DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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RE: ***EJR Determination***
14-0613, Memorial Healthcare Center, 23-0121, FYE 12/31/2008
14-0614, Memorial Healthcare Center, 23-0121, FYE 12/31/2009
15-0408, Evangelical Community Hospital, 39-0013, FYE 06/30/2011
15-0409, Evangelical Community Hospital, 39-0013, FYE 06/30/2012

Dear Ms. Griffin and Mr. Lamprecht:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above-referenced providers' ("Providers") January 14, 2021 request for expedited judicial review ("EJR Request") and the Providers' March 3, 2021 response to the Medicare Contractor's jurisdictional challenge. The Board's determination regarding the EJR Request is set forth below.

Issue in Dispute:

Providers are requesting EJR for the following issue:

> The days at issue in these group [sic] appeals are the days of care furnished by the Hospitals to patients who were entitled to Medicare Part A and Supplemental Security Income ("SSI") benefits. The issue presented in these appeals is whether the Intermediary erred in calculating the [SSI] percentage included in the "Medicare fraction" for purposes of calculating the Provider's [Disproportionate Share Hospital ("DSH")] payment, as required by 42 U.S.C. § 1395ww(d)(5)(F)(vi).
>
> The Providers respectfully assert that under the rules of statutory construction [the Centers for Medicare and Medicaid Services ("CMS")] is compelled to interpret "entitlement to SSI" benefits to include all inpatients who were eligible for and/or enrolled in the SSI program at the time of their hospitalization and, further, to provide the Providers with a listing of those SSI Enrollees/Eligible patients for the relevant hospitalizations so that its DSH adjustments can be recalculated in accordance with the Medicare

> Act. Furthermore, Provider seeks a ruling that CMS has failed to provide the Providers with adequate information to allow them to check and challenge CMS's disproportionate patient percentage ("DPP") calculations. Provider is entitled to this data under Section 951 of the Medicare Prescription Drug, Improvement, and Modernization Act, Pub. L. 108-173. Because the summary data that CMS currently provides only gives providers the underlying data for SSI days that are limited to the three (3) SSI status codes chosen by CMS instead of the full list of Medicare patients who are enrolled in SSI and/or eligible for SSI benefits, and does not give Provider any meaningful means of challenging the SSI days chosen by CMS to be used in Provider's DPP calculations, CMS continually violates its § 951 mandate.[1]

Board's Authority:

The Board's authority to consider a provider's EJR request is contained within 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R.§ 405.1842(f)(1) (2019). Under its statutory and regulatory authority, the Board is required to grant a provider's EJR request if it determines that (1) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (2) the Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute or to the substantive or procedural validity of a regulation or CMS Ruling.

Procedural Background:

In all four of these subject individual appeals, the original Provider Representative was Plante Moran, PLLC ("Plante Moran"). Plante Moran, filed requests for a Board Hearing ("RFHs") on behalf of the above-referenced Providers from original Notices of Program Reimbursement ("NPR") and the Board assigned individual PRRB Case Numbers for each appeal.[2] Within each Provider's respective RFH, Plante Moran describes the ***same*** four issues:

1. Medicare Fraction—Medicare Advantage Days;
2. Medicaid Fraction—Exhaust Days[sic];
3. Medicare Fraction—Medicare Advantage Days; and
4. Medicare Fraction—[Supplemental Security Income ("SSI")] Percentage.[3]

[1] EJR Request at 1-2
[2] The Board received Memorial Healthcare Center's ("Memorial's) appeals of its 12/31/2008 and 12/31/2009 NPRs on 11/12/2013, with PRRB Case Nos. 14-0613 and 14-0614 assigned to the appeals, respectively. The Board received Evangelical Community Hospital's ("Evangelical's") appeals of its 6/30/2011 and 6/30/2012 NPRs on 11/17/2014, with PRRB Case Nos. 15-0408 and 15-0409 assigned to the appeals, respectively.
[3] RFH for 14-0613, 14-0614, 15-0408 and 15-0409 TAB 3.

In all four individual cases, Providers transferred Issues 1 and 3 to group appeals and withdrew Issue 2. For PRRB Case Nos. 15-0408 and 15-0409, Evangelical Community Hospital ("Evangelical") included an inpatient rehabilitation facility low income patient ("LIP") adjustment sub-issue for each of the four issues listed above. For PRRB Case No. 15-0409, the Board dismissed the LIP portion of the issues,[4] while Evangelical either transferred or withdrew the LIP portion of its issues in PRRB Case No 15-0408.[5] In sum, Providers' DSH SSI Percentage issue, Issue 4, is the *only remaining* issue in all four cases and is the issue for which Providers request EJR.

Within all four cases, Plante Moran used the ***same identical*** language in the RFH to describe Issue 4:

> Statement of the Issue:
>
> The intermediary erred by incorrectly calculating the SSI percentage for inclusion in the "Medicare Fraction" for purposes of the calculation of the provider's [DSH] payment.
>
> Brief Description of the Issue[]:
>
> The Provider believes the Intermediary's calculation of the Providers' Medicare [DSH] payments contain[s] errors in the calculation of the SSI percentage for purposes of 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II) and 42 C.F.R. § 412.106(b).
>
> Amount in Controversy:
>
> The Provider believes that its DSH reimbursement should correctly reflect an accurate SSI percentage for purposes of the "Medicare fraction." The correct value of this adjustment is not able to be fully calculated from the information currently available to the provider, but is in excess of $10,000. The documents or data relating to CMS's calculation of the adjustment to the DSH payment were utilized in CMS's calculation as required by DSH are, to the best of Provider's knowledge, solely in the possession of CMS.
>
> Legal Basis for Appeal:
>
> The Provider believes that inclusion of correct data and calculation of the SSI percentage for purposes of the [DSH] payment is

[4] *See* Board determination dated 8/13/2020, Jurisdictional Challenge for 15-0409 Ex. C3.
[5] Evangelical transferred the LIP portion of its Issues 1 & 4 to PRRB Case No. 18-0137G on 10/2/2018, *see* Jurisdictional Challenge for 15-0408 Ex. C3. The Board acknowledged that Evangelical withdrew the LIP portion of its Issues 2 & 4 on 12/21/2020, *see* Jurisdictional Challenge for 15-0408 Exs. C5 and C6.

> supported by the plain language of 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II) and 42 C.F.R. § 412.106(b).[6]

Plante Moran served the preliminary position papers for Case Nos. 14-0613, 14-0614 on the Medicare Contractor on 8/6/2014,[7] and the preliminary position papers for Case Nos. 15-0408 and 15-0409 on 7/29/2015.[8] Within all four preliminary position papers, Plante Moran once again describes the Providers' Issue 4 using the ***same identical*** language in just 7 sentences:

> The Provider believes the Intermediary and/or CMS erred in its calculation of the SSI percentage and its application to this Provider. The propriety of the SSI percentage calculation has been, and continues to be, the subject of considerable litigation. For example, the Board ruled on this specific issue in a case styled *Baystate Medical Center v. Mutual of Omaha Insurance Company*, PRRB Dec. No. 2006-D20 (March 17, 2006; rev'd by CMS Administrator Decision (May 11, 2006) CCH ¶81,506. On March 31, 2008, the United States District Court for the District of Columbia reversed the Adminstrator's decision and found, like the Board below, that there were errors in the SSI percentage which CMS was directed to correct. Baystate Med. Ctr. v. Leavitt, 544 F.Supp. 2d 20 (D.D.C. 2008). The Provider believes there remains errors in the calculation of its SSI percentage that adversely affect its DSH reimbursement.
>
> Therefore, the Provider has appealed the calculation used by the Intermediary in determining the Provider's DSH adjustment believing the same to be inaccurate and/or incomplete. Because the calculation used by the Intermediary was improper, the Provider's DSH calculation is incorrect and the Provider requests that the same be corrected.[9]

Subsequently, in 2018, the Providers in PRRB Case Nos. 14-0613, 14-0614 and 15-0409 requested to transfer Issue 4—the SSI Percentage issue (the issue for which Providers have requested EJR) to corresponding "Dual Eligible Days" group appeals.[10] These groups concern the treatment of Medicare-no-pay dual eligible days (*e.g.*, Medicare exhausted and Medicare secondary payor days) in the Medicare DSH adjustment calculation.

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[6] RFH for 14-0613, 14-0614, 15-0408 and 15-0409 TAB 3.
[7] *See* Jurisdictional Challenge for 14-0613, Ex. C5 at 1; and Jurisdictional Challenge for 14-0614, Ex. C5 at 15.
[8] *See* Jurisdictional Challenge for 15-0408, Ex. C7 at 15; and Jurisdictional Challenge for 15-0409, Ex. C5 at 15.
[9] Copies of the Providers' preliminary position papers are included as exhibits within the Medicare Contractor's individual Jurisdictional Challenges. *See* Jurisdictional Challenge for 14-0613 Ex.C5 ; Jurisdictional Challenge for 14-0614 Ex. C5; Jurisdictional Challenge for 15-0408 Ex. C7; and Jurisdictional Challenge for 15-0409 Ex. C5.
[10] For PRRB Case No. 14-0613, Memorial requested to transfer Issue 4 into 18-0336G on 3/30/2018; *see* Jurisdictional Challenge for 14-0613 Ex. C4. For Case No. 14-0614, Memorial requested to transfer Issue 4 into 18-0334G on 3/29/2018; *see* Jurisdictional Challenge for 14-0614 Ex. C4. For Case No. 15-0409, Evangelical requested to transfer Issue 4 into 18-1122G on 6/20/2018; *see* Jurisdictional Challenge for 15-0409 Ex. C7.

Following a jurisdictional review of Providers' transfer requests for Issue 4 in Case Nos. 14-0613, 14-0614, and 15-0409, the Board issued determinations dated 7/17/2018, 7/17/2018, and 6/25/2018, respectively, finding that the Providers' Medicare Fraction—SSI Percentage issue (Issue 4) set out within those cases did "***not*** include DSH Medicare Fraction Dual Eligible Days as part of the issue."[11] Thus the Board *denied* Providers' requests to transfer Issue 4 to the corresponding group appeals.

In June 2018, the Provider in Case Nos. 14-0408 and 15-0409 changed its representative from Plante Moran to the current representative, Hall, Render, Killian, Heath & Lyman ("Hall Render"). Similarly, in November 2018, the Provider in Case Nos. 14-0613 and 14-0614 changed its representative from Plante Moran to Hall Render.

In December 2020, Hall Render filed final position papers for the Providers in all four cases. Within each of the Providers' final position papers, Hall Render describes the "Statement of Issue" for Issue 4 as: "Whether the Intermediary erred in calculating the [SSI] percentage included in the "Medicare fraction" for purposes of calculating the Provider's DSH payment?" The final position papers go on to include a discussion of the issue, using the following section headers under "Argument":

A. CMS has conceded that it systematically excludes many categories of SSI eligible individuals from the Medicare Fraction numerator, and published SSI data confirms the magnitude of the Agency's actions on the Provider.
B. The Agency's matching choices have a progfound impact on the Provider's DSH reimbursement.
C. SSI eligibility data must be produced by the MAC/CMS, not the provider.
D. CMS violated the plain language of the DSH statue by adopting conflicting interpretations of the term "entitled to benefits" with respect to Part A and SSI; therefore, its interpretation fails under Step One of Chevron.
    a. Despite Congress's clear intent, CMS doesnot consistently interpret and apply the term "entitled to benefits."
    b. CMS's matching process is flawed because it only uses three SSI codes, a violation of the DSH statute.
E. The Agency's categorical exclusion of SSI eligible individuals' inpatient days from the Medicare fraction numerator conflicts with Congress's express intent to capture SSI eligible patients who are Medicare beneficiaries in the Medicare Fraction numerator; therefore, the Agency's narrow construction of "entitled to

[11] Jurisdictional Challenge for 14-0613 Ex. C4 (emphasis added); Jurisdictional Challenge for 14-0614 Ex. C4 (emphasis added); and Jurisdictional Challenge for 15-0409 Ex. C7 (emphasis added).

> Supplemental Security Income benefits" also fails under Chevron Step One.
>
> F. The Agency's contruction and interpretation of the DSH statute leads to results so absurd that the interpretation cannot be ascribed to a difference in opinion or agency expertise; therefore, it is arbitrary and capricious under Chevron Step Two.

On January 14, 2021, Hall Render filed the instant EJR Request on behalf of the Providers for the "DSH SSI Percentage issue"[12] (*i.e.*, Issue 4). Within the EJR Request, Hall Render describes the issue as follows:

> The days at issue in these appeals are days of care furnished by the Hospitals to patients who were entitled to Medicare Part A and Supplemental Security Income ("SSI") benefits. The issue presented in these appeals is whether the Intermediary erred in calculating the [SSI] percentage included in the "Medicare fraction" for purposes of calculating the Provider's [Disproportionate Share Hospital ("DSH")] payment, as required by 42 U.S.C. § 1395ww(d)(5)(F)(vi)."
>
> Provider respectfully asserts that under the rules of statutory construction [the Centers for Medicare and Medicaid Services ("CMS")] is compelled to interpret "entitlement to SSI" benefits to include all inpatients who were eligible for and/or enrolled in the SSI program at the time of their hospitalization and, further, to furnish Provider with a listing of those SSI Enrollees/Eligible patients for the relevant hospitalizations so that its DSH adjustments can be recalculated in accordance with the Medicare Act. Furthermore, Provider seeks a ruling that CMS has failed to provide the Providers with adequate information to allow them to check and challenge CMS's disproportionate patient percentage ("DPP") calculations. Provider is entitled to this data under Section 951 of the Medicare Prescription Drug, Improvement, and Modernization Act, Pub. L. 108-173. Because the summary data that CMS currently provides only gives providers the underlying data for SSI days that are limited to the three (3) SSI status codes chosen by CMS instead of the full list of Medicare patients who are enrolled in SSI and/or eligible for SSI benefits, and does not give Provider any meaningful means of challenging the SSI days chosen by CMS to be used in Provider's DPP calculations, CMS continually violates its § 951 mandate.[13]

[12] RFH at 1.
[13] EJR Request at 2.

On January 29, 2021, the Medicare Contractor filed Jurisdictional Challenges in all four individual appeals. The arguments presented by the Medicare Contractor are almost identical in all of the Jurisdictional Challenges, with specific claims including the following:

a. The Provider effectively abandoned the Baystate SSI Data Accuracy issue when it filed its EJR Request; and

b. The Medicare Fraction Dual Eligible Days issue was improperly added in the Provider's EJR Request.[14]

On February 1, 2021, the Board issued, to the parties, a Request for Information in which the Board gave Providers an opportunity to respond to the Medicare Contractor's Jurisdictional Challenge arguments.

On March 3, 2021, Hall Render filed the Providers joint response to the challenge ("Jurisdictional Response"). Within the Jurisdictional Response, Hall Render make the following arguments for the Providers:

a. Providers argue that the "brief language" and "brief argument" presented in their respective RFHs and preliminary position papers does not "box" the Providers into a *Baystate* matching argument.[15]

b. Providers argue, within their preliminary position papers, that the statement that DSH adjustments are "inaccurate and/or incomplete" suggests that "a category of data might be missing."[16]

c. Providers state that they "expanded" on the notion that their SSI Fractions are "not only inaccurate [but also] incomplete" within their respective final position papers.[17]

d. Within their respective RFH Issue Statements, Providers state that the Amount in Controversy section notes "[t]he documents or data relating to CMS's calculation of the adjustment to the DSH payment that were utilized in CMS's calculation as required by DSH, [are], to the best of Provider[s'] knowledge, solely in the possession of CMS." Providers argue that this declaration puts the Medicare Contractor and the Board "on notice that neither of them have access to any data that woud help assert their respective theories."[18]

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[14] *See* individual Jurisdictional Challenges.
[15] Jurisdictional Response at 4.
[16] *Id*.
[17] *Id* at 5.
[18] Id.

e. Providers argue that central to their assertion that the Medicare Fractions are incomplete "is a belief that the 3 [Payment Status Codes ("PSC")] codes are incomplete in terms of capturing the correct number of SSI enrollees in the numerator of the Medicare Fraction."[19]

Analysis, Findings of Fact and Conclusions of Law:

As noted *supra*, the Board's authority to consider a provider's EJR request is contained within 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R.§ 405.1842 (2019). Under the implementing regulations, the Board is required to grant a provider's EJR request if it determines that: (1) the Board has jurisdiction to conduct a hearing on the specific matter at issue (as described in 42 C.F.R. § 405.1840); and (2) the Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute or to the substantive or procedural validity of a regulation or CMS Ruling. Further, under 42 C.F.R.§ 405.1842(e)(1), in relevant part, "[i]f the Board makes a finding that it has jurisdiction to conduct a hearing on a specific matter at issue in accordance with § 405.1840 . . . then (and only then) it must consider whether it lacks the authority to decide a legal question relevant to the matter at issue." Thus, a Board finding of jurisdiction is a *prerequisite* to any review of an EJR request.

Under 42 C.F.R. § 405.1840(b), the Board has jurisdiction to grant a hearing over a *specific* matter at issue in an appeal *only if* the provider has a right to a Board hearing as a single provider appeal under § 405.1835. The regulation at 42 C.F.R. § 405.1835 describes the right to a Board hearing in subsection (a) and the content requirements of a hearing request in subsection (b). A provider's written hearing request must include certain elements. More specifically, under 42 C.F.R. § 405.1835(b)(2), a provider's written request for hearing must contain, 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:

> (b) *Contents of request for a Board hearing on final contractor determination*. The provider's request for a Board hearing under paragraph (a) of this section must be submitted in writing to the Board, and the request **must include the elements described in paragraphs (b)(1), (b)(2), or (b)(3)** of this section, the Board may dismiss with prejudice the appeal or take any other remedial action it considers appropriate. . . .
>
> (2) **An explanation** (for each specific item at issue, see paragraph (a)(1) of this section) **of the provider's dissatisfaction** with the contractor's or Secretary's determination under appeal, **including** an account of all of the following:

[19] Id. at 6.

> (i) **Why** the provider believes **Medicare payment is incorrect for <u>each</u> disputed item** (or, where applicable, why the provider is unable ot 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, **a description of the nature and amount of each self-disallowed item** and the reimbursement or payment sought for the item.[20]

Accordingly, the regulations also prescribe that if a provider submits a hearing request that *does not* meet the requirements of (b)(1), (2), or (3), the Board may dismiss with prejudice the appeal or take any other remedial action it considers appropriate.[21]

In keeping with the above-quoted regulation's specificity requirement, the Board's Rules in effect at the time that the Providers filed their respective RFH state the following:

> **Rule 8—Framing Issues for Adjustment Involving Multiple Components**
>
> **8.1—General**
>
> Some issues may have multiple components. To comply with the regulatory requirement to <u>*specifically* identify</u> the items in dispute, *each* contested component must be appealed as a separate issue and described <u>*as narrowly*</u> as possible using the applicable format outlines in Rule 7. See common examples below.
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> **8.2—Disproportionate Share Cases** (e.g., dual eligible, general assistance, charity care, HMO days, etc.)[22]

In addition, Board Rule 25 addresses requirements for preliminary position papers and includes the following Commentary:

> **COMMENTARY**: Under the Regulations effective August 21, 2008, all issues will have been identified well in advance of the due date for preliminary position papers. Unlike the prior practice, preliminary position papers are now expected to present <u>*fully*</u>

[20] (Bold and underline emphasis added.)
[21] 42 C.F.R. § 405.1835(b).
[22] Board Rules at 8 (March 1, 2013 & July 1, 2015) (emphasis added).

> *developed* positions of the parties and, therefore, require analysis well in advance of the filing deadline.[23]

Further, Board Rule 25.1 specifies that a provider's preliminary position paper must include the following "content": (1) "[f]or each issue, state the material facts that support your claim"; (2) "[i]dentify the controlling authority (e.g., statutes, regulations, policy, or case law) supporting your position"; and (3) "Provide a conclusion applying the material facts to the controlling authorities."[24] Finally, the Board Rules gave the following instruction in Board Rule 25.2 for including exhibits to the preliminary position paper and for identifying unavailable documentation:

> **25.2—Preliminary Documents**
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> **A. General:** With the preliminary position papers, the parties must exchange *all available documentation* as preliminary exhibits to fully support your position. The Intermediary must also give the Provider all evidence the Intermediary considered in making the determination (see 42 C.F.R. § 405.1853(a)(3)) and identify any documentary evidence that the Intermediary believes is necessary for resolution which has not been submitted by the Provider.
>
> **B. Unavailable and Omitted Preliminary Documents:** If documents necessary to support your position are still unavailable, *identify the missing documents*, explain why the documents remain unavailable, state the efforts made to obtain the documents, and explain when the documents will be available. Once the documents become available, promptly forward them t the opposing party.
>
> **C. Preliminary Documentation List:** Parties must attach a list of the exhibits exchanged with the preliminary position paper.[25]

The Board notes that its Rules addressing position papers are authorized by 42 C.F.R. §§ 405.1868(a)-(b) and 405.1853(b). Further, paragraphs (1) and (2) of § 405.1853(b) specify that "the parties must file position papers in order to narrow the issues further" and that "[e]ach postion paper must set forth the relevant facts and arguments regading the Board's jurisdiction over each remaining matter at issue in the appeal . . . and the merits of the provider's Medicare payment claims for each remaining issue."

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[23] Board Rule 25 "Commentary" on page 25 (March 1, 2013 and July 1, 2015) (italics and underline emphasis added). This Commentary goes on to explain that the deadlines for filing position papers are set to permit "sufficient time to develop meaningful position papers." To the exent additional time is needed parties may request extention to the filing deadline. *See* Board Rule 23.5 (July 1, 2015).

[24] *Id*.

[25] Board Rule 25.2 (March 1, 2013 and July 1, 2015) (italics and underline emphasis added).

Here, in all four cases, the Providers' RFH issue statements filed by Plante Moran for "Issue 4—SSI percentage" is set forth as follows:

> The intermediary *erred by incorrectly calculating* the SSI percentage for inclusion in the "Medicare Fraction" for purposes of the calculation of the provider's DSH payment.[26]

However, this description of the issue statement is overly broad and does not describe what is incorrect in the SSI percentage. Even when considering its further description and legal basis, the issue remains very broad and the source of the Providers' dissatisfaction remains unclear:

> Brief Description of the Issue:
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> The Provider believes the Intermediary's calculation of the Providers' Medicare DSH payments *contains errors* in the calculation of the SSI percentage for purposes of 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II) and 42 C.F.R. § 412.106(b).
>
> Legal Basis for Appeal:
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> The Provider believes that *inclusion of correct data* and calculation of the SSI percentage for purposes of the DSH payment is supported by the plain language of 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II) and 42 C.F.R. § 412.106(b).[27]

When considering the specificity of the "contents" requirements in 42 C.F.R. § 405.1835(b), the Board finds Providers' Issue 4 to be deficient because the Providers' respective RFH issue statements for Issue 4 failed to meet the "contents" requirements in subsection (b)(2). More specifically, the RFHs generically refer to "errors" in the SSI calculation, but fails to include any description of the alleged "errors" much less explain "*why* . . . Medicare payment is incorrect for each disputed item" or "*how* and why Medicare payment must be determined differently for each disputed item." Similarly, it fails to comply with Board Rule 8.1: "to *specifically identify* the items in dispute" and describe each item "*as narrowly* as possible." The Board notes that, by the time, Plante Moran filed the Providers' respective RFHs in 2013/2014, there had been much litigation and several Agency publications describing certain systemic errors in the data matching process used to calculate SSI percentage:

1. *Baystate Med. Ctr. v. Mutual of Omaha Ins. Co*., PRRB Dec. 2006-D20 (Mar. 17, 2006), *rev'd by* CMS Adm'r Dec. (May 11, 2006);

[26] (Italics emphasis added.)
[27] RFHs TAB 3 (italics emphasis added).

2. *Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008), *amended by* 587 F. Supp. 2d 37 (D.D.C. 2008), *judgment entered by* 587 F. Supp. 2d 44 (D.D.C. 2008);

3. CMS Ruling 1498-R (April 28, 2010) (recognizing that "[h]ospitals have filed numerous appeals challenging CMS' data matching process, which the agency uses in determining the SSI fraction by matching Medicare and SSI eligibility data" and taking steps to "adopt the same revised data matching process . . . used to implement the *Baystate* decision"); and

4. 75 Fed. Reg. 50042, 50275-85 (Aug. 16, 2010) (adopting a new data matching process post-*Baystate*).

However, none of these documents/litigation nor the myriad of detailed errors described therein are referenced in the RFHs. The vague reference to "inclusion of correct data" in the "Legal Basis for the Appeal" section of Issue 4 does nothing to cure this deficiency. Similarly, the vague reference in the "Amount in Controvery" section of Issue 4 to certain documents solely in CMS' possession does nothing to cure this deficiency. Specifically, Providers' inability to calculate the amount in controvery because "documents or data relating to CMS's calculation of the adjustment to the DSH payment that were utilized in CMS's calculation of the adjustment . . . are, to the best of the Provider[s'] knowledge, solely in the possession of CMS" does nothing to cure this deficiency.

Finally, not only is the appeal statement too vague, it clearly does not refer to the issue that is the subject of the EJR, namely the SSI dual eligible days issue. In particular, there is no discussion or reference to SSI entitlement or SSI status or SSI-related MMA § 951 data issues.[28] Accordingly, on this basis alone, the Board may dismiss the EJR requests for lack of jurisdiction.

The Board's conclusion is further supported by Providers' own actions in these individual appeals in that the Providers have already attempted to transfer Issue 4—SSI Percentage issues to corresponding "Dual Eligible Days" group appeals in three of the four individual appeals. As noted *supra*, the Board issued "Denial of Transfer" letters regarding the Issue 4 transfer requests for Case Nos. 14-0613, 14-0614 and 15-0409.[29] Within the denials, the Board found that Providers' Issue 4 does "not include DSH Medicare Fraction Dual Eligible Days as part of the issue."[30] Thus, if the Providers, within their respective RFHs, complied with the issue specificity requirements set out within the Board hearing jurisdictional regulations, then the Providers' intention for their Issue 4—SSI percentage issues was *to challenge SSI dual eligible days*. To pivot and claim that the Issue 4—SSI percentage issue is ***now*** not an SSI dual eligible days issue but, rather, part of the issue in the instant EJR Request[31] further demonstrates that the Providers

[28] The Board notes that the August 16, 2010 final rule adopting the new data matching process discusses in significant detail the SSI status codes used to determine SSI entitlement. 75 Fed. Reg. at 50280-81.
[29] See n. 11, *supra*.
[30] *Id*.
[31] The Board recognizes that the Medicare contractor's Jurisdictional Challenges argue that the issue presented in the instant EJR Request is, in fact, a dual eligible days issue. As the Board, however, finds that the Providers' RFH

did not comply with the initial regulatory issue specificity requirements when submitting their respective RFHs.

