, each appealing the Medicare Fraction (SSI) – Statutory & Systemic Errors issue. Both of the group appeals were formed in the Office of Hearings Case & Document Management System ("OH CDMS") without any participants.

On **February 27, 2025**, the Medicare Contractor filed its Rule 15.2 Review letters, in which it advised the Board that the two CIRP groups had been formed in OH CDMS without any participants and that the groups had still not been brought into compliance with Board Rule 12.6 since no participants have been transferred or added.

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.

42 C.F.R. § 405.1837(b)(1) discusses the use of Mandatory groups and states:

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

42 C.F.R. § 405.1837(b)(3) provides the details for initiating a group appeal and indicates:

> 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….

Regarding the establishment of groups in OH CDMS, the commentary under Board Rule 12.1 indicates:

> . . . if a group is to be formed solely through transfers, it **may initially** be established in OH CDMS **with no participating providers. In such cases, the providers must be transferred i*mmediately* following the establishment of the group case** in order to fulfill the regulatory requirement for the minimum number of providers per Rule 12.6. **The Board will close all group cases that do not meet the minimum participant requirements**.[1,2]

Board Rule 12.6.1, goes on to state that "[a] CIRP group **may be initiated by a single provider under common ownership or control**, but at least two different providers must be in the group upon full formation. (See Rule 19.)"[3]

The Board finds that the subject group appeals, under Case Nos. 25-2168GC and 25-2170GC are CIRP groups that were formed without any providers. Further, there have been no additions or transfers to the groups in more than forty ("40") days since their formation. Because the CIRP groups were not filed in compliance with Board Rules or the regulations, the Board hereby dismisses Case Nos. 25-2168GC and 25-2170GC.[4] Review of this

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[1] Board Rules v, 3.2 (Dec. 15, 2023).
[2] Bold emphasis added.
[3] Bold emphasis added.
[4] Should QRS identify a Houston Methodist participant appealing this issue for either of the referenced CYs, it may form a new CIRP group by either effectuating a transfer or by including a CIRP provider when the group is formed if it is still within the filing deadline (i.e., Direct Add from receipt of the final determination).

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

Finally, the Board notes that QRS has filed many group appeals, both CIRP and optional, over the years. It is also noted that QRS is not new to using OH CDMS, which became mandatory for all filings as of November 2021. The improper formation of these "provider-less" CIRP groups appear to be an attempt by QRS to create a "holding spot" for the future addition or transfer of related providers pursuing the Medicare Fraction (SSI) - Statutory & Systemic Errors issue. Although the Commentary at Board Rule 12.1 does permit a "shell" to be formed in OH CDMS, it is only on a limited basis - for the sole purpose of allowing the ***transfer*** of issues from pending individual appeals. QRS' formation of these CIRP groups, where there have been no transfers effectuated in over 40 days, violates the intent of the Board's rules and creates an unnecessary administrative burden on the Board and its staff (***i.e.***, having to formally dismiss the CIRP group.) The Board admonishes QRS for again failing to follow Board Rules governing the formation of a group.[5] The Representative is on notice that if this type of filing violation continues, the Board may prohibit the Representative from re-filing perfected CIRP groups for the same issue/CYs in future cases.

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

For the Board:

3/20/2025

X Kevin D. Smith, CPA

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

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services
Michael Redmond, Novitas Solutions, Inc. c/o GuideWell Source (J-H)

[5] In January and March of this year, the Board dismissed two other QRS CIRP groups under Case No. 25-1169GC and Case No. 25-1011GC, for the same reason.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

Re: ***Dismissal for Failure to Meet Minimum Filing Requirements & Failure to Timely Cure Defect After Board Request***

Ballad Health CY 2004 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group, Case Number: 25-2763GC

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the above-referenced group appeal request. After review of the facts outlined below, the Board has determined that the appeal request is fatally flawed as it was not filed in accordance with the regulations and Board Rules. The Pertinent Facts and the Board's Review and Determination are set forth below.

Pertinent Facts:

On **February 14, 2025**, Quality Reimbursement Services, Inc. ("QRS") filed a common issue related party ("CIRP") group appeal for the 2004 Medicare Fraction (SSI) - Statutory & Systemic Errors issue with the Board under Case No. 25-2763GC. The appeal was filed with fourteen providers that filed from an "Other" determination - the CMS Manual SSI Publication dated August 13, 2024.

When it filed the group, QRS uploaded an Appointment of Designated Representative letter ("Representative letter") rather than the required Issue Support. Board Rule 7.2 indicates that an Issue Statement must include: An issue title and a concise issue statement describing: the relevant adjustment(s), including the adjustment number(s); the controlling authority (e.g., specific regulation, Federal Register issuance, manual provision, or Ruling); why the adjustment(s) is incorrect; how the payment should be determined differently; the reimbursement effect, and the basis for jurisdiction. The Representative letter does not meet these criteria and therefore, does not qualify as an Issue Statement.[1]

Further direction regarding the filing of a group issue statement in the Office of Hearing Case & Document Management System ("OH CDMS") is specified in Section 3.2.2.1.2

[1] Board Rules Version 3.2 (Dec 15, 2023)

of the OH CDMS User Manual, where it directs the user to (1.) Identify a brief Issue Title and (2.) Select the Upload button to attach the Issue Statement.[2]

On **February 21, 2025**, the Board issued an Acknowledgement and Critical Due Dates Notice ("ACDD") in which it set a briefing schedule for the Parties to file preliminary position papers and requested an Issue Statement. The ACDD stated that "The Issue Statement uploaded for the group is a copy of the Appointment of Designated Representative letter. You must submit a copy of the Group Issue Statement in accordance with Rules 7.2 and 8 by the deadline." The deadline for the required Issue support was set for **March 7, 2025**.

The ACDD also noted that the Appointment of Representative letter for two of the group participants, Lee Regional Medical Center (Prov. No. 49-0012) and Mountain View Regional MC Norton (Prov. No. 49-0027), did not include the calendar year ("CY") under appeal in the group, CY 2004. Instead, it authorized the Representative for CYs 2008 through 2021). The notice indicated that an updated Representative letter for these two providers was required and was to be filed using the Group Supplement button by the same **March 7, 2025** deadline.

Rules/Regulations:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the 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.

42 C.F.R. § 405.1837(c)(2) establishes the required contents for a group appeal which must include:

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

[2] PRRB External User Manual (Aug. 22, 2018)

> and why the provider self-disallowed the item instead of claiming reimbursement for the item.

Finally, Board Rule 41.2 permits the Board to dismiss a case (or an issue) on its own motion ". . . upon failure of the provider or group to comply with Board procedures or filing deadlines (*see* 42 C.F.R. § 405.1868)."

Board Determination:

The Board has determined that the Providers' appeal request is fatally flawed as it was not filed in accordance with the regulations at 42 C.FR. § 405.1837(c)(2) and Board Rules.

First, the Board finds that the document QRS uploaded and described as an "Issue Statement" is merely another copy of the Representative letter for the parent organization, Ballad Health. This document does not constitute an issue statement consistent with the appeal content requirements in Board Rule 7.2 and 42 C.F.R. § 405.1837(c)(2). Board Rule 7.2 requires, among other things, that an issue statement include an issue title and a concise statement describing any relevant adjustment numbers, the controlling authority, why the adjustment is incorrect, how the payment should be determined differently and the basis for the Board's jurisdiction.

Second, the Board finds that QRS was afforded an opportunity to cure the noted deficiencies but failed to respond to either of the Board's requests as detailed in the February 21, 2025 ACDD notification. Accordingly, the Board hereby dismisses Case No. 25-2763GC since the appeal request is fatally flawed and does not meet the *minimum* filing requirements as outlined above and based on QRS' failure to respond by the deadline.

Based on the above, the Board closes this case and removes it from its docket. Review of this determination may be available under the provisions of 42 U.S.C. §1395oo(f) and 42 C.F.R. §§ 405.1875 and 105.1877.

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

For the Board:

3/20/2025

X Kevin D. Smith, CPA

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

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services
Cecile Huggins, Palmetto GBA (J-J)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

Re: ***Dismissal for Failure to Meet Minimum Filing Requirements & Failure to Timely Cure Defect After Board Request***

Ballad Health CY 2001 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group, Case Number: 25-2845GC

Dear Mr. Ravindran:

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

Pertinent Facts:

On **February 14, 2025**, Quality Reimbursement Services, Inc. ("QRS") filed a common issue related party ("CIRP") group appeal for the 2001 Medicare Fraction (SSI) - Statutory & Systemic Errors issue with the Board under Case No. 25-2845GC. The appeal was filed with thirteen providers that filed from an "Other" determination - the CMS Manual SSI Publication dated August 13, 2024.