Even if the Board were to find, as a threshold matter, that the Providers' RFH issue statements for Issue 4 comply with the specificity requirements under 42 C.F.R. § 405.1835(b), the Board finds that Providers' preliminary position papers *filed by Plane Moran* similarly lack the requisite detail regarding Issue 4 to consider that issue "fully developed . . . to give the parties a thorough understanding of their opponent's position"[32] and "to narrow the issues."[33] The Board observes that, within the preliminary position papers *filed by Plante Moran*, Providers' Issue 4 description does *not* discuss interpretation of "entitlement to SSI" benefits under the statute as is emphasized in the issue presented for EJR or any "data" issues.[34] To this end, the discussion of Issue 4 in the preliminary position paper is bare bones in that it is less than a page (7 sentences long) and includes no exhibits. Accordingly, even if the RFHs were found to comply with § 405.1835(b) and were found to include the dual eligible days issue realting to SSI entitlement and SSI status codes and related MMA § 951 data issue(s) covered by the EJR request, Providers' preliminary position papers clearly failed to identify, much less brief, those issues (*i.e.*, fully develop its position on that issue to give the parties a through understanding of their opponent's position).[35] As such, the Board finds that, to the exent Issue 4 in the RFH could be construed under 42 C.F.R. § 405.1835(b) to properly include the dual eligible days issue or any related MMA § 951 data issues, those issues were wholly abandoned in the preliminary position papers.

Indeed, the Board finds that Providers' briefing of Issue 4 *that did occur* in their respective preliminary positon papers for all four cases relates to the *Baystate* data matching issue and is in and of itself wholly inadequate and perfunctory, and fails to comply with the Board Rule 25 requirement to "present fully developed positions." As noted above, the discussion of Issue 4 in the preliminary position papers is a mere 7 sentences long. To that end, the discussion is limited to generic discussions of alleged calculation "errors" remaining after *Baystate* and general assertions that the DSH adjustment is "inaccurate and/or incomplete." As such, this briefing fails to comply with Board Rules governing position papers. Specifically, the briefing of Issue 4 was not "fully developed positions" and, in particular, did not "state the material facts that support your claim" that there were such "errors" in the SSI fraction (and again failed "to give the parties

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issue statements for Issue 4 do not comply with regulatory requirements governing Board jurisdiction, the Board does not need to address the Medicare contractor's claims.

[32] Board Rule 23.3 Commentary (March 1, 2013 and July 1, 2015) ("Because the date for adding issues will have expired and transfers are severely limited, the Board expects preliminary position papers to be fully developed and include all available documentation necessary to give the parties a thorough understanding of their opponent's position.").

[33] 42 C.F.R. § 405.1853(b)(1).

[34] Indeed, the word "data" does not appear in the 7 sentence-long discussion of Issue 4 in the Providers' preliminary position paper nor is there any reference to the August 16, 2010 final rule.

[35] Specifically, the preliminary position papers contain no reference or discussion of any data issues such as CMS compliance with § 951 of the Medicare Prescription Drug, Improvement, and Modernization Act, Pub. L. 108-173 ("MMA") or the final rule that implemented MMA § 951, the FY 2006 IPPS Final Rule, 70 Fed. Reg. 47278, 27438-43 (Aug. 12, 2005).

a thorough understanding of their opponent's position").[36] To the extent that documents were unavailable, Board Rule 25.2 is very clear that the position paper must describe what documents are unavailable, explain why they are unavailable, describe the efforts made to obtain them, and explain when those documents are expected to become available.[37] However, the preliminary position papers do not contain any discussion about unavailable documentation (much less discuss or identify any "data" availiabity issues). Thus, the Board finds that, while the Providers' discussion of Issue 4—SSI percentage in the preliminary position papers for purported *Baystate* data matching issues provides some clarification of the Providers' statement of the issue in its RFH, it wholly fails to comply with Board Rules governing the content of preliminary position papers.

Finally, the Board notes that the first place that the Providers raise the SSI dual eligible days issues (SSI entitlement and SSI status codes) and associated SSI-related MMA § 951 data access issues is in the context of the Providers' final position papers. The fact that, between the filing of their preliminary position papers and their final position papers, the Providers changed their representative from Plante Moran to Hall Render does not give the Providers' license to otherwise change, alter, amend, or otherwise transform the Issue 4 that they appealed into something else. As provided by 42 C.F.R. § 405.1835(e), there is only a limited 60-day window in which to add issues to an appeal and that window had closed well over 5 years prior to the Providers' filing of their final position papers in December 2020.[38]

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[36] Board Rule 23.3 Commentary (March 1, 2013 and July 1, 2015) ("because the date for adding issues will have expired and transfers are severely limited, the Board expects preliminary position papers to be fully developed and include all available documentation necessary to give the parties a thorough understanding of their opponent's position.").

[37] The Board recognizes that, in its RFHs, Providers suggest that they did not have access to data to calculate an amount in controversy but failed to describe what data it needed or was unavailable. To any extent it was a distinct issue, Providers' preliminary position papers abandoned that issue as it is devoid of identifying or discussing any "data" issues. If it had addressed the data issue in the preliminary position paper and asserted unavailability, the Board would have expected compliance with Board Rule 25.2 (March 1, 2013 and July 1, 2015). Further highlighting the perfunctory nature of the briefing of Issue 4, is the fact that providers can obtain certain data used to calculate their DSH SSI ratios directly from CMS. *See e.g.*, https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh (last accessed Apr. 2, 2021); https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH (last accessed Apr. 2, 2021) (CMS webpage describing access to DSH data from 1998 to 2017: "DSH is now a self-service application. This new self-service process enables you to enter your data request(s) and retrieve your data files through the CMS Portal."). Finally, while the Board did not review the adequacy of the substance of the EJR request, the fact that certain data related to the calculation of SSI ratios is available may raise concerns about whether factual development potentially may be needed for the EJR request.

[38] The Board notes that the EJR request was filed in January 2021 after the Providers had filed their final position papers in December 2020. The Board did not reach reviewing the sufficiency of the Providers' final position papers to confirm it was fully developed (*see* Board Rule 27.2 incorporating Board Rule 25 content and exhibit requirements for preliminary positon papers) and, thereby, included the regulatory challenges raised in the EJR request itself. For example, the final position papers only contains two specific references MMA §951. *See also supra* note 36 regarding briefing of data availability issues.

Conclusion:

1) The Board hereby **denies** Memorial Healthcare Center's (23-0121) and Evangelical Community Hospital's (39-0013) instant request for EJR regarding its Issue 4—SSI Percentage issue as set out within PRRB Case Nos. 14-0613, 14-0614, 15-0408 and 15-0409, finding that, pursuant to 42 C.F.R. § 405.1835(b)(2) and Board Rules 8 and 25, the issue(s) presented for EJR was not included in either the Providers' respective RFHs or preliminary position papers and that, as a result, the Board lacks the requisite jurisdiction under 42 C.F.R. § 405.1842 (f)(2);

2) The Board hereby **dismisses** the Issue 4—SSI Percentage issues in its entirety from PRRB Case Nos. 14-0613, 14-0614, 15-0408 and 15-0409 as the issue statement in the RFHs for Issue 4 do not comply with the specificity requirements under 42 C.F.R. § 405.1835(b) and Board Rule 8 and, in the alternative, the Providers failed to properly brief Issue 4 in their respective preliminary position papers in compliance with Board Rules governing position papers;[39] and

3) As Issue 4—SSI Percentage is the last issue in PRRB Case Nos. 14-0613, 14-0614, 15-0408 and 15-0409, these cases are now closed.

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

Board Members Participating:

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

For the Board:

4/2/2021

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: Clayton J. Nix -A

cc: Wilson Leong, FSS
Bruce Snyder, Novitas Solutions, Inc.

[39] Pursuant to the Board's authority under the same regulation.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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Re: ***EJR Determination***
Sharp HC FFY 2005 5% Outlier Underpayment Group
Case No. 09-2196GC

Dear Mr. Roth:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' August 7, 2020 request for expedited judicial review ("EJR") for the common issue related party ("CIRP") group appeal referenced above. This CIRP group originally only covered federal fiscal year ("FFY") 2005 and, by letter dated January 13, 2011, the Group Representative requested that CIRP group be expanded to include FFY 2004 and add Sharp Memorial Hospital for FFY 2004 to this group because "[t]he provider does not have more than one provider that appealed the issue in FY 04 to establish a CIRP group appeal in FYE 9/30/4" and "[t]he issue, arguments and decision would be the same regardless of fiscal year or provider." The Board's determination regarding the request for expansion and the EJR are set forth below.

Effect of COVID -19 on Board Operations

On March 13, 2020, following President Trump's declaration of a national emergency as a result of COVID-19, the Centers for Medicare & Medicaid Services required its personnel to telework and limited employees' access to their offices. On March 26, 2020, the Board issued Alert 19, notifying affected parties "Temporary COVID-19 Adjustments to PRRB Processes." On August 31, 2020, subsequent to the submission of the EJR request, the Board notified you of the relevance of Alert 19 to the EJR request. Specifically, the Board notified you that, "[a]s the Board does not have access to the hard copy Schedules of Providers filed in the above-referenced list of . . . cases (regardless of whether they were filed shortly before the EJR, after the EJR, or at some point in the past), the Board is not able to process them in the usual manner and establish jurisdiction, *i.e.*, whether "a provider of services may obtain a hearing under' the PRRB statute, which is a necessary jurisdictional prerequisite for a case to eligible for EJR. 42 U.S.C. § 1395oo(f); see also 42 C.F.R. § 405.1842(b)." Accordingly, the Board stayed the 30-day period for responding to the EJR request for the above-captioned appeals.

The stay remains in effect as the Board has not resumed normal operations. As a result, the Board is attempting to process EJR requests expeditiously and is still governed by the standards set forth in 42 C.F.R. § 405.1801(d)(2) when calculating the 30-day time period for issuing an EJR by excluding all days where the Board is not able to conduct its business in the usual manner.

Issue

The issue under appeal in this case is:

> Whether [ ] CMS [the Centers for Medicare & Medicaid Services] knowingly or inadvertently under paid the [P]roviders the required 5% outlier payments by establishing higher than necessary outlier thresholds and overestimating payment projections.[1]

Statutory and Regulatory Background on IPPS Outliers

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the inpatient prospective payment system ("IPPS").[2] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[3]

The statutory provisions governing IPPS contain a number of provisions that adjust reimbursement based on hospital-specific factors.[4] These include hospitals that treat a high percentage of low income patients which receive a percentage add-on payment receive known as the disproportionate share hospital ("DSH") adjustment. Also approved teaching hospitals receive a percentage add-on for cases known as an indirect medical education ("IME") adjustment. In addition, hospitals receive additional payments for cases that involve new technology that is considered a substantial clinical improvement over what is otherwise available.

Relevant here are add-on payments for particular cases that are unusually costly, known as outlier cases where the IPPS payment is increased. "This additional payment is designed to protect the hospital from large financial losses due to unusually expensive cases."[5]

An outlier payment is added to the diagnosis related group ("DRG") adjusted base payment rate, plus any DSH, IME and new technology add-on adjustments.[6] To qualify for an outlier payment, a case must have costs above a fixed-loss cost threshold amount (*i.e.*, a dollar amount by which

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[1] Providers' August 28, 2009 hearing request, Tab 1.
[2] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[3] *Id.*
[4] *See* 42 U.S.C. § 1395ww(d)(5).
[5] 69 Fed. Reg. 48916, 48920 (Aug. 11, 2004).
[6] *Id.* at 4820, 49275.

the costs of the case must exceed payments in order to qualify for outliers).[7] The Medicare statute, 42 U.S.C. § 1395ww(d)(5)(A), establishes the outlier payment mechanism and states that:

> **(ii)** . . . A hospital may request additional payments in any case where charges, adjusted to cost, exceed a fixed multiple of the applicable DRG prospective payment rate, or exceed such other fixed dollar amount, whichever is greater, or, for discharges in fiscal years beginning on or after October 1, 1994, exceed the sum of the applicable DRG prospective payment rate plus any amounts payable under subparagraphs (B) and (F) plus a fixed dollar amount determined by the Secretary.
>
> **(iii)** The amount of such additional payment under clauses (i) and (ii) shall be determined by the Secretary and shall . . . approximate the marginal cost of care beyond the cutoff point applicable under clause (i) or (ii).
>
> **(iv)** The total amount of the additional payments made under this subparagraph for discharges in a fiscal year may not be less than 5 percent nor more than 6 percent of the total payments projected or estimated to be made based on DRG prospective payment rates for discharges in that year.

Pursuant to 42 U.S.C. § 1395ww(d)(5)(A)(iv), outlier payments for any year must be "*projected*" to be not less than 5 percent nor more than 6 percent of total operating DRG payments plus outlier payments.[8] The statute, 42 U.S.C. § 1395ww(d)(3)(B), "requires the Secretary[9] to reduce the average standardized amounts by a factor to account for the *estimated* proportion of the total DRG payments made to outlier cases."[10]

The Secretary implemented the outlier statute through the payment methodology set forth in the regulations at 42 C.F.R. §§ 412.80 through 412.86.

A. 2003 Changes to the Calculation of Outlier Payments

In the September 30, 1988 IPPS final rule[11] the Secretary initiated the use of hospital-specific cost-to-charge ratios rather than a nationwide cost-to-charge ratio to determine hospitals costs to determine whether a case qualified for an outlier payment. This change to hospital-specific cost-

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[7] *Id.* at 49275.
[8] *Id.*
[9] of the Department of Health and Human Services.
[10] *Id.* (emphasis added). 42 U.S.C. § 1395ww(d)(3)(B) states: "The Secretary shall reduce each of the average standardized amounts determined under subparagraph (A) by a factor equal to the proportion of payments under this subsection (as estimated by the Secretary) based on DRG prospective payment amounts which are additional payments described in paragraph (5)(A) (relating to outlier payments)."
[11] *See* 53 Fed. Reg. 38476, 38502-38510 (Sept. 30, 1988).

to-charge ratios was done to ensure that outlier payments were made only for cases that had extraordinary high costs, not just high charges.[12]

In the June 9, 2003 final rule addressing high-cost outliers, the Secretary revised the methodology for determining payments for high-cost outliers.[13] The Secretary explained that recent analysis had determined that some hospitals had taken advantage of two "vulnerabilities" in the outlier methodology "to maximize their outlier payments."[14] One vulnerability was "the time lag between the current charges on a submitted bill and the cost-to-charge ratio taken from the most recent settled cost report."[15] The second vulnerability was that, in some cases, "hospitals may increase their charges so far above costs that their cost-to-charge ratios fall below 3 standard deviations from the geometric mean of cost-to-charge ratios and a higher statewide average cost-to-charge ratio is applied."[16]

The June 9, 2003 final rule revised 42 C.F.R. § 412.84 to implement new regulations to correct these vulnerabilities so that outlier payments are only made for truly high cost cases.[17] As described below, these regulations involved three significant changes to the outlier calculation.

B. First 2003 Revision to § 412.84 – Use of an Up-to-Date Cost to Charge Ratio

First, the Secretary instructed the Medicare contractors[18] to use more up-to-date data when determining the cost to charge ratio for each hospital through the promulgation of 42 U.S.C. § 412.84(i)(1). The Secretary explained that, under the existing outlier methodology at the time, the cost-to-charge ratios from hospitals' latest settled cost reports were used in determining a fixed-loss amount cost outlier threshold. However, he noted that the Centers for Medicare & Medicaid Services ("CMS") had become aware that, in some cases, hospitals' recent rate-of-charge increases "greatly exceed*"* their rate-of-cost increases.[19] "Because there is a time lag between the cost-to-charge ratios from the latest settled cost report and current charges, this disparity in the rate-of increases for charges and costs results in cost-to-charge ratios that are too high, which in turn results in an overestimation of hospitals' current costs per case."[20] Therefore,

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[12] 68 Fed. Reg. 34494, 34495 (June 9, 2003). *See also See* 71 Fed. Reg. 45870, 48148 (Aug. 18, 2006) ("To determine whether the costs of a case exceed the fixed-loss cost threshold, a hospital's CCR is applied to the total covered charges for the case to convert the charges to costs. Payments for eligible cases are then made based on a marginal cost factor, which is a percentage of the costs above the fixed loss cost threshold. The marginal cost factor for FY 2007 is 80 percent, the same marginal cost factor we have used since FY 1995 [59 Fed. Reg. 45330, 45367 (Sept. 1, 1994)].").
[13] 68 Fed. Reg. 34494 (June 9, 2003).
[14] *Id.* at 34496.
[15] *Id.*
[16] *Id.*
[17] *Id.* at 34515.
[18] Medicare contractors are also known as Medicare administrative contractors ("MACs") and were formerly known as intermediaries or fiscal intermediaries.
[19] *Id.* at 34494.
[20] *Id.*

the Secretary revised the outlier payment methodology "to ensure that outlier payments are made *only* for truly expensive cases."[21]

The Secretary pointed out that "[b]ecause the fixed-loss threshold is determined based on hospitals' historic charge data, hospitals that have been inappropriately maximizing their outlier payments have caused the threshold to increase dramatically for FY 2003, and even more dramatically for the proposed IPPS FY 2004 outlier threshold of $50,645 (68 FR 27236, May 19, 2003)."[22] For example, the outlier threshold increased from $9,700 in 1997 to $17,550 in 2001, with another large increase in fiscal year ("FY") 2003 to $33,560.[23] The statute, 42 U.S.C. § 1395ww(d)(2)(E), requires that the average standardized amounts[24] be offset equal to projected outlier payments.[25] As a result of the inappropriate maximization of outline payments, "hospitals that do not aggressively increase their charges do not receive outlier payments or receive reduced outlier payments for truly costly cases."[26]

As a result of these issues with outlier payments, the Secretary issued a new regulation, 42 C.F.R. § 412.84(i)(1), that allows Medicare contractors "to use more up-to-date data when determining the cost-to-charge ratio for each hospital."[27] To this end, it permitted Medicare contractors to "use either the most recent settled cost report ***or*** the most recent tentative settled cost report, *whichever is from the later cost reporting period*" to update cost-to-charge ratios.[28] The Secretary estimated that this regulation would "reduce[] the time lag for updating the cost-to-charge ratio by a year or more."[29]

The Secretary recognized that even using later cost-to-charge ratios calculated from tentative settle cost reports could over-estimate costs for hospitals that continue to increase their charges much faster than costs during the time between the tentative settlement and the time when a claim is processed. This could be a 1 to 2 year lag during which a hospital's charges may increase faster than charges. As a result, the new regulation specifies that, in the event that more

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[21] *Id*. (emphasis added).
[22] *Id*. at 34496.
[23] *Id*.
[24] *See also* 59 Fed. Reg. 45330, 45404 (Sept. 1, 1994) ("Section 1886(d)(2)(A) of the Act [42 U.S.C. § 1395ww(d)(2)(A)] required the establishment of base-year cost data containing allowable operating costs per discharge of inpatient hospital services for each hospital. The preamble to the September 1, 1983 interim final rule (48 FR 38763) contains a detailed explanation of how base-year cost data were established in the initial development of standardized amounts for the prospective payment system and how they are used in computing the Federal rates. . . . The standardized amounts are based on per discharge averages from a base period . . . updated and otherwise adjusted in accordance with the provisions of section 1886(d) of the Act. Section 1886(d)(2)(C) and (d)(2)(B)(ii) of the Act required that the updated base-year per discharge costs . . . be standardized in order to remove from the cost data the effects of certain sources of variation in costs among hospitals. These include case mix, differences in area wage levels, cost of living adjustments for Alaska and Hawaii, indirect medical education costs, and payments to hospitals serving a disproportionate share of low-income patients.")
[25] 68 Fed. Reg. at 34496.
[26] *Id.* at 34497.
[27] *Id.*
[28] *Id.*
[29] *Id.*

recent changes indicate that a hospital's charges have been increasing at an excessive rate relative to other hospitals, "CMS would have the authority to direct [the Medicare contractor] to change hospital's operating and capital cost-to-charge ratios to reflect the high charge increases evidenced by the later data."[30]

C. Second 2003 Revision to § 412.84 – Elimination of the Use of a Statewide Cost-to-Charge Ratio

Second, the Secretary implemented new regulation at 42 C.F.R. §§ 412.84(i)(1) that removed the requirement that a Medicare contractor assign a hospital the statewide average cost-to-charge ratio when the hospital has a cost-to-charge ratio that falls ***below*** an established threshold (3 standard deviations below the national geometric mean cost-to-charge ratio). Under the new regulations, 42 C.F.R. § 412.84(i)(1), hospitals in those situations would receive their *actual* cost to charge ratio, regardless of how low their ratios fall.[31] The Secretary did not believe there was any justification to continue making outlier payments on the basis of cost-to-charge ratio that "clearly" results in excessive outlier payments.[32]

D. Third 2003 Revision to § 412.84 – Using Outlier Reconciliation

Third, the Secretary added 42 C.F.R. § 412.84(i)(4) and (m) to the regulations to provide that outlier payments for some hospitals would become the subject to a "reconciliation" process when a hospital's cost report is settled. In addition, the outlier payments would be subject to an adjustment for the "time value of money" of any underpayments ***or*** overpayments that are reconciled.[33]

Outlier payments, unlike other IPPS payments, are not made on an interim basis, rather they are made on a claim-by-claim basis. Some hospitals which increased their charges at extremely high rates were aware that there would be a lag cost-to-charge ratio would be adjusted to reflect the high charges. The Secretary believed that the steps noted above, directing Medicare contractors to update cost-to-charge ratios using the most recent tentative settled cost report and using actual, rather than statewide average ratios for hospitals with cost-to-charge ratios higher than 3 standard deviation above the geometric mean, would greatly reduce the opportunity for hospitals to manipulate the system to maximize outlier reimbursement. However, this would not eliminate all opportunities. [34]

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[30] *Id.* at 34497-98.
[31] *Id.* at 34500; 68 Fed. 45345, 45478 (Aug. 1, 2003). *See also* 68 Fed. Reg. at 45478 ("The statewide cost-to-charge ratios would still apply in those instances in which a hospital's operating cost-to-charge ratio falls outside of the reasonable parameters (i.e. exceed the upper threshold. In addition, hospitals that have not yet filed their first Medicare cost report with their Medicare contractor would still receive statewide cost to charge ratios. CMS will continue to set the reasonable parameters and the statewide ratios in each year's IPPS rule.")
[32] 68 Fed. Reg. at 34498.
[33] 68 Fed. Reg. at 44476.
[34] *Id.* at 34501.

Consequently, the Secretary added 42 C.F.R. § 412.84(i)(3) to the regulations. This provision provided that when a cost report was settled, outlier reimbursement would be based on a reconciliation from the cost report and charges computed from the cost report and charge data determined at the time the cost report coinciding with the discharge were settled.[35] Where a provider had received excess outlier payments, the provider would be required to reimburse the Medicare Trust Fund and the amount repaid could be adjusted to reflect "the time value of the funds"; the same would be true if there was an *underpayment* of outlier reimbursement by CMS and monies were owed by the Medicare program to the provider.[36]

Providers' Position

Each of the Providers' fiscal years at issue corresponds to the Federal fiscal year ("FFY") and they explain that they received insufficient outlier payments for discharges that occurred during the FFYs 2004 and 2005. The Providers are "challenging the outlier payment methodology including the 'outlier threshold' that the Secretary adopted in the FFY 2004 and 2005 [IPPS] Final Rules which were published in the Federal Register on August 1, 2003 and August 11, 2004 respectively. *See* 68 Fed. Reg. 45,345, 45,476-77 and 69 Fed. Reg. 48,915, 49,275-78 (August 11, 2004)."[37]

Pursuant to 42 U.S.C. § 1395ww(d)(5)(A)(iv), outlier payments cannot be less than 5 percent nor more than 6 percent "of the total payments projected or estimated to be made based on DRG prospective payment rates for discharges in that year." The Providers note that this group appeal arose because, for both FFY 2004 and 2005, the Secretary's outlier methodology and data caused the outlier threshold to be set too high, which caused all of the outlier payments made for discharges in those years to be too low. Thus, the Secretary failed to pay out the total amount of outlier "pool" created by a reduction in standardized payments to fund the FFYs 2004 and 2005 outlier payments. Consequently, the Providers contend that the FFY 2004 and 2005 outlier payments were otherwise unlawful and the Providers failed to receive their outlier payments in accordance with the law. The Providers note that there is no factual dispute that the Secretary did not meet the target percentage because, in the August 12, 2005 Federal Register, the Secretary confirmed that the 5 to 6 percent target for outlier payments had not been met during the FFYs 2004 and 2005 (specifically stating that outlier payments were 3.52 percent of total DRG payments in FFY 2004 and were 4.1 percent of total DRG payments in 2005).[38]

The Providers are "challenging the Secretary's outlier payment methodology because, *inter alia*, various elements of the methodology (including data) used to project the outlier are alleged to be

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[35] *Id.* at 34504.
[36] *Id.* at 34501.
[37] EJR Request at 2.
[38] EJR Request at 3 (citing to 70 Fed. Reg. 47278, 47496 (Aug. 12, 2005)). *See also* 71 Fed. Reg. 47870, 48152 (Aug. 18, 2006) (In the FFY 2007 Final Rule, the Secretary stated that the current estimate using available FFY 2005 bills indicted that actual outlier payments were approximately **3.96%** of actual total DRG payments.). Notwithstanding, the Providers "do not necessarily agree with the Secretary's calculation of how far the outlier payments ended up below the target percentage for FFYs 2004 and 2005, believing that they were likely further below…." EJR Request at 3 n.2.

arbitrary and capricious."[39] The Providers noted, without attribution, that the Secretary refused to implement modifications to the outlier projects for FFY 2004 and 2005 suggested by commentators during the rulemaking process:

> Particularly, we note that comments were submitted on behalf of hospital providers during the FFYs 2004 and 2005 IPPS rulemaking process that criticized the Secretary's payment methodology for outliers and proposed alternate methodologies that would lead to more accurate projections. While the Secretary refused to follow the proposed modifications to the outlier projection methodology during FFYs 2004 and 2005, the Secretary (a) did eventually agree that the methodology should be improved and (b) eventually adopted suggestions that had been reasonably and repeatedly made during earlier rulemakings. Such refusal to discontinue an imperfect process when information was available that should have resulted in a more accurate process being used has been held by courts to be arbitrary and capricious and, thus, invalid. *See, e.g., Alvarado Cmty Hosp. v. Shalala*, 155 F.3d 1115 (9th Cir. 1998) and *Cnty. of L.A. v. Shalala*, 192 F.3d 1005 (D.C. Cir. 1999).
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> The Providers' outlier methodology/threshold/data issue has been litigated in the past few years in the U.S. Court of Appeals for the District of Columbia Circuit in two cases and, in both cases, the Court remanded the FFY 2004 threshold to the Secretary for additional explanation, which could also affect the threshold for FFY 2005. *See Banner Health v. Price*, 867 F.3d 1323 (D.C. Cir. August 18, 2017); *see also Dist. Hosp. Partners, L.P., v. Burwell*, 786 F.3d 46 (D.C. Cir. 2015).[40]

Accordingly, the Providers assert that "if the Secretary had properly modified *the outlier projection methodology* in accordance with comments that were made to the FFYs 2004 and 2005 IPPS Proposed Rules, (a) the threshold would have been lower and considerably more accurate and (b) the Providers thus would have received the additional outlier payments to which they are entitled by law."[41] Accordingly, "the Providers seek their proper outlier payments for FFYs 2004 and 2005 *plus interest* calculated under 42 U.S.C. § 1395oo(f)(2) and/or 42 U.S.C. § 1395g(d)."[42]

The Providers assert that EJR is appropriate where the Board has jurisdiction to conduct a hearing on the matter at issue, but lacks the authority to decide a specific legal question relevant

[39] EJR Request at 3.
[40] EJR Request at 3.
[41] EJR Request at 4 (emphasis added).
[42] EJR Request at 4 (emphasis added).

to the matter at issue. The Providers state that their appeals were timely filed and they have met the $50,000 threshold for a group appeal as required by 42 U.S.C. § 1395oo(a) for Board jurisdiction. Further, the Providers assert that "the Board does not have the power to (a) set aside either the outlier threshold or other aspects of the outlier methodology (including data) because they were published in regulatory form by the Secretary, or (b) order the payment of additional sums to compensate the Providers for the difference between the amounts paid for outliers and the amounts that would have been paid if the Secretary had not acted in an arbitrary and capricious manner when projecting the outlier thresholds for FFYs 2004 and 2005."