When it filed the group, QRS uploaded a copy of the Calculation Support for the participants in the group rather than the required Issue Support. Board Rule 7.2 indicates that an Issue Statement must include: "An issue title and a concise issue statement describing: the relevant adjustment(s), including the adjustment number(s); the controlling authority (e.g., specific regulation, Federal Register issuance, manual provision, or Ruling); why the adjustment(s) is incorrect; how the payment should be determined differently; the reimbursement effect, and the basis for jurisdiction." The Calculation Support does not meet this criteria and therefore, does not qualify as an Issue Statement.[1]

Further direction regarding the filing of a group issue statement in the Office of Hearing Case & Document Management System ("OH CDMS") is specified in Section 3.2.2.1.2

[1] Board Rules Version 3.2 (Dec 15, 2023)

of the OH CDMS User Manual, where it directs the user to (1.) Identify a brief Issue Title and (2.) Select the Upload button to attach the Issue Statement.[2]

On **February 21, 2025**, the Board issued an Acknowledgement and Critical Due Dates Notice ("ACDD") in which it set a briefing schedule for the Parties to file preliminary position papers and requested an Issue Statement. The ACDD stated that "Instead of the Group Issue Statement, the Representative uploaded a copy of the calculation support for participants in the group. You must submit a group issue statement in accordance with Board Rules 7.2 and 8 by the deadline." The deadline for the required Issue support was set for **March 7, 2025**.

The ACDD also noted that the Appointment of Representative letter for two of the group participants, Lee Regional Medical Center (Prov. No. 49-0012) and Mountain View Regional MC Norton (Prov. No. 49-0027), did not include the calendar year ("CY") under appeal in the group, CY 2001. Instead, it authorized the Representative for CYs 2008 through 2021). The notice indicated that an updated Representative letter for these two providers was required and was to be filed using the Group Supplement button by the same **March 7, 2025** deadline.

Rules/Regulations:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the 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.

42 C.F.R. § 405.1837(c)(2) establishes the required contents for a group appeal which must include:

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

[2] PRRB External User Manual (Aug. 22, 2018)

> and why the provider self-disallowed the item instead of claiming reimbursement for the item.

Finally, Board Rule 41.2 permits the Board to dismiss a case (or an issue) on its own motion ". . . upon failure of the provider or group to comply with Board procedures or filing deadlines (*see* 42 C.F.R. § 405.1868)."

Board Determination:

The Board has determined that the Providers' appeal request is fatally flawed as it was not filed in accordance with the regulations at 42 C.FR. § 405.1837(c)(2) and Board Rules.

First, the Board finds that the document QRS uploaded and described as an "Issue Statement" is merely another copy of the Calculation Support for the group participants. This document does not constitute an issue statement consistent with the appeal content requirements in Board Rule 7.2 and 42 C.F.R. § 405.1837(c)(2). Board Rule 7.2 requires, among other things, that an issue statement include an issue title and a concise statement describing any relevant adjustment numbers, the controlling authority, why the adjustment is incorrect, how the payment should be determined differently and the basis for the Board's jurisdiction.

Second, the Board finds that QRS was afforded an opportunity to cure the noted deficiencies but failed to respond to either of the Board's requests as detailed in the February 21, 2025 ACDD notification. Accordingly, the Board hereby dismisses Case No. 25-2845GC since the appeal request is fatally flawed and does not meet the *minimum* filing requirements as outlined above and based on QRS' failure to respond by the deadline.

Based on the above, the Board closes this case and removes it from its docket. Review of this determination may be available under the provisions of 42 U.S.C. §1395oo(f) and 42 C.F.R. §§ 405.1875 and 105.1877.

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

For the Board:

3/20/2025

X Kevin D. Smith, CPA

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

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services
Cecile Huggins, Palmetto GBA (J-J)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Ms. Kelly Carroll
Partner
Hooper, Lundy & Bookman, P.C.
401 9th St., NW, Suite 550
Washington, DC 20004

RE: **Determination re: Filing of Appeal**
Valdese General Hospital Inc. (34-0055)
Appealed Period: FYE 09/30/1997
PRRB Case No.: 25-3857

Dear Ms. Carroll:

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

BACKGROUND:

On March 17, 2025, Hooper, Lundy & Bookman ("HLB"), on behalf of the above referenced Provider, filed an appeal request for the Fiscal Year End ("FYE") 09/30/1997. The jurisdictional documentation filed for the appeal indicate that the appeal is based on a Revised Notice of Program Reimbursement ("RNPR") dated August 16, 2024. The appeal request identified two (2) issues in dispute:

Medicare DSH – Additional SSI Eligible Days
Medicare DSH – SSI Days Matching Errors

As set forth below, the appeal was untimely filed since it was filed on the 213th day passed the final determination date of August 16, 2024.

RULES/REGULATIONS:

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

Board Rule 4.4.1. states: **Due Dates for New Appeals** New appeals must be received by the Board *no later than 180 days* from the commencement of the appeal period as specified in Rule

4.3. See Rule 2.1.4 for instructions on requesting an extension under 42 C.F.R. § 405.1836 "due to extraordinary circumstance beyond [the party's] control."

Board Rule 4.4.3 states: **Due Date Exceptions** If the due date falls on a Saturday, a Sunday, a federal legal holiday, (as enumerated in Rule 6(a) of the Federal Rules of Civil Procedure), or a day on which the Board is unable to conduct business in the usual manner (e.g., "if OH CDMS were down for the entire last day of a deadline" (85 Fed. Reg. 58432, 58987 (Sept. 18, 2020))), the deadline becomes the next day that is not one of the aforementioned days. See 42 C.F.R. § 405.1801(d)(3).

Board Rule 4.5 states: **Date of Receipt by the Board** The timeliness of a filing is determined based on the date of receipt by the Board. The date of receipt is presumed to be: A. The date of filing in OH CDMS as evidenced by the Confirmation of Correspondence generated by the system; or B. If the filing is permitted pursuant to an exemption under Rule 2.1.2, the date of receipt is: • The date of delivery to the Board as evidenced by the courier's tracking bill for documents transmitted by a nationally recognized next-day courier. It is the responsibility of the provider to maintain a record of the delivery. See 42 C.F.R. § 405.1801(a)(2)(i). • The date stamped "received" by the Board on documents submitted by regular mail, hand delivery, or couriers not recognized as a national next-day courier. This provision also applies if the party is unable to supply the next-day courier's tracking bill as noted above. See 42 C.F.R. § 405.1801(a)(2)(ii).

Per PRRB Rule 6.1, the Board will dismiss appeal requests that do not meet the minimum filing requirements as identified in 42 C.F.R. § 405.1835(b).

BOARD DETERMINATION:

As noted in the facts above, the final determination support documentation states that the subject appeal is based on a Revised NPR dated August 16, 2024. Allowing for the 180-day appeal period and a five-day presumption for mailing, the 185th day fell on Monday, February 17, 2025. The date of delivery for the subject appeal, as evidenced by the Confirmation of Correspondence generated by OH CDMS, is March 17, 2025. The appeal was filed 28 days past the 185th day deadline of February 17, 2025 and 213 days past the final determination date of August 16, 2024 and was, therefore, untimely filed.

As a result, the Board hereby dismisses case number 25-3857 in its entirety since it failed to meet the minimum filing requirements pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 and Board Rules 4.4.1, 4.4.3 and 4.4.5.

Review of this determination may be available under the provisions of 42 U.S.C. §1395oo(f) and 42 C.F.R. §§ 405.1875 and 105.1877.

Board Members:

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

FOR THE BOARD:

3/21/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Ms. Kelly Carroll
Partner
Hooper, Lundy & Bookman, P.C.
401 9th St., NW, Suite 550
Washington, DC 20004

RE: **Determination re: Filing of Appeal**
Valdese General Hospital Inc. (34-0055)
Appealed Period: FYE 09/30/1996
PRRB Case No.: 25-3856

Dear Ms. Carroll:

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

BACKGROUND:

On March 17, 2025, Hooper, Lundy & Bookman ("HLB"), on behalf of the above referenced Provider, filed an appeal request for the Fiscal Year End ("FYE") 09/30/1996. The jurisdictional documentation filed for the appeal indicate that the appeal is based on a Revised Notice of Program Reimbursement ("RNPR") dated August 16, 2024. The appeal request identified two (2) issues in dispute:

Medicare DSH – Additional SSI Eligible Days
Medicare DSH – SSI Days Matching Errors

As set forth below, the appeal was untimely filed since it was filed on the 213th day past the final determination date of August 16, 2024.

RULES/REGULATIONS:

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

Board Rule 4.4.1. states: **Due Dates for New Appeals** New appeals must be received by the Board *no later than 180 days* from the commencement of the appeal period as specified in Rule 4.3. See Rule 2.1.4 for instructions on requesting an extension under 42 C.F.R. § 405.1836 "due to extraordinary circumstance beyond [the party's] control."

Board Rule 4.4.3 states: **Due Date Exceptions** If the due date falls on a Saturday, a Sunday, a federal legal holiday, (as enumerated in Rule 6(a) of the Federal Rules of Civil Procedure), or a day on which the Board is unable to conduct business in the usual manner (e.g., "if OH CDMS were down for the entire last day of a deadline" (85 Fed. Reg. 58432, 58987 (Sept. 18, 2020))), the deadline becomes the next day that is not one of the aforementioned days. See 42 C.F.R. § 405.1801(d)(3).