Decision of the Board

Pursuant to 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R.§ 405.1842(f)(1) (2017), the Board is required to grant an EJR request if it determines that: (i) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (ii) the Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute or to the substantive or procedural validity of a regulation or CMS Ruling.

A. Jurisdiction

The participants that comprise the group appeal within this EJR request have filed appeals involving their fiscal years 2004 and 2005.

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 issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hosp. Ass'n v. Bowen* ("*Bethesda*").[43] 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.[44]

On August 21, 2008, new regulations governing the Board were effective.[45] Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required, for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hosp. v. Burwell*

[43] 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.).
[44] *Bethesda*, 108 S. Ct. at 1258-59.
[45] 73 Fed. Reg. 30190, 30240 (May 23, 2008).

("*Banner*").[46] 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.[47]

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

B. Jurisdiction, Expansion of the Group, and EJR

The Board has determined that the participants involved with the instant EJR request are governed by the decision in *Bethesda* as the Providers are challenging the validity the outlier thresholds published in the August 1, 2003 and August 11, 2004 Federal Registers. The Board has further determined that the CIRP group can be expanded to encompass FFY 2004 as the Providers alleged that the Secretary used the same flawed "outlier projection methodology" to calculate the outlier thresholds for FFYs 2004 and 2005.[48] Finally, the appeals were timely filed and the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[49] Based on the above, the Board finds that it has jurisdiction for the above-captioned appeal 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.

The Board finds that it lacks the authority to grant the relief sought by the Providers, namely calculation of "their proper outlier payments for FFYs 2004 and 2005 plus interest calculated under 42 U.S.C. § 1395oo(f)(2) and/or 42 U.S.C. § 1395g(d)."[50] Consequently, the Board finds that EJR is appropriate.

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[46] 201 F. Supp. 3d 131 (D.D.C. 2016).
[47] *Id.* at 142.
[48] EJR Request at 4.
[49] *See* 42 C.F.R. § 405.1837.
[50] EJR Request at 4.

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 this group appeal are entitled to a hearing before the Board;

2) Based upon the participants' assertions regarding validity the outlier rates in the IPPS final rules published in the August 1, 2003, and August 11, 2004 Federal Registers, there are no findings of fact for resolution by the Board;

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

4) It is without the authority to: (a) decide the legal question of whether the "outlier projection methodology" used to set the outlier threshold in the IPPS final rules for FFYs 2004 and 2005, as published in the August 1, 2003, and August 11, 2004 Federal Registers is valid; and (b) grant the relief sought by the Providers, namely calculation of "their proper outlier payments for FFYs 2004 and 2005 plus interest calculated under 42 U.S.C. § 1395oo(f)(2) and/or 42 U.S.C. § 1395g(d)."[51]

Accordingly, the Board finds that the question of the validity the FFY 2004 and 2005 outlier thresholds properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for EJR for the issue and the subject years. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in this case, the Board hereby closes the case.

Board Members Participating:

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

For the Board:

4/6/2021

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: Clayton J. Nix -A

Enclosure: Schedule of Providers

cc: Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators
Wilson Leong, FSS

[51] EJR Request at 4.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Re: ***Jurisdictional Decision in Part***
participant Downey Community Hospital (Prov. No. 05-0393, FYE 6/30/2007)
HQ 2007 Medicaid Fraction Part C Days Group
Case No. 13-2346G

Dear Mr. Dreyfus and Ms. Frewert,

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above referenced appeal in response to the Medicare Administrative Contractor's ("MAC") Jurisdictional Challenge that challenges the participation of Downey Community Hospital ("Downey") in the group appeal. The Board's decision is set forth below.

Background

On August 5, 2008, the MAC issued Downey a Notice of Program Reimbursement ("NPR") for fiscal year end ("FYE") 6/30/2007.[1] On January 19, 2009, Downey filed a hearing request with the Board.[2] On June 10, 2013, Downey requested to transfer Issue 1 to this group appeal, Case No. 13-2346G. Issue 1 was articulated as follows:

> The Intermediary did not include all eligible Medi-Cal days pursuant to HCFA Ruling No. 97-2 and 42 C.F.R. § 412.106.[3]

On October 22, 2014, the MAC filed a jurisdictional challenge, alleging that Downey untimely and improperly added a second issue in its transfer request to the group, Part C days in the Medicaid Fraction.[4] Downey's transfer request articulates the issue as:

> All of the Medicaid eligible days were not include pursuant to HCFA Ruling 97-2, 42 C.F.R. § 412.106 and applicable court cases. Dual eligible Medicare Advantage s/b included in Medicaid ratio.[5]

[1] MAC's Jurisdictional Challenge, at 2 (Oct. 22, 2014).
[2] *Id*. at 1.
[3] *Id*.
[4] *Id*. at 2.
[5] *Id*.

The MAC contends that this is a completely new issue as it was not specifically identified within the Downey's appeal request nor was it timely added in accordance with 42 C.F.R. § 405.1835(c).[6]

Medicare Contractor's Jurisdictional Challenge

The MAC argues that HCFA Ruling No. 97-2 is not relevant to the issue of dual eligible Medicare Advantage days in the Medicaid ratio. This Ruling addresses days for patients who are Medicaid eligible, but who have exceeded Medicaid coverage limitations on inpatient hospital days of service (and, consequently, no Medicaid payment was made for those days). The MAC contends that the issue of dual eligible Medicare Advantage in the Medicaid ratio is a completely new issue – one that was not raised in Downey's original appeal request. In effect, Downey is attempting to add an issue via its transfer request.[7]

The regulations for adding issues to a hearing request are at 42 C.F.R. § 405.1835(c). This section states:

> After filing a hearing request in accordance with paragraphs (a) and (b) of this section, a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the Board, only if the following requirements are met:
>
> (1) The request to add issues complies with the requirements of paragraphs (a)(l) and (b) of this section as to each new issue.
>
> (2) The specific matters at issue raised in the initial hearing request and the matters identified in subsequent requests to add issues, when combined, satisfy the requirements of paragraph (a)(2) of this section.
>
> (3) The Board receives the request to add issues no later than 60 days after the expiration of the applicable 180-day period prescribed in paragraph (a)(3) of this section.[8]

Section 405.1835(c) is effective with appeals filed on or after August 21, 2008. On January 19, 2009, Downey filed its appeal request and, as a result, 42 C.F.R. § 405.1835(c) applies to this case.

Downey appealed from its NPR dated August 5, 2008. The NPR is presumed to have been received by Downey on August 10, 2008. The 180-day period pursuant to § 405.1835(a)(3) expired on February 6, 2009.[9] This means that Downey had until April 7, 2009 to add an issue to

[6] *Id*.
[7] MAC's Jurisdictional Challenge, at 2 (Oct. 22, 2014).
[8] 42 C.F.R. § 405.1835(c).
[9] MAC's Jurisdictional Challenge, at 2.

its appeal request. However, Downey failed to do so. Therefore, the MAC concludes that the addition of this issue does not comport with the requirements of 42 C.F.R. § 405.1835(c)(3), which mandates that issues added to an appeal must be received no later than 60 days after the expiration of the applicable 180-day period prescribed in § 405.1835(a)(3) (i.e., not later than 180 days after receipt of the MAC's determination). Accordingly, the MAC concludes that the Board does not have jurisdiction over this issue.

The Group Representative's Jurisdictional Response

The Group Representative filed a Response to Jurisdictional Challenge on February 6, 2020. The Group Representative maintains that Downey transferred Issue 1 to the subject optional group and that transferred Issue 1 included the Part C Days issue. The Group Representative argues the following:

> The lead MAC takes a strict view and argues that it did not make an adjustment excluding Part C days from the Medicaid fraction in Downey's NPR, and therefore, it did not render a final determination that was appealable under the regulations. Further, the MAC claims that Downey attempted to "add" the issue in an untimely fashion, even though the Providers see no evidence of any attempt to add the issue. In fact, Downey included the Medicaid fraction Part C days issue among the issues it initially appealed in its individual appeal prior to transferring the issue to this group appeal, case no. 13-23460.[10]

The Group Representative continues:

> In Downey's FYE 2007 notice of program reimbursement ("NPR"), the MAC adjusted Downey's SSI fraction specifically to include Part C days. On this there is no question. For the MAC to claim that an adjustment of Part C days in the SSI fraction is not a reconsideration of Part C days in the Medicaid fraction is a myopic (and logically inconsistent) view of the DSH calculation. The Providers contend that the DSH statute requires dually eligible (Medicare and Medicaid) Part C days to be included in the DSH Medicaid fraction. A decision to include such dually eligible Part C days in the SSI fraction is necessarily a decision not to include the dually eligible portion of those same Part C days in the Medicaid fraction. As such, the issue ultimately being decided is where to place Part C days in the DSH calculation. Downey is appealing the inclusion of Part C days in the SSI fraction in a "sister" group appeal for FYE 2007. The MAC has not contested jurisdiction over Downey's appeal on that part of this issue. These

[10] Provider's Jurisdictional Response (Feb. 6, 2020).

> two issues (exclusion of dually eligible Part C days from the Medicaid fraction and inclusion of Part C days in the SSI fraction) work together in tandem. Government counsel representing the Secretary of Health and Human Services have admitted this on various occasions in the ongoing Allina Health Services series of cases. It is not logical to claim that the Board has jurisdiction over the issue of certain days in one fraction, but not over a subset of those very same days, which the Provider is arguing belong in the other fraction. Moreover, as discussed below, it cannot be said in this case that Downey did not reference the days at issue in its original appeal, in a timely manner.[11]

The Group Representative requests that the Board accept jurisdiction over the Medicare Part C issue for Downey, as applicable to the Medicaid Fraction of DSH, in the instant appeal.

Board's Analysis and Decision

The Board finds that it does not have jurisdiction over Downey as a participant in this group, because Downey did not timely appeal or add the Part C days issue to its individual appeal prior to requesting to transfer the issue to this group. Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2008), a provider has a right to a hearing before the Board with respect to specific items claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.[12]

Downey filed its appeal with the Board in January of 2009 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 the elements described in paragraphs (b)(1) through (b)(4) of this section. If the provider submits a hearing request that does not meet the requirements of paragraphs (b)(1), (b)(2), or (b)(3) of this section, the Board may dismiss with prejudice the appeal, or take any other remedial action it considers appropriate.
>
> (2) An explanation (for **each specific** item at issue, see paragraph (a)(1) of this section) of the provider's dissatisfaction with the intermediary's or Secretary's determination under appeal, including an account of **all** of the following:

[11] *Id*. at 2.
[12] Board Rule 4.4.1 (Aug. 29, 2018); 42 CFR §405.1835.

> (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, a description of the nature and amount of each self-disallowed item and the reimbursement or payment sought for the item.[13]

Board Rule 8 (Aug. 21, 2008), which was in effect when Downey filed its appeal, elaborated on this regulatory requirement as follows:

> **Rule 8 - Framing Issues for Adjustments Involving Multiple Components**
>
> **8.1 - General**
>
> Some issues may have multiple components. To comply with the regulatory requirement to *specifically identify* the items in dispute, each contested component must be appealed as a separate issue and *described as narrowly as possible* using the applicable format outlined in Rule 7. See common examples below.
>
> **8.2 - Disproportionate Share Cases** (e.g., dual eligible, general assistance, charity care, HMO days, etc.)[14]

Effective August 21, 2008, new Board regulations went into effect that limited the addition of issues to appeals.[15] 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 --
>
> ***
>
> (3) 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.

[13] 42 C.F.R. § 405.1835(b) (FFY 2009) (bold and underline emphasis added).
[14] *Available at* https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/Downloads/PRRBRules2008.pdf (last visited Apr. 6, 2021).
[15] *See* 73 Fed. Reg. 30190 (May 23, 2008).

The Group Representative maintains that, its jurisdictional response, that Downey's Issue 1 included the Medicare Part C days issue. However, as discussed below, the Board disagrees.

On June 10, 2013, Downey requested to transfer Issue 1 to this group appeal (and, indeed, as noted by the MAC, Downey specifically marked Issue 1 on the attached copy of the appeal request as the "group issue" being transferred). Indeed, the Group Representative admits that the following facts are "not in dispute" with respect to Downey:

1. "On 6/10/13, Downey requested to transfer 'Issue 1' to the present group appeal."

2. "In Downey's initial appeal request, it characterized Issue 1 as 'The Intermediary did not include all eligible Medi-Cal days pursuant to HCFA Ruling 97-2 and 42 C.F.R. 412.106.'"

3. Further, all parties agree that Downey 'starred' this issue [Issue 1] as a "group issue."[16]

In the appeal request, Downey articulated Issue 1 very simply as follows:

> ISSUE I
> Were the ***Medi-Cal*** eligible days included in the Disproportionate Share Percentage correct?
>
> | | |
> |---|---|
> | Adjustment No. | 23 |
> | Reimbursement Impact | $350,000 |
> | Calculation | $1000**350days**=$350,000 |
>
> The Intermediary did not include all eligible ***Medi-Cal*** days pursuant to HCFA Ruling No. 97-2 and 42 CFR 412.106.[17]

It is clear that Issue 1 only pertains to Medicaid eligible days through the reference to HCFA Ruling No. 97-2. CMS, formerly known as HCFA, issued this Ruling in February 1997 to "state[] the policy of [CMS] concerning the determination to change its interpretation of [42 U.S.C. § 1395ww(d)(5)(F)(vi)(II)] and 42 CFR 412.106(B)(4) to follow the holdings of the United States Courts of Appeals for the Fourth, Sixth, Eighth, and Ninth Circuits." The Ruling holds:

> Under the new interpretation, the Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to include all inpatient hospital days of service for patients who were eligible on that day for medical assistance under a State Medicaid plan in the Medicaid fraction,

[16] Provider's Jurisdictional Response (Feb. 6, 2020).
[17] (Emphasis added.)

> whether or not the hospital received payment for those inpatient hospital services.[18]

At no point in the Ruling are "dual eligible days" (*i.e*., day much less dual eligible Part C days discussed, as the Ruling itself begins with a designation that it applies to ***Part A***.[19] Indeed, as noted above, Ruling 97-2 was issued in February 1997 and *necessarily* ***predates*** *when Medicare Part C was enacted in August 1997* in § 4001 of the Balanced Budget Act of 1997. Issue 1 essentially parrots Ruling 97-2.

To this end, Issue 1 focuses on "Medi-Cal days" which are those days relating to California's Medicaid program.[20] This is a public health insurance program which provides needed health care services for low-income individuals including families with children, seniors, persons with disabilities. Medi-Cal is financed equally by the state and federal government. In this regard, the Board takes administrative notice that: (1) Ruling 97-2 established that "[t]he hospitals bear the burden of proof and must verify with the State that a patient was eligible for Medicaid (for some covered services) during each day of the patient's inpatient hospital stay"; (2) providers in California have historically not received been able to perform this state verification with the Medi-Cal program prior to filing their cost report as Medi-Cal eligibility records have not available until sometime after the cost report is due to be filed; and (3) as a result, providers in California have routinely appealed Medicaid eligible days as an issue to the Board.

Indeed, there is no indication that any of the "350 days" included in Downey's amount in controversy calculation for Issue 1 in the appeal request include any Part C days. The Board notes that Downey has not offered up any explanation or documentation to indicate what patients were included in the stated 350 days. The fact that Downey identifies 350 days in dispute also suggests that, contrary to the Group Representative's assertion, Downey was able to identify the days at issue for Issue 1 on or about the time it filed its appeal request.

The Board notes that 42 C.F.R. § 405.1835(b)(2)(ii) required Downey to specify in its appeal request how Medicare payment must be determined differently for ***each*** disputed item."[21] Accordingly, to the extent, Downey intended to appeal the Part C days issue, it was required to identify it and specify how Medicare payment must be determined differently. In this regard, the Board notes that with the Part C issue, the group is seeking to remove Part C days from the SSI fraction so that Part C days may be counted in the Medicaid fraction. However, Downey did not include any such discussion in Issue 1 because, for Issue 1. Rather, it is the Board finding that, in Issue 1, Downey was not trying to change CMS' stated reimbursement methodology for the Medicaid fraction but rather just trying to add an additional 350 Medicaid eligible days (*i.e.,* 350 Medi-Cal days) that otherwise complied with Ruling 97-2 (which again predates the addition of Part C to the Medicare program). In further support of this finding, the Board notes that the Medicaid fraction as defined at 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II) does not refer to dual eligible days but rather only to Medicaid eligible days (i.e., "patients who . . . were eligible for

[18] CMS HCFA Ruling No. 97-2 (Feb. 1997).
[19] *Id*.
[20] Indeed, Issue 1 in the request for hearing does not even use the more generic term "Medicaid eligible days."
[21] (Emphasis added.)

medical assistance under a State plan approved under title XIX, but who were not entitled to benefits under part A of this title"). The generic reference to 42 C.F.R. § 412.106 in Issue 1 clarifies nothing as it does not, as noted in Board Rule 8.1, *specifically* identify the item in dispute or describe the item at issue as *narrowly* as possible.

Finally, the Board recognizes that the Group Representative further argued that "[its] intent to appeal missing Part C Dual Eligible Medicaid days in the Medicaid Fraction ***under Issue 1*** is further evidenced by some of Downey's other appealed issues for fiscal year ending 2007" including Issues 4 through 6.[22] Specifically, the Group Representative argues that: (1) once these other issues are accounted for, "[w]hat remained ***in Issue No. 1*** were all the remaining dual eligible days that improperly were not included in Downey's Medicaid fraction through the original NPR"; and (2) "[g]iven the coverage in Issue 4 through 6, this did not leave many other categories of unappealed missing Medicaid eligible days."[23] Accordingly, the Group Representative concludes that "[c]learly, the exclusion of dual eligible Part C days was one of the few remaining types of days to be appealed, and these dual eligible Part C days . . . were included and appealed ***under Issue 1***."[24] However, these arguments, again, fail to account for the *specificity* requirements in 42 C.F.R. § 405.1835(b) and Board Rule 8. The fact that, for ***other*** issues, Downey was specific in its issue statement and did comply with these *specificity* requirements (as the Group Representative admits) only reaffirms Downey's failure to properly include the Part C days issue in its appeal request ***under Issue 1***. Pursuant to these *specificity* requirements, the Board cannot simply infer Downey's intent through generic references in Issue 1 and/or through a process of elimination of issues commonly appealed by *other* providers.

* * * * *

In summary, for the reasons set forth above, the Board hereby dismisses Downey Community Hospital from Case No. 13-2346G pursuant to its authority under 42 C.F.R. 405.1835(b). This appeal remains open as other Providers remain pending in the group appeal, which will be remanded pursuant to CMS Ruling 1739-R under separate cover.

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

Board Members Participating:

Clayton J. Nix, Esq.
Gregory H. Ziegler, CPA
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

For the Board:

4/7/2021

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: Clayton J. Nix -A

cc: Wilson Leong, Federal Specialized Services

[22] Provider's Jurisdictional Response at 11 (emphasis added).
[23] Provider's Jurisdictional Response at 11 (emphasis added).
[24] Provider's Jurisdictional Response at 11 (emphasis added).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Ms. Mari Dee Sandra Cid
Administrator/Director of Patient Care
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Escondido, CA 92025

RE: ***Jurisdiction Determination***
Hospice Care of the Coast (Prov. No. A0-1506)
FFY 2021
Case No. 21-1070

Dear Ms. Cid:

The subject appeal, for the Federal Fiscal Year ("FFY") 2021, was submitted via the Office of Hearings Case and Document Management System ("OH CDMS") on March 16, 2021 and is based on the Notice of Quality Reporting Program Noncompliance Decision Upheld dated September 10, 2020. The Board assigned the appeal request to Case No. 21-1070. The Board's determination regarding the jurisdiction of the subject appeal is set forth below.

Procedural Background:

42 C.F.R. § 1801(a) defines "date of receipt" for purposes of receiving a final determination as follows, in pertinent part:

> The date of receipt . . . is presumed to be 5 days after the date of issuance of a contractor notice or a reviewing entity document. 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.

The final determination in dispute for the subject appeal is CMS' Notice of Quality Reporting Program Noncompliance Decision Upheld dated September 10, 2020. Pursuant to the above regulation, the Provider is *presumed* to have received the final determination 5 days later, September 15, 2020. In the appeal request, the Provider indicated that the final determination was received 10 days after its issuance and was not received by the Provider until September 20, 2020. Upon review of the final determination, it was noted that the final determination does not reflect an internal Provider date stamp or internal markings confirming that the Provider actually received the final determination from CMS on September 20, 2020.

As a result, the Board sent an inquiry to the Provider on March 16, 2021 advising that, since the Provider indicated it received the final determination more than 5 days from issuance, it needed to submit proof to the Board regarding the date it received the final determination. The Board advised the Provider that the Proof of Receipt must either be a copy of the cancelled envelope showing the USPS ("United States Postal Service") date stamp or a copy of the national courier (UPS, FedEx, etc.) routing slip verifying that the Provider received the final determination on September 20, 2020. (See Rule 4.3.1 and 42 C.F.R. 405.1801(a) (definition of "date of receipt at paragraph (1)(iii)).)

Provider's Response:

On April 1, 2021, the Provider submitted its response to the Board's inquiry regarding the proof of receipt. The Provider's official response was a letter stating that it was unable to provide a Proof of Receipt, nor did it have a copy of the cancelled envelope showing the USPS date stamp or any other routing slip for verification. The Provider stated that, upon further investigation and recall of events leading to the date of receipt of the final determination, the Administrator of the Provider, who received the letter of determination, sent a copy of the letter to the company's biller for their information on the day it was received. As a result, the Provider is correcting its previous submission that the final determination was received more than 5 days from the date of issuance, and advises that the final determination was received just 1 day from the date of issuance.

Board Determination:

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

Board Rule 4.3.1 states, in part:

> The date of receipt of a contractor final determination is ***presumed*** to be 5 days after the date of issuance. This ***presumption***, which is otherwise conclusive, may be overcome if it is established by a preponderance of the evidence that such materials were actually received ***on a later date***. *See* 42 C.F.R. § 405.1801(a)(1)(iii).
>
> The appeal period begins on the date of receipt of the contractor final determination as defined above and ends 180 days from that date. (Emphasis added.)

Board Rule 4.5.A states, in part:

> Timely filing is determined based on the date of receipt by the Board. The date of receipt is presumed to be:

A. The date submitted to OH CDMS as evidenced by the Confirmation of Correspondence generated by the system.

The Board notes that the Provider advised that it could not forward a proof of receipt in accordance with the Board's request of March 16, 2021 to establish receipt beyond the 5-day presumption window noted above. Rather, in its response, the Provider advised that it was correcting its original statement and advised that it had received its final determination just 1 day from the date of issuance, rather than the 10 days as originally noted. As a result, the 5-day presumption applies.

The subject appeal was submitted via OH CDMS on March 16, 2021 with a final determination date of September 10, 2020. Pursuant to the regulations and Board Rules cited above, the Provider had 185 days (180 days + the 5-day allowance) from September 10, 2020 to file an appeal with the Board. The 185-day deadline for filing the appeal was March 14, 2021, which was a Sunday. Pursuant to Board Rule 4.4.3, "If the due date falls on a Saturday, 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, the deadline becomes the next business day that is not one of the aforementioned days. See 42 C.F.R. § 405.1801(d)(3)." The subject appeal request, therefore, should have been filed on Monday, March 15, 2021. The Board notes that the subject appeal request was not submitted until the following day, March 16, 2021, 186 days from the date of the final determination, September 10, 2020.

Based on the above findings, the Board determines that the subject appeal was not timely filed in accordance with the Board Rules and 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840. Accordingly, the Board hereby dismisses the subject appeal in its entirety and removes it from its docket.

Board Members Participating:

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

FOR THE BOARD:

4/15/2021

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: Clayton J. Nix -A

cc: Wilson C. Leong, Federal Specialized Services
Danene Hartley, National Government Services, Inc.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Wade H. Jaeger
Sutter Health
P.O. Box 619092
Roseville, CA 95661

Lorraine Frewert
Noridian Healthcare Solutions c/o Cahaba
Safeguard Administrators (J-E)
P.O. Box 6782
Fargo, ND 58108-6782

RE: ***Jurisdictional Determination***
California Pacific Medical Center (Prov. No. 05-0305)
FYE 12/31/2010
Case No. 20-2154

Dear Mr. Sutter and Ms. Frewert,

The Provider Reimbursement Review Board ("Board") has reviewed the above-captioned appeal and finds an impediment to the Board's jurisdiction. The pertinent facts and the Board's jurisdictional determination are set forth below.

Background

By letter dated July, 17, 2019, Toyon Associates, Inc. ("Toyon") requested a reopening of the Provider's cost report. The reopening specifically states that the Provider ". . . requests a recalculation of its SSI ratio based on its cost reporting period rather than the federal fiscal year. The Provider's cost reporting period is 1/1/2010 to 12/31/2010."