Board Rule 4.5 states: **Date of Receipt by the Board** The timeliness of a filing is determined based on the date of receipt by the Board. The date of receipt is presumed to be: A. The date of filing in OH CDMS as evidenced by the Confirmation of Correspondence generated by the system; or B. If the filing is permitted pursuant to an exemption under Rule 2.1.2, the date of receipt is: • The date of delivery to the Board as evidenced by the courier's tracking bill for documents transmitted by a nationally recognized next-day courier. It is the responsibility of the provider to maintain a record of the delivery. See 42 C.F.R. § 405.1801(a)(2)(i). • The date stamped "received" by the Board on documents submitted by regular mail, hand delivery, or couriers not recognized as a national next-day courier. This provision also applies if the party is unable to supply the next-day courier's tracking bill as noted above. See 42 C.F.R. § 405.1801(a)(2)(ii).

Per PRRB Rule 6.1, the Board will dismiss appeal requests that do not meet the minimum filing requirements as identified in 42 C.F.R. § 405.1835(b). (Emphasis added.)

BOARD DETERMINATION:

As noted in the facts above, the final determination support documentation states that the subject appeal is based on a Revised NPR dated August 16, 2024. Allowing for the 180-day appeal period and a five-day presumption for mailing, the 185th day fell on Monday, February 17, 2025. The date of delivery for the subject appeal, as evidenced by the Confirmation of Correspondence generated by OH CDMS, is March 17, 2025. The appeal was filed 28 days past the 185th day deadline of February 17, 2025 and 213 days past the final determination date of August 16, 2024 and was, therefore, untimely filed.

As a result, the Board hereby dismisses case number 25-3856 in its entirety since it failed to meet the minimum filing requirements pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 and Board Rules 4.4.1, 4.4.3 and 4.4.5. Review of this determination may be available under the provisions of 42 U.S.C. §1395oo(f) and 42 C.F.R. §§ 405.1875 and 105.1877.

Board Members:

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

FOR THE BOARD:

3/24/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Ms. Jessica Heilig
Support Specialist
RubinBrown LLP
3150 Owen Road
Fenton, MI 48430

RE: **Determination re: Timely Filing of Appeal**
Hill Regional Hospital (Provider Number 45-0192)
Appealed Period: FYE 08/21/2019
Case Number: 25-1944

Dear Ms. Heilig:

The above-captioned appeal was filed with the Provider Reimbursement Review Board ("Board") via the Office of Hearings Case and Document Management System ("OH CDMS"). After review of the facts outlined below, the Board has determined that the subject appeal has not met the jurisdictional requirements pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840.

BACKGROUND:

On February 5, 2025, the Provider filed an appeal for its Fiscal Year End ("FYE") 8/29/2019. The proceedings for the appeal indicate that the Provider is filing the appeal based on a Volume Decrease Adjustment ("VDA") Denial dated April 9, 2024. The Board's data management system indicated that the appeal was filed on the 302nd day after the final determination date of April 9, 2024.

RULES/REGULATIONS:

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

Board Rule 4.4.1. states: **Due Dates for New Appeals** New appeals must be received by the Board *no later than 180 days* from the commencement of the appeal period as specified in Rule 4.3. See Rule 2.1.4 for instructions on requesting an extension under 42 C.F.R. § 405.1836 "due to extraordinary circumstance beyond [the party's] control."

Board Rule 4.4.3 states: **Due Date Exceptions** If the due date falls on a Saturday, a Sunday, a federal legal holiday, (as enumerated in Rule 6(a) of the Federal Rules of Civil Procedure), or a day on which the Board is unable to conduct business in the usual manner (e.g., "if OH CDMS were down for the entire last day of a deadline" (85 Fed. Reg. 58432, 58987 (Sept. 18, 2020))), the deadline becomes the next day that is not one of the aforementioned days. See 42 C.F.R. § 405.1801(d)(3).

Board Rule 4.5 states: **Date of Receipt by the Board** The timeliness of a filing is determined based on the date of receipt by the Board. The date of receipt is presumed to be: A. The date of filing in OH CDMS as evidenced by the Confirmation of Correspondence generated by the system; or B. If the filing is permitted pursuant to an exemption under Rule 2.1.2, the date of receipt is: • The date of delivery to the Board as evidenced by the courier's tracking bill for documents transmitted by a nationally recognized next-day courier. It is the responsibility of the provider to maintain a record of the delivery. See 42 C.F.R. § 405.1801(a)(2)(i). • The date stamped "received" by the Board on documents submitted by regular mail, hand delivery, or couriers not recognized as a national next-day courier. This provision also applies if the party is unable to supply the next-day courier's tracking bill as noted above. See 42 C.F.R. § 405.1801(a)(2)(ii).

Per PRRB Rule 6.1, the Board will dismiss appeal requests that do not meet the minimum filing requirements as identified in 42 C.F.R. § 405.1835(b).

BOARD REVIEW/DETERMINATION:

After review, it is noted that the final determination filed with the initial appeal request is dated April 9, 2024. Allowing for the 180-day appeal period and a five-day presumption for mailing, 185 days from April 9, 2024 was Friday, October 11, 2024. The date of delivery for the subject appeal, as evidenced by the Confirmation of Correspondence generated by OH CDMS, is February 5, 2025; 302 days from the date the Medicare Contractor ("MAC") issued the VDA Adjustment Denial.[1]

On March 11, 2025**,** the Provider filed a copy of the August 13, 2024 determination as an "Individual Supplement." As evidenced by the Confirmation of Correspondence, that document was received on March 11, 2025. (The time frame from the date of the final determination, August 13, 2024, to the date it was filed on OH CDMS, March 11, 2025 is 210 days, which still makes the appeal untimely filed.) Upon review, the August 13, 2024 denial states:

> **This denial was based on the following reason(s):**
> **There was no new information submitted with the reconsideration request that changes the determination that the request was not received timely. As stated previously, the request was received in our office on March 7, 2024, which is not within 180 days of the Notice of Amount of Program Reimbursement dated May 31, 2023. Therefore, in accordance with 42 CFR 412.92(e) this request is denied as it was not submitted timely.**

[1] It is noted, however, that in the Letter of Representation and the second paragraph of the Issue Statement, the Provider Representative stated that the MAC issued a second final determination dated August 13, 2024. If the August 13, 2024 final determination had been filed with the initial appeal request on February 5, 2025, it would have been timely filed within the 185-day allowable timeframe.

42 C.F.R. § 405.1835(b) states:

> ***Contents of request for a Board hearing on final contractor determination.*** The provider's request for a Board hearing under paragraph (a) of this section must be submitted in writing in the manner prescribed by the Board, and the request must include the elements described in paragraphs (b)(1) through (4) of this section. **If the provider submits a hearing request that does not meet the requirements of paragraph (b)(1), (2), or (3) of this section, the Board may dismiss with prejudice the appeal or take any other remedial action it considers appropriate.**

42 C.F.R. § 405.1835(b)(3) states:

> A copy of the final contractor or Secretary determination under appeal and any other documentary evidence the provider considers necessary to satisfy the hearing request requirements of paragraphs (b)(1) and (b)(2) of this section.

The Board has determined, in the past, that including the *actual determination* being appealed with the appeal request is critical for a myriad of reasons, including to determine whether the Provider met the claim filing requirements specified in 42 C.F.R. § 405.1835.

As a result, the Board hereby dismisses the subject appeal for late filing from the April 9, 2024 determination that was initially uploaded as the final determination since it was not filed within the 185 day timeframe. In addition, the Board finds that the August 13, 2024 determination that was subsequently filed as an Individual Supplement on the 210th day was also untimely. The second determination did not update or CHANGE the denial but instead stated there was nothing new to consider. Therefore, even if the Provider had filed timely from the second letter dated August 13, 2024, there was not a "new determination" to appeal, as the MAC didn't consider anything different in that denial.

Both final determinations failed to meet the requirements in accordance with 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 and Board Rules 4.4.1, 4.4.3 and 4.4.5. As a result, the Board hereby dismisses case number 25-1944 in its entirety and removes it from the Board's docket.

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

Board Members:

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

FOR THE BOARD:

3/25/2025

X Kevin D. Smith, CPA

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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410-786-2671

Via Electronic Delivery

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

Re: ***Dismissal for Failure to Meet Minimum Filing Requirements & Failure to Timely Cure Defect After Board Request***

Hartford Health CY 2010 Medicare Fraction (SSI) - Statutory & Systemic Errors
CIRP Group, Case Number: 25-2467GC

Dear Mr. Ravindran:

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

Pertinent Facts:

On **February 10, 2025**, Quality Reimbursement Services, Inc. ("QRS") filed a common issue related party ("CIRP") group appeal for the 2010 Medicare Fraction (SSI) - Statutory & Systemic Errors issue on behalf of Hartford Health under Case No. 25-2467GC. The appeal was filed with one provider that filed from an "Other" determination - the CMS Manual SSI Publication dated August 13, 2024. When it filed the group, QRS uploaded a copy of Hartford Health's Calculation Support rather than the required copy of the final determination under appeal.

On **February 14, 2025**, the Board issued an Acknowledgement and Critical Due Dates Notice ("ACDD") in which it set a briefing schedule for the Parties to file preliminary position papers and requested an Issue Statement. The ACDD stated that "The final determination support uploaded for the initiating provider in this group, Hartford Hospital (Prov. No. 07-0025), was a copy of the calculation support. Submit a copy of the final determination under appeal for Prov. No. 07-0025 using the Group Supplement button by the deadline or the group appeal will be dismissed." The deadline for the required copy of the final determination support was set for **February 21, 2025**.

Rules/Regulations:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the 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.

Group appeal requirements are set forth at 42 C.F.R. § 405.1837, which states that providers pursuing a group appeal must satisfy ". . . individually the requirements for Board hearing under § 405.1835(a). . ., except for the $10,000 amount in controversy requirement."

Relatedly, 42 C.F.R. § 405.1835(b)(3) specifies the contents of a request for Board hearing and requires that the Provider file "[a] copy of the final contractor or Secretary determination under appeal and any other documentary evidence the provider considers necessary to satisfy the hearing request requirements . . . ". Including the actual determination with the appeal request is critical for a myriad of reasons, including to determine whether the Provider meets the claim filing requirements.

Finally, 42 C.F.R. § 405.1837(c)(3) requires that a group appeal must include:

> A copy of each final contractor or Secretary determination under appeal, and any other documentary evidence the providers consider to satisfy the hearing request requirements of paragraphs (c)(1) and (c)(2) of this section, and a precise description of the one question of fact or interpretation of law, regulations, or CMS Rulings that is common to the particular matter at issue in the group appeal.

Board Rule 41.2 permits the Board to dismiss a case (or an issue) on its own motion ". . . upon failure of the provider . . . to comply with Board procedures or filing deadlines (*see* 42 C.F.R. § 405.1868)."

Board Determination:

Upon review, the Board finds that the subject group appeal request is fatally flawed as it was not filed in accordance with the regulations at 42 C.FR. § 405.1837(c)(3).

First, the Board finds that the document QRS uploaded and described as the "Final Determination Document" is merely another copy of the Calculation Support for Hartford Hospital (the sole participant in the group). This document does not constitute a final determination consistent with the appeal content requirements in 42 C.F.R. § 405.1837(c)(3).

Second, the Board finds that QRS was afforded an opportunity to cure the noted deficiency but failed to respond to the Board's request as detailed in the February 14, 2025 ACDD notification. Accordingly, the Board hereby dismisses Case No. 25-2467GC since the appeal request is fatally flawed and does not meet the *minimum* filing requirements as outlined above AND based on QRS' failure to respond by the deadline.

Based on the above, the Board closes this case and removes it from its docket. Review of this determination may be available under the provisions of 42 U.S.C. §1395oo(f) and 42 C.F.R. §§ 405.1875 and 105.1877.

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

For the Board:

3/25/2025

X Kevin D. Smith, CPA

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

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

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Via Electronic Delivery

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

Re: ***Dismissal for Failure to Meet Minimum Filing Requirements & Failure to Timely Cure Defect After Board Request***

Barnes Jewish Hospital (Provider Number 26-0032)
FYE: 12/31/2013
Case Number: 25-1589

Dear Mr. Ravindran:

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

Pertinent Facts:

On **January 22, 2025**, Quality Reimbursement Services, Inc. ("QRS") filed an individual appeal on behalf Barnes Jewish Hospital (Prov. No. 26-0032) for its calendar year ("CY") 2013. The appeal was filed from a July 26, 2024 CMS Manual - SSI Publication. When it filed the appeal, QRS uploaded a copy of a Representation Letter for a different provider: Boone Hospital Center (Prov. No. 26-0068) for its CYs 1988 through 2024.

On **March 14, 2025**, the Board issued an Acknowledgement and Critical Due Dates Notice ("ACDD") in which it set a briefing schedule for the Parties to file preliminary position papers and requested a correct Representation Letter. The ACDD noted that "the Letter of Representation filed with the subject individual appeal request involves a different Provider than the subject Provider and is, therefore, insufficient. Please resubmit the Letter of Representation pursuant to Board Rule 5.4. Per Board Rule 5.1, the Board will not accept an appeal or other correspondence from any external organization that is not the case representative's organization." The deadline for the corrected copy of the Representation Letter was set for **March 21, 2025**.

Rules/Regulations:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the 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.

42 C.F.R. § 405.1883 addresses the authority of a representative & states in pertinent part: A representative appointed by a provider . . . may accept or give on behalf of the provider or other party any request or notice relative to any proceeding before a hearing officer or the Board. A representative shall be entitled to present evidence and allegations as to facts & law in any proceeding affecting the party."

Based on its authority under 42 C.F.R. § 405.1868(a), the Board issued rules to implement § 405.1883. Specifically, Board Rule 5.1 stipulates that "[t]he Board will not accept an appeal or other correspondence from any external organization that is not the case representative's organization."

Board Rule 6.5 discusses Certifications for Individual Appeals: This rule requires that the Representative certify that:

- none of issues in the appeal are pending in any other appeal for same period and provider, nor have they been adjudicated, withdrawn, or dismissed from any other PRRB appeal.
- there are no other [related providers] that have a pending request for a Board hearing on any of the same issues for a cost reporting period that ends in the same year covered in [the appeal].
- [they] have read and [are] familiar with Board statutes, regulations, and rules . . . and [that] the appeal [was] filed in full compliance AND
- ***[that it is] authorized to submit an appeal on behalf of the listed provider***.

Finally, Board Rule 41.2 permits the Board to dismiss a case (or an issue) on its own motion "upon failure of the provider . . . to comply with Board procedures or filing deadlines (*see* 42 C.F.R. § 405.1868)."

Board Determination:

Upon review, the Board finds that the subject individual appeal request is fatally flawed as it was not filed in accordance with the regulations at 42 C.FR. § 405.1883.

When filing an individual appeal for a provider or directly adding a provider to a group, the representative must certify that it is authorized to make the filing on behalf of the provider and include a copy of the representation letter evidencing that authorization.[1] Requiring a representation letter to be properly executed for the fiscal year at issue

[1] *See* Board Rules 5, 6.1.1, 6.5, Model Form A, Model Form E.

protects providers and health chains from potentially coercive or abusive representation situations, whether in the context of an individual or group appeal.

The Board finds that QRS filed a Representation Letter that related to a different provider other than the one for which it filed the appeal. Therefore, the Board finds that QRS did not have authorization to file on behalf of Barnes Jewish Hospital (Prov. No. 26-0032) and that QRS falsely "certif[ied] that I am authorized to submit an appeal of behalf of the listed provider."

The Board also finds that QRS was afforded an opportunity to cure the noted deficiency but failed to respond to the Board's request as detailed in the March 14, 2025 ACDD notification. Accordingly, the Board hereby dismisses Case No. 25-1589 since the appeal request is fatally flawed and does not meet the *minimum* filing requirements as outlined above AND based on QRS' failure to respond by the deadline.

Based on the above, the Board closes this case and removes it from its docket. Review of this determination may be available under the provisions of 42 U.S.C. §1395oo(f) and 42 C.F.R. §§ 405.1875 and 105.1877.

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

For the Board:

3/27/2025

X Kevin D. Smith, CPA

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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

Re: ***Dismissal for Failure to Meet Minimum Filing Requirements & Failure to Timely Cure Defect After Board Request***

Baptist Health System CY 2011 Medicare Fraction (SSI) - Statutory & Systemic Errors GCE CIRP Group, Case Number: 25-3125GC

Dear Mr. Ravindran:

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

Pertinent Facts:

On **February 21, 2025**, Quality Reimbursement Services, Inc. ("QRS") filed a common issue related party ("CIRP") group appeal for the 2011 Medicare Fraction (SSI) - Statutory & Systemic Errors issue on behalf of Baptist Health System with the Board under Case No. 25-3125GC. The appeal was filed with three providers that filed from an "Other" determination - the CMS Manual SSI Publication dated August 13, 2024. When it filed the group, QRS uploaded a copy of the CMS Manual SSI Publication (which is the final determination under appeal) rather than the required Group Issue Support.

On **March 7, 2025**, the Board issued an Acknowledgement and Critical Due Dates Notice ("ACDD") in which it set a briefing schedule for the Parties to file preliminary position papers and requested an Issue Statement. The ACDD stated that "the Final Determination document was filed in lieu of an Issue Statement. An Issue Statement must include: An issue title and a concise issue statement describing: the relevant adjustment(s), including the adjustment number(s); the controlling authority (e.g., specific regulation, Federal Register issuance, manual provision, or Ruling); why the adjustment(s) is incorrect; how the payment should be determined differently; the reimbursement effect, and the basis for jurisdiction." The deadline for the required Issue support was set for **March 21, 2025**.

Rules/Regulations:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the 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.

42 C.F.R. § 405.1837(c)(2) establishes the required contents for a group appeal which must include:

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

Board Rule 7.2 provides the criteria for an Issue Statement and states the Issue Statement must include: An issue title and a concise issue statement describing: the relevant adjustment(s), including the adjustment number(s); the controlling authority (*e.g.*, specific regulation, Federal Register issuance, manual provision, or Ruling); why the adjustment(s) is incorrect; how the payment should be determined differently; the reimbursement effect, and the basis for jurisdiction before the Board.[1]

Further direction regarding the filing of a group issue statement in the Office of Hearing Case & Document Management System ("OH CDMS") is specified in Section 3.2.2.1.2 of the OH CDMS User Manual, where it directs the user to (1.) Identify a brief Issue Title and (2.) Select the Upload button to attach the Issue Statement.[2]

Finally, Board Rule 41.2 permits the Board to dismiss a case (or an issue) on its own motion "upon failure of the provider . . . to comply with Board procedures or filing deadlines (*see* 42 C.F.R. § 405.1868)."