On August 22, 2019, the Medicare Contractor ("MAC") issued the Notice of Reopening advising that the cost report was being reopened "[t]o adjust the SSI ratio used to calculate the provider's disproportionate share adjustment based on the data from the hospital's actual cost reporting period rather than the federal fiscal year and to amend the disproportionate share adjustment to account for the change in SSI ratio." On April 2, 2020, the MAC issued the Notice of Amount of Corrected Reimbursement ("RNPR").[1]

On September 25, 2020, Sutter Health ("Sutter') filed the individual appeal from the RNPR to which the Board assigned Case No. 20-2154.[2] The RNPR appeal included six issues:

[1] Hereafter, the Notice of Amount of Corrected Program Reimbursement will be referred to as a revised Notice of Program Reimbursement ("RNPR").
[2] Sutter Health filed a separate appeal for the RNPR rather than using the "Add Determination" case action to add it to the pending appeal for the Provider's FYE 12/31/2010 pending NPR based appeal (Case No. 19-0750).

1. DSH SSI Ratio – Inaccurate Data (SSI Accuracy)
2. DSH SSI Ratio Dual Eligible Part C Days (SSI Fr. Part C days)
3. DSH SSI Ratio Dual Eligible Part A Days (SSI Fr. Part A days)
4. DSH SSI Ratio MMA Section 951 (SSI MMA Section 951)
5. DSH Medicaid Ratio Dual Eligible Part C Days (M'caid Fr. Part C days)
6. DSH Medicaid Ratio Dual Eligible Part A Days (M'caid Fr. Part A days)

The Provider referenced Audit Adjustment # 5 for all six issues appealed from the RNPR. Although in reviewing the audit adjustment pages submitted as issue support, it appears that adjustment #5 was an adjustment to ". . . include the latest final settlement payment on the cost report for proper reporting of the payments." Adjustment #4 was issued "[t]o adjust the SSI% and the Disproportionate Share Amount *based on the latest CMS Letter of SSI% Realignment*."[3]

Board Determination

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2019), a provider has a right to a hearing before the Board with respect to specific items claimed on a timely filed cost report if: (1) it is dissatisfied with the final determination of the Medicare contractor; (2) the amount in controversy is $10,000 or more (or $50,000 for a group); and (3) the request for a hearing is filed within 180 days of the date of receipt of the final determination.

The Code of Federal Regulations provides for an opportunity for a reopening and RNPR at 42 C.F.R. § 405.1885 (2018), which provides in relevant part:

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

Additionally, 42 C.F.R. § 405.1889 (2018) explains the effect of a cost report revision:

> (a) If a revision is made in a Secretary or contractor determination or a decision by a reviewing entity after the determination or decision is reopened as provided in §405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the provisions of §§ 405.1811, 405.1834, 405.1835, 405.1837, 405.1875, 405.1877 and 405.1885 of this subpart are applicable.

[3] (Emphasis added.)

> (b)(1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.
>
> (2) Any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision.

The Board finds that it does not have jurisdiction over the six issues in this individual appeal filed from the revised NPR because the revised NPR was issued as a result of the Provider' SSI Realignment request, and did not specifically adjust these issues. As a result, the provider does not have the right to appeal under 42 C.F.R. § 405.1889(b) as referenced in § 405.1835(a)(1).

When a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[4] The reopening in this case was a result of the Provider's request to realign its SSI percentage from the federal fiscal year end to its individual cost reporting fiscal year end. Based on the Provider's Request to Reopen, the Notice of Reopening, as well as audit adjustment (#4) associated with the RNPR under appeal clearly only revised the SSI percentage in order to realign it from a federal fiscal year to the provider's respective fiscal year.[5] The realignment process (as described in the Federal Register) does not change any of the underlying data that is gathered on a month-by-month basis (*e.g.*, does not change data on either Part A or Part C days) since CMS does not rerun the data matching process in order to effectuate a realignment. Indeed, to this end, CMS' stated realignment policy is that the provider must accept the realigned SSI percentage.[6] Since the only matter specifically revised in the RNPR was an adjustment to realign the SSI percentage from federal fiscal year to the provider's fiscal year, the Board does not have jurisdiction over the SSI Accuracy, SSI Fr. Part C days, SSI Fr. Part A days, SSI MMA Section 951, M'caid Fr.

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[4] 42 C.F.R. § 405.1889(b)(1).

[5] CMS does not re-run the data match process when it issues a realigned SSI percentage. CMS describes the matching process that it uses as part of the FY 2011 IPPS final rule published on August 16, 2010. *See* 75 Fed. Reg. 50042, 50275-85 (Aug. 16, 2010). All of the underlying data which is gathered on a month-by-month basis remains the same and the realigned SSI percentage simply reflects a different 12-month time period being used. *See* 42 C.F.R. § 412.106(b)(2) (noting that CMS gathers data on a month-by-month basis). The realignment solely takes the SSI data for each provider and the total Medicare days for each provider (previously accumulated on a month-by-month basis and used in the original CMS published SSI percentages) and reports it on the provider's cost reporting period instead of the September 30 FFY. *See also* 75 Fed. Reg. 50042, 50279 (Aug. 16, 2010) (stating: "The SSI fractions are generally based on the Federal fiscal year; however, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived from the data match process for the two Federal fiscal years that spanned the hospital's cost reporting period.); 70 Fed. Reg. 47278, 47439 (Aug. 12, 2005) (stating: "Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period, and *the hospital **must accept** the resulting DSH percentage for that year, whether or not it is a more favorable number than the DSH percentage based on the Federal fiscal year*." (emphasis added)).

[6] *See supra* note 5 (quoting CMS realignment policy at 70 Fed. Reg. at 47439).

Part C days, or M'caid Fr. Part A days issues in the subject individual appeal. In making this ruling, the Board notes that its application of 42 C.F.R. § 405.1889(b) has been upheld by courts on review.[7]

In addition, the Board directs the Representative's attention to Board Rule 6.3, which gives guidance on multiple determinations appealed by a Provider for the same fiscal year end. The Rule states:

> **6.3 Adding a New Determination to an Individual Case**
>
> **6.3.1 Request and Supporting Documentation**
>
> For individual appeals, an appeal may be for only one cost reporting period. *If multiple final determinations were issued **on different dates** for the cost reporting period being appealed(e.g., NPR, revised NPRs, exception request denials, etc.), providers **must** timely request to add the subsequent determination to its pending appeal for that cost reporting period.*" Reference Model Form A – Individual Appeal Request (Appendix A) for all required data fields and supporting documentation.[8]

Similarly, Board Rule 4.6 prohibits "Duplicate Filings":

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

Accordingly, in this instance, the appeal of the RNPR should have been added to the Provider's pending individual appeal under Case No. 19-0750 which, in addition to others, contained the

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[7] *See St. Mary's of Mich. V. Azar*, No. 18-01790, 2020 WL 4049912 (D.D.C. July 20, 2020); *McLaren Flint v. Azar*, No. 18-2005, 2020 WL 2838566 (D.D.C. May 31, 2020)*, Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F.Supp.3d 348 (D.D.C. 2014); *HCA Health Servs. of OK v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994).
[8] Board Rules. (Aug. 29, 2018)

same six issues addressed herein.[9] ***The Board directs the Representative to review Board Rules 4.6 and 6.3 for compliance to ensure duplicate individual appeals are not filed.*** *The Board also notes that the OH CDMS PRRB Module External User Manual at §§ 3.3.4.3 and 3.3.4.3.1 describes how a determination may be added to an existing individual appeal in OH CDMS using the Case Correspondence Drop-Down Menu.*[10]

* * * * *

In conclusion, the Board ***dismisses*** the six issues appealed from the RNPR in Case No. 20-2154 as the Provider does not have the right to appeal the RNPR at issue for these issues. As there are no remaining issues in the individual appeal, the Board hereby closes Case No. 20-2154 and removes it from the Board's docket.

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

Board Members Participating:
Clayton J. Nix, Esq.
Gregory H. Ziegler, CPA
Robert A. Evarts, Esq.
Susan A. Turner, Esq.
Kevin D. Smith, CPA

FOR THE BOARD:

4/16/2021

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: Clayton J. Nix -A

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

[9] The Board notes that, of the six duplicate issues included in the original NPR appeal, all but the M'caid Fr. Part C days issue were transferred to common issue related party ("CIRP") groups on April 23, 2019. The M'caid Part C days issue was subsequently transferred to a CIRP group on February 22, 2021 groups.
[10] OH CDMS PRRB Module External User Manual, Version 1.0, at 64-65 (Aug. 22, 2018) (PDF copy available at: https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/Electronic-Filing).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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Lorraine Frewert
Noridian Healthcare Solutions c/o Cahaba
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Fargo, ND 58108-6782

RE: ***Jurisdictional Determination***
Sutter Delta Medical Center (Prov. No. 05-0523)
FYE 12/31/2014
Case No. 21-0805

Dear Mr. Sutter and Ms. Frewert,

The Provider Reimbursement Review Board ("Board") has reviewed the above-captioned appeal and finds an impediment to the Board's jurisdiction. The pertinent facts and the Board's jurisdictional determination are set forth below.

Background

On September 18, 2019, the Medicare Contractor ("MAC") issued the Notice of Reopening advising that the cost report was being reopened "[t]o adjust the SSI ratio used to calculate the provider's disproportionate share adjustment based on the data from the hospital's actual cost reporting period rather than the federal fiscal year and to amend the disproportionate share adjustment to account for the change in SSI ratio." On September 23, 2020, the MAC issued the Notice of Amount of Corrected Reimbursement (RNPR).[1]

On February 23, 2021, Sutter Health ("Sutter") filed the individual appeal from the RNPR to which the Board assigned Case No. 21-0805.[2] The RNPR appeal included the six issues:

1. DSH SSI Ratio – Inaccurate Data (SSI Accuracy)
2. Medicare DSH SSI Ratio Part C Days (SSI Fr. Part C days)
3. Medicare DSH SSI Ratio Part A Days (SSI Fr. Part A days)
4. Medicare DSH SSI Ratio MMA Section 951 (SSI MMA Section 951)
5. Medicare DSH Medicaid Dual Eligible Part C Days (M'caid Fr. Part C days)
6. Medicare DSH Medicaid Dual Eligible Part A Days (M'caid Fr. Part A days)

[1] Hereafter, the Notice of Amount of Corrected Program Reimbursement will be referred to as a revised Notice of Program Reimbursement ("RNPR").
[2] Sutter Health filed a separate appeal for the RNPR rather than using the "Add Determination" case action to add it to the pending appeal for the Provider's FYE 12/31/2014 pending NPR based appeal (Case No. 17-1483).

The Provider referenced Audit Adjustment #4 from the RNPR for all six issues appealed from that RNPR. Audit Adjustment #4 was issued "[t]o adjust the SSI% and the Disproportionate Share Amount based on the latest CMS letter of SSI% Realignment."

Board Determination

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2019), a provider has a right to a hearing before the Board with respect to specific items claimed on a timely filed cost report if: (1) it is dissatisfied with the final determination of the Medicare contractor; (2) the amount in controversy is $10,000 or more (or $50,000 for a group); and (3) the request for a hearing is filed within 180 days of the date of receipt of the final determination.

The Code of Federal Regulations provides for an opportunity for a reopening and RNPR at 42 C.F.R. § 405.1885 (2018), which provides in relevant part:

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

Additionally, 42 C.F.R. § 405.1889 (2018) explains the effect of a cost report revision:

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

The Board finds that it does not have jurisdiction over the six issues in this individual appeal filed from the RNPR because the RNPR was issued as a result of the Provider' SSI Realignment request, and did not specifically adjust these issues. As a result, the Provider does not have the right to appeal under 42 C.F.R. § 405.1889(b) as referenced in § 405.1835(a)(1).

When a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[3] The reopening in this case was a result of the Provider's request to realign its SSI percentage from the federal fiscal year end to its individual cost reporting fiscal year end. Based on the Notice of Reopening, the RNPR under appeal clearly only revised the SSI percentage in order to realign it from a federal fiscal year to the provider's respective fiscal year.[4] The realignment process (as described in the Federal Register) does not change any of the underlying data that is gathered on a month-by-month basis (*e.g.*, does not change data on either Part A or Part C days) since CMS does not rerun the data matching process in order to effectuate a realignment. Indeed, to this end, CMS' stated realignment policy is that the provider must accept the realigned SSI percentage.[5] Since the only matter specifically revised in the RNPR was to realign the SSI percentage from federal fiscal year to the provider's fiscal year, the Board does not have jurisdiction over the SSI Accuracy, SSI Fr. Part C days, SSI Fr. Part A days, SSI MMA Section 951, M'caid Fr. Part C days, or M'caid Fr. Part A days issues in the subject individual appeal. In making this ruling, the Board notes that its application of 42 C.F.R. § 405.1889(b) has been upheld by courts on review.[6]

In addition, the Board directs the Representative's attention to Board Rule 6.3, which gives guidance on multiple determinations appealed by a Provider for the same fiscal year end. The Rule states:

> **6.3 Adding a New Determination to an Individual Case**
>
> **6.3.1 Request and Supporting Documentation**

---

[3] 42 C.F.R. § 405.1889(b)(1).

[4] CMS does not re-run the data match process when it issues a realigned SSI percentage. CMS describes the matching process that it uses as part of the FY 2011 IPPS final rule published on August 16, 2010. *See* 75 Fed. Reg. 50042, 50275-85 (Aug. 16, 2010). All of the underlying data which is gathered on a month-by-month basis remains the same and the realigned SSI percentage simply reflects a different 12-month time period being used. *See* 42 C.F.R. § 412.106(b)(2) (noting that CMS gathers data on a month-by-month basis). The realignment solely takes the SSI data for each provider and the total Medicare days for each provider (previously accumulated on a month-by-month basis and used in the original CMS published SSI percentages) and reports it on the provider's cost reporting period instead of the September 30 FFY. *See also* 75 Fed. Reg. 50042, 50279 (Aug. 16, 2010) (stating: "The SSI fractions are generally based on the Federal fiscal year; however, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived from the data match process for the two Federal fiscal years that spanned the hospital's cost reporting period.); 70 Fed. Reg. 47278, 47439 (Aug. 12, 2005) (stating: "Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period, and *the hospital **must accept** the resulting DSH percentage for that year, whether or not it is a more favorable number than the DSH percentage based on the Federal fiscal year*." (emphasis added)).

[5] *See supra* note 4 (quoting CMS realignment policy at 70 Fed. Reg. at 47439).

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

> For individual appeals, an appeal may be for only one cost reporting period. *If multiple final determinations were issued **on different dates** for the cost reporting period being appealed(e.g., NPR, revised NPRs, exception request denials, etc.), providers **must** timely request to add the subsequent determination to its pending appeal for that cost reporting period.*" Reference Model Form A – Individual Appeal Request (Appendix A) for all required data fields and supporting documentation.[7]

Similarly, Board Rule 4.6 prohibits "Duplicate Filings":

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

Accordingly, in this instance, the appeal of the RNPR should have been added to the Provider's pending individual appeal under Case No. 17-1483 which purportedly contained some or all of the same six issues addressed herein.[8] ***The Board directs the Representative to review Board Rules 4.6 and 6.3 and come into compliance with them to ensure duplicate individual appeals are not filed. The Board directs the Representative to review Board Rules 4.6 and 6.3 for compliance to ensure duplicate individual appeals are not filed.*** *The Board also notes that the OH CDMS PRRB Module External User Manual at §§ 3.3.4.3 and 3.3.4.3.1 describes how a determination may be added to an existing individual appeal in OH CDMS using the Case Correspondence Drop-Down Menu.*[9]

* * * * *

[7] Board Rules. (Aug. 29, 2018)

[8] The Board notes that because Case No. 17-1483 is a Legacy case, filed prior to the effectuation of the Office of Hearings Case & Document Management System ("OH CDMS") and due to the issues addressed in Board Alerts 18 and 19, we do not currently have access to a copy of the appeal request to verify the issues appealed from the original NPR appeal are the same as those appealed in the RNPR case. Notwithstanding, the Board notes that the Provider filed transfer requests in Case No. 17-1483 to the following CIRP groups 18-0879GC, 18-0880GC, 18-0891GC, and 18-0893GC.

[9] OH CDMS PRRB Module External User Manual, Version 1.0, at 64-65 (Aug. 22, 2018) (PDF copy available at: https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/Electronic-Filing).

In conclusion, the Board ***dismisses*** the six issues appealed from the RNPR in Case No. 21-0805 as the Provider does not have the right to appeal the RNPR at issue for these issues. As there are no remaining issues in the individual appeal, the Board hereby closes Case No. 21-0805 and removes it from the Board's docket.

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

Board Members Participating:
Clayton J. Nix, Esq.
Gregory H. Ziegler, CPA
Robert A. Evarts, Esq.
Susan A. Turner, Esq.
Kevin D. Smith, CPA

FOR THE BOARD:

4/16/2021

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: Clayton J. Nix -A

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Noridian Healthcare Solutions c/o
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RE: ***Jurisdictional Determination***
Huntington Hospital (Prov. No. 05-0438)
FYE 12/31/2013
Case No. 21-1162

Dear Ms. Marin-Bautista and Ms. Frewert,

The Provider Reimbursement Review Board ("Board") has reviewed the above-captioned appeal, which was received by the Board on May 31, 2019. The hard copy appeal was identified as a Supplemental Appeal from Additional Final Determination applicable to Case No. 17-1699. The request was associated to that original case, but Case No. was closed on April 18, 2018, prior to this filing. Therefore, this request is being established as a new, independent appeal and this notification serves as acknowledgement of the case. The pertinent facts and the Board's jurisdictional determination are set forth below.

Background

On April 4, 2019, the Medicare Contractor ("MAC") issued the Notice of Reopening advising that the cost report was being reopened "[t]o adjust the SSI ratio used to calculate the provider's Disproportionate Share Adjustment based on data from the hospital's actual cost reporting period rather than the federal fiscal year and to amend the Disproportionate Share Adjustment to account for the change in the SSI ratio." On December 3, 2018, the MAC issued the Notice of Amount of Corrected Reimbursement ("RNPR").[1]

On May 31, 2019, Huntington Hospital ("Huntington") filed the individual appeal from the RNPR to which the Board has assigned Case No. 21-1162. The RNPR appeal includes two issues:

1. Medicare DSH Accuracy of CMS Developed SSI Ratio ("SSI Accuracy")
2. Medicare Exclusion of Medicare Part C Days in SSI % ("SSI Fr. Part C days")

[1] Hereafter, the Notice of Amount of Corrected Program Reimbursement will be referred to as a revised Notice of Program Reimbursement ("RNPR").

Huntington referenced Audit Adjustment #4 for both issues appealed from the RNPR. Audit Adjustment #4 was issued "[t]o adjust the SSI % and the Disproportionate Share Amount based on the latest CMS letter of SSI % Realignment."

Board Determination

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2018), a provider has a right to a hearing before the Board with respect to specific items claimed on a timely filed cost report if: (1) it is dissatisfied with the final determination of the Medicare contractor; (2) the amount in controversy is $10,000 or more (or $50,000 for a group); and (3) the request for a hearing is filed within 180 days of the date of receipt of the final determination.

The Code of Federal Regulations provides for an opportunity for a reopening and RNPR at 42 C.F.R. § 405.1885 (2018), which provides in relevant part:

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

Additionally, 42 C.F.R. § 405.1889 (2018) explains the effect of a cost report revision:

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

The Board finds that it does not have jurisdiction over the two issues in this individual appeal filed from the RNPR because the RNPR was issued as a result of the Provider' SSI Realignment request, and did not specifically adjust these issues. As a result, the Provider does not have the right to appeal under 42 C.F.R. § 405.1889(b) as referenced in § 405.1835(a)(1).

When a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[2] The adjustment and reopening in this case were issued as a result of the Provider's request to realign its SSI percentage from the federal fiscal year end to its individual cost reporting fiscal year end. Based on the Notice of Reopening and Adjustment #4, the RNPR under appeal clearly only revised the SSI percentage in order to realign it from a federal fiscal year to the provider's respective fiscal year.[3] The realignment process (as described in the Federal Register) does not change any of the underlying data that is gathered on a month-by-month basis (*e.g.*, does not change data on either Part A or Part C days) since CMS does not rerun the data matching process in order to effectuate a realignment. Indeed, to this end, CMS' stated realignment policy is that the provider must accept the realigned SSI percentage.[4] Since the only matter specifically revised in the RNPR was to realign the SSI percentage from federal fiscal year to the provider's fiscal year, the Board does not have jurisdiction over the SSI Accuracy or SSI Fr. Part C days issues in the subject individual appeal. In making this ruling, the Board notes that its application of 42 C.F.R. § 405.1889(b) has been upheld by courts on review.[5]

In conclusion, the Board ***dismisses*** the two issues appealed from the RNPR in Case No. 21-1162 as the Provider does not have the right to appeal the RNPR at issue for these issues. As there are no remaining issues in the individual appeal, the Board hereby closes Case No. 21-1162 and removes it from the Board's docket.

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[2] 42 C.F.R. § 405.1889(b)(1).

[3] CMS does not re-run the data match process when it issues a realigned SSI percentage. CMS describes the matching process that it uses as part of the FY 2011 IPPS final rule published on August 16, 2010. *See* 75 Fed. Reg. 50042, 50275-85 (Aug. 16, 2010). All of the underlying data which is gathered on a month-by-month basis remains the same and the realigned SSI percentage simply reflects a different 12-month time period being used. *See* 42 C.F.R. § 412.106(b)(2) (noting that CMS gathers data on a month-by-month basis). The realignment solely takes the SSI data for each provider and the total Medicare days for each provider (previously accumulated on a month-by-month basis and used in the original CMS published SSI percentages) and reports it on the provider's cost reporting period instead of the September 30 FFY. *See also* 75 Fed. Reg. 50042, 50279 (Aug. 16, 2010) (stating: "The SSI fractions are generally based on the Federal fiscal year; however, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived from the data match process for the two Federal fiscal years that spanned the hospital's cost reporting period.); 70 Fed. Reg. 47278, 47439 (Aug. 12, 2005) (stating: "Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period, and *the hospital **must accept** the resulting DSH percentage for that year, whether or not it is a more favorable number than the DSH percentage based on the Federal fiscal year*." (emphasis added)).

[4] *See supra* note 3 (quoting CMS realignment policy at 70 Fed. Reg. at 47439).

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

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

Board Members Participating:
Clayton J. Nix, Esq.
Gregory H. Ziegler, CPA
Robert A. Evarts, Esq.
Susan A. Turner, Esq.
Kevin D. Smith, CPA

FOR THE BOARD:

4/16/2021

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: Clayton J. Nix -A

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Jurisdictional Challenge***
Aspirus Wausau Hospital (Prov. No. 52-0030)
FYE 6/30/2010
Case No. 14-2297

Dear Ms. Goron and Ms. Hartley,

The Provider Reimbursement Review Board ("Board") has reviewed the jurisdictional documents in the above referenced appeal and finds that it does not have jurisdiction over *either* the DSH/SSI Percentage (Provider Specific) issue *or* the DSH Payment – Medicaid Eligible Days issue. The jurisdictional decision of the Board is set forth below.

Pertinent Facts:

On August 12, 2013, Provider was issued an original Notice of Program Reimbursement ("NPR"). The Provider then appealed the following issues in its appeal request filed on February 4, 2014:

Issue 1: Disproportionate Share Hospital (DSH)/Supplemental Security Income (SSI) Percentage (Provider Specific)
Issue 2: Rural Floor Budget Neutrality Adjustment

On April 7, 2014, the Provider requested to add the following two issues to its individual appeal:

Issue 3: DSH Payment – Medicaid Eligible Days
Issue 4: Outlier Payments – Fixed Loss Threshold

On May 14, 2015, the Provider requested to withdraw Issue No. 2, and on May 19, 2014 the Provider requested to transfer Issue No. 4 to Group Case No. 14-1804G.

The Medicare Contractor filed a jurisdictional challenge in this appeal on March 8, 2021. The Provider's representative filed a response to the jurisdictional challenge on April 5, 2021. In the jurisdictional response, the Provider's representative requested to withdraw Issue No. 1, SSI Provider Specific, from the appeal. The only issue currently remaining in the appeal is the Medicaid Eligible Days issue.

Medicare Contractor Jurisdictional Challenge

On March 8, 2021, the Medicare Contractor filed a jurisdictional challenge with the Board over two issues: (1) DSH/SSI Provider Specific and (3) DSH Payment – Medicaid Eligible Days. Additionally, the Medicare Contractor argues that the Provider Representative needs to update the representation letters for this appeal since the letter reflects an incorrect FYE date.

Issue No. 1: DSH – SSI Percentage (Provider Specific)

The Medicare Contractor argues that this issue should be dismissed since it is duplicative of an issue in Group Case No. 14-1806G pursuant to PRRB Rule 4.6.1. In its initial appeal request, the Provider contended that the Medicare reimbursement for their DSH payments was not in accordance with 42 U.S.C. § 1395ww (d)(5)(F)(i). On February 4, 2014, the Provider filed a request to be directly added to Group Case No. 14-1806G, where the group appealed the calculation of the Medicare reimbursement pursuant to 42 U.S.C. § 1395ww (d)(5)(F)(i). The Medicare Contractor contends that "the Provider is arguing the same issue in both cases; that is, that the SSI percentage is flawed."[1] Therefore, the Medicare Contractor asks that this issue be dismissed from the appeal.

Issue No. 3: DSH Payment – Medicaid Eligible Days

The Medicare Contractor argues that this issue should be dismissed by the Board since it was not added to the Provider's open appeal in a timely manner. The Medicare Contractor contends that pursuant to PRRB Rule 6.2.1, the additional issues added to the individual appeal had to be filed by April 9, 2014. However, since the Medicare Contractor received the request to add issue on April 13, 2014, the Medicare Contractor contends that the additional issues were not timely filed and should be dismissed.[2]

Provider's Jurisdictional Response

On April 5, 2021, the Provider filed a response to the Medicare Contractor's Jurisdictional Challenge, which included a request to withdraw the SSI Provider Specific Issue. With respect to the Medicare Contractor's challenge to Medicaid Eligible Days, the Provider argues that the issue was timely filed. The Provider's appeal was timely filed on February 6, 2014, and requested to add two issues, including the Medicaid Eligible Days issue, to the appeal on April 7, 2014. Based on the Provider's NPR date of August 12, 2013, the deadline to add issues was April 9, 2014, therefore the issues were timely filed.[3]

[1] Jurisdictional Challenge at 5 (March 8, 2021).
[2] *Id.* at 5-6.
[3] Provider's Jurisdictional Response (April 5, 2021).

Board Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1841, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination. The Provider timely filed this appeal and met the amount in controversy requirement.

Issue No. 1: DSH Supplemental Security Income (SSI) Percentage

The Provider representative withdrew this issue, therefore the Board need not address the jurisdictional challenge with respect to this issue.

Issue No. 3: DSH Payment – Medicaid Eligible Days

Although the Medicaid Eligible Days issue was timely added to this appeal as required by 42 C.F.R. 405.1835(e), the Board nevertheless finds that it does not have jurisdiction over this issue because the Healthcare Reimbursement Services, In. ("HRS") was not *authorized* to file an appeal in the first instance on behalf of this Provider for this FYE. Board Rule 6.4 (2013) addresses certification when filing an individual appeal and states:

> *An **authorized** representative of the Provider **must sign** the appeal*. If the authorized representative is not a Provider employee, attach an Authorization of Representation letter with the Initial Filing on the Provider's letterhead, signed by an owner or officer of the Provider.[4]

Board Rule 5.4 (2013) addresses Authorization of Representation letters and states that:

> The letter designating the representative must be on the Provider's letterhead and be signed by an owner or officer of the Provider. *The letter must reflect the Provider's fiscal year under appeal* and must also contain the following contact information: name, organization, address, telephone number, fax number, and e-mail address of the representative.[5]

In this case, Provider is appealing from the 2010 fiscal period; however, the representative letter filed with the appeal request on February 4, 2014 authorized representation for the 2009 fiscal period. Accordingly, the representation letter attached to the appeal request did ***not*** authorize the representative to file the appeal for FY 2010. The Medicare Contractor noted this issue in its

[4] (Emphasis added.)
[5] (Emphasis added.)

Jurisdictional Challenged and the Provider failed to respond. Due to the fact that the representative letter does not reflect the fiscal year that is under appeal, the representative was not authorized to appeal this issue in the first instance on February 4, 2014. The Provider failed to meet the requirements of PRRB Rules 5.4 and 6.4 when the appeal was filed on February 4, 2014 and, therefore, the Board dismisses the appeal of this issue.

Conclusion

The Board finds that HRS was not properly designated as the representative for this Provider and FYE under appeal and, therefore, HRS was not authorized to file an appeal on behalf of the Provider on February 4, 2014. For this reason, pursuant to its authority under 42 C.F.R. § 405.1868, the Board dismisses the last issue pending in the appeal, the Medicaid Eligible Days issue. Additionally, the Board necessarily denies the Provider's request to transfer the Outliers Payment – Fixed Loss Threshold issue to Case No. 14-1804G, and dismisses this issue from this appeal as well because the representative was not authorized to file the appeal of this issue.

The Board hereby closes Case No. 14-2297 and removes it from its docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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Robert A. Evarts, Esq.
Susan A. Turner, Esq.
Kevin D. Smith, CPA

For the Board:

4/16/2021

X Clayton J. Nix

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RE: ***Jurisdictional Determination***
Rochester General Hospital
FYE 12/31/2015
Case No. 20-1881

Dear Ms. Webster and Ms. VanArsdale,

The Provider Reimbursement Review Board (the "Board") has reviewed jurisdiction in the above-referenced appeal. The Board's jurisdictional decision is set forth below.

Background

The Provider submitted a request for hearing on July 17, 2020, based on a Notice of Program Reimbursement ("NPR") dated January 22, 2020. The Provider appealed the inpatient rehabilitation facility ("IRF") outlier recoupment of $467,494, including $427,010 of outlier payments and $40,484 for the time value of money (interest). The Provider describes the issue as follows:

> In Audit Adjustment 43, the MAC disallowed $427,010 in outlier payments previously made to the hospital based on a recalculation of the Provider's cost-to-charge ratio for the cost reporting period ending December 31, 2015. In addition, through this adjustment, the MAC charged the Provider interest in the amount of $40,484 relating to the recoupment of these outlier payments. The Provider contends that the MAC's adjustment is incorrect, and should be reversed.[1]

Discussion and Analysis

As part of the Balanced Budget Act of 1997, Congress promulgated 42 U.S.C. § 1395ww(j) to create the IRF-PPS for cost reporting periods beginning on or after October 1, 2002.[2] 42 U.S.C. § 1395ww(j) authorized the implementation of a per-discharge PPS for IRFs. As required by § 1395ww(j), the Federal rates reflect all costs of furnishing IRF services. With respect to the "prospective payment rates," § 1395ww(j)(3) states, in part:

[1] Provider's Appeal Request, Statement of the Issue at 1.
[2] Pub. L. No. 105-33, 111 Stat. 251 (1997).

> (3) **Payment rate**.
>
> (A) **In general**.
>
> The Secretary shall determine a prospective payment rate for each payment unit for which such rehabilitation facility is entitled to receive payment under this title. Subject to subparagraph (B), such rate for payment units occurring during a fiscal year shall be based on the average payment per payment unit under this title for inpatient operating and capital costs of rehabilitation facilities using the most recent data available (as estimated by the Secretary as of the date of establishment of the system) adjusted—
>
> (i) by updating such per-payment-unit amount to the fiscal year involved by the weighted average of the applicable percentage increases provided under subsection (b)(3)(B)(ii) (for cost reporting periods beginning during the fiscal year) covering the period from the midpoint of the period for such data through the midpoint of fiscal year 2000and by an increase factor (described in subparagraph (C)) specified by the Secretary for subsequent fiscal years up to the fiscal year involved;
>
> (ii) by reducing such rates by a factor equal to the proportion of payments under this subsection (as estimated by the Secretary) based on prospective payments amounts which are additional payments described in paragraph (4) (relating to outlier and related payments);
>
> (iii) for variations among rehabilitation facilities by area under paragraph (6);
>
> (iv) by the weighting factors established under paragraph (2)(B); and
>
> (v) by such other factors as the Secretary determines are necessary to properly reflect variations in necessary costs of treatment among rehabilitation facilities.

With respect to "outlier and special payments," § 1395(j)(4) states:

> (A) **Outliers**
>
> (i) **In general**
> The Secretary may provide for an additional payment to a rehabilitation facility for patients in a case mix group, based upon

> the patient being classified as an outlier based on an unusual length of stay, costs, or other factors specified by the Secretary.
>
> (ii) **Payment based on marginal cost of care**
> The amount of such additional payment under clause (i) shall be determined by the Secretary and shall approximate the marginal cost of care beyond the cutoff point applicable under clause (i).
>
> (iii) **Total payments**
> The total amount of the additional payments made under this subparagraph for payment units in a fiscal year may not exceed 5 percent of the total payments projected or estimated to be made based on prospective payment rates for payment units in that year.
>
> (B) **Adjustment**
> The Secretary may provide for such adjustments to the payment amounts under this subsection as the Secretary deems appropriate to take into account the unique circumstances of rehabilitation facilities located in Alaska and Hawaii.

In creating new paragraph (j), Congress also limited administrative and judicial review with respect to the IRF PPS payment rates. Specifically, § 1395ww(j)(8) provides:

> (8) **Limitation on review**.
>
> There shall be no administrative or judicial review under section 1869, 1878, or otherwise of the establishment of—
>
> (A) case mix groups, of the methodology for the classification of patients within such groups, and of the appropriate weighting factors thereof under paragraph (2),
>
> (B) the prospective payment rates under paragraph (3),
>
> (C) *outlier and special payments under paragraph (4)*, and
>
> (D) area wage adjustments under paragraph (6).[3]

With regard to the limitation on review, the regulation at 42 C.F.R. § 412.630 reads as follows:

> Administrative or judicial review under sections 1869 or 1878 of the Act, or otherwise, is prohibited with regard to the establishment of the methodology to classify a patient into the case-mix groups and the associated weighting factors, the Federal per discharge

[3] (Italics emphasis added.)

> payments rates, *additional payments for **outliers** and special payments*, and the area wage index.[4]

Under 42 U.S.C. § 1395ww(j)(8)(B), Congress specifically precludes administrative or judicial review of the prospective payment rates for IRFs. Providers have attempted to dispute exactly what rate-setting "steps" Congress intended to shield from review under the statute. The 2018 decision of the U.S. Court of Appeals for the District of Columbia Circuit ("D.C. Circuit") in *Mercy Hospital, Inc. v. Azar* ("*Mercy*") sets out its analysis of this issue when it answers this question and clarifies what is shielded from review.[5]

In *Mercy*, the D.C. Circuit describes CMS' two-step rate-setting process for Medicare reimbursement for IRFs. The first step takes place prior to the beginning of the fiscal year and involves CMS' establishment of a standardized reimbursement rate, while the second step involves CMS' adjustments (calculated by the Medicare contractor) to "the standardized rates to reflect the particular circumstances of each hospital for that year." One of the ways in which CMS adjusts a hospital's IRF Medicare payment is by taking into account the number of low income patients ("LIP") served by the hospital, also known as the LIP adjustment. In *Mercy*, the Circuit Court affirmed the District Court's decision to dismiss, for lack of subject-matter jurisdiction, the provider's challenge to the Medicare Contractor's calculation of the provider's LIP adjustment for the fiscal years under appeal. In explaining its reasoning behind upholding the dismissal, the Circuit Court concludes that the statute's plain language prohibits administrative and judicial review of not only the statutory adjustments, but also the "step two rates" utilized by the Medicare Contractor when adjusting the standardized reimbursement rate and then calculating a hospital's final payment.[6]

Board Decision

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

The Medicare statute at 42 U.S.C. § 1395ww(j) directs CMS to set Medicare rates for inpatient rehabilitation services through a two-step process. The first step involves establishing a standardized reimbursement rate for each discharges patient based on the average estimated cost of inpatient operating facilities and treating patients for the upcoming year. The second step takes place after the fiscal year has ended, when CMS adjusts the standardized rates to reflect the particular circumstances of each hospital for that year. These adjustments authorized in the statute include four specific adjustments for price increases in the relevant market, outlier adjustments, wage index adjustments and case mix adjustments.

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[4] (Emphasis added.)
[5] 891 F.3d 1062 (June 8, 2018).
[6] *Mercy*, 891 F.3d at 1068

The D.C. Circuit in *Mercy* ruled that subsection (8) expressly shields from administrative and judicial review "prospective payment rates" and most statutory adjustments used to calculate them under the inpatient rehabilitation formula. The D.C. Circuit rejected the provider's limited reading of the language "prospective payment rates" as including only the unadjusted rates at step one of the formula, that is the standardized payment rates. The D.C. Circuit concluded that the statute defines "prospective payment rate" as the amount that is determined after the fiscal year ends, when CMS, as the second step of the payment process, adjusts the standardized rates to reflect the particular circumstances of each hospital for that year. The D.C. Circuit ruled that both as a textual and practical matter, the LIP adjustment is inextricably intertwined with the step-two rate, and thus that the preclusion provision applies to the LIP adjustment just as it applies to the other adjustments described in paragraph (8).

In the instant appeal, Rochester General Hospital seeks Board review of one of the "step two rates" utilized by the Medicare Contractor when adjusting the standardized reimbursement rate and calculating Rochester General Hospital's final payment. Congress has specifically prohibited administrative and judicial review of both the prospective payment rates for IRFs ***and*** the outlier payment adjustment, as codified at 42 U.S.C § 1395ww(j)(8) and 42 C.F.R. § 412.630. Accordingly, the Board lacks the jurisdiction to hear Rochester General Hospital's appeal pursuant to 42 U.S.C § 1395ww(j)(8) and 42 C.F.R. § 412.630.[7] In making this finding, the Board notes that the Court of Appeals decision in *Mercy* is controlling precedent for interpretation of § 1395ww(j)(8) because the Provider could bring suit in the D.C. Circuit.[8]

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

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[7] *See also* 78 Fed. Reg. 47860, 47901 (Aug. 6, 2013) (stating: "the preclusion applies to all aspects of the IRF PPS payment rates, not just the formulas. Courts have applied nearly identical preclusion provisions in other parts of the Medicare statute to prevent review of all subsidiary aspects of the matter or determination protected from review. Finally, while precluding review of the IRF LIP adjustment may prevent correction of certain errors, we can only conclude that Congress has made the judgment that such a result is an appropriate trade-off for the gains in efficiency and finality that are achieved by precluding review. Similarly, although applying the preclusion here may result in certain questions being reviewable for an IPPS hospital but not an IRF, this is a judgment that Congress has made. We note that there is a preclusion of review provision in the IPPS statute also, at section 1886(d)(7). The precise contours of these preclusive provisions were for Congress to draw.")

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

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For the Board:

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RE: ***Jurisdictional Determination***
California Pacific Medical Center (Prov. No. 05-0047, FYE 12/31/2007)
Case No. 21-1042

Dear Mr. Sutter and Ms. Frewert,

The Provider Reimbursement Review Board ("Board") has reviewed the above-captioned appeal and finds an impediment to the Board's jurisdiction. The pertinent facts and the Board's jurisdictional determination are set forth below.

Background

On June 26, 2017, the Medicare Contractor ("MAC") issued the Notice of Reopening, advising that the cost report was being reopened "[t]o adjust the SSI ratio used to calculate the provider's Disproportionate Share Adjustment based on the data from the hospital's actual cost reporting period rather than the federal fiscal year and to amend the Disproportionate Share Adjustment to account for the change in the SSI ratio." On October 15, 2010, the MAC issued the Notice of Amount of Corrected Reimbursement ("RNPR").[1]

On March 12, 2021, Sutter Health ("Sutter") filed the individual appeal from the RNPR to which the Board assigned Case No. 21-1042.[2] The RNPR appeal included six issues:

1. DSH SSI Ratio – Inaccurate Data (SSI Accuracy)
2. Medicare DSH SSI Ratio Part C Days (SSI Fr. Part C days)
3. Medicare DSH SSI Ratio Part A Days (SSI Fr. Part A days)
4. Medicare DSH SSI Ratio MMA Section 951 (SSI MMA Section 951)
5. Medicare DSH Medicaid Dual Eligible Part C Days (M'caid Fr. Part C days)
6. Medicare DSH Medicaid Dual Eligible Part A Days (M'caid Fr. Part A days)

[1] Hereafter, the Notice of Amount of Corrected Program Reimbursement will be referred to as a revised Notice of Program Reimbursement ("RNPR").
[2] Sutter Health filed a separate appeal for the RNPR rather than using the "Add Determination" case action to add it to the pending appeal for the Provider's FYE 12/31/2007 pending NPR based appeal (Case No. 17-0929).

The Provider referenced Audit Adjustment #4 for all six issues appealed from the RNPR. Audit Adjustment #4 was issued "[t]o adjust the SSI Percentage and Disproportionate Share Amount based on the latest CMS letter of SSI Percentage Realignment."

Board Determination

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2019), a provider has a right to a hearing before the Board with respect to specific items claimed on a timely filed cost report if: (1) it is dissatisfied with the final determination of the Medicare contractor; (2) the amount in controversy is $10,000 or more (or $50,000 for a group); and (3) the request for a hearing is filed within 180 days of the date of receipt of the final determination.

The Code of Federal Regulations provides for an opportunity for a reopening and RNPR at 42 C.F.R. § 405.1885 (2018), which provides in relevant part:

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

Additionally, 42 C.F.R. § 405.1889 (2018) explains the effect of a cost report revision:

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

The Board finds that it does not have jurisdiction over the six issues in this individual appeal filed from the RNPR because the RNPR was issued as a result of the Provider' SSI Realignment

request, and did not specifically adjust these issues. As a result, the Provider does not have the right to appeal under 42 C.F.R. § 405.1889(b) as referenced in § 405.1835(a)(1).

When a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[3] The adjustment and reopening in this case were issued as a result of the Provider's request to realign its SSI percentage from the federal fiscal year end to its individual cost reporting fiscal year end. Based on the Notice of Reopening and Adjustment #4, the RNPR under appeal clearly only revised the SSI percentage in order to realign it from a federal fiscal year to the provider's respective fiscal year.[4] The realignment process (as described in the Federal Register) does not change any of the underlying data that is gathered on a month-by-month basis (*e.g.*, does not change data on either Part A or Part C days) since CMS does not rerun the data matching process in order to effectuate a realignment. Indeed, to this end, CMS' stated realignment policy is that the provider must accept the realigned SSI percentage.[5] Since the only matter specifically revised in the RNPR was to realign the SSI percentage from the federal fiscal year to the provider's fiscal year, the Board does not have jurisdiction over the SSI Accuracy, SSI Fr. Part C days, SSI Fr. Part A days, SSI MMA Section 951, M'caid Fr. Part C days, ***or*** M'caid Fr. Part A days issues in the subject individual appeal. In making this ruling, the Board notes that its application of 42 C.F.R. § 405.1889(b) has been upheld by courts on review.[6]

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[3] 42 C.F.R. § 405.1889(b)(1).

[4] CMS does not re-run the data match process when it issues a realigned SSI percentage. CMS describes the matching process that it uses as part of the FY 2011 IPPS final rule published on August 16, 2010. *See* 75 Fed. Reg. 50042, 50275-85 (Aug. 16, 2010). All of the underlying data which is gathered on a month-by-month basis remains the same and the realigned SSI percentage simply reflects a different 12-month time period being used. *See* 42 C.F.R. § 412.106(b)(2) (noting that CMS gathers data on a month-by-month basis). The realignment solely takes the SSI data for each provider and the total Medicare days for each provider (previously accumulated on a month-by-month basis and used in the original CMS published SSI percentages) and reports it on the provider's cost reporting period instead of the September 30 FFY. *See also* 75 Fed. Reg. 50042, 50279 (Aug. 16, 2010) (stating: "The SSI fractions are generally based on the Federal fiscal year; however, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived from the data match process for the two Federal fiscal years that spanned the hospital's cost reporting period.); 70 Fed. Reg. 47278, 47439 (Aug. 12, 2005) (stating: "Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period, and *the hospital **must accept** the resulting DSH percentage for that year, whether or not it is a more favorable number than the DSH percentage based on the Federal fiscal year*." (emphasis added)).

[5] *See supra* note 4 (quoting CMS realignment policy at 70 Fed. Reg. at 47439).

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

In addition, the Board directs the Representative's attention to Board Rule 6.3, which gives guidance on multiple determinations appealed by a Provider for the same fiscal year end. The Rule states:

> **6.3 Adding a New Determination to an Individual Case**
>
> **6.3.1 Request and Supporting Documentation**
>
> For individual appeals, an appeal may be for only one cost reporting period. *If multiple final determinations were issued **on different dates** for the cost reporting period being appealed(e.g., NPR, revised NPRs, exception request denials, etc.), providers **must** timely request to add the subsequent determination to its pending appeal for that cost reporting period.*" Reference Model Form A – Individual Appeal Request (Appendix A) for all required data fields and supporting documentation.[7]

Similarly, Board Rule 4.6 prohibits "Duplicate Filings":

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

Accordingly, in this instance, the appeal of the RNPR should have been added to the Provider's pending individual appeal under Case No. 17-0929. ***The Board directs the Representative to review Board Rules 4.6 and 6.3 and come into compliance with them to ensure duplicate individual appeals are not filed.*** *The Board also notes that the OH CDMS PRRB Module External User Manual at §§ 3.3.4.3 and 3.3.4.3.1 describes how a determination may be added to an existing individual appeal in OH CDMS using the Case Correspondence Drop-Down Menu.*[8]

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[7] Board Rules. (Aug. 29, 2018)
[8] OH CDMS PRRB Module External User Manual, Version 1.0, at 64-65 (Aug. 22, 2018) (PDF copy available at: https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/Electronic-Filing).

In conclusion, the Board ***dismisses*** the six issues appealed from the RNPR in Case No. 21-1042 as the Provider does not have the right to appeal the RNPR at issue for these issues. As there are no remaining issues in the individual appeal, the Board hereby closes Case No. 21-1042 and removes it from the Board's docket.

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

Board Members Participating:
Clayton J. Nix, Esq.
Gregory H. Ziegler, CPA
Robert A. Evarts, Esq.
Susan A. Turner, Esq.
Kevin D. Smith, CPA

FOR THE BOARD:

4/20/2021

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: Clayton J. Nix -A

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***EJR Determination***
16-1593, Evangelical Community Hospital, 39-0013, FYE 6/30/2013
17-0506, Evangelical Community Hospital, 39-0013, FYE 6/30/2014

Dear Ms. Griffin and Mr. Snyder:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above-referenced provider's ("Provider" or "Evangelical") February 19, 2021 request for expedited judicial review ("EJR Request") and March 25, 2021 response to the Board's March 17, 2021 Request for Information. The Board's determination regarding the EJR Request is set forth below.

Issue in Dispute:

Evangelical is requesting EJR for the following issue:

> The days at issue in these appeals are the days of care furnished by the Hospitals to patients who were entitled to Medicare Part A and Supplemental Security Income ("SSI") benefits. The issue presented in these appeals is whether the Intermediary erred in calculating the [SSI] percentage included in the "Medicare fraction" for purposes of calculating the Provider's [Disproportionate Share Hospital ("DSH")] payment, as required by 42 U.S.C. § 1395ww(d)(5)(F)(vi).
>
> The Providers respectfully assert that under the rules of statutory construction [the Centers for Medicare and Medicaid Services ("CMS")] is compelled to interpret "entitlement to SSI" benefits to include all inpatients who were eligible for and/or enrolled in the SSI program at the time of their hospitalization and, further, to furnish Provider with a listing of those SSI Enrollees/Eligible patients for the relevant hospitalizations so that its DSH adjustments can be recalculated in accordance with the Medicare Act. Furthermore, Provider seeks a ruling that CMS has failed to provide the Providers with adequate information to allow them to check and challenge CMS's disproportionate patient percentage ("DPP") calculations. Provider is entitled to this data under Section 951 of the Medicare

> Prescription Drug, Improvement, and Modernization Act, Pub. L. 108-173. Because the summary data that CMS currently provides only gives providers the underlying data for SSI days that are limited to the three (3) SSI status codes chosen by CMS instead of the full list of Medicare patients who are enrolled in SSI and/or eligible for SSI benefits, and does not give Provider any meaningful means of challenging the SSI days chosen by CMS to be used in Provider's DPP calculations, CMS continually violates its § 951 mandate.[1]

Board's Authority:

The Board's authority to consider a provider's EJR request is contained within 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R.§ 405.1842(f)(1) (2019). Under its statutory and regulatory authority, the Board is required to grant a provider's EJR request if it determines that (1) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (2) the Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute or to the substantive or procedural validity of a regulation or CMS Ruling.

Procedural Background:

Evangelical's original respresentative was Plante Moran, PLLC ("Plante Moran"). Plante Moran filed requests for a Board hearing ("RFHs") on behalf of Evangelical from original Notices of Program Reimbursement ("NPR"), with the Board assigning individual PRRB Case Numbers for each appeal.[2] Within each of Evangelical's respective RFHs, Plante Moran describes the ***same*** four issues:

1. Medicare Fraction—Medicare Advantage Days;
2. Medicaid Fraction—Exhaust Days[sic];
3. Medicare Fraction—Medicare Advantage Days; and
4. Medicare Fraction—SSI Percentage.[3]

In both cases, Providers transferred Issues 1 and 3 to group appeals and withdrew Issue 2. Within their respective Issue 4 Issue Statements, Evangelical included an inpatient rehabilitation facility low income patient ("LIP") adjustment sub-issue for Issue 4. Evangelical did not include the LIP challenge within its description of Issue 4 in the preliminary position papers, final position papers or the EJR Request, thus effectively abandoning that portion of the issue. In sum, Evangelical's DSH SSI Percentage issue, Issue 4, is the only remaining issue in both cases and is the sole issue for which Evangelical requests EJR.

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[1] EJR Request at 1-2
[2] The Board received Evangelical Community Hospital's ("Evangelical's") appeals of its 11/25/2015 and 5/13/2016 NPRs on 5/12/2016 and 11/9/2016, assigning PRRB Case Nos. 16-1593 and 17-0506 to the appeals, respectively.
[3] RFH for 16-1593 and 17-0506 TAB 3.

Within both cases, Plante Moran uses the ***same identical*** language in the RFH to describe Issue 4:

> Statement of the Issue:
>
> The intermediary erred by incorrectly calculating the SSI percentage for inclusion in the "Medicare Fraction" for purposes of the calculation of the provider's [DSH] and [LIP] payments.
>
> Brief Description of the Issue[]:
>
> The Provider believes the Intermediary's calculation of the Providers' Medicare [DSH] and [LIP] payments contain errors in the calculation of the SSI percentage for purposes of 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II), 42 C.F.R. § 412.106(b), and 42 C.F.R. § 412.624(e)(2).
>
> . . .
>
> Amount in Controversy:
>
> The Provider believes that its DSH & LIP reimbursement should correctly reflect an accurate SSI percentage for purposes of the "Medicare fraction." The correct value of this correct adjustment is not able to be fully calculated from the information currently available to the provider, but is in excess of $10,000. The documents or data relating to CMS's calculation of the adjustment to the DSH payment were utilized in CMS's calculation as required by DSH are, to the best of Provider's knowledge, solely in the possession of CMS.
>
> Legal Basis for Appeal:
>
> The Provider believes that inclusion of correct data and calculation of the SSI percentage for purposes of the [DSH] and [LIP] payments is supported by the plain language of 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II), 42 C.F.R. § 412.106(b) and 42 C.F.R. § 412.624(e)(2)[4]

Plante Moran served the preliminary position paper for Case No. 16-1593 on the Medicare Contractor on 12/21/2016, and the preliminary position paper for Case Nos. 17-0506 on 7/17/2017. Within both position papers, Plante Moran once again describe Issue 4 using the ***same identical*** language in just 7 sentences:

[4] RFH for 16-1593 & 17-0506 TAB 3.

> The Provider believes the Intermediary and/or CMS erred in its calculation of the SSI percentage and its application to this Provider. The propriety of the SSI percentage calculation has been, and continues to be, the subject of considerable litigation. For example, the Board ruled on this specific issue in a case styled *Baystate Medical Center v. Mutual of Omaha Insurance Company*, PRRB Dec. No. 2006-D20 (March 17, 2006; rev'd by CMS Administrator Decision (May 11, 2006) CCH ¶81,506. On March 31, 2008, the United States District Court for the District of Columbia reversed the Adminstrator's decision and found, like the Board below, that there were errors in the SSI percentage which CMS was directed to correct. *Baystate Med. Ctr. V. Leavitt*, 544 F.Supp. 2d 20 (D.D.C. 2008). The Provider believes there remains errors in the calculation of its SSI percentage that adversely affect its DSH reimbursement.
>
> Therefore, the Provider has appealed the calculation used by the Intermediary in determining the Provider's DSH adjustment believing the same to be inaccurate and/or incomplete. Because the calculation used by the Intermediary was improper, the Provider's DSH calculation is incorrect and the Provider requests that the same be corrected.

In October 2018, Evangelical changed its representative from Plante Moran to the current representative, Hall, Render, Killian, Heath & Lyman ("Hall Render").