[1] Board Rules Version 3.2 (Dec 15, 2023)
[2] PRRB External User Manual (Aug. 22, 2018)

Board Determination:

The Board has determined that the Providers' appeal request is fatally flawed as it was not filed in accordance with the regulations at 42 C.F.R. § 405.1837(c)(2) and Board Rules.

First, the Board finds that the document QRS uploaded and described as an "Issue Statement" is merely another copy of the final determination under appeal in the group. This document does not constitute an issue statement consistent with the appeal content requirements in Board Rule 7.2 and 42 C.F.R. § 405.1837(c)(2). Board Rule 7.2 requires, among other things, that an issue statement include an issue title and a concise statement describing any relevant adjustment numbers, the controlling authority, why the adjustment is incorrect, how the payment should be determined differently and the basis for the Board's jurisdiction.

Second, the Board finds that QRS was afforded an opportunity to cure the noted deficiency but failed to respond to the Board's request as detailed in the March 7, 2025 ACDD notification. Accordingly, the Board hereby dismisses Case No. 25-3125GC since the appeal request is fatally flawed and does not meet the *minimum* filing requirements as outlined above and based on QRS' failure to respond by the deadline.

Based on the above, the Board closes this case and removes it from its docket. Review of this determination may be available under the provisions of 42 U.S.C. §1395oo(f) and 42 C.F.R. §§ 405.1875 and 105.1877.

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

For the Board:

3/27/2025

X Kevin D. Smith, CPA

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

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services
Geoff Pike, First Coast Service Options, Inc. c/o GuideWell Source (J-N)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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

RE: ***Notice of Dismissal***
Tomball Regional Medical Center, Prov. No. 45-0670, FYE 06/30/2015
Case No. 19-1377

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 19-1377. Set forth below is the decision of the Board to dismiss the 2 remaining issues in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") for SSI Percentage (Provider Specific) and Medicaid Eligible Days.

Background

A. *Procedural History for Case No. 19-1377*

On **August 13, 2018**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end June 30, 2015.

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

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

On **March 12, 2019**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

[1] On September 24, 2019, this issue was transferred to PRRB Case No. 18-0552GC.
[2] On September 24, 2019, this issue was transferred to PRRB Case No. 18-0555GC.
[3] On September 24, 2019, this issue was transferred to PRRB Case No. 18-0554GC.

> Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the Provider will use to support its position* and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. *See* Board Rule 25.[4]

The Provider is commonly owned/controlled by Community Health Systems (hereinafter "CHS") and, thereby, is subject to the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1). For that reason, on **September 24, 2019**, the Provider transferred Issues 2, 4, and 5 to CHS groups.

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

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

---

[4] (Emphasis added).
[5] Provider's Preliminary Position Paper at 8-9 (Oct. 2, 2019).

The following is the Provider's ***complete*** position on Issue 3 set forth therein:

> Specifically, the Provider disagrees with the MAC's calculation 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…
>
> CMS 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 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 2015 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.[6]

On **January 8, 2020**, the Medicare Contractor filed a jurisdictional challenge, requesting the dismissal of Issue 1. The Provider filed a timely response to the jurisdictional challenge on **February 4, 2020**.

On **February 24, 2020**, the Medicare Contractor filed its preliminary position paper.

On **July 5, 2024**, the Board issued a Notice of Hearing and Critical Due Dates, providing among other things, the filing deadlines for the parties' final position papers. This Notice also gave the following instructions to the Provider regarding the content of its final position paper:

---

[6] Provider's Preliminary Position Paper at 7-8 (Oct. 2, 2019).

> Provider's Final Position Paper – *For each remaining issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the Provider will use to support its position* and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. *See* Board Rule 27 for more specific content requirements.[7]

On **January 13, 2025**, the Provider timely filed its final position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Calculation of the SSI Percentage**
>
> 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)(S)(F)(i). The Provider contends that the SSI percentage calculated by [CMS] and used by the MAC to settle their Cost Report was incorrectly computed because of the following reasons:
>
> **Issue #1: Provider Specific**
>
> The Provider contends that its SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation.
>
> The Provider is seeking a *full and complete* set of the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. *See* 65 Fed. Reg. 50,548 (2000). Although some MEDPAR data is now routinely made available to the provider community, what is provided lacks all data records necessary to fully identify all patients properly includable in the SSI fraction. The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction. The [Provider] hereby incorporates all of the

[7] (Emphasis added).

> arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra (Appellants' reply brief included as Exhibit P-3).[8]

The following is the Provider's ***complete*** position on Issue 3 set forth therein:

> Specifically, the Provider disagrees with the MAC's calculation 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…
>
> CMS 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 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.
>
> Under section 1886(d)(5)(F)(vi)(II) of the Social Security Act (42 U.S.C. § 1395ww(d)(5)(F)(vi)(ii) and 42 C.F.R. § 412.106(b)(4)(1), Medicaid eligible days (***including section 1115 waiver days, which are paid under the authority of section 1115 of the Social Security Act and regarded and treated as Medicaid eligible days***) are to be included in the numerator of the Provider's Medicaid Fraction of the disproportionate patient percentage. The issue is whether the Medicare Administrative Contractor (MAC) included in the Provider's Medicaid Fraction of the disproportionate patient percentage all Medicaid eligible days (***including section 1115 waiver days***).

[8] Provider's Final Position Paper at 8-9 (Jan. 13, 2025).

> Based on the Listing of Medicaid Eligible days being sent under separate cover directly to the MAC, including Section 1115 waiver days, the Provider contends that the total number of days reflected in its 2015 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.
>
> With respect to section 1115 waiver days, the courts have firmly rejected CMS's interpretation of its regulations, holding instead that the plain language of the statute and the regulations require inclusion in the Medicaid Fraction of the days belonging to individuals who are included in a section 1115 demonstration project. *See Forrest General Hospital*, 926 F.3d 221 (5th Cir. 2019); *HealthAlliance Hospitals, Inc. v. Azar*, 346 F. Supp. 3d 43 (D.D.C. 2018); *Bethesda Health Inc., v. Azar*, 389 F. Supp. 3d 32, (D.D.C. 2019), *aff'd,* 980 F.3d 121 (D.C. Cir. 2020). CMS has acquiesced in *Bethesda* and is now following the statute and the plain meaning of its own regulations (which regulations represent the official policy of CMS all along) and properly accounting for 1115 Waiver days as Medicaid Eligible days. *See* CMS Manual Instructions System, Change Request 12669, Transmittal No. 11912 (March 16, 2023) ("Transmittal 11912").[9]

On **February 6, 2025**, the Medicare Contractor timely filed its final position paper.

On **February 7, 2025**, the Medicare Contractor filed a jurisdictional challenge, requesting the dismissal of Issue 3. The Provider filed a timely response to the jurisdictional challenge on **February 24, 2025**.

On **February 11, 2025**, the Provider requested a Change of Representative to Quality Reimbursement Services, Inc

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

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

> The Provider contends that the MAC did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § l395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the MAC's calculation of the computation of the

[9] Provider's Final Position Paper at 9-10 (Jan. 13, 2025) (emphasis added).

> DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations.
>
> 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 contends that the SSI percentage issued by CMS is flawed.
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395(d)(5)(F)(i).
>
> The Provider also contends that CMS inconsistently interprets the term "entitled" as it 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.[10]

The group issue statement in Case No. 18-0552GC, QRS CHS CY 2015 DSH SSI Percenatge CIRP Group, to which the Provider transferred Issue 2 reads, in part:

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

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

> 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 [CMS] and used by the MAC to settle their Cost Report were incorrectly computed.
>
> The Provider(s) also contend(s) that CMS inconsistently interprets the term "entitled" as it is used in the statute. CMS requires SSI payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the denominator. CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days of care) as Medicare Part A days, yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment.
>
> The Provider(s) further contend(s) that the SSI percentages calculated by CMS fail to address all the deficiencies as described in *Baystate Medical Center v. Michael O. Leavitt*, 544 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.[11]

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $55,000.

C. Description of Issue 3 in the Appeal Request

[11] Group Issue Statement at 1 (Jan. 18, 2018).