On March 26, 2021, Hall Render filed final position papers for Evangelical for both cases. Within both final position papers, Hall Render describes the "Statement of Issue" for Issue 4 using identical language as within the RFH, minus the references to the "LIP payment." The position papers go on to include a discussion of the issue, using the following section headers under "Argument":

A. CMS has conceded that it systematically excludes many categories of SSI eligible individuals from the Medicare Fraction numerator, and alternative proxies such as Dual Eligible Days and published SSI data illustrate the magnitude of the Agency's erroneous actions on the Provider.
B. The Agency's matching choices have a profoundly negative impact on Providers' DSH reimbursement.
C. SSI eligibility data must be produced by the MAC/CMS, not the provider.
D. CMS violated the plain language of the DSH statue by adopting conflicting interpretations of the term "entitled to benefits" with respect to Part A and SSI; therefore, its interpretation fails under Step One of *Chevron*.
    a. Despite Congress's clear intent, CMS does not consistently interpret and apply the term "entitled to benefits."
    b. CMS's matching process is flawed because it only uses three SSI codes, a violation of the DSH statute.

E. The Agency's categorical exclusion of SSI eligible individuals' inpatient days from the Medicare fraction numerator conflicts with Congress's express intent to capture SSI eligible patients who are Medicare beneficiaries in the Medicare Fraction numerator; therefore, the Agency's narrow construction of "entitled to Supplemental Security Income benefits" also fails under *Chevron* Step One.
F. The Agency's contruction and interpretation of the DSH statute leads to results so absurd that the interpretation cannot be ascribed to a difference in opinion or Agency expertise; therefore, it is arbitrary and capricious under *Chevron* Step Two.
G. Since the PRRB is bound by CMS rules and policy, it does not have the authority to decide the issues raised by the Provider in the DSH appeal, and therefore the only proper action by the Board here is to determine that this appeal should receive expedited judicial review.

On February 19, 2021, Hall Render filed the instant EJR Request on behalf of Evangelical for the "DSH SSI Percentage issue" (i.e., Issue 4). Within the EJR Request, Providers describe the issue as follows:

> The days at issue in these appeals are days of care furnished by the Hospitals to patients who were entitled to Medicare Part A and Supplemental Security Income ("SSI") benefits. The issue presented in these appeals is whether the Intermediary erred in calculating the [SSI] percentage included in the "Medicare fraction" for purposes of calculating the Provider's [Disproportionate Share Hospital ("DSH")] payment, as required by 42 U.S.C. § 1395ww(d)(5)(F)(vi)."
>
> Provider respectfully asserts that under the rules of statutory construction [the Centers for Medicare and Medicaid Services ("CMS")] is compelled to interpret "entitlement to SSI" benefits to include all inpatients who were eligible for and/or enrolled in the SSI program at the time of their hospitalization and, further, to furnish Provider with a listing of those SSI Enrollees/Eligible patients for the relevant hospitalizations so that its DSH adjustments can be recalculated in accordance with the Medicare Act. Furthermore, Provider seeks a ruling that CMS has failed to provide the Providers with adequate information to allow them to check and challenge CMS's disproportionate patient percentage ("DPP") calculations. Provider is entitled to this data under Section 951 of the Medicare Prescription Drug, Improvement, and Modernization Act, Pub. L. 108-173. Because the summary data that CMS currently provides only gives providers the underlying data for SSI days that are limited to the three (3) SSI status codes chosen by CMS instead of the full list of Medicare patients who are enrolled in SSI and/or eligible for SSI benefits, and does not give Provider any meaningful means of challenging the SSI days chosen by CMS to be used

> in Provider's DPP calculations, CMS continually violates its § 951 mandate.[5]

On March 17, 2021, the Board issued, to Hall Render, a Request for Information in which the Board requested that Evangelical provide its preliminary position papers for the Board's consideration. Hall Render filed the preliminary position papers as requested on March 25, 2021.

Analysis, Findings of Fact and Conclusions of Law

As noted *supra*, the Board's authority to consider a provider's EJR request is contained within 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R.§ 405.1842 (2019). Under the implementing regulations, the Board is required to grant a provider's EJR request if it determines that (1) the Board has jurisdiction to conduct a hearing on the specific matter at issue (as described in 42 C.F.R. § 405.1840); and (2) the Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute or to the substantive or procedural validity of a regulation or CMS Ruling. Further, under 42 C.F.R.§ 405.1842(e)(1), in relevant part, "[i]f the Board makes a finding that it has jurisdiction to conduct a hearing on a specific matter at issue in accordance with § 405.1840 . . . then (and only then) it must consider whether it lacks the authority to decide a legal question relevant to the matter at issue." Thus a Board finding of jurisdiction is a *prerequisite* to any review of an EJR request.

Under 42 C.F.R. § 405.1840(b), the Board has jurisdiction to grant a hearing over a *specific* matter at issue in an appeal *only if* the provider has a right to a Board hearing as a single provider appeal under § 405.1835. The regulation at 42 C.F.R. § 405.1835 describes the right to a Board hearing in subsection (a) and the content requirements of a hearing request in subsection (b). A provider's written hearing request must include certain elements. More specifically, under 42 C.F.R. § 405.1835(b)(2), a provider's written request for hearing must contain, 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:

> (b) Contents of request for a Board hearing on final contractor determination. The provider's request for a Board hearing under paragraph (a) of this section must be submitted in writing to the Board, and the request **must include the elements described in paragraphs (b)(1), (b)(2), or (b)(3)** of this section, the Board may dismiss with prejudice the appeal or take any other remedial action it considers appropriate. . . .
>
> (2) **An explanation** (for each specific item at issue, see paragraph (a)(1) of this section) **of the provider's dissatisfaction** with the contractor's or Secretary's determination under appeal, **including** an account of all of the following:

[5] EJR Request at 2.

(i) **Why** the provider believes **Medicare payment is incorrect for <u>each</u> disputed item** (or, where applicable, why the provider is unable ot 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, **a description of the nature and amount of each self-disallowed item** and the reimbursement or payment sought for the item.[6]

Accordingly, the regulations also prescribe that if a provider submits a hearing request that *does not* meet the requirements of (b)(1), (2), or (3), the Board may dismiss with prejudice the appeal or take any other remedial action it considers appropriate.[7]

In keeping with the above-quoted regulation's specificity requirement, the Board's Rules in effect at the time that the Providers filed their respective RFH state the following:

> **Rule 8—Framing Issues for Adjustment Involving Multiple Components**
>
> **8.1—General**
>
> Some issues may have multiple components. To comply with the regulatory requirement to *<u>specifically</u> identify* the items in dispute, each contested component must be appealed as a separate issue and described *<u>as narrowly</u>* as possible using the applicable format outlines in Rule 7. See common examples below.
>
> **8.2—Disproportionate Share Cases** (e.g., dual eligible, general assistance, charity care, HMO days, etc.)[8]

In addition, Board Rule 25 addresses requirements for preliminary position papers and includes the following Commentary:

> **COMMENTARY**: Under the Regulations effective August 21, 2008, all issues will have been identified well in advance of the due date for preliminary position papers. Unlike the prior practice, preliminary position papers are now expected to present *<u>fully developed</u>* positions of the parties and, therefore, require analysis well in advance of the filing deadline.[9]

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[6] Bold and underline emphasis added.
[7] 42 C.F.R. § 405.1835(b).
[8] Board Rules at 8 (March 1, 2013) (emphasis added).
[9] Board Rule 25 "Commentary" on page 25 (July 1, 2015) (emphasis added). This Commentary foes on to explain that the deadlines for filing position papers are set to permit "sufficient time to develop meaningful position papers." To the extent additional time is needed, parties may request extension to the filing deadline. *See* Board Rule 23.5 (July 1, 2015).

Further, Board Rule 25.1 specifies that a provider's preliminary position paper must include the following "content": (1) "[f]or each issue, state the material facts that support your claim"; (2) "[i]dentify the controlling authority (e.g., statutes, regulations, policy, or case law) supporting your position"; and (3) "Provide a conclusion applying the material facts to the controlling authorities."[10] Finally, the Board Rules gave the following instruction in Board Rule 25.2 for including exhibits to the preliminary position paper and for identifying unavailable documentation:

> **25.2—Preliminary Documents**
>
> **A. General:** *With the preliminary position papers, the parties must exchange all available documentation* as preliminary exhibits to fully support your position. The Intermediary must also give the Provider all evidence the Intermediary considered in making the determination (see 42 C.F.R. § 405.1853(a)(3)) and identify any documentary evidence that the Intermediary believes is necessary for resolution which has not been submitted by the Provider.
>
> **B. Unavailable and Omitted Preliminary Documents:** If documents necessary to support your position are still unavailable, *identify the missing documents*, explain why the documents remain unavailable, state the efforts made to obtain the documents, and explain when the documents will be available. Once the documents become available, promptly forward them t the opposing party.
>
> **C. Preliminary Documentation List:** Parties must attach a list of the exhibits exchanged with the preliminary position paper.[11]

The Board notes that its Rules addressing poition papers are authorized by 42 C.F.R. §§ 405.1868(a)-(b) and 405.1853(b). Further, paragraphs (1) and (2) of § 405.1853(b) specify that "the parties must file position papers in order to narrow the issues further" and that "[e]ach position paper must set forth the relevant facts and arguments regarding the Board's jurisdiction over each remaining matter at issue in the appeal . . . and the merits of the provider's Medicare payment claims for each remaning issue."

Here, in both cases, Evangelical's RFH issue statements filed by Plante Moran for "Issue 4—SSI percentage" are set forth as follows:

> The intermediary *erred by incorrectly calculating* the SSI percentage for inclusion in the "Medicare Fraction" for purposes of the calculation of the provider's DSH payment.[12]

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[10] *Id*.
[11] Board Rule 25.2 (July 1, 2015).
[12] Emphasis added.

However, this description of the issue statement is overly broad and does not describe what is incorrect in the SSI percentage. Even when considering its further description and legal basis, the issue remains very broad and the source of the Providers' dissatisfaction remains unclear:

> Brief Description of the Issue:
>
> The Provider believes the Intermediary's calculation of the Providers' Medicare DSH payments *contains errors* in the calculation of the SSI percentage for purposes of 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II) and 42 C.F.R. § 412.106(b).
>
> Legal Basis for Appeal:
>
> The Provider believes that *inclusion of correct data* and calculation of the SSI percentage for purposes of the DSH payment is supported by the plain language of 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II) and 42 C.F.R. § 412.106(b).[13]

When considering the specificity of the "contents" requirements in 42 C.F.R. § 405.1835(b), the Board finds Providers' Issue 4 to be deficient because the Providers' respective RFH issue statements for Issue 4 failed to meet the "contents" requirements in subsection (b)(2). More specifically, the RFHs generically refer to "errors" in the SSI calculation, but fail to include any description of the alleged "errors" much less explain "*why* . . . Medicare payment is incorrect for each disputed item" or "*how* and why Medicare payment must be determined differently for each disputed item." Similarly, it fails to comply with Board Rule 8.1: "to *specifically identify* the items in dispute" and describe each item "as narrowly as possible." The Board notes that, by the time, Plante Moran filed the Providers' respective RFHs in 2016, there had been much litigation and several Agency publications describing certain systemic errors in the data matching process used to calculate SSI percentage:

1. *Baystate Med. Ctr. V. Mutual of Omaha Ins. Co*., PRRB Dec. 2006-D20 (mar. 17, 2006), rev'd by CMS Adm'r dec. (May 11, 2006);

2. *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008);

3. CMS Ruling 1498-R (April 28, 2010); and

4. 75 Fed. Reg. 50042, 50275-85 (Aug. 16, 2010) (adopting a new data matching process post-*Baystate*).

However, none of these documents/litigation nor the myriad of detailed errors described therein are referenced in the RFHs. The vague reference to "inclusion of correct data" in the "Legal Basis for the Appeal" section of Isue 4 does noting to cure this deficiency. Similarly, the vague

[13] RFHs TAB 3 (emphasis added).

reference in the "Amount inControversy" section of issue 4 to certain documents solely in CMS' possession does nothing to cure this deficiency. Specifically, Providers' inability to calculate the amount in controvery because "documents or data relating to CMS's calculation of the adjustment to the DSH payment that were utilized in CMS's calculation of the adjustment . . . are, to the best of the Provider[s'] knowledge, solely in the possession of CMS" does nothing to cure this deficiency.

In addition, not only is the appeal statement too vague, it clearly does not refer to the issue that is the subject of the EJR, namely the SSI dual eligible days issue. In particular, there is no discussion or reference to SSI entitlement or SSI status or SSI-related MMA § 951 data issues.[14] Accordingly, on this basis alone, the Board may dismiss the EJR request for lack of jurisdiction.

Even if the Board were to find, as a threshold matter, that the Provider's RFH issue statements for Issue 4 comply with the specificity requirements under 42 C.F.R. § 405.1835(b), the Board finds that Provider's preliminary position papers *filed by Plante Moran* similarly lack the requisite detail regarding Issue 4 to consider that issue "fully developed . . . to give the parties a thorough understanding of their opponent's position."[15] The Board observes that, within the preliminary position papers *filed by Plante Moran*, Provider's Issue 4 description does *not* discuss interpretation of "entitlement to SSI" benefits under the statute as is emphasized in the issue presented for EJR or any "data" issues.[16] To this end, the discussion of Issue 4 in the preliminary position paper is bare bones in that it is less than a page (7 sentences long) and includes no exhibits. Accordingly, even if the RFHs were found to comply with § 405.1835(b) and were found to include the dual eligible days issue relating to SSI entitlement and SSI status codes and related MMA § 951 data issue(s) covered by the EJR request, Provider's preliminary position papers clearly failed to identify, much less brief, those issues (i.e., fully develop its position on that issue to give the parties a thorough understanding of thoer opponent's position).[17]covered by the EJR request, Providers' preliminary position papers failed to brief that issue (i.e., fully develop its position on that issue).[18] As such, the Board finds that, to the extent Issue 4 in the RFH could be construed under 42 C.F.R. § 405.1835(b) to properly include the dual eligible days issue or any related MMA § 951 data issues, those issues were wholly abandoned in the preliminary position papers.

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[14] The Board notes that the August 16, 2010 final rule adopting the new data matching process discusses in significant detail the SSI status codes used to determine SSI entitlement. 75 Fed. Reg. at 50280-81.

[15] Board Rule 23.3 Commentary (July 1, 2015) ("because the date for adding issues will have expired and transfers are severely limited, the Board expects preliminary position papers to be fully developed and include all available documentation necessary to give the parties a thorough understanding of their opponent's position.").

[16] Indeed, the word "data" does not appear in the 7 sentence-long discussion of Issue 4 in the Providers' preliminary position paper nor is there any reference to the August 16, 2010 final rule.

[17] Specifically, the preliminary position papers contain no reference or discussion of any data issues such as CMS compliance with § 951 of the Medicare Prescription Drug, Improvement, and Modernization Act, Pub. L. 108-173 ("MMA") or the final rule that implemented MMA § 951, the FY 2006 IPPS Final Rule, 70 Fed. Reg. 47278, 47438-43 (Aug. 12, 2005).

[18] Similarly, there is no reference or dicusiion of data issues such as CMS compliance with § 951 of the Medicare Prescription Drug, Improvement, and Modernization Act, Pub. L. 108-173.

Indeed, the Board finds that Providers' briefing of Issue 4 *that did occur* in their respective preliminary positon papers for both cases related to the *Baystate* data matching issue and is in and of itself wholly inadequate and perfunctory, and fails to comply with the Board Rule 25 requirement to "present fully developed positions." As noted above, the discussion of Issue 4 in the preliminary position papers is a mere 7 sentences long. To that end, the discussion is limited to generic discussions of alleged calculation "errors" remaining after *Baystate* and general assertions that the DSH adjustment is "inaccurate and/or incomplete." As such, this briefing fails to comply with Board Rules governing position papers. Specifically, the briefing of Issue 4 was not a "fully developed position" and, in particular, did not "state the material facts that support your claim" that there were such "errors" in the SSI fraction (and again fail "to give the parties a thorough understanding of their opponent's position").[19] To the extent that documents were unavailable, Board Rule 25.2 is very clear that the position paper must describe what documents are unavailable, explain why they are unavailable, describe the efforts made to obtain them, and explain when those documents are expected to become available.[20] However, the preliminary position papers do not contain any discussion about unavailable documentation (much less discuss or identify any "data" availability issues). Thus, the Board finds that, while Provider's discussion of Issue 4—SSI percentage in the preliminary position papers for purported *Baystate* data matching issues provides some clarification of the Provider's statement of the issue in its RFH, it wholly fails to comply with Board Rules foverning the content of preliminary position papers.

Finally, the Board notes that the first place the the Provider raises the SSI dual eligible days issue (SSI entitlement and SSI status codes) and associated SSI-related MMA § 951 data access issues is in the context of Provider's final position papers. The fact that, between the filing of their preliminary position papers and their final position papers the Provider changed its representative from Plante Moran to Hall Render does not give the Provider license to change, alter, amend, or otherwise transform the Issue 4 that they appealed into something else. As provided by 42 C.F.R. § 405.1835(e), there is only a limited 60-day window in which to add issues to an appeal

[19] Board Rule 23.3 Commentary (March 1, 2013 and July 1, 2015) ("because the date for adding issues will have expired and transfers are severely limited, the Board expects preliminary position papers to be fully developed and include all available documentation necessary to give the parties a thorough understanding of their opponent's position.").

[20] The Board recognizes that, in its RFHs, Provider suggests that it did not have access to data to calculate an amount in controversy but failed to describe what data it needed or was unavailable. To any extent it was a distinct issue, Provider's preliminary position papers abandoned that issue as it is devoid of identifying or discussing any data issues. If it had addressed the data issue in the preliminary position paper and asserted unavailability, the Board would have expected compliance with Board Rule 25.2 (July 1, 2015). Further highlighting the perfunctory nature of the briefing of Issue 4, is the fact that providers can obtain certain data used to calculate their DSH SSI ratios directly from the Centers for Medicare and Medicaid Services ("CMS"). *See e.g.*, https://www.cms.gov/Medicare/MedicareFee-for-Service-Payment/AcuteInpatientPPS/dsh (last accessed Mar. 19, 2021); https://www.cms.gov/ResearchStatistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH (last accessed Mar. 19, 2021) (CMS webpage describing access to DSH data from 1998 to 2017: "DSH is now a self-service application. This new self-service process enables you to enter your data request(s) and retrieve your data files through the CMS Portal."). Finally, while the Board did not review the adequacy of the substance of the EJR request, the fact that certain data related to the calculation of SSI ratios is available may raise concerns about whether factual development potentially may be needed for the EJR request.

and that window had closed well over 4 years prior to the Provider's filing of its final position papers in March 2021.

Conclusion

1) The Board hereby **denies** Evangelical Community Hospital's (39-0013) instant request for EJR regarding its Issue 4—SSI Percentage issue as set out within PRRB Case Nos. 16-1593 and 17-0506, finding that the issue presented for EJR was not included in Provider's respective RFHs or preliminary position papers, thus the Board lacks the requisite jurisdiction under 42 C.F.R. § 405.1842 (f)(2);

2) The Board hereby **dismisses** the Issue 4—SSI Percentage issues from PRRB Case Nos. 16-1593 and 17-0506 as the issues do not comply with the specificity requirements under 42 C.F.R. § 405.1835(b);[21] and

3) As Issue 4—SSI Percentage is the last issue in PRRB Case Nos. 16-1593 and 17-0506, these cases are now closed.

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

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For the Board:

4/22/2021

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: Clayton J. Nix -A

cc: Wilson Leong, FSS

[21] Pursuant to the Board's authority under the same regulation.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Ms. Adria Loertscher
Silverado Hospice, Inc.
6400 Oak Canyon, Ste. 200
Irvine, CA 92618

Re: ***Determination to Dismiss***
Silverado Hospice, Inc. (Prov. No. 14-1660, FFY 2021)
Case No. 21-1208

Dear Ms. Loertscher:

The Provider Reimbursement Review Board ("Board") recently began a review of the above-captioned appeal and notes an impediment to the Board's jurisdiction. The pertinent facts of the case and the Board's determination to dismiss are set forth below.

Background – Final Determination:

On April 15, 2021, the Provider filed the subject appeal using the Office of Hearings Case and Document Management System ("OH CDMS") to which the Board assigned Case No. 21-1208. The Provider noted in OH CDMS that the "final determination" being appealed was issued on July 10, 2020 and, to that end, uploaded as the "final determination document" a copy of a letter from the Medicare Contractor ("MAC") regarding the Notice of Quality Reporting Reduction dated July 10, 2020. Upon review of the MAC's July 10, 2020 letter, the Board notes that the last paragraph states: "A hospice must submit a request for reconsideration and receive a decision on that request ***before*** they can file an appeal with the Provider Reimbursement Review Board (PRRB)."[1]

At the time of the initial filing, the Provider did not submit a copy of its request for reconsideration nor did it submit a copy of the MAC's decision regarding that reconsideration request as documentation in support of the final determination.

Law & Regulations Governing Board Appeals:

Here, the determination being appealed involves the hospice quality reporting program. The regulation governing the hospice quality reporting program is located at 42 C.F.R. § 418.312 and it grants the following appeal rights in subsection (h):

> (h) *Reconsiderations and appeals of Hospice Quality Reporting Program decisions*.
>
> (1) A hospice may request reconsideration of a decision by CMS that the hospice has not met the requirements of the Hospice Quality Reporting Program for a particular reporting period. **A**

[1] (Emphasis added.)

> **hospice must submit a reconsideration request <u>to CMS</u>** no later than 30 days from the date identified on the annual payment update notification provided to the hospice.
>
> (2) Reconsideration request submission requirements are available on the CMS Hospice Quality Reporting Web site on CMS.gov.
>
> (3) **A hospice that is dissatisfied with a decision made by CMS <u>on its reconsideration request</u> may file an appeal with the Provider Reimbursement Review Board under part 405, subpart R of this chapter**.[2]

Accordingly, § 418.312(h) only grants hospices appeal rights to the Board if the hospice is appealing a *reconsideration* determination. To this end, pursuant to Board Rule 7.1.2.4., when an appeal is based on a Quality Reporting Payment Reduction Determinations, you must "identify the type of quality reporting payment program" and "[a]lso provide the original decision from CMS in which the payment reduction was identified (preliminary decision) ***<u>and</u>*** *the final* ***reconsideration*** *decision on which the appeal is based*."[3]

Further, 42 C.F.R. § 405.1835(b) states: "[i]f 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." Paragraph (b)(3) states in part that the following must be included in the Provider's request:

> 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 . . . .[4]

Further, pursuant to 42 C.F.R §§ 405.1835(a)(3), a provider must file its hearing request within 180 days of the date of receipt of the final determination. Board Rule 4.3.1 states, in part:

> The date of receipt of a contractor final determination is presumed to be 5 days after the date of issuance. This presumption, which is otherwise conclusive, may be overcome if it is established by a preponderance of the evidence that such materials were actually received on a later date. *See* 42 C.F.R. § 405.1801(a)(1)(iii).
>
> The appeal period begins on the date of receipt of the contractor final determination as defined above and ends 180 days from that date.

Board Rule 4.5.A states, in part:

> Timely filing is determined based on the date of receipt by the Board. The date of receipt is presumed to be:

---

[2] (Bold and underline emphasis added.)
[3] (Emphasis added.)
[4] (Emphasis added.)

A. The date submitted to OH CDMS as evidenced by the Confirmation of Correspondence generated by the system.

Board Determination:

The Board finds that the Provider's appeal is jurisdictionally deficient and does not meet the regulatory requirements for filing since the Provider failed to appeal from a ***reconsideration*** determination as required by 42 C.F.R. 418.312(h). Rather, the Provider *improperly* appealed from the original July 10, 2020 preliminary CMS decision (as evidenced in OH CDMS by both the entry of the date of the determination being appealed and the document uploaded as the "final determination document").[5] As a result, it is unclear whether the Provider even requested reconsideration by CMS (much less obtained a final *reconsideration* decision from which it could have appealed to the Board). Regardless, the Provider failed to comply with the mandate in 42 C.F.R. 405.1835(b)(3) that it attach a copy of the final *reconsideration* decision to its appeal request. Accordingly, the Board exercises its authority under 42 C.F.R. 405.1835(b) to dismiss the Provider's appeal for failure to comply with this mandate as well as for failure to appeal from a reconsideration determination as required by 42 C.F.R. 418.312(h).

In addition, even if the original preliminary CMS decision could be considered a final determination from which Board appeal rights flow, the Board has determined that the subject appeal was not filed in a timely manner. The Provider filed the subject appeal using OH CDMS on April 15, 2021 based on the CMS preliminary decision dated July 10, 2020. The Provider has 185 days (180 days + the 5-day allowance) from July 10, 2020 to file an appeal with the Board. The 185-day deadline for filing the appeal was January 11, 2021. The Board notes that the subject appeal request was submitted 279 days from the date of the CMS preliminary decision dated July 10, 2020.

Based on the above findings, the Board finds that dismissal is appropriate and hereby closes Case No. 21-1208 and removes it from its docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. § 405.1875 and 405.1877.

Board Members:

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For the Board:

4/23/2021

X Clayton J. Nix

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Chair
Signed by: Clayton J. Nix -A

cc: Wilson C. Leong, Federal Specialized Services
Laurie Polson, Palmetto GBA c/o National Government Services, Inc.

[5] Indeed, the July 10, 2020 preliminary CMS decision explicitly confirms that the Provider could not yet appeal to the Board based on the July 10, 2020 preliminary CMS decision: "A hospice must submit a request for reconsideration and receive a decision on that request ***before*** they can file an appeal with the Provider Reimbursement Review Board (PRRB)." (Emphasis added.)

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RE: **Jurisdictional Decision**
Sutter Solano Medical Center (05-0101)
FYE: 12/31/2013
PRRB Case: 17-0360

Dear Mr. Jaeger and Ms. Frewert,

The Provider Reimbursement Review Board ("Board") has reviewed the above-captioned appeal in response to the Medicare Contractor's jurisdictional challenge. The pertinent facts of the case, the Parties' positions and the Board's jurisdictional determination are set forth below.

Pertinent Facts:

The Provider submitted a request for appeal on October 28, 2016, based on a Notice of Program Reimbursement dated May 5, 2016. The hearing request included twelve issues:

- Issue 1 – Medicare DSH SSI Ratio – Realignment,
- Issue 2 – Medicare DSH SSI Ratio – Accurate Data,
- Issue 3 – Medicare DSH SSI Ratio – Inclusion of Part C Days,
- Issue 4 – Medicare DSH SSI Ratio – Inclusion of Dual Eligible Part A Days,
- Issue 5 – Medicare DSH SSI Ratio – MMA Section 951,
- Issue 6 – Medicare DSH Medicaid Eligible Days RAC 2 & 3,
- Issue 7 – Medicare DSH Medicaid LLP Eligible Days RAC MB2 & MB3,
- Issue 8 – Medicare DSH Medicaid Ratio - Exclusion of Dual Eligible Part C Days,
- Issue 9 – Medicare DSH Medicaid Ratio - Exclusion of Dual Eligible Part A Exhausted/No Pay Days,
- Issue 10 – Medicare DSH – Medicaid Eligible Days,
- Issue 11 – Two Midnight Rule, and
- Issue 12 – Uncompensated Care Payments ("UCC Payments").