In its Individual Appeal Request, the Provider summarizes its DSH Payment – Medicaid Eligible Days issue as follows:

> 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)(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.[12]

The Provider estimated the reimbursement impact of the issue at $52,167 based on an increase of 100 additional Medicaid days but failed to include a list of the additional days.[13]

MAC's Jurisdictional Challenges

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

The Medicare Contractor notes that according to the Provider's appeal request, Issue 1 has three components: 1) SSI data accuracy; 2) realignment; and 3) individuals who are eligible for SSI but did not receive SSI payment.[14]

The Medicare Contractor contends that the first and third sub-issues should be dismissed because they are duplicative of Issue 2 which was transferred to Group Case No. 18-0552GC, QRS CHS CY 2015 DSH SSI Percentage CIRP Group. This means that the Provider is appealing an issue from a single final determination in more than one appeal, which is prohibited by Board Rule 4.6.1.[15]

The Medicare Contractor asserts that the Board does not have jurisdiction over the SSI realignment component. To date the Provider has not formally requested to have its SSI percentage realigned in accordance with 42 C.F.R. 412.106(b)(3). There was no final determination over SSI realignment and the appeal is premature as the Provider has not exhausted all available remedies for this issue.[16]

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[12] Issue Statement at 3 (Feb. 5, 2019).
[13] Issue Statement at 3 (Feb. 5, 2019).
[14] Medicare Contractor's jurisdictional challenge at 3 (Jan. 8, 2020).
[15] *Id.* at 3 and 6.
[16] *Id.* at 7.

Issue 3 – DSH Payment – Medicaid Eligible Days

The Medicare Contractor contends that this issue should be dismissed because the Provider failed to complete preliminary or final position papers 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.

The Medicare Contractor notes that a Medicaid eligible days listing was never received with the Provider's preliminary position paper. The Medicare Contractor further notes that the Provider failed to submit either a redacted or unredacted listing of additional Medicaid eligible days with its final position paper.[17]

The Medicare Contractor contends that the Provider was in violation of Board Rules 25.3 and 27.2 when it failed to sufficiently develop and set forth the relevant facts and arguments regarding the merits of its claim in its preliminary and final 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. The Provider has not submitted accurate and sufficient data to demonstrate that patients were eligible for Medicaid on the claimed patient hospital days or identified as to why the data is not yet available or when it will become available. [18]

Additionally, the Medicare Contractor argues this issue should be dismissed because the Provider is attempting to untimely and improperly add the issue of Section 1115 waiver days as a sub-issue via its final position paper filed on January 13, 2025. The Medicare Contractor issued the Provider's NPR on August 13, 2018. In accordance with 42 C.F.R. § 415.1835(e), the deadline for adding issues to the appeal was April 10, 2019. The issue was informally added through the Provider's final position paper, more than five years after the filing deadline to add an issue.[19]

The Medicare Contactor contends that the Section 1115 Waiver Days issue is one component of the DSH issue that must be appealed as a separate issue. The Medicare Contractor notes that Board Rule 8 explains that one issue can have multiple components. Within Board Rule 8, some of the disproportionate share hospital (DSH) components are identified. Specifically, the Board identifies Section 1115 waiver days as a distinct DSH component that the Provider must appeal separately.[20]

Provider's Jurisdictional Responses

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

[17] Medicare Contractor's Jurisdictional Challenge at 2 and 6 (Feb. 7, 2025).
[18] Medicare Contractor's jurisdictional challenge at 6 and 8 (Feb. 7, 2025).
[19] Medicare Contractor's jurisdictional challenge at 10 (Feb. 7, 2025).
[20] Medicare Contractor's jurisdictional challenge at 11 (Feb. 7, 2025).

The Provider contends that the Medicare Contractor is incorrect when it states that the SSI Percentage (Provider Specific) issue is duplicative of the SSI Percentage (Systemic Errors) issue that was transferred to a group appeal. 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. 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 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 previously been identified in the *Baystate* litigation. Once these patients are identified, the Provider contends it will be entitled to a correction of these errors of omission to its SSI percentage. The DSH/SSI percentage was adjusted on the Provider's cost report. Therefore, the Board should find jurisdiction over the SSI provider specific issue in the instant appeal.[21]

Issue 3 – DSH Payment – Medicaid Eligible Days

The Provider argues that the phrasing of its issue statement with respect to the Medicaid Eligible Days issue makes clear that the Provider appealed all Medicaid eligible days, including section 1115 waiver days. By definition, section 1115 waiver days are Medicaid eligible days. Whereas the Medicare Contractor states that the Section 1115 Waiver Days issue is one component of the DSH issue, the regulations at 42 C.F.R. § 405.1835 contain requirements for appealing an "issue" and a time limit on adding an "issue" – not on clarifying "sub-issues" or "components" of an issue. Both a June 25, 2004 proposed rule (69 *Fed. Reg.* 35716) and a May 23, 2008 final rule (73 *Fed. Reg.* 30190) indicate that an "issue" is encapsulated by a specific cost report adjustment. They do not slice and dice an "issue" into component parts, including the specific reason why Medicaid eligible days were not counted in the numerator of the Medicaid Fraction of the Disproportionate Payment Percentage. There is no dispute that the same cost report adjustment that affects other types of Medicaid eligible days also affects section 1115 waiver days.[22]

The Provider goes on to contend that the version of Board Rule 8 (July 1, 2015) that it alleges was effective when the Provider filed its appeal, makes no mention of "section 115 waiver days" nor even "Medicaid eligible days." Thus, even if Rule 8's extension to "components of issues" were valid (and the Provider contends it is not), the Provider had no notice that it was required to specify section 1115 waiver days in its appeal request, and it would be a denial of due process for the PRRB to dismiss the section 1115 waiver days component of its appeal of Medicaid eligible
days.[23]

[21] Provider's Jurisdictional Response at 2 (Feb. 4, 2020).
[22] Provider's Jurisdictional Response at 1-2 (Feb. 24, 2025).
[23] Provider's Jurisdictional Response at 2-3 (Feb. 24, 2025).

Finally, the Provider contends that prior to submission of the Provider's Final Position Paper, the Fifth Circuit ruled that the statute and CMS's own regulations require that CMS regard inpatient days attributable to an uncompensated care pool population as Medicaid eligible days, *Forrest General Hospital v. Azar*, 926 F.3d 221 (5th Cir. 2019). The Medicare Contractor is required by specific command of CMS to accept and audit the Provider's section 1115 waiver days in providers' Medicaid Fractions. Following a string of litigation defeats, including those in *Forrest General Hospital* and *Bethesda Health, Inc. v. Azar*, 980 F.3d 121 (D.C. Cir.2020), CMS issued Change Request 12669, Transmittal No. 11912 (March 16, 2023). The Provider asserts that under this Transmittal, the Medicare Contractor has the duty to accept the Provider's listing of section 1115 days and audit them. The Provider states that it submitted an unredacted listing to the Medicare Contractor on February 24, 2025.[24]

Decision of the Board

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

As set forth below, the Board hereby ***dismisses*** the Provider's two (2) remaining issues.

A. DSH Payment/SSI Percentage (Provider Specific)

The jurisdictional analysis for Issue 1 has several relevant aspects to consider: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period; and 3) the Provider incorporating the arguments from *Advocate Christ*[25] into its appeal. As set forth below, the Board dismisses all aspects of Issue 1.

1. *First Aspect of Issue 1*

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH SSI Percentage (Systemic Errors) issue that was appealed in PRRB Case No. 18-0552GC.

The DSH Payment/SSI Percentage (Provider Specific) issue in the present appeal concerns "whether the Medicare Administrative Contractor used the correct Supplemental Security

[24] Provider's jurisdictional response at 3-4 (Feb 24, 2025).
[25] The Provider has included the Appellants' Reply Brief in *Advocate Christ Med. Ctr. v. Becerra*, No. 22-5214 (D.C. Cir.), which is on appeal from the decision in *Advocate Christ Med. Ctr. V. Azar*, 17-cv-1519 (TSC), 2022 WL 2064830, (D.D.C. June 8, 2022).

Income percentage in the Disproportionate Share Hospital calculation."[26] The Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[27] 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."[28]

The Provider's DSH SSI Percentage (Systemic Errors) issue in group Case No. 18-0552GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds the DSH Payment/SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH SSI Percentage (Systemic Errors) in Case No. 18-0552GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6.1,[29] the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

The Board has previously noted that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and the Provider has failed to explain how this argument is ***specific to this provider***. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[30] Accordingly, Provider's reference to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, Provider has failed to sufficiently distinguish (by sufficient explanation or evidence) how the alleged "provider specific" errors averred in Issue 1 are distinguished from the alleged "systemic" issues argued in Issue 2, and why those alleged "provider specific" errors should not be subsumed into the "systemic errors" issue appealed in Case No. 18-0552GC.

To this end, the Board also reviewed the Provider's Preliminary and Final Position Papers to see if they further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 18-0552GC but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider's Preliminary and Final Position Papers failed to comply with the Board Rules 25 and 27 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

[26] Issue Statement at 1.
[27] Issue Statement at 1.
[28] Issue Statement at 1.
[29] PRRB Rules v. 3.2 (Dec. 2023).
[30] The types of systemic errors documented in *Baystate* did not uniformly impact the SSI calculation for all providers but that does not make the errors any less systemic. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). *See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).

is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 and explain the nature of the any alleged "errors" in its Preliminary or Final Position Papers and include *all* exhibits.

Moreover, the Board finds that 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.[31]

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

> https://www.cms.gov/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh.[32]

[31] (Emphasis added).
[32] Last accessed March 24, 2025.