After all transfers and withdrawals, *only* one issue remains in the appeal – Issue 12 addressing UCC Payments. The Medicare Contractor has submitted a Jurisdictional Challenge (April 20, 2018) regarding this issue.

The Provider alleges in Issue 12 that its DSH payment is understated because the Provider has not received an allocation of the uncompensated care pool which is the result of either 1) CMS stating in the Federal

Register the Provider does not qualify for an allocation, or 2) the Medicare Contractor failed to implement an adjustment to the Provider's cost report allowing uncompensated care payment.[1] The Provider further explains this issue in its Final Position Paper by claiming that problems with cost report Worksheet S-10 data adversely impact the Provider's allocation because of improper reporting by other hospitals.[2] The Provider believes the method used to calculate UCC payments does not result in accurate or adequate payments.[3]

Medicare Contractor's Position

The Medicare Contractor states that administrative and judicial review of the UCC Payment issue is precluded by law and regulation. The Medicare Contractor cites to 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2) in support of its position, and argues that Congress has made clear its intent that administration of the new DSH payment must be free of appeal and the Board lacks the authority to decide this issue. The Medicare Contractor also cites to the *Florida Health Sciences Center* case in support of its position.

Board Decision

As set forth below, the Board finds it does not have jurisdiction over the DSH UCC Payment issue in this appeal because jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2). In this regard, 42 C.F.R. § 412.106(g)(2) implements essentially *verbatim* the bar on certain administrative/judicial review that is delineated in 42 U.S.C. § 1395ww(r)(3):

> *Preclusion of administrative and judicial review*. There is no administrative or judicial review under sections 1869 or 1878 of the Act [*i.e.*, 42 U.S.C. §§ 1395ff or 1395oo], or otherwise, of the following:
> (A) **Any estimate** of the Secretary for purposes of determining the factors described in paragraph (g)(1) of this section;[4] and
>
> (B) Any period selected by the Secretary for such purposes.[5]

Further, in *Fla. Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Serv.* ("*Tampa General*"),[6] the D.C. Circuit Court upheld a D.C. District Court decision[7] that there is no judicial or administrative review of UCC DSH payments. In *Tampa General*, the provider challenged the

[1] Model Form A – Individual Appeal Request (Oct. 27, 2016), Tab 3 at Issue 12.
[2] Provider's Final Position Paper (Dec. 21, 2020) at 41.
[3] *Id.*
[4] Paragraph (g)(1) is a reference to the three factors that make up the uncompensated care payment. Factor 1 represents 75 percent of estimated DSH payments that would be paid in absence of § 1395ww(r). 78 Fed. Reg. 50495, 50627-28 (Aug. 19, 2013). Factor 2, for FYs 2014-2017, is one (1) minus the percentage of individuals under age 65 who are uninsured in 2013. *Id.* at 50631. Factor 3 is a hospital-specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital with the potential to receive DSH payments relative to the estimated uncompensated care amount for all hospitals estimated to receive DSH payments in the fiscal year for which the uncompensated care payment is to be made. *Id.* at 50634.
[5] (Bold emphasis added and italics emphasis in original.)
[6] 830 F.3d 515 (D.C. Cir. 2016).
[7] 89 F. Supp. 3d 121 (D.D.C. 2015).

calculation of the amount it would receive for uncompensated care for fiscal year 2014. The provider claimed that the Secretary used inappropriate data when she selected the hospital cost data updated in March 2013, instead of data updated in August 2013, when calculating its uncompensated care payments. The provider argued that it was not challenging the estimate of its uncompensated care, but rather the underlying data on which the Secretary relied, judicial review of which is not barred.

The D.C. Circuit affirmed the District Court's finding that there was specific language in the statute that precluded administrative or judicial review of Tampa General's claims because in challenging the use of the March 2013 update data, the hospital was seeking review of an "estimate" used by the Secretary to determine the factors used to calculate additional payments. The D.C. Circuit Court went on to hold that, "the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well."[8] The D.C. Circuit also rejected Tampa General's argument that it could challenge the underlying data, finding that there cannot be judicial review of the underlying data because they are "indispensable" and "integral" to, and "inextricably intertwined" with, the Secretary's estimate of uncompensated care.[9]

The D.C. Circuit went on to address Tampa General's attempt to reframe its challenge to something other than an estimate of the Secretary. Specifically, it rejected the characterization as a challenge to the "general rules leading to the estimate rather than as a challenge to the estimate itself []" because it was merely an attempt to undo a shielded determination.[10] Finally, it addressed the argument that the estimate made by the Secretary was *ultra vires*, or beyond the scope of statutory authority, but plainly found that "the Secretary's choice of data is not obviously beyond the terms of the statute."[11]

In 2019, the D.C. Circuit Court revisited the judicial and administrative bar on review of uncompensated care DSH payments again in *DCH Regional Med. Ctr. V. Azar* ("*DCH v. Azar*").[12] In *DCH v. Azar*, the provider alleged that it was challenging the methodology adopted and employed by the Secretary to calculate Factor 3 of the DSH payment, and that the bar on review applied only to the estimates themselves, and not the methodology used to make the estimates. The D.C. Circuit disagreed, stating that "a challenge to the methodology for estimating uncompensated care is unavoidably a challenge to the estimates themselves" and that there is "no way to review the Secretary's method of estimation without reviewing the estimate itself." It further stated that, allowing an attack on the methodology "would eviscerate the statutory bar, for almost any challenge to an estimate could be recast as a challenge to its underlying methodology." The D.C. Circuit recognized that it had previously held in *Tampa General* that the choice of data used to estimate an uncompensated care DSH payment was not reviewable because the data is "inextricably intertwined" with the estimates themselves. The D. C. Circuit then applied this holding *DCH v. Azar* and found that the same relationship existed with regard to the methodology used to generate the estimates.

The Board concludes the same findings are applicable to the Provider's challenge to their FFY 2014 UCC payments. The Providers here are challenging their uncompensated care DSH Payment amounts, as well as the general rules governing the methodology used in calculating those amounts, for FFY 2014**.**[13] The

[8] 830 F.3d 515, 517.
[9] *Id.* at 519.
[10] *Id.* at 521-22.
[11] *Id.* at 522.
[12] 925 F.3d 503 (D.C. Cir. 2019).
[13] Provider's Final Position Paper (Dec. 21, 2020) at 42-44.

challenge to the UCC payment methodology focuses on the application of the underlying data used by the Secretary to determine the UCC payments, but *Tampa General* held that the underlying data cannot be reviewed or challenged. Likewise, the Provider's request that UCC payment be revised to reflect "accurate data" challenges the underlying data. Again, a challenge to the underlying data used in calculating UCC DSH payments is not subject to administrative or judicial review. Likewise, any challenge to the methodology used to determine the payment amounts was rejected in *DSCH v. Azar*, finding that the methodology was just as "inextricably intertwined" with the actual estimates as the underlying data, and barred from review.

Conclusion

The Board finds it does not have jurisdiction over the uncompensated care DSH issue in the above referenced appeal because judicial and administrative review of the estimates and methodologies used is barred by statute and regulation. In denying jurisdiction, the Board notes that the D.C. Circuit's decisions in *Tampa General* and *DCH v. Azar* are controlling precedent for the interpretation of 42 U.S.C. § 1395ww(r)(3) because the Providers could bring suit in the D.C. Circuit.[14] As the UCC payment DSH issue is the only remaining issue in the appeal, the Board hereby closes the case and removes it from the Board's docket.

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

Board Members Participating:

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For the Board:

4/23/2021

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Signed by: Clayton J. Nix -A

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

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

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RE: ***Jurisdictional Decision in Part***
Mennonite General 2002-2004 Puerto Rico M+C Days CIRP
FYE 2002-2004
Case No. 14-4131GC

Dear Mr. Roth and Mr. Pike,

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above referenced common issue related party ("CIRP") group appeal as part of its review of jurisdiction for remands guided by CMS Ruling 1739-R for Part C Days issues. The CIRP group appeal contains several participants that appealed from a Revised NPR *where no audit adjustment report was provided*. The Board's decision is set forth below.

Background:

The Board received the Providers Request for Hearing dated July 11, 2014 and this appeal challenges the inclusion of Medicare Part C days in the Medicare fraction of the disproportionate share ("DSH") percentage and/or the exclusion of Medicare Part C days for patients who are dually eligible for Medicaid from the Medicaid fraction of the DSH percentage, for patient discharges *before* October 1, 2013.

This issue is governed by Ruling CMS-1739-R and, under the terms of this Ruling, the Board must remand this issue to the Medicare Contractor for calculation of the DSH payment adjustment in accordance with the forthcoming final rule.

In its review of the jurisdictional documentation for the remand in the above case, three Revised NPR appeals were noted to have *no audit adjustment reports to document that the Part C days issue was appeals from the revised NPRs*[1]:

- Hospital Menonita Cayey (40-0013), 3/31/2002
- Hospital Menonita Cayey (40-0013), 3/31/2003
- Hospital Menonita Aibonito (40-0018), 3/31/2003

[1] Participant Numbers 1.1, 2.1, and 4.1 on the attached Schedule of Providers, each of which are revised NPR appeals where the provider also has an appeal of the original NPR with providers 1, 2 and 4, respectively.

The Providers RNPRs, all dated March 1, 2006, were not accompanied by Audit Adjustment reports when filed with the Board. There is no indication of any specific adjustments to either the SSI or Medicaid fraction in such Audit Adjustment reports.

Board's Analysis and Decision

The Code of Federal Regulations provides for an opportunity for a revised NPR. 42 C.F.R. § 405.1885 (2006) provides in relevant part:

> (a) A determination of an intermediary . . . may be reopened with respect to findings on matters at issue in such determination or decision, by such intermediary officer . . . .

42 C.F.R. § 405.1889 (2006) explains the effect of a cost report revision:

> Where a revision is made in a determination or decision on the amount of program reimbursement after such determination or decision has been reopened as provided in s§405.1885, such revision shall be considered a separate and distinct determination or decision to which the provisions of §§405.1811, 405.1835, 405.1875 and 405.1877 are applicable. (See §405.1801(c) for applicable effective dates.)

Finally, 42 C.F.R. § 405.1835(a) (2006) provides:

> (a) Criteria. The provider (but no other individual, entity, or party) has a right to a hearing before the Board about any matter designated in §405.1801(a)(1), if:
>
> (1) An intermediary determination has been made with respect to the provider; and
>
> (2) The provider has filed a written request for a hearing before the Board under the provisions described in §405.1841(a)(1); and
>
> (3) The amount in controversy (as determined in §405.1839(a)) is $10,000 or more.

Board Rules, Part I at B.I.a.3 (2002) states the following with respect to the Board's jurisdiction over Revised NPR appeals:

> The Board accepts jurisdiction over appeals from a revised Notice of Program Reimbursement (NPR) where the issues(s) in dispute were ***specifically*** adjusted by that revised NPR. The Board typically follows the courts by limiting the scope of such an appeal to *only the revised issue(s)*. See Anaheim Memorial Hospital v. Shalala, 130 F.3d 845 (9th Cir. 1997).[2]

[2] (Emphasis added.)

Further, Board Rules, Part I at B.II.a (2002) states the following regarding the requirements for a hearing request for individual appeals:

> You *must* include a copy of the final determination you are appealing ***and*** of the *audit adjustment page(s) relating to the issue(s) in dispute*, if applicable.[3]

The Board finds that it does not have jurisdiction over the three Participants from their revised RNPRs, as there is no evidence that the Part C Days issue, was specifically adjusted in the Provider's revised NPR. The regulation and Board Rules governing appeals of revised NPRs in effect during the time at issue make clear that a provider can only appeal items that are specifically adjusted from a revised NPR. Here, the Board finds that it does not have jurisdiction over Part C days in the SSI or Medicaid fractions, as there is no evidence those days were adjusted in the respective RNPRs as required by 42 C.F.R. § 405.1889. Indeed, these three Participants failed to comply with Board Rules in effect when the appeals were filed that required the attachment of the audit adjustment reports for the RNPRs at issue. As such, the Board hereby dismisses the three previously-identified Participants (as noted in the attached Schedule of Providers) from the case, and the case will proceed with remand via CMS Ruling 1739-R. *The Board does note that each Provider/FYE for which the Board dismissed the revised NPR appeal, also has a valid appeal of its original NPR that remains in the appeal and will be subject to remand.*

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

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For the Board:

4/23/2021

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: Clayton J. Nix -A

cc: Edward Lau, Esq., Federal Specialized Services
Wilson Leong, Federal Specialized Services

[3] (Emphasis added.)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Request for Reconsideration of Jurisdictional Decision***
St. Elizabeth Healthcare CY 2014 DSH SSI Fraction Part C Days CIRP Group
PRRB Case No. 19-2547GC
Specifically: St. Elizabeth Medical Center Ft. Thomas (18-0001) and
St. Elizabeth Medical Center North (18-0035) as participants

Dear Mr. Newell and Ms. Cummings:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' request for reconsideration of the Board's August 18, 2020 jurisdictional decision in the above-referenced appeal. As set forth below, the Board affirms its original jurisdictional decision and denies the request for reconsideration.

Background

In a jurisdictional determination issued on August 18, 2020, the Board dismissed the revised NPR appeals of St. Elizabeth Medical Center Ft. Thomas (Prov. No. 18-0001) and St. Elizabeth Medical Center North (Prov. No. 18-0035) pursuant to 42 C.F.R. § 405.1889 because the revised NPRs at issue effectuated an SSI realignment and there was no adjustment on the revised NPR of the issue for which the Providers appealed. This left one participant remaining in the group – St. Elizabeth North (based on its *original* NPR appeal). On the same date, the Board requested the Parties' comments on its proposal to transfer the sole remaining participant in the group to a 2015 CIRP group for the same issue (Case No. 19-0940GC), or whether it was preferred that the Board create a new individual case for St. Elizabeth Medical Center North (for the 10/1/2013 to 12/31/2013 period) for the Part C Days issue.

In response to the Board's inquiry, on September 4, 2020, the Representative requested that the Board refrain from taking action until he had the opportunity to request a reconsideration of the jurisdictional determination. In the alternative, the Representative requested that, instead of transferring the sole provider to the CY SSI Part C Days 2015 CIRP group (Case No. 19-0940GC), that it be transferred to a CY 2014 SSI Part C Days CIRP group (Case No. 19-0388GC). On October 16, 2020, the Representative filed a request for reconsideration of the Board's August 18, 2020 jurisdictional determination.

In responding to the Representative's request for reconsideration on January 5, 2021, the Board determined that it would allow the Representative to supplement his request for reconsideration. The Board informed the Representative that the supplement must set forth the merits of his request, *i.e.*, brief the legal arguments explaining why the Board should reverse its dismissal of the revised NPR appeals of St. Elizabeth Ft. Thomas and St. Elizabeth North.

Providers' Supplement to October 16, 2020 Request for Reconsideration

The Providers argue they are dissatisfied with the treatment of Part C days in the Medicare Part A/SSI fractions applied by the MAC in those revised NPRs, and therefore there is jurisdiction over their challenge to those new fractions and the resulting DSH payment calculations. Because the revised NPRs at issue adjusted the Providers' DSH payment calculations, the Board has jurisdiction over any challenge to the DSH calculation, even if the specific aspect was not adjusted by the Medicare Contractor in the NPR. The Providers further maintain that the Board also has jurisdiction under 42 U.S.C. § 1395oo(d) because the Providers are "dissatisfied" with the amount of their total program reimbursement as required by § 1395oo(a).[1]

The Providers contend that Medicare Part C days must be excluded from the Medicare Part A/SSI fractions calculated and applied in arriving at the DSH payment determinations under appeal. The Board has jurisdiction over the Providers' challenge to the inclusion of these days in the Medicare Part A/SSI fraction, whether challenging Medicare Part A/SSI fractions incorporated in original NPRs, or challenging recalculated Medicare Part A/SSI fractions (based on the provider cost year) incorporated in revised NPRs. Because the universe of Part C days in the Medicare Part A/SSI fractions changed in the new fractions, the Providers' challenge to their inclusion is a specific matter at issue in the revised NPRs and the Board therefore has jurisdiction under 42 C.F.R. § 405.1889(b)(1).[2]

The Providers explain that the revised payment determinations under appeal applied entirely new Medicare Part A/SSI fractions that are based on different patient days due to the use of different time periods for the data used in the calculation (the hospitals' cost reporting periods rather than the federal fiscal year). Specifically, the revised NPRs incorporated new Medicare Part A /SSI fractions calculated using a different set of inpatient discharges – January 1, 2013 through December 31, 2013 in the revised NPRs as opposed to discharges from October 1, 2012 through September 30, 2013 that were applied in the original NPRs. The incorporation of the new Medicare Part A/SSI fractions yielded new, distinct DSH payment determinations that applied the challenged Part C days policy. Even the SSI fractions increased from the original NPRs to the revised NPR under appeal due to the use of different time periods for the data, the Providers are still dissatisfied with the inclusion of Part C days and contend the Medicare Part A/SSI fraction should be even higher.[3]

[1] Providers' Supplement to October 16, 2020 Request for Reconsideration at 1-2.
[2] *Id.* at 12.
[3] *Id.* at 13.

The Providers argue that, even if the Board's jurisdiction is properly limited to "[o]nly those matters that are specifically revised in [the] revised determination," there is no question that the Medicare Part A/SSI fractions, as well as the DSH payment calculations, were "specifically revised" in the revised NPRs. Because the incorporation of new Medicare Part A/SSI fractions yielded new, distinct DSH payment determinations, and the Providers are challenging the inclusion of Part C days in the newly incorporated fractions, there is no question the Board has jurisdiction and may grant relief with respect to the entirety of that calculation.[4]

Further, the Providers contend the Board has jurisdiction over the entire DSH payment, including aspects not considered or reviewed by the MAC. Long-standing agency precedents establish that the DSH payment calculation is a singular issue. This view of the issue is consistent with the position that CMS itself has taken in Ruling 1498. In addition to the revised process for calculating the Medicare Part A/SSI fraction, CMS also expressed that the agency can recalculate one aspect of a hospital's DSH payment even if that aspect is not contested in an appeal or if another distinct aspect of the DSH payment is reopened by the Medicare Contractor. CMS' position under the Ruling is that if a hospital has appealed the exclusion of certain Medicaid eligible days from the numerator of the Medicaid fraction (*i.e.,* labor and delivery room days or dual eligible days), the Secretary can reopen the hospital's SSI fraction and recalculate it to correct the errors and omissions that were the subject of the *Baystate* litigation, and also to add dual eligible days to that fraction. This part of the Ruling applies even if (i) the SSI fraction was never appealed and (ii) the NPR for the cost reporting period at issue is no longer subject to reopening. In other words, the Ruling established CMS' position that the DSH payment constitutes a singular issue, an on remand from an appeal to the Board on one aspect of this singular issue, the Medicare Contractor may effect changes to other components of the DSH payment calculation, regardless of whether those other aspects of the payment calculation were appealed or timely reopened.[5]

Likewise, the Provider assert that, in certain prior jurisdictional decisions involving the DSH payment, the Board has previously viewed the DSH issue as a single issue. For example in *Beverly Hospital*, Case No, 04-1083, the Provider maintains that the Board found that "uncompensated care pool days, Medicare+Choice [Part C] days, and the SSI percentage issues are components of a single DSH calculation, and the Board has jurisdiction over all three aspects of the issue where a revised NPR reflected an adjustment to "the DSH calculation."[6]

The Providers timely and properly appealed from the revised NPRs issued by the Medicare Contractor that revised the Providers' DSH payment determinations by applying new SSI fractions. Thus, having established jurisdiction over that aspect of the singular DSH issue, the Board's jurisdiction extend over the "entire issue" relating to the DSH payment, including the Providers' challenge to the inclusion of Medicare Part C days in the Medicare Part A/SSI fractions at issue.[7]

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[4] *Id.* at 13-14.
[5] *Id.* at 14.
[6] Providers' Supplement to October 16, 2020 Request for Reconsideration at 15.
[7] *Id.*

Finally, the Providers argue that the Board also has the power to review and revise the calculation of the Providers' Medicare DSH calculation in accordance with 42 U.S.C. § 1395oo(d) even if it would not otherwise have jurisdiction under § 1395oo(a), which it does. Put simply, "once Board jurisdiction pursuant to subsection (a) obtains, anything else in the original cost report is fair game for a challenge by virtue of subsection (d).[8]

Board Decision

The Code of Federal Regulations provides for an opportunity for a reopening and RNPR at 42 C.F.R. § 405.1885 (2018), which provides in relevant part:

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

Additionally, 42 C.F.R. § 405.1889 (2018) explains the effect of a cost report revision:

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

42 C.F.R. § 405.1835(a) explains a provider's right to appeal to the Board and specifically references § 405.1889(b):

> (a) *Right to hearing on final contractor determination*. A provider (but no other individual, entity, or party) has a right to a Board

[8] *HCA Health Services of Oklahoma v. Shalala,* 27 F.3d 614, 617 (D.C. Cir. 1994).

> hearing, as a single provider appeal, with respect to a final contractor or Secretary determination for the provider's cost reporting period, if—
>
> (1) The provider is dissatisfied with the contractor's final determination of the total amount of reimbursement due the provider, as set forth in the contractor's written notice specified under §405.1803. *Exception*: **If a final contractor determination is reopened under §405.1885, any review by the Board must be limited solely to those matters that are specifically revised in the contractor's revised final determination** (§§405.1887(d), **405.1889(b)**, and the ''Exception'' in §405.1873(c)(2)(i)).[9]

In the Board's letter dated January 5, 2021, the Board noted that the Representative's request for reconsideration is in essence a Motion for Reinstatement of the appeals of the revised NPRs of St. Elizabeth Medical Center Ft. Thomas and St. Elizabeth Medical Center North. As such, the Board looks to Board Rule 47.1 – Motion for Reinstatement, which states:

> A provider may request reinstatement of an issue(s) or case within three years of the date of the Board' decision to dismiss the issue(s)/case, or if no dismissal was issued, within three years of the Board's receipt of the provider's withdrawal of the issue(s) (*see* 42 C.F.R. § 405.1885 addressing reopening of Board decisions). The request for reinstatement is a motion and must be in writing setting out the reasons for reinstatement (see Rule 44 governing motions). The Board will not reinstate an issue(s)/case if the provider was at fault.

In reviewing the Medicare Contractor's Notices of Reopening dated November 7, 2017 for St. Elizabeth Medical Center Ft. Thomas and St. Elizabeth Medical Center North, the Board notes that the Medicare Contractor stated that the cost reports were being reopened for the following reasons:

> To update the SSI% based on the hospital fiscal year end instead of the federal fiscal year end in accordance with 42 CFR 412.106(b)(3) and the Provider's request received 11/6/2017.
>
> To recalculate the allowable DSH percentage based on the updated SSI%.

In reviewing the Group Issue Statement the Board notes it reads as follows:

> This appeal concerns the determination of the Provider's Medicare disproportionate share adjustment ('DSH") payments under the

[9] (Bold emphasis added.)

> prospective payment system ("PPS") for inpatient hospital services. The issue is whether the Centers for Medicare & Medicaid Services ("CMS") has correctly determined the "SSI fraction" used in calculating the Provider's disproportionate patient percentage for purposes of the DSH adjustment. Specifically, the common issue in this group appeal concerns the treatment in the calculation of the Medicare disproportionate share hospital ("DSH") payment of inpatient days for patients who were enrolled in a Medicare Advantage plan under Part C of the Medicare statute.[10]

In previously dismissing the revised NPR appeals of St. Elizabeth Medical Center Ft. Thomas and St. Elizabeth Medical Center North from the instant group appeal, the Board stated the following:

> The reopenings in this case were a result of the Providers' request to realign their SSI percentage from the Federal Fiscal Year End to its individual cost reporting fiscal year end pursuant to the process permitted under 42 C.F.R. 412.106(b)(3). The audit adjustments associated with the revised NPRs under appeal clearly only revised the SSI percentage in order to realign it from a federal fiscal year to the provider's respective fiscal year. In other words, the determinations were only being reopened to include realigned SSI percentages and the underlying data used in the realignment process (which CMS gathers on a month-by-month basis per 42 C.F.R. § 412.106(b)(2)) to change the 12 month period from the federal fiscal year to the provider's fiscal year remains the same.

The Board has consistently found that it does not have jurisdiction over revised NPRs that were issued as a result of a Provider's request for realignment of its SSI percentage. As noted in 42 C.F.R. § 412.106(b)(2), CMS gathers data to be used in the SSI fraction on a month-by-month basis:

> (2) *First computation: Federal fiscal year*. **For each month** of the Federal fiscal year in which the hospital's cost reporting period begins, CMS -
>
> (i) Determines the number of patient days that -
>
> (A) Are associated with discharges occurring **during each month**; and
>
> (B) Are furnished to patients who **during that month** were entitled to both Medicare Part A (including Medicare Advantage

[10] Statement of Group Issue at 1.

> (Part C)) and SSI, excluding those patients who received only State supplementation;
>
> (ii) Adds the results for the whole period; and
>
> (iii) Divides the number determined under paragraph (b)(2)(ii) of this section by the total number of days that -
>
> (A) Are associated with discharges that occur during that period; and
>
> (B) Are furnished to patients entitled to Medicare Part A (including Medicare Advantage (Part C)).[11]

The data matching process by which CMS gathers this *monthly* data is described in the FY 2011 IPPS Final Rule.[12] As described in the Federal Register, under the realignment process, CMS calculates the SSI fraction using the *previously-gathered* data for the months included in the published SSI fractions for 2 Federal fiscal years that encompass the hospital's cost reporting period:

1. *75 Fed. Reg. 50042, 50279 (Aug. 16, 2010)*.—"[W]e publish these [SSI fraction] data for every hospital based on the Federal fiscal year but, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived *from the data match process* ***for the two Federal fiscal years that spanned the hospital's cost reporting period***."[13]

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

   Beginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108–173), we will arrange to furnish, consistent with the Privacy Act, MedPAR LDS data for a hospital's patients eligible for both SSI and Medicare at the hospital's request, regardless of

[11] (Emphasis added.)
[12] 75 Fed. Reg. 50042, 50275-85 (Aug. 16, 2010).
[13] (Emphasis added.)