This CMS webpage describes access to DSH data ***from 1998 to 2022*** and instructs providers to send a request via email to access their DSH data."[33]

Indeed, the D.C. Circuit affirmed in *Advocate Christ Med. Ctr. v. Becerra*, 80 F.4th 346 (D.C. Cir. 2023) that "What [MMA] section 951 cannot mean is that HHS must give hospitals data that it never received from SSA in the first place. And SSA does not provide HHS with the specific codes assigned to individual patients. See 75 Fed. Reg. at 50,276." Here, the Provider does not explain what information it needs or is waiting on or claims that it should have access to or why this is not a common issue already covered by the CIRP group under Case No. 18-0552GC.

Accordingly, the Board finds that the issue in the instant appeal and the group issue from Group Case 18-0552GC are the same issue.[34] Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6.1, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

Additionally, in its Final Position Paper, the Provider states, "The [Provider] hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra [sic] (Appellants' reply brief included as Exhibit P-3)." The Board finds that this incorporation by reference does not comply with the regulatory and Board rule requirements to *fully* develop the Provider's position in the position papers. Particularly, 42 C.F.R. § 405.1853 provides 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*.[35]

An incorporation of arguments by reference from a different case simply fails to do so. Accordingly, the Board dismisses that portion of the issue as well.

2. *Second Aspect of Issue 1*

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

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[33] Emphasis added.
[34] Moreover, even if it were not a prohibited duplicate, it was not properly in the individual appeal because it is a common issue that would be required to be in a CHS CIRP group per 42 C.F.R. § 405.1837(b)(1).
[35] (Emphasis added).

Under 42 C.F.R. § 412.106(b)(3), the applicable regulation for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." Moreover, without this written request, the Medicare Contractor cannot issue a final determination with which the Provider can be dissatisfied for Board appeal purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding DSH SSI Percentage *realignment*. Therefore, in accordance with 42 C.F.R. § 405.1835(a)(1), the Board dismisses this aspect of the appeal.

B. DSH Payment – Medicaid Eligible Days

1. *Section 1115 Waiver Days*

The Board finds that the section 1115 Waiver days issue is not a part of this appeal as it was not properly or timely added. The Provider failed to include section 1115 Waiver days as a cost issue in its appeal request and failed to timely and properly add this additional issue to the appeal. While the Provider appealed Medicaid eligible days, this issue is separate and distinct from the section 1115 Waiver days.

The appeal was filed with the Board in February of 2019 and the regulations required the following:

> (b) *Contents of request for a Board hearing on final contractor determination.* The provider's request for a Board hearing…must be submitted in writing to the Board, and the request must include…
>
> (2) For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final…determination under appeal, including an account of…
>
> (i) why the provider believes Medicare payment is incorrect for each disputed item...[and]
>
> (ii) how and why the provider believes Medicare payment must be determined differently for each disputed item…[36]

Board Rule 7.2.1 (2018) elaborated on this regulatory requirement instructing providers:

> The following information and supporting document must be submitted for each issue raised in the appeal request.

[36] 42 C.F.R. § 405.1835(b).

- An issue title and a concise issue statement describing:
  - the adjustment, including the adjustment number,
  - the controlling authority,
  - why the adjustment is incorrect,
  - how the payment should be determined differently,
  - the reimbursement effect, and
  - the basis for jurisdiction before the Board.[37]

Board Rule 8 (2018) explains that when framing issues for adjustments involving multiple components, that providers must specifically identify each item in dispute, and "…each contested component must be appealed as a separate issue and described as narrowly as possible…". The Rule goes on:

> Several examples are identified below, but these examples are not exhaustive lists of categories or issues.
>
> **A. Disproportionate Share Hospital Payments**
>
> Common examples include, but are not limited to:
>
> …
>
> - ***Section 1115 waiver days (program/waiver specific)***[38]

Effective August 21, 2008, following the appropriate notice and comment period, new Board regulations went into effect that limited the addition of issues to appeals.[39] 42 C.F.R. § 405.1835(e) provides in relevant part:

> (c) *Adding issues to the hearing request*. After filing a hearing request… a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the Board, only if –
>
> . . .
>
> (2) The Board receives the provider's request to add issues no later than 60 days after the expiration of the applicable 180–day period prescribed in paragraph (a)(3) or paragraph (c)(2) of this section.

In practice this means that new issues had to be added to this case no later than 240 days after receipt of the contractor's determination. However, there is no evidence in the record to indicate

[37] v. 2.0 (Aug. 2018).
[38] (Bold and italic emphasis added).
[39] *See* 73 Fed. Reg. 30190 (May 23, 2008).

the Provider added the section 1115 Waiver days to the case properly or timely.

In this regard, the Board notes that section 1115 Waiver days are not traditional Medicaid eligible days and indeed were only incorporated into the DSH calculation effective January 20, 2000.[40] Rather, they relate to Medicaid expansion program(s) and are only includable in the DSH adjustment calculation if they meet the requirements in 42 C.F.R. § 412.106(b)(4) relating to section 1115 Waiver days. Indeed, not every state Medicaid program has a qualifying 1115 expansion program ***and*** not every inpatient day associated with beneficiary enrolled in an 1115 waiver program qualifies to be included in the Medicaid fraction.[20] In contrast, every state has a Medicaid state plan, and every state Medicaid plan includes inpatient hospital benefits.

Specifically, § 412.106(b)(4) states in pertinent part:

> (4) *Second computation*. The fiscal intermediary determines, for the same cost reporting period used for the first computation, the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period. For purposes of this second computation, the following requirements apply:
>
> (i) For purposes of this computation, a patient is deemed eligible for Medicaid on a given day only if the patient is eligible for inpatient hospital services under an approved State Medicaid plan **or under a waiver authorized under section 1115(a)(2) of the Act** on that day, regardless of whether particular items or services were covered or paid under the State plan or the authorized waiver.
>
> **(ii) Effective with discharges occurring on or after January 20, 2000, for purposes of counting days under paragraph (b)(4)(i) of this section, hospitals may include all days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act**.
>
> (iii) The hospital has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.

Because the Provider did not raise the section 1115 Waiver days prior to the deadline to add issues, and it is a distinct issue, the Board finds that the issue was not properly or timely

[40] 65 FR 47054, 47087 (Aug. 1, 2000).

appealed. The DSH Medicaid Eligible Days issue as stated in the original appeal request cannot be construed to include section 1115 Waiver days. Additionally, there is no indication that any 1115 waiver days were included with the as-filed cost report which, if true, would make them an unclaimed cost and provide an independent basis for dismissal.

Regardless, even if the Provider had included in its appeal request (which it did not), the Provider failed to properly develop the issue in its position paper filings. First, the Provider's preliminary position paper does not even mention § 1115 waiver days (much less even identify the specific 1115 waiver day program(s) at issue) notwithstanding its obligations to do so pursuant to 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 25 (2018). Pursuant to 42 C.F.R. § 412.106(b)(4)(iii), the Provider "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." Similarly, 42 C.F.R. § 405.1871(a)(3) confirms that the Provider has the "burden of production of evidence and burden of proof by establishing, by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue." The Provider's briefing fails to establish the merits of its position on the *alleged* § 1115 waiver days sub-issue.

Finally, even in the Provider's final position paper, the Provider fails to identify what § 1115 waiver program(s) are involved and whether or not the § 1115 waiver days at issue would qualify under 42 C.F.R. § 412.106(b)(i)-(ii) as "days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act" and the patients underlying those days are "deemed eligible for Medicaid" based on "the patient [being] eligible for inpatient hospital services . . . under a waiver authorized under section 1115(a)(2) . . . on that day, regardless of whether particular items or services were covered." Rather, the final position paper is perfunctory in that it only makes perfunctory conclusions.[41] Again, the Provider failed to so develop its position paper notwithstanding 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 25 (2023) as applied via Board Rule 27.2.

The Board's finding that neither the appeal request nor final position paper met the Board content requirements is consistent with the recent ruling by the U.S. District Court for the District of Columbia in *Evangelical Community Hospital, et al. v. Becerra*.[42] In that case, the provider's issue was tied to improper calculation to DSH payment and read in part, "[t]he intermediary erred by incorrectly calculating the SSI percentage for inclusion in the 'Medicare Fraction' for purposes

[41] For example, QRS cites to *Forrest General Hosp.*, 926 F.3d 221 (5th Cir. 2019) for the proposition that "the plain language of the statute and regulations require inclusion in the Medicaid Fraction of the days belong to individual who are included in a section 1115 demonstration project that provides benefits through an uncompensated care pool." However, QRS fails to explain why this sweeping statement is relevant to the § 1115 waiver days at issue. Is QRS asserting that the § 1115 waiver days at issue relate to an uncompensated care pool? Is that pool similar to that in *Forrest General Hosp.*? QRS fails to brief the merits of its claims and fails to establish the Board's jurisdiction over the § 1115 waiver day issue as required by 42 C.F.R. § 405.1853(b)(2). Indeed, the quoted sentence is the only time the final position paper references "uncompensated care pool."

[42] No. 21-cv-01368, 2022 WL 4598546 (D.D.C. Sep. 30, 2022).

of the calculation of the provider's [disproportionate share] payment . . ."[43] The Court found that "[t]his description does not specify which portion of the calculation was incorrect nor how the fraction should have been calculated differently."[44] The Court found that this was a description of the issue was a violation of Board rules and a proper basis on which for the Board to dismiss the appeal.[45] Here, the Board makes the same finding based on similarly *overly generalized language*.

Based on the above, the Board finds that the appeal did not include the *alleged* § 1115 waiver days sub-issue consistent with 42 C.F.R. §§ 405.1835(b)(2)-(3), 412.106(b)(4)(iii), and 405.1871(a)(3) and Board Rules 7.1, 8, 25, and 27.2.[46] In the alternative, the Board finds that, even if it had been included as part of the appeal, the Board would find that the issue was not properly developed in the position paper process.

2. *Medicaid Eligible Days*

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

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

> **No Access to Data**
>
> If the provider elects to not claim an item on the cost report because, through no fault of its own, it did not have access to the underlying information to determine whether it was entitled to payment, describe the circumstances why the underlying information was unavailable upon the filing of the cost report.

42 C.F.R. § 405.1853(b)(2)-(3) addresses the content of position papers:

> (b) *Position papers*. . . . (2) The Board has the discretion to extend the deadline for submitting a position paper. **Each position paper must set forth the relevant facts and arguments regarding** the

[43] *Id*. at *11.
[44] *Id.*
[45] *Id.*
[46] If § 1115 waiver days were found to be part of the appeal request and had been properly briefed, the Board would still need to address an additional jurisdictional issue – review whether it had jurisdiction over the 1115 waiver days. For example, the Board has found that when a class of days (*e.g*., 1115 waiver days) is excluded due to choice, error, and/or advertence from the as-filed cost report, then that class of days is an unclaimed cost for which the Board would lack jurisdiction under 42 U.S.C. § 1395oo(a). *See, e.g.,* PRRB Jurisdictional Decision, Case Nos. 06-1851, 061852 (Nov. 17, 2017) (dismissing the class of adolescent psychiatric days from the appeal because no days were claimed with the as-filed cost report due to choice, error and/or inadvertence and, as such, the practical impediment standard or futility concept in the *Norwalk* and *Danbury* Board decisions is not applicable).

> 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.[47]

The regulations require the parties to fully brief the merits of each issue in their position paper (including the relevant facts and legal arguments) and specify that the Board has discretion about setting the time frame for the submission of exhibits supporting the merits of the appeal.

Board Rule 25 (Aug. 2018) requires the Provider to file its complete, *fully* developed preliminary position paper with all available documentation and gives the following instruction on the content of position papers:

> **Rule 25 Preliminary Position Papers**[48]
>
> **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…Therefore, the Board requires preliminary position papers to present the ***fully*** developed positions of the parties and expects that parties will be diligent in planning and conducting any required investigation, discovery, and analysis well in advance of the filing deadline.
>
> **25.1 Content of Position Paper Narrative**
>
> The text of the position papers must include the elements addressed in the following sub-sections.
>
> **25.1.1 Provider's Position Paper**

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

The provider's preliminary position paper must:

A. Identify any issues that were raised in the appeal but are already resolved (whether by administrative resolution, agreement to reopen, transfer, withdrawal, dismissal, etc.) and require no further documentation to be submitted.
B. For *each* issue that has not been fully resolved, state the material facts that support the provider's claim.
C. Identify the controlling authority (e.g. statutes, regulations, policy, or case law) supporting the provider's position.
D. Provide a conclusion applying the material facts to the controlling authorities

25.2 Position Paper Exhibits

25.2.1 General

With the position papers, the parties must exchange ***all*** available documentation as exhibits to fully support your position. . . . When filing those exhibits in the preliminary position paper, ensure that the documents are redacted in accordance with Rule 1.4. Unredacted versions should be exchanged by the parties separately from the position paper, if necessary.

25.2.2 Unavailable and Omitted Documents

If documents necessary to support your position are still unavailable, identify the missing documents, explain why the documents remain unavailable, state the efforts made to obtain the documents, and explain when the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.

25.2.3 List of Exhibits

Parties must attach a list of the exhibits exchanged with the position paper.

25.3 Filing Requirements to the Board

Parties should file with the Board a *complete* preliminary position paper with a fully developed narrative (Rule 23.1), all exhibits (Rule 23.2), a listing of exhibits, and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R.

> § 405.1853. Any issue appealed, but not briefed by the Provider in its position paper will be considered withdrawn.

> **COMMENTARY**: Note that this is a change in previous Board practice. Failure to file a complete preliminary position paper with the Board will result in dismissal of your appeal or other actions in accordance with 42 C.F.R. § 405.1868. (*See* Rule 23.4.)

The Notice of Case Acknowledgement and Critical Due Dates issued to the Provider on March 12, 2019 included instructions on the content of the Provider's preliminary position paper consistent with the above Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

Moreover, in connection with Issue 3, Medicare regulations specifically place the burden on hospitals to provide documentation from the State to establish ***each*** *Medicaid eligible day* being claimed. Specifically, when determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(4)(iv) 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.[49]

Along the same line, 42 C.F.R. § 405.1871(a)(3) makes clear that, in connection with appeals to the Board, "the provider carrie[s the] burden of production of evidence and burden of proof by establishing, by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue."

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

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

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

- if it has reasonable basis to believe that the issues have been

[49] (Emphasis added.)

fully settled or abandoned,
- upon failure of the provider or group to comply with Board procedures (see 42 C.F.R. § 405.1868),
- if the Board is unable to contact the provider or representative at the last known address, or
- upon failure to appear for a scheduled hearing.

On October 2, 2019, the Provider filed its preliminary position paper in which it indicated that the eligibility listing was imminent by promising that the listing was being sent under separate cover.[50] Significantly, the position paper did ***not*** include *the material fact* of how many Medicaid eligible days remained in dispute in this case, but rather continued to reference the "estimated impact" included with its appeal request (i.e., the estimated impact of $52,167 based on an estimated 100 days).

On January 13, 2025, the Provider filed its final position paper. The position paper stated that a redacted version of the Provider's Medicaid Eligible Days listing was being included with the paper, but no such listing was included. Subsequently, on March 12, 2025, the Provider submitted a redacted Medicaid Eligible Days Listing to the Board. The Listing was 15 pages with 2,673 Medicaid eligible days. No explanation was provided as to why the listing of days was being submitted at this late date, ***more than 9 years after the fiscal year at issue had closed***. NOTE—the 2,673 days included in this belated listing is *exponentially* larger than the original estimate of 100 days included with the appeal request. Regardless, this filing, *importantly,* ***was more than 5 years past the deadline for including it with the preliminary position paper*** since the position paper deadline was October 3, 2019.

The Board concurs with the Medicare Contractor that the Provider is required to identify *the material facts* (*i.e*., the number of days at issue) and provide relevant supporting documentation to identify and prove the specific additional Medicaid Eligible days at issue and for which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3), Board Rule 25, and 42 C.F.R. § 412.106(b)(iii). Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. § 412.106(b)(iii) and 405.1853(b)(2)-(3) and Board Rules 25.2.1 and 25.2.2 related to the submission of documentary evidence required to support its claims or describe why said evidence is unavailable. The Board finds that the Provider also failed to fully develop the merits of the Medicaid eligible days issue because the provider has failed to identify any specific Medicaid eligible days at issue (much less any supporting documentation for those days).

Finally, pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[51] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. As the Provider failed to submit a finalized listing of Medicaid eligible days, notwithstanding its obligations under 42 C.F.R. §§

[50] Provider's Preliminary Position Paper at 10.
[51] (Emphasis added.)

412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25, the Board must find that there are no such days in dispute and that the actual amount in controversy is $0.

Based on the above, the Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(iii) and Board Rules 25.2.1 and 25.2.2 related to identifying the days in dispute (a material fact) and the timely submission of documentary evidence required to support its claims or describe why said evidence is unavailable, which the Provider has failed to do.[52]

Based on the foregoing, the Board dismisses the two (2) remaining issues in this case – (Issues 1 and 3). As no issues remain, the Board hereby closes Case No. 19-1377 and removes it from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

3/27/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

cc: Michael Redmond, Novitas Solutions, Inc. c/o GuideWell Source (J-H)
Wilson Leong, Federal Specialized Services

[52] *See also Evangelical Commty Hosp. v. Becerra*, No. 21-cv-01368, 2022 WL 4598546 at *5 (D.D.C. 2022):
The Board acts reasonably, and not arbitrarily and capriciously, when it applies its "claims-processing rules faithfully to [a provider's] appeal." *Akron*, 414 F. Supp. 3d at 81. The regulations require that a RFH provide "[a]n explanation [ ]for each specific item under appeal." 42 C.F.R. § 405.1835(b)(2). The Board rules further explain that "[s]ome issues may have multiple components," and that "[t]o comply with the regulatory requirement to specifically identify the items in dispute, each contested component must be appealed as a separate issue and described as narrowly as possible." Board Rules § 8.1. The Board rules also specifically delineate how a provider should address, as here, a challenge to a Disproportionate Share Hospital reimbursement. Board Rule 8.2 explains that an appeal challenging a Disproportionate Share Hospital payment adjustment is a "common example" of an appeal involving issues with "multiple components" that must be appealed as "separate issue[s] and described as narrowly as possible." Board Rules §§ 8.1, 8.2.