> 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."[14]

Accordingly, contrary to the Providers' characterization, the realignment process does not change any of the data underlying the realigned SSI fraction (*e.g.*, Part C days or Part A days) because that data had been previously gathered on a month-by-month basis and there is no need for CMS to rerun the data matching process in order to effectuate a realignment (*i.e.*, realigning the SSI fraction from the federal fiscal year to the provider's fiscal year). Indeed, as noted in the second Federal Register excerpt, CMS' stated realignment policy is that the provider "must accept" the realigned SSI percentage.

The Board recognizes that the Providers' reference a prior unrelated Board jurisdictional decision dated September 1, 2006 in Beverly Hospital, Case No. 04-1083 ("Beverly") regarding an RNPR issued on May 28, 2003 for fiscal year 1999. However, this jurisdictional decision is distinguishable for multiple reasons, including but not limited to:

1. The regulation and Board Rules governing the 2003 RNPR in the Beverly case are different than those at issue here.

2. The facts in Beverly differ materially from those here. The adjustment at issue in Beverly's 2003 RNPR (as described in the Board jurisdictional decision) appears to be very generic ("[T]o incorporate into the settled Cost Report and [*sic* an] adjustment to the DSH calculation" (emphasis added)) *and*, in this regard, there was evidence that the intermediary "expressly reconsidered Medicare+Choice and uncompensated care pool days" as part of the audit following reopening. In contrast, the reopenings and adjustments at issue here are specific to realignment (*e.g.*, each Provider's adjustment states: "To update the SSI% and payment factor in accordance with CMS' SSI realignment calculation") and there is no evidence to suggest the MAC or CMS "expressly" considered any additional Part C days as part of the realignment process; and

3. It is unclear to what extent, if any, the September 1, 2006 jurisdictional decision was appealed, reviewed, and potentially modified.

Finally, the Board recognizes that the Providers reference their appeal rights under 42 U.S.C. § 1395(a) and the Board's discretionary authority with respect to those appeals under 42 U.S.C.

[14] (Emphasis added.)

§ 1395(d). However, pursuant to 42 C.F.R. § 405.1867, the Board is bound by the Secretary's interpretation of 42 U.S.C. § 1395oo(a) as codified in the regulations, in relevant part, at 42 C.F.R. § 405.1889(b) (which is reference in 42 C.F.R. § 405.1835(a)(1)) and the Secretary's interpretation of 42 U.S.C. § 1395oo(d) as codified in the regulations at 42 C.F.R. § 405.1869(a). Here, § 405.1889(b) mandates a finding of no jurisdiction since the Providers do not have the right to appeal the Part C Days issue under § 405.1889(b) as referenced in 405.1835(a)(1); and § 405.1869(a) is not applicable since, under this regulation, jurisdiction is a pre-requisite to the Board's subsection (d) discretionary authority and, here, the Board lacks jurisdiction.

Based on the above, the Board affirms its August 18, 2020 finding that neither St. Elizabeth Medical Center Ft. Thomas nor St. Elizabeth Medical Center North had the right to appeal the Part C Days issue from the *revised* NPRs at issue pursuant to 42 C.F.R. § 405.1889(b) as referenced in § 405.1835(a)(1). In making this ruling, the Board notes that its application of 42 C.F.R. § 405.1889(b) has been upheld by courts on review.[15] Accordingly, the Board ***denies*** the Providers' request to reverse the August 18, 2020 jurisdictional decision in this appeal, and denies the request to reinstate St. Elizabeth Medical Center Ft. Thomas and St. Elizabeth Medical Center North (*revised* NPRs) as participants.

The Board has also identified a CY 2015 CIRP group for the *same* issue under Case No. 19-0940GC, entitled "St. Elizabeth Healthcare CY 2015 DSH SSI Fraction Part C Days CIRP Group."

Accordingly, this letter serves as notice to the Parties that the Board intends to take the following actions:

1) Leave the period from 1/1/2013-9/30/2013 for St. Elizabeth Medical Center North (18-0035) pending in Case No. 19-2547GC.[16]

2) Remand the period from 1/1/2013 – 9/30/2013 pursuant to CMS 1739-R for St. Elizabeth Medical Center North. The Parties will receive the Remand under separate cover in Case No. 19-2547GC.

3) Transfer the remaining period from 10/1/2013-12/31/2013 for St. Elizabeth Medical Center from Case No.19-2547GC ***to*** Case No. 19-0940GC.

4) Case No. 19-0940GC would be expanded to include the Post CY 10/1/2013 period and would be renamed the "St. Elizabeth Healthcare Post CY 10/1/2013 & CY 2015 DSH

[15] *See, e.g., St. Mary's of Mich. v. Azar*, No. 18-01790, 2020 WL 4049912 (D.D.C. July 20, 2020); *McLaren Flint v. Azar*, 464 F. Supp. 3d 1 (D.D.C. 2020), *Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F. Supp. 3d 348 (D.D.C. 2014); *St. Dominic-Jackson Mem'l Hosp. v. Sebelius*, No. 3:12cv832, 2014 WL 8515280 (S.D. Miss. Mar. 31. 2014); *HCA Health Servs. of OK v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994).

[16] The Board notes that, when Case No. 19-2547GC was bifurcated from Case No. 16-2589GC it was named the "St. Elizabeth Healthcare ***CY 2014*** DSH SSI Fraction Part C Days Group." We note that it would have been more accurate to name the bifurcated group the "St. Elizabeth Healthcare Post 10/1/2013 DSH SSI Fraction Part C Days CIRP Group." Therefore, the group name for Case No. 19-2547GC will be updated to reflect this change.

SSI Fraction Part C Days CIRP Group." Following the transfer, close Case No. 19-2547GC.

Therefore, the Parties have ***fifteen (15) days from this letter's signature date*** to comment on the Board's intended actions. *Be advised that* ***this filing deadline is firm*** *and that the Board has determined to specifically* ***exempt*** *it from Board Alert 19's suspension of Board filing deadlines. As a result, failure of either Party to respond by the above filing deadline will result in the Board ruling on its intended actions without the benefit of that Party's input.*

Board Members Participating:

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

For the Board:

4/28/2021

X Clayton J. Nix

Clayton J. Nix. Esq.
Chair
Signed by: Clayton J. Nix -A

cc: Wilson C. Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: **Jurisdictional Decision in Whole**
Seton Medical Center - Harker Heights (Prov. No. 67-0080)
FYE 9/30/2016
Case No. 16-0772

Dear Mr. Hettich and Mr. Lattimore,

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above-referenced appeal for jurisdiction on its own motion. The Board's decision is set forth below.

Background:

The Provider filed their appeal request on January 27, 2016, challenging the Final Rule in the Federal Register issued on August 17, 2015.[1] The Provider's appeal focuses on whether its DSH payment contained a calculation error related to the third factor ("Factor 3") used to determine the payment for its proportion of uncompensated care. Specifically, the Provider has framed two issues as follows:

> *Issue 1:* Whether CMS's failure to use a full 12-month cost reporting period to determine the number of the Provider's Medicaid eligible days in calculating factor 3 of the Provider's uncompensated care ("UCC") payment was lawful?
>
> *Issue 2:* Whether CMS erred and acted beyond its authority, i.e., *ultra vires*, by failing to effectuate the D.C. circuit's *Allina* decision when it calculated factor 3 in the Provider's UCC payment.[2]

For Issue 1, the Provider points out that CMS credited the Provider with a full 12-month period in FY 2014.[3] Rather than using Provider's full 12-month period that began in 2014, CMS instead

[1] Individual Appeal Request, (Jan. 27, 2016); 80 Fed. Reg. 49326 (Aug. 17, 2015).
[2] Individual Appeal Request, Tab 3 at 1-3.
[3] *Id.* at 1.

used the Provider's Medicaid days from a 10 month cost reporting period ("stub-period"), which "comes *before* the full year that CMS previously gave the Provider credit for in FY 2014."[4]

Provider claims that CMS is statutorily required to calculate the UCC payment for each hospital "for a period selected by the Secretary," and that comparing the days in a stub-period for Provider to a full twelve-month period for other providers employs different "periods" in violation of that statutory requirement.[5] Provider also argues that the use of a stub-period violates the statutory requirement that any "estimate" used by the Secretary be "based on appropriate data." It claims that this practice arbitrarily penalizes certain providers with "stub-periods."[6] Finally, Provider argues that it is not being provided the same protection afforded to Indian Health Service ("IHS") hospitals. It notes that, originally, because cost reports for IHS hospitals are not uploaded to HCRIS, the UCC payments calculated by CMS understated the amount of uncompensated care that IHS hospitals provide. CMS later revised its policy to consider supplemental cost report data in determining Factor 3 to allow the Medicaid days for HIS hospitals to be included.[7]

For Issue 2, Provider discusses *Allina Health Servs. v. Sebelius*, 746 F.3d 1102 (D.C. Cir. 2014) ("*Allina*") with regard to the calculation of Factor 3 of the UCC payment, reiterating the argument that SSI days should exclude Medicare Advantage ("MA") days, and MA dual eligible days should be included as Medicaid days in the FY 2016 Factor 3 calculation. Provider points out CMS' position that it does not believe *Allina* has any bearing on the estimate of Factor 3 for FY 2016 since it had readopted the policy of counting MA says in the SSI ration for FY 2014 and beyond. Provider argues that this policy still relies on SSI and Medicaid data from a period predating this re-adopted policy, and that CMS was obligated to correct those numbers to confirm with the Court's ruling in *Allina.* Provider contends that this approach results in CMS acting beyond its authority by continuing to treat Part C days as "days entitled to benefits under Part A" for periods pre-dating their re-adopted policy.[8]

Relevant Law and Analysis:

A. Bar on Administrative Review

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

[4] *Id.*
[5] *Id.* at 2-3.
[6] *Id.*
[7] *Id.* (citing 78 Fed. Reg. 61191, 61195 (Oct. 3, 2013)).
[8] *Id.* at 2-3. *See also* 79 Fed. Reg. 49853.

(A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).[9]
(B) Any period selected by the Secretary for such purposes.

B. Interpretation of Bar on Administrative Review

1. Tampa General v. Sec'y of HHS

In *Fla. Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Servs.* ("*Tampa General*"), [10] the D.C. Circuit Court upheld the D.C. District Court's decision[11] that there is no judicial or administrative review of uncompensated care DSH payments. In that case, the provider challenged the calculation of the amount it would receive for uncompensated care for fiscal year 2014. The provider claimed that the Secretary used inappropriate data when she selected the hospital cost data updated in March 2013, instead of data updated in August 2013, when calculating its uncompensated care payments. The provider argued that it was not challenging the estimate of its uncompensated care, but rather the underlying data on which the Secretary relied, judicial review of which is not barred.

The D.C. Circuit found that there was specific language in the statute that precluded administrative or judicial review of the provider's claims because in challenging the use of the March 2013 update data, the hospital was seeking review of an "estimate" used by the Secretary to determine the factors used to calculate additional payments. The D.C. Circuit Court went on to hold that, "the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well."[12] The D.C. Circuit also rejected the provider's argument that it could challenge the underlying data, finding that there cannot be judicial review of the underlying data because they are "indispensable" and "integral" to, and "inextricably intertwined" with, the Secretary's estimate of uncompensated care.[13]

The D.C. Circuit went on to address the provider's attempt to reframe its challenge to something other than an estimate of the Secretary. Specifically, it rejected the characterization as a challenge to the "general rules leading to the estimate rather than as a challenge to the estimate itself []" because it was merely an attempt to undo a shielded determination.[14]

2. DCH Regional Med. Ctr. v. Azar

[9] Paragraph (2) is a reference to the three factors that make up the uncompensated care payment: (1) 75 percent of estimated DSH payments that would be paid in absence of § 1395ww(r); (2) 1 minus the percentage of individuals under age 65 who are uninsured in 2013 for the FY 2014 calculation; and (3) the hospital specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital with potential to receive DSH payments, to the amount of uncompensated care for all subsection (d) hospitals that receive payment under 42 U.S.C. § 1395ww(r)(2)(C). 78 Fed. Reg. 50496, 50627, 50631 and 50634.
[10] 830 F.3d 515 (D.C. Cir. 2016).
[11] 89 F. Supp. 3d 121 (D.D.C. 2015).
[12] 830 F.3d 515, 517.
[13] *Id.* at 519.
[14] *Id.* at 521-22.

The D.C. Circuit Court addressed the judicial and administrative bar on review of uncompensated care DSH payments again in *DCH Regional Med. Ctr. v. Azar* ("*DCH v. Azar*").[15] In *DCH v. Azar*, the provider alleged that it was challenging the methodology adopted and employed by the Secretary to calculate Factor 3 of the DSH payment. Indeed, they stated that the bar on review applied only to the estimates themselves, and not the methodology used to make the estimates. The D.C. Circuit disagreed, stating that "a challenge to the methodology for estimating uncompensated care is unavoidably a challenge to the estimates themselves" and that there is "no way to review the Secretary's method of estimation without reviewing the estimate itself."[16] It continued that allowing an attack on the methodology "would eviscerate the statutory bar, for almost any challenge to an estimate could be recast as a challenge to its underlying methodology." Recalling that the D.C. Circuit had held in *Tampa General* that the choice of data used to estimate an uncompensated care DSH payment was not reviewable because the data is "inextricably intertwined" with the estimates themselves, it found the same relationship existed with regard to the methodology used to generate the estimates.[17]

3. Scranton Quincy Hosp. Co. v. Azar

Recently, in *Scranton Quincy Hosp. Co. v. Azar*,[18] the D.C. District Court considered a similar challenge and held that administrative review was precluded. In *Scranton*, the providers were challenging how the Secretary determined the amount of uncompensated care that would be used in calculating Factor 3 for their FY 2015 DSH adjustments.[19] For 2015 payments, the Secretary announced she would calculate DSH payments based on Medicaid and SSI patient days from 2012 cost reports, unless that cost report was unavailable or was for a period less than twelve months. In that scenario, the Secretary would calculate the FY 2015 DSH payments based on either the 2012 or 2011 cost report that was closest to a full twelve month cost report.[20] Since the providers in *Scranton* changed ownership in FY 2012, each had two cost reports that began in 2012: an initial cost report less than twelve months and a subsequent cost report that was a full twelve months.[21] Nevertheless, the Secretary used each hospital's shorter cost reporting period in calculating the Factor 3 values for their FY 2015 DSH payments.[22]

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

[15] 925 F.3d 503 (D.C. Cir. 2019).
[16] *Id.* at 506.
[17] *Id.* at 507.
[18] No. 18-32310 (ABJ) (consolidated 19-cv-1602), 2021 WL 65449 (D.D.C. Jan. 7, 2021) ("*Scranton*").
[19] *Id.* at *3.
[20] *Id.* (quoting 79 Fed. Reg. 49854, 50018 (Aug. 22, 2014)).
[21] *Id.* One provider had a cost report for the six-month period from July 1, 2011 to December 31, 2011 and another for the twelve-month period from July 1, 2012 to June 30, 2013, while the second had a cost report for the nine-month period from October 1, 2011 to June 30, 2012 and another for the twelve-month period from July 1, 2012 to June 30, 2013.
[22] *Id.*

that the complaint was still about the method used and the particular data the Secretary chose to rely upon when estimating the amount of uncompensated care calculated. Just like in *Tampa General* and *DCH v. Azar*, the selection of one cost report for FY 2012 over another was "inextricably intertwined" with the Secretary's estimate in Factor 3 and not subject to administrative review. Similarly, the challenge to the decision to use one cost report over another was also a challenge to a "period selected by the Secretary," which is also barred from review.[23]

Finally, and perhaps most importantly, the D.C. District Court found that any allegations that the Secretary departed from her own policy and/or acted *ultra vires* did not alter its decision. The D.C. District Court found that, in the context of the bar on review of the Secretary's estimates used and periods chosen for calculating the factors in the UCC payment methodology, "saying that the Secretary wrongly departed from his own policies when he chose the data for the estimate or selected the period involved is fundamentally indistinguishable from a claim that he chose the wrong data or selected the wrong period."[24] While there is some case law to support that claims of *ultra vires* acts may be subject to review in narrow circumstances where such review is precluded by statute, the criteria in *Scranton* were not met.[25] For review to be available in these circumstances, the following criteria must satisfied:

> (i) the statutory preclusion of review is implied rather than express; (ii) there is no alternative procedure for review of the statutory claim; and (iii) the agency plainly acts in excess of its delegated powers and contrary to a specific prohibition in the statute that is clear and mandatory.[26]

The D.C. District Court found that the preclusion of review for this issue was express, not implied, which fails to satisfy the first prong of this test. Second, the departure from the period to be used announced in the Secretary's rulemaking does not satisfy the third prong, which requires a violation of a clear statutory command.[27] The D.C. District Court ultimately upheld the Board's decision that it lacked jurisdiction to consider the providers' appeals.

C. Announced Methodology for Factor 3 Calculation

When the Secretary began implementing the Uncompensated Care payments ahead of FY 2014, the Secretary proposed to estimate Factor 3 values based on the most recently available full year cost report data with respect to a federal fiscal year. For FY 2014, the Secretary used data from the 2010/2011 cost reports to estimate Factor 3.[28] For FY 2015, the Secretary maintained this

[23] *Id.* at *9.
[24] *Id.* at *10.
[25] *Id.* (discussing *Leedom v. Kyne*, 358 U.S. 184, 188 (1958)).
[26] *Id.* (quoting *DCH v. Azar*, 925 F.3d at 509-510).
[27] *Id.* at *11 (quoting *DCH v. Azar*, 925 F.3d at 509).
[28] 78 Fed. Reg. 50495, 50638 (Aug. 19, 2013).

approach and estimated the values for Factor 3 calculations based on the 2011/2012 cost reports, using 2012 unless that cost report was unavailable or reflected less than a full 12-month year, in which case the cost report from 2012 or 2011 that was closest to being a full 12-month cost report was used.[29] For FY 2016, the Secretary opted to use more recently updated data from the same 2012 or 2011 cost reports, noting that more recent cost reports may be available, but that these FYs would be more accurate since they had continued to be updated.[30]

Board Decision:

With regard to any argument that the Secretary could have used more accurate or recent data to calculate any portion of Provider's 2016 Uncompensated Care payments, the Board finds that the same findings from *Tampa General* are applicable. The Provider is challenging the inclusion and/or exclusion of certain days and/or data in the estimates used by the Secretary, as well as the use of a stub-period cost report. The Board finds in challenging data included or excluded in calculating its Factor 3 values, the Provider is seeking review of an "estimate" used by the Secretary to determine the factors used to calculate their final payment amounts. The Board finds in essence, the Provider is challenging the underlying data relied on by the Secretary to obtain those final payment amounts. The D.C. Circuit Court in *Tampa General* held the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well. Furthermore, in challenging the Medicare Contractor's use of a stub-period cost report covering one time period, rather than a twelve-month cost report covering a different period, the Provider is challenging the "period selected by the Secretary" used in creating those estimates, which is also barred from review.

Likewise, with regard to the argument that the period used by the MAC was incorrect and in conflict with CMS' stated policy, the Board finds that it does not have jurisdiction to review this. While the Provider is not challenging any "estimate" or "period" which was ***actually*** chosen by the Secretary to calculate its 2016 Uncompensated Care payments, but rather the Medicare Contractor's alleged deviation from CMS' stated policy for making the calculation, the D.C. District Court held in *Scranton* that such a challenge is still barred from review, succinctly stating that any argument "that the Secretary wrongly departed from his own policies when he chose the data for the estimate or selected the period involved is fundamentally indistinguishable from a claim that he chose the wrong data or selected the wrong period."[31]

Based on the above, the Board hereby dismisses both issues from the appeal. The Board notes that its ruling is consistent with the D.C. Circuit's decision in *Tampa General* and *DCH v. Azar* and that these decisions are controlling precedent for the interpretation of 42 U.S.C. § 1395ww(r)(3) because the Providers could bring suit in the D.C. Circuit.[32] Review of this

[29] 79 Fed. Reg. 49853, 50018-50019 (Aug. 22, 2014).
[30] 80 Fed. Reg. 49325, 49528 (Aug. 17, 2015).
[31] *Scranton* at *10.
[32] The CMS Administrator generally has applied as controlling precedent the law of the Circuit in which the Provider is located. *See, e.g., QRS CHW DSH Labor room Days Groups v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (Apr. 13, 2009), affirming, PRRB Dec. No. 2009-D11 (Feb. 27, 2009); *St. Vincent Mercy Med. Ctr. v.*

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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For the Board:

4/30/2021

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Chair
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BlueCross BlueShield Ass'n, Adm'r Dec. (Nov. 17, 2008), *affirming in part and reversing in part*, PRRB Dec. No. 2008-D35 (Sept. 15, 2008). However, in recognizing that providers may file suit with the appropriate District Court either in the Circuit in which they are located or the D.C. Circuit, the Administrator also applies as controlling precedent the law of the D.C. Circuit. *See, e.g., Jordan Hosp. v. Blue Cross Blue Shield Ass'n.*, Adm'r Dec. (Apr. 30, 2007), *vacating*, PRRB Dec. No. 2007-D23 (Feb. 28, 2007).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: **Jurisdictional Decision in Whole**
City Hospital (Prov. No. 51-0008)
FYE 12/31/2013
Case No. 16-1331

Dear Ms. Repine and Ms. Polson,

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above-referenced appeal as part of a jurisdictional challenge filed by the MAC. The Board's decision is set forth below.

Background:

The Board received the Providers Request for Hearing dated March 24, 2016, which included nine (9) issues which all concerned components of the Medicare disproportionate share percentage:

Issue 1: Disproportionate Share Hospital ("DSH") Payment/SSI Percentage (Provider Specific)
Issue 2: DSH Payment/SSI Percentage
Issue 3: DSH – SSI Fraction/Medicare Managed Care Part C Days
Issue 4: DSH Payment – SSI Fraction/Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)
Issue 5: DSH Payment – Medicaid Fraction/Medicare Managed Care Part C Days
Issue 6: DSH Payment – Medicaid Fraction/ Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)
Issue 7: DSH Payment – Medicaid Eligible Days
Issue 8: DSH Payment – Medicare Managed Care Part C Days
Issue 9: DSH Payment – Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)

On November 15, 2016, the Provider withdrew Issue 7 (the DSH Payment – Medicaid Eligible Days issue), and on November 28, 2016, the Provider transferred several issues to group appeals, including the Medicare Part C days issue to Group Case 17-0568GC, QRS WVUHS 2013 DSH Medicaid Fraction Medicare Managed Care Part C Days CIRP Group. On June 14, 2018, the Board issued a letter to Provider dismissing the last issue in the appeal, SSI Provider Specific,

finding that it did not have jurisdiction over the issue. At this point, Case No. 16-1331 was closed as no issues remained pending in the appeal.

On August 12, 2019, in Case No. 17-0568GC, the Board bifurcated the period from 10/1/2013 – 12/31/2013 and established Case No. 19-2376GC for that period (WVU Medicine CY 2013 DSH Medicaid Fraction Medicare Managed Care Part C Days CIRP Group – Post 10/1/2013). The Board granted EJR over the Part C days issue for the 1/1/2013 – 9/30/2013 in Case No. 17-0568GC on August 14, 2019 and that appeal was closed.

However, subsequent to that EJR determination, the MAC requested the Board reconsider its previous bifurcation and EJR decision. Upon reconsideration, the Board determined that it did not have jurisdiction over the other two participants both in that group and, in 19-2376GC, the post 10/1/2013 period.

Accordingly, on August 12, 2020, the Board reinstated this individual appeal, Case No. 16-1331, and transferred the Provider's Part C days issue for the post 10/1/2013 period back to Case No. 16-1331. On August 14, 2020, the Board issued a Critical Due Dates notice for the appeal, requiring the Provider to file a Preliminary Position Paper on the post 10/1/13 Part C days issue *by November 16, 2020*.

On November 13, 2020, the Provider submitted a Supplemental Position Paper, which included two issues:

1. Whether the correct SSI percentage was used in the DSH calculation; and

2. Whether the numerator of the "Medicaid fraction" properly includes all "eligible" Medicaid days, regardless of whether such days were paid days.[1]

On December 21, 2020, the Medicare Contractor filed a jurisdictional challenge with the Board over the Medicare Part C days issue, requesting the Board dismiss the sole issue in the appeal as the Provider failed to brief it in its preliminary position paper.

MAC's Contentions

The MAC argues that the DSH – Medicare Part C days in the Medicaid Fraction issue was not briefed and should be considered abandoned. It asserts that the Provider's Position Paper is devoid of material facts, discussion, or analysis of the issue in dispute and thus has abandoned the post 10/1/2013 Medicaid Fraction Part C Days issue, pursuant to Board Rule 25.[2]

Provider's Response

The Provider did file a response to the MAC's Jurisdictional Challenge.

[1] *See* Exhibits to MAC's Jurisdictional Challenge for a full copy of the Provider's Supplemental Position Paper.
[2] MAC's Jurisdictional Challenge (Dec. 21, 2020).

Board's Analysis and Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1841, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination. The amount in controversy for the Provider's appeal is $149,000.

For each cost issue appealed, providers are required to give a brief summary of the determination being appealed and the basis for dissatisfaction.[3] With respect to position papers, the regulations at 42 C.F.R. § 405.1853(b)(2) state the following:

> Each position paper **must set forth** the relevant facts and arguments regarding the Board's jurisdiction over each remaining matter at issue in the appeal, and **the merits** of the provider's Medicare payment claims **for each remaining issue**.[4]

Board Rule 25 addresses preliminary position papers and guides how they should address each remaining issue in the appeal. In this regard, it states:

> **Rule 25 Preliminary Position Papers**
>
> 25.1 Content of Position Paper Narrative
>
> The text of the position papers must contain the elements addressed in the following subsections.
>
> 25.1.1 Provider's Position Paper
>
> A. Identify any issues that were raised in the appeal but are already resolved (whether by administrative resolution, agreement to reopen, transfer, withdrawal, dismissal, etc.) and require no further documentation to be submitted.
> B. For each issue that has not been fully resolved, state the material facts that support the provider's claim.
> C. Identify the controlling authority (e.g., statutes, regulations, policy, or case law) supporting the provider's position.
> D. Provide a conclusion applying the material facts to the controlling authorities.

[4] 42 C.F.R. § 405.1853(b)(2) (emphasis added).

The regulations at 42 C.F.R. § 405.1853(b)(2), as well as Board Rule 25 make it clear that Preliminary Position Papers must address the merits of each remaining issue in the appeal. The Board finds that the Provider has essentially abandoned the issue by filing a perfunctory position paper that includes broad statements on issues not remaining in the appeal and failed to brief the final remaining issue in the case – the post 10/1/13 Part C days issue. As such, the Board concludes that the Provider has violated Board Rule 25.1.1 and 42 C.F.R. 405.1853(b)(2) because the Provider's position paper did not set forth the relevant facts and arguments regarding the merits of the Provider's claims regarding the post 10/1/13 Part C days issue.

Therefore, the Board dismisses the issue and dismisses Case No. 16-1331 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.

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For the Board:

4/30/2021

